WHAT IS RECOVERY?: UNDERSTANDING CHEMICAL DEPENDENCY STAKEHOLDER EXPECTATIONS

by

Curtis W. Watson

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STATEMENT OF DISSERTATION APPROVAL

The dissertation of **Curtis W. Watson**

has been approved by the following supervisory committee members:

David Derezotes	, Chair	**July 19, 2016** Date Approved
Joanne Yaffe	, Member	**July 19, 2016** Date Approved
Caren J. Frost	, Member	**July 19, 2016** Date Approved
Joanna Bettmann-Schaefer	, Member	**Sept. 2, 2016** Date Approved
Glenn E. Richardson	, Member	**July 19, 2016** Date Approved

and by **Lawrence Henry Liese** , Chair/Dean of

the Department/College/School of **Social Work**

and by David B. Kieda, Dean of The Graduate School.

ABSTRACT

This study explored the expectations of stakeholders in substance abuse treatment services. These findings may help inform treatment, research, and policy development concerning substance abuse disorders. An exploratory qualitative approach was taken to minimize the effect of the model on outcomes. A cohort of 15 self-declared addicts in recovery were interviewed, using advertising in treatment centers and using a snowball method for additional respondents. Respondents were divided into either short-term or long-term recovery groups, each with different perspectives. The study design included an initial individual interview and follow-up interviews. Individual interviews were semistructured with open-ended questions to allow participants to provide the maximum amount of information. Data were entered into the computer journal, and analyzed reflexively after each interview. Relevant concepts, ideas, themes, and categories were identified and relationships explored. To improve trustworthiness, credibility, and plausibility, data were triangulated to improve accuracy and understanding. Recovery was found to be a process in which individuals empower themselves through development of their own values, self-discovery, self-determination, self-responsibility, and community membership. This recovery process is ongoing and based on preferred values that become habitual to each individual.

I would like to take a moment and dedicate this to the friends I have lost along the way. There are far too many to name without missing someone, so I won't try to name them. Their passing due to the problem of addiction saddens me greatly, even to this day, and their presence in my life is missed. I hope that one day, the understanding of what it takes to recover from these dependencies will be known and the loss of bright and creative individuals will come to an end.

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INTRODUCTION

Problem Statement

Although recovery is the most commonly sought goal in addiction treatment, there is still no clear consensus on how to define this term. Since the 18th century, the term recovery has been used to describe the outcome of addiction treatment (White, 1998).Today, for most stakeholders, recovery has become a buzzword used to describe any possible positive outcome (Betty Ford Institute, 2007; Laudet, 2007). As a result, the word has become less effective in describing treatment outcomes.

Basic social work practice requires a concrete, defined goal as part of any treatment and outcome evaluation. A well-defined, concrete definition for addiction treatment outcomes might enhance practice, improve treatment compliance, and enrich outcomes. Thus, without a long-term outcome definition, treatment success is ultimately uncertain.

Background

Today, there is no clear definition of recovery. A survey conducted by Arndt and Taylor (2007) showed that some of the public define recovery not as the outcome of treatment or abstinence, but simply as the process of quitting addictive substances. Other stakeholders define the term only in the sense of abstinence from the addictive substance (Arndt & Taylor, 2007; Gagne, White, & Anthondy, 2007; Kellogg, 1993).

The general public as well as professionals in the field cannot definitely say what makes up recovery. There have been some efforts at starting a conversation about recovery. One of the groups discussing recovery, the Betty Ford Institute (2007), in a statement on long-term outcomes, stated "a commonly accepted and operationally defined measure of recovery could lead to improved research and understanding in the addiction field" (p. 221). However, often the outcomes used in research and in treatment tend to be short-term in nature. Substance abuse and addiction tend to be long-term problems. However, addiction often affects individuals, families, and communities for years at a time. The use of short-term outcome definitions for anything other than benchmarks of progress makes little sense (National Institute on Drug Abuse [NIDA], 2009). Most treatment outcomes only consider temporal, behavioral, cognitive, and affective components and are typically short-term in nature, usually less than 1 year (Betty Ford Institute, 2007; Fiorentine, 2001). There has been a reluctance among stakeholders to define long-term outcomes of addiction treatment (Gitlow, 2007).

Social workers are partially responsible for this reluctance (Blagen, 2002). Despite the realization that substance misuse has been present in many areas of social work, social workers historically have often been disinclined to treat substance abuse or addiction, instead tending to refer clients to paraprofessionals or other professionals to treat substance misuse (Amodeo & Fassler, 2001; Lightfoot & Orford, 1986).

The reluctance of providers to treat substance misuse and the lack of definition of addiction treatment goals have resulted in a recent movement to describe long-term recovery in concrete, discrete, and measurable ways (Betty Ford Institute, 2007; Blagen, 2002; Laudet, 2007). Most professional stakeholders realize the lack of an outcome

model negatively influences practice, research, and policy development (Arndt & Taylor, 2007; Betty Ford Institute, 2007; Laudet, 2007). Stakeholders have begun asking for an adequately defined, long-term definition of recovery with the expected result of improving assessment, treatment provision, and outcomes (American Psychological Association [APA], 2005; Gagne et al., 2007; Gitlow, 2007).

Purpose of the Study

The purpose of this study is to uncover stakeholder attitudes and expectations regarding long-term addiction treatment outcomes in order to help define treatment goals. Focusing on the feedback of addicts seeking recovery and addicts who are self-declared to be in recovery can aid in the development of a stakeholder-based construct of addiction and recovery. The basic research question guiding the study was, "What is recovery?" The supporting research questions were; "What kinds of behaviors are expected from an individual in long-term recovery?", and "What kinds of thoughts and feelings do individuals in long-term recovery have?" The study design assumes that by defining attitudes, beliefs, and expectations of addicts, researchers can begin to understand how chemically dependent individuals view recovery from addiction, in order to begin to develop a typology of long-term addiction treatment outcome expectations.

This qualitative grounded theory project was developed because there is currently no generally accepted theory to describe long-term recovery (5 years or more). The Social Work Code of Ethics (National Association of Social Workers [NASW], 1996) stated that outcome descriptions should be based on stakeholder needs and empirically-based research (Hepworth, Rooney, Rooney, Strom-Gottfried, & Larsen, 2006; NASW, 1996). Therefore, any outcome theory should include the input from all affected

stakeholders. This research project only focuses on the addicts.

Theoretical Framework

Historically, people in the field of substance abuse treatment have grounded treatment provision by addressing problems in morals, guilt and shame, trauma, diet, disease, and personal failure (Poland, 1997; Saleebey, 1996; White, 1998). Treatment has focused on short-term outcomes (5 years or less); the focus on short-term treatment results has resulted in assumptions about prevention, intervention, and treatment that may not support long-term outcomes. The addiction treatment field could benefit from a consensus definition of the long-term outcome's of treatment.

The lived experience of the substance abusing individual is important to understanding any concept of recovery. Therefore, this research used philosophical hermeneutics (i.e., the idea that a concept is best understood from the perspective, traditions, and beliefs of the person seeking recovery) to ground the research in the experiences of addicts rather than in the expectations of professionals and policy makers. This hermeneutical framework complements social work values of basing theory on where the clients are (Denzin & Lincoln, 2000; Flick, 2002; Patton, 1990; Sherman & Reid, 1994).

Hermeneutics accepts that all verbal or written texts have underlying meaning, and this meaning can be discovered through reflective interpretation and reinterpretation of the texts (Bernard, 2002). Patton (1990) states "Hermeneutics asks, what are the conditions under which a human act took place or a product was produced that makes it possible to interpret its meanings?"(p. 84). This epistemological stance holds that understanding the text must be done in the context of both the observed data and the

observer. Both contexts of data and observer must be not only accepted but illuminated. In short, hermeneutics is the search for meaning and interconnectivity of meaning in context (Bernard, 2002), although this meaning may change during the process of discovery (Schwandt, 2000). Hermeneutics, also, highlights biases in the shifting landscape between both observer and observed (Schwandt, 2000) generating essential data and interpretations, communicating findings (Flick, 2002) to the witness.

Implications for Social Work

Drug and alcohol misuse is common among individuals and families and affects approximately 20%–40% of clients seen by social workers (Googins, 1984). However, social workers have been reluctant to work directly with clients with substance use disorders (Amodeo & Fassler, 2001), preferring to refer them to other professionals or paraprofessionals (Googins, 1984; Suppes & Wells, 1991). Richmond (1917) identified substance abuse treatment as a component of social work. In spite of her recommendations, however, social workers continued to avoid addiction treatment (Suppes & Wells, 1991). This attitude continued among social workers until the 1970s, when legislation was introduced that affected service delivery to alcoholic clients (Suppes & Wells, 1991).

Googins (1984) attributed the institutional bias within social work about directly treating drug and alcohol abuse to this poor policy development and the poor education of social workers. Substance abuse has been a part of the problems social work clients face and social work would be a logical field to develop and provide treatment to these people. As a result, it would make sense that social workers would take a lead in development of assessment, diagnosis, and treatment of substance abuse disorders.

Organization of the Dissertation

Chapter 1 of the dissertation provides an overview of the importance of defining recovery for addiction treatment stakeholders and how this research will support this goal. Chapter 2 describes the current literature regarding treatment outcomes, including the history of addiction treatment practice and implications of developments in the treatment of addiction. Chapter 3 describes the methods of the study and the atheoretical, exploratory, qualitative grounded theory design. Chapter 3 also explains the process of data analysis and synthesis and how the data were gathered into a coherent, objective theory. Finally, Chapter 3 describes the efforts made to minimize researcher subjectivity and increase the level of credibility and trustworthiness of the emerging theory. Next, Chapter 4 reports the results of the data analysis. Chapter 5 concludes the dissertation with a discussion of the findings and interpretation of the results. Chapter 5 also contains a description of the generalizations, implications, and study limitations.

LITERATURE REVIEW

Currently, there is no definition of long-term recovery in the field of addiction treatment. White (2005) theorized, "The concept of recovery as a governing image has had a long birth period and a stormy adolescence but is poised to emerge as the central organizing construct within the addictions fields" (p. 12). Although there have been efforts to create a working definition of long-term recovery, without a consensus on an effective construct that focuses on both the individual and the system, any new model may simply be a recapitulation of old methods without a clear understanding of the desired outcomes.

The current usage of the word recovery is broad and unclear for the public, researchers, and policy makers alike (Betty Ford Institute, 2007; Laudet, 2007). Currently, there are various models and theories of recovery but no consensus or clearly defined model of long-term recovery. This chapter details the review of the literature conducted for this study, demonstrating the need for a concrete definition of recovery that includes long-term, client-centered goals.

Historical Review of Addiction Practice in the United States

The treatment and support of alcoholics and addicts has been a social work concern since the beginning of the profession (Holleran-Steiker & MacMaster, 2008; Richmond, 1917). Many 19th- and early 20th-century religious, community, and political

leaders made comments concerning the effect of addiction on individuals and their communities (White, 1998). The temperance movement most clearly recognized the problem of addiction and successfully instigated a U.S. constitutional amendment restricting alcohol use (White, 1998).

Starting in 1929, the U.S. Public Health Services (PHS) began researching issues related to drug abuse. In 1930, the PHS founded the Narcotics Division within the Division of Mental Hygiene (DMH). For the first time, under the DMH, mental health organizations, including research and treatment programs, brought together researchers and practitioners to deal with drug addiction and study the causes, prevalence, and means of preventing and treating addiction and mental illness. The field of addiction treatment was further influenced by World War II. The impact of various combat stresses on returning soldiers during and immediately following World War II caused the U.S. government to acknowledge the shortage of professional mental health personnel. The government also found that the causes, treatment, and prevention of "mental illness significantly lagged behind other fields of medical science and public health"(National Institute of Health [NIH], 1998, p. 2). As a result, there was a call for action to remedy these problems.

In 1946, proponents for more proactive mental health programs sent a proposal for a national mental health program to the surgeon general. This proposal formed the basis for the National Mental Health Act of 1946. On July 3, 1946, President Harry S. Truman signed the National Mental Health Act into law. In 1947, the U.S. government founded the National Institute of Mental Health (NIMH). Mental health treatment became a focus of the newly created NIMH as it became obvious that being involved in war

seriously affected soldiers (Scull, 2011).

The NIMH based its work on the American Psychiatric Association's disease model of mental health, which included substance abuse and other aspects of mental health (NIH, 1998).The NIMH focused its efforts on supporting medically trained professionals (Scull, 2011). Medically trained professionals had a scientific focus that encouraged research and practice (Leshner, 2010). This scientific focus was based on an inductive method that integrated laboratory and field observation into theory rather than inductively moving from theory to guide observation (Weiderhold, 2010). As this research began, the focus was on returning soldiers using medically trained professionals. focused on symptom reduction (Scull, 2011; Seligman, 2005) rather than one focused on long-term outcomes (Eghigian, 2011).

Recognition of this focus is critical to understanding the failure of the addiction treatment community to develop long-term outcome measures. Although the medical treatment of addiction as a disease has been critical in improving the lives of individuals, the assumptions behind the treatment provided limited research and treatment methods (Eghigian, 2011). Thus, as the mental health industry grew and split into smaller co-industries (Fussinger, 2011; Henckes, 2011), these co-industries focused in their development of service models centered on specific areas of concern (e.g., mental illness, disability, hospice, and addiction)(Seligman, 2005).

Funders and mental health professionals also encouraged these co-industries to develop new treatment and asked providers to demonstrate effectiveness in their area to compete successfully for funds (Moos, 2003; Rosenheck & Seibyl, 2005). Thus, practitioners, constrained by funding needs, usually presented short-term results in order

to qualify for resources (Blagen, 2002; Vaillant, 2003; Thoombs & Osborn, 2001). This focus on the short-term results, though, has led to poor long-term treatment outcomes during the 20th century (Vaillant, 2003; Wolf & Colyer, 1999) as well as no clear definitions of long-term success (Betty Ford Institute, 2007).

Social Work and Addiction Practice

Social work emerged as a practice in the context of the Progressive Era. Since that time, social workers believed that through science and technology, they could shape and improve society.

Initially, social workers provided services for families in the context of larger social problems (Leighninger, 2008). Gradually, social workers shifted their focus from larger social issues toward micro and mezzo practice (Leighninger, 2008). This early trend entrenched social work in what Richmond called "social diagnosis" (Blundo, 2006; Davis, 2008; Richmond, 1917; Woodside & McClam, 2009).

Abuse of chemicals was a part of life in these families early social workers saw. Mary Richmond (1917) was among the first social workers to note and teach addiction as a disease and to develop assessment tools for substance-abusing clients. Since that time, various stakeholders have continued to draft and measure key constructs concerning addiction, examining salient theoretical issues (Berrios, 2011; Betty Ford Institue, 2007; Blagen, 2002). Since that time, substantial progress in understanding the ebb and flow of addictive disorders has been made (Miller & Carroll, 2006). However, there is even more confusion than in the 20th century due to a continually changing clinical perspectives and social context (Moos, 2003). As a result, today, there is conflict between stakeholders as to how treatment and treatment outcomes should be described (Betty Ford Institute,

2007).

In addition, despite the recognition of substance misuse as a problem (Richmond, 1917; Suppes & Wells, 1991), some social workers seemed to be ambivalent toward addiction treatment and tended to avoid the assessment or treatment of addiction. Some social workers have minimized the impact of addiction on clients, failed to maintain good records of addiction treatment, and/or passed substance-abusing clients on to other agencies or paraprofessionals (Amodeo & Fassler, 2001; Lightfoot & Orford, 1986). Googins (1984) attributed these trends to poor policy development and limited staff knowledge about addicted clients. As a result, some of the barriers to treatment provision for addicts persist today, even within the addiction treatment industry (Amodeo & Fassler, 2001; Lightfoot & Orford, 1986).

Outcome Models

The current working definitions of recovery in the field of mental health services include indications that individual choice, personal health, community, and personal growth are important. The Substance Abuse and Mental Health Services Administration (SAMHSA) (2011) released the following working definition of recovery for mental health and substance use disorders, “a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.” (p. 1) In addition, SAMHSA outlined four supporting dimensions of recovery: (a) personal health and healthy living, (b) a stable and safe place to live, (c) a meaningful and purposeful life, and (d) participating in a supportive community (2011).

In 2007, Betty Ford Institute Consensus Panel released its own working definition of recovery, "a voluntarily maintained lifestyle characterized by sobriety, personal health

and citizenship" (p. 221). However, like SAMHSA's working definition, this definition is different than the current model of addiction treatment because of the focus on short-term outcomes rather than long-term.

Focus on short-term outcomes and symptom reduction is still inadequate in terms of addressing long-term needs providing treating addiction and dependency-related disorders (Betty Ford Institute, 2007; SAMHSA, 2011). Unqualified acceptance of this short-term focus distorted clinical theory development (Albee, 2000). Symptom reduction as the only goal fails to address the entire problem of addiction.

Social work embraces a model combining systems theory, the strengths perspective, and social diagnosis. Social work practitioners provide treatment to individuals within their own environment and highlight their capacities and strengths (Hepworth et al., 2010) understanding the needs of people within the individual's self and his or her environment. In terms of addiction, only the addict and his or her family have lived the experience of the individual's addiction. It is from these stakeholders that what it recovery means and how to define it can be best understood (Arndt & Taylor, 2007).

Given this, input from these stakeholders might provide the foundation for an understanding of long-term outcomes. By building on the various factors associated with the addict's experience, treatment providers might begin to address environmental inequities and power disparities (Wright & Lopez, 2005), remake outcome models, and scrutinize client labels such as race, gender, age, intellectual level, physical condition, and status.

White (2007) states that a long-term outcome model must meet four challenges. First, the outcome model must describe the lived experience of families and individuals.

These stakeholders should see the model as representative of their lives and expectations. Second, other stakeholders must recognize the model as descriptive of desirable treatment goals and based on objective standards. The third challenge is to ensure the outcome is measurable, so that objective observers can reliably assess the individual's treatment program. Finally, the model must be easily identifiable as a logical set of goals.

Addiction Treatment Review

A brief literature search was conducted to gather information about addiction treatment studies. This search was not intended to be a comprehensive description of the literature but a manageable, descriptive sample of time frames. This search was intended to keep the data brief, small, and manageable. The variables looked at were timeframes and outcome measures used by researchers. The date was arbitrarily chosen for ease of data handling and gave about 18 years of research, which seemed sufficient to see a variety of variables. In this small search of articles, no long-term time frames (5 years or more) were used and no consistent definition of recovery from addiction.

Treatment Implications and Concerns

One issue with the lack of a long-term outcome definition is that the short-term definitions accepted by service providers determine funding, treatment guidelines, and research agendas for addiction (Eghigian, 2011; Scull, 2011). Miller and Carroll (2006) stated that power, authority, and funding shape who can provide treatment and how treatment is provided. For example, Miller and Carroll (2006) noted that certain preferred treatments continue despite evidence that some prevention and treatment programs have shown no significant effect and some are identified as harmful. These short-term

outcomes, though, may be inadequate or even dangerous for determining best practice (Betty Ford Institute, 2007; Miller, 2006; SAMHSA, 2011; White, 2004, 2005, 2007). In addition, even within the treatment community, it is often the case that "what works is held to be obvious" (Latessa, Cullen, & Gendreau, 2002, p. 43), and practitioners do not always rely on supportable evidence. As a result, what is used is often based on 'what worked' for someone rather than the long-term best interest of the individual.

Furthermore, because of power and authority in the field, there are social pressures to continue some services and avoid challenging beliefs despite what the research indicates (Fussinger, 2011; Morrell, 1996). Miller and Carroll (2006) maintained that a disparity persists between practice and research and that outcome definitions are different in nearly every study and program (Betty Ford Institute, 2007; Kurland, Kurland, & Malekoff, 2003; Laudet, 2007).

To address these pressures within the field, practitioners must begin to challenge, question, test, and change basic assumptions of the current addiction treatment models to both reduce symptoms of addiction and improve the long-term well-being of stakeholders (Morrell, 1996). Treatment frameworks focused on dynamics such as well-being, efficient and meaningful living, and rational choices are significantly better motivators than a some of the focuses used today in the field (Rose & Chang, 2010; Seligman, 2005).

Another issue with the current treatment model is that those in power, due to the implicit authority of the established order, decide what treatment frameworks are followed without granting a voice or a choice of possible treatment methods to the addicted individual (Taylor, 2005). Practitioners place addicts in the position of receiving

medical treatment rather than being in charge or having an equal authority in shaping their own treatment. Many question whether it is feasible or even practical for addicts to determine which treatment options are viable. However, social work values and ethical standards are clear about the primacy of self-determination, personal dignity, self-worth, informed consent, and social justice (NASW, 1996). These standards necessitate involving clients in the determination of their treatments and the delineation of their goals.

As a result of these problems within the treatment provision field, a growing number of researchers in the field are discussing how to construct recovery as a governing pattern for treatment and outcomes (Betty Ford Institute, 2007; Laudet, 2007; SAMHSA, 2011; White, 2000a, 2000b, 2005, 2007). However, reconstruction of the concept of recovery may significantly change the process of selecting and training service providers and making funding decisions (Roe, Rudnick, & Gill, 2007; Thoombs & Osborn, 2001;White, 2004,2007).

Conclusion

Addiction treatment stakeholders have called for a concise, logical, concrete, and measurable outcome construct as the central point of addiction treatment (White, 2007). There is significant evidence that the lack of a concrete construct defining long-term addiction treatment outcomes is a problem that affects significant portions of society (Betty Ford Institute, 2007; Laudet, 2007; White, 2005). This study, focused on the attitudes and expectations of addicts regarding recovery, may help to redefine long-term addiction recovery.

Developing a new governing long-term recovery definition may provide a clear

vision of how to engage in the social work provision of services for addiction. Social work values of social justice and respect for the dignity and worth of the clients mean an ethical commitment to giving clients a choice. If social workers fail to develop addiction treatment models emphasizing social work values of personal autonomy, choice, individual capacity, and ecological approaches, they may continue to see clients as passive disempowered recipients of expert care, more about how "people should live their lives and about what makes life worth living" (Maddux, 2005, p. 16) rather than empowering individuals' initiative and choice.

METHODS

Chapter Overview

In this chapter, first, the purpose of the study is discussed and the research questions are outlined. The second section describes the strengths and limitations of the research. The third section describes the theoretical framework. The fourth section describes the research design. The final section of Chapter 3 describes the data analysis.

Rationale for Qualitative Study

Since the concept of Recovery remains controversial and is still being explored by researchers and constructed by theoreticians, an exploratory methodology is required to explore and explain the topic complexity and context. Qualitative studies are suited for exploration and explanation of complex problems in a broad context, especially when measurements may not fit the problem well (Sauro, 2015). This examination should be done in a way to be inclusive as to ideas, patterns, and themes as to what makes up recovery as well as attempt to explain the process in a way that it can be constructed and explained to the individuals both at a consumer level as well as at a provider, researcher, and policy maker level. Qualitative research best fits these requirements. Until there are criterions that can be adequately defined as well as measured, qualitative discussions of the ideas that stakeholders consider important and relevant would be the important place to begin the search (Sauro, 2015).

Research Purpose and Questions

The purpose of this qualitative study was to look at the expectations of addicts regarding long-term treatment outcomes. It was expected that clarified expectations would facilitate development of a clear model of treatment outcomes consistent with the needs and wants of stakeholders and framed within social work values. The study was exploratory in nature and took an atheoretical approach. The study did not relying on a priori theory but used a grounded theory approach. Prior to beginning research, Institutional Review Board (IRB) approval was sought by the researcher and approval was given as well as an extension of approval by the IRB (see Appendix C). The basic research question guiding the study was, "What is recovery?" The supporting research questions were, "What kind of behaviors are expected from an individual in long-term recovery?" and "What kind of thoughts and feelings do individuals in long-term recovery have?"

Theoretical Framework

Grounded theory is focused on the generation of theories. Straus and Corbin (1998) explained that new, significant, and useful insights and understanding are at the core of grounded theory. Grounded theory techniques are designed to be used flexibly and creatively. These techniques are a set of devices used to approach research, enhancing confidence and creativity. However, grounded theory research has no clear-cut stages, as data collection and analysis overlap.

Grounded theory was used as the underlying theoretical paradigm for this research concerning development of a model for addiction and recovery. Denzin and Lincoln (2000) described a theoretical paradigm as a guiding set of beliefs and feelings

used to interpret, understand, and study phenomena. Using the grounded theory paradigm provided guidelines for working with these collected data in order to build an explanatory theory (Charmaz, 2000). Sherman (1994) stated that using grounded theory contextualizes the data within the experience of the participants, giving preference to the data in context rather than to a priori theory (Flick, 2002).

Grounded theory was a logical choice for this study as it supports the development of a theory from the data. In grounded theory, the analyst collects, codes, and analyzes the data. Early analysis is used to select the next place to find data and to develop the theory as it emerges from the data (Pandit, 1996). According to grounded theory, the researcher inductively develops new theory from the raw data gathered. The data, analysis, and theory stand in a reciprocal relationship, and allowed theory emerge from the data rather than having theory drive the data collection (Glaser & Strauss, 1967). All research has some element of subjectivity, but in order to reduce bias, the data were collected in a rigorous manner (Glaser & Strauss, 1967).

In grounded theory research, the literature and analysis should not interweave until the final stage of data analysis. Strauss and Corbin (1998) argued that it is important to take appropriate measures to minimize the subjectivity of the analyses. These theorists recognized the improbability of the researcher being a blank slate and that all research has elements of subjectivity. As a result, the authors stressed taking measures to minimize subjectivity in analyses. One way to do this is to begin not with organizing assumptions but by using method to draw theory out of the data collected. Instead of beginning with a theory and then proving it, the researcher begins with a question, gathers data about the question, and proposes a theory (Pandit, 1996). The researcher also

compares the data collected to data previously gathered and looks for areas of comparison, developing categories, concepts, and constructs from the data. Instead of using theory as a box within which to look for the answers, the researcher uses the data analysis to select the next source of data. The data serve merely as a map of the phenomena, representing the themes, concepts, categories, or propositions arising from the phenomena (Pandit, 1996).

Grounded theory relies on a hermeneutical approach to the data. In the hermeneutic approach to research, researchers do not try to corroborate or falsify previous theory; rather, they attempt to give voice to stakeholders' views of an outcome. The research questions are the starting point of the hermeneutic circle, an iterative, six-step process of adjusting questions, checking and updating the design, gathering data (for example, from the literature or interviews), interpreting data, reflexive journaling, and adjusting the sample (Brand, 2003).

Constant comparisons and contrasts of the data are used to gauge the development of theory. To track these comparisons and contrasts, researchers must maintain and regularly update a reflexive journal during the study to record the hermeneutic progression, data collection, and interpretation. For this study, the researcher kept a reflexive journal on a dedicated, password-protected hard drive in order to ensure confidentiality and portability. The hard drive contained audio, video, and written data. Entries were made in the journal each day and after each interview to reflexively record thoughts, reactions, and feelings. Reflexive journaling was also used to clarify any influences and inherent prejudices in order to make the research process more transparent.

On an almost daily basis, the researcher spent time reviewing interviews and comparing the new information to the previously gathered data. Connections and contradictions in the data were looked for by the researcher. Data were deconstructed in terms of the time, place, and mood of the respondent as well as the researcher. Component parts of the data were dissembled, and then reassembled in different ways in the journal. The journal was used to attempt understanding of what was being said by the respondents.

In the journal, maps of the data were created to connect one piece of data to others. Connections were tried and challenged by connecting other pieces of data. Often these connections and challenges questioned personal beliefs and understanding of recovery. The researcher found that the data confronted personal bias and professional values as the data analysis continued.

Sample

The sample consisted of 15 addicts who self-declared themselves as seeking recovery and/or in recovery. It was expected that these two groups of stakeholders would provide different perspectives on long-term recovery. The researcher placed advertisements in local treatment programs. The first 3 participants made contact with the researcher after seeing one of the advertisements left at three local addiction treatment centers and one counseling center. Each of the 3 contacts were then interviewed and after their interview, each of the first participants was invited to give names to contact who might be interested in being interviewed (Sherman & Reid, 1994). Originally, there were 16 total respondents to the advertisements but 1 of the respondents did not meet the participation standards and so was excluded. However, the respondent did provide names

of individuals who might be interested in participating. Each of the individuals recommended by the respondents were approached about participating. All the suggested interviewees were willing to participate.

Consent was secured from each participant prior to participation in this study. After the interviews were completed, a follow-up contact was done with participants to review findings with them. During the follow-up interviews, the theory concepts were presented for participants to consider and to voice concerns and support.

As the research progressed, ages and gender were explored. The respondent's ages break down was 3 respondents were in their 20s, 6 were in their 30s, 5 were in their 40s and 1 was in his/her 60s. In this sample, 7 respondents were female and 8 respondents were male. Two of the 15 reported they were homosexual. The other 13 respondents reported heterosexual relationships. 12 of the 15 were in committed relationships. Two of the project respondents were homosexual partners at the time of interview, and 2 project respondents were heterosexual partners. Twelve of the 15 respondents were parents. Three respondents were divorced and single. All 15 respondents claimed to be in recovery although 3 of the 15 were still using. The respondent sample was developed using a theoretical snowball method in order to develop a broad understanding of the topic. The individuals interviewed were of multiple ages, backgrounds, and relationship statuses. The sample was not representative of any group.

Three respondents reported using drugs or alcohol at times but not consistently. Four of the 15 were working in the substance abuse field. Eight respondents had less than 5 years of recovery and 7 respondents had claimed more than 5 years of recovery. Nine

of the 15 respondents were born in Utah, while the 6 were born in other states. Thirteen were Caucasian and 2 were Hispanic. Each respondent was assigned to a group labeled Short-Term Recovery (STR), Long-Term Recovery: Using (LTRU), or Long-Term Recovery: Abstinent (LTRA) based on their interview content to describe their level of recovery. These demographics are presented as Table 1.

Sampling continued until saturation of the topic was reached. Strauss and Corbin (1998) state "a category is considered saturated when no new information seems to emerge during coding, that is, when no new properties, dimensions, conditions, actions/interactions, or consequences are seen in the data" (p. 136).

Design

The study design included individual interviews and follow-up interviews. The individual interviews were semistructured in order to reduce questioner bias. However, the questions were left open-ended to allow participants to provide the maximum amount of information. In the second part of the study, a follow-up interview was conducted with each participant to ensure complete saturation of the data.

The interviews each lasted between 20 and 60 min. Each interview consisted of a single introductory question, which was a variation on the question, "In your opinion, what is recovery? "The follow-up questions expanded the data provided by participants. Probing questions were used to obtain precise descriptions, structuring questions were used to keep the interview on track, and interpreting questions were used to ensure understanding (Kvale, 1996). A full list of the semi-structured interview questions may be found in Appendix B.

Table 1

Sample Demographics

Gender	Age	Respondent Label	Time in recovery
Male	25	STR	Less than 5years
Female	26	STR	Less than 5years
Female	28	STR	Less than 5years
Male	34	LTRA	5 years +
Female	35	LTRA	5 years +
Female	35	STR	Less than 5years
Female	36	LTRA	5 years +
Male	36	STR	Less than 5years
Male	38	STR	Less than 5years
Male	39	LTRA	5 years +
Female	40	LTRA	5 years +
Male	41	LTRU	5 years +
Female	43	LTRU	5 years +
Male	45	LTRA	5 years +
Male	62	LTRU	5 years +

Respondents were also asked to consider during the interview three working definitions of recovery and respond to the parts as well as the whole of each: 1. “A voluntarily maintained lifestyle characterized by sobriety, personal health and citizenship” (Betty Ford Institute, 2007, p. 221).

2. “A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential” (SAMHSA, 2014).

3. “Recovery is the experience (a process and a sustained status) through which individuals, families, and communities impacted by severe alcohol and other drug (AOD) problems utilize internal and external resources to voluntarily resolve these problems, heal the wounds inflicted by AOD-related problems, actively manage their continued

vulnerability to such problems, and develop a healthy, productive, and meaningful life" (White, 2007).

These three statements defining recovery should be considered Substantive Grounded Theory (SGT) rather than Formal Grounded Theory (FGT). Stake (1983) called these types of SGT naturalistic generalizations rather than FGT, coming from the experience of individuals steeped in the field and coming from implicit understanding of the definition of things as they are known. FGT is theory that can be based on SGT core categories and implications as well as using other SGT data and studies in the same and other substantive areas of inquiry (Glaser, 2011). This research is a conceptual extension of the discussion about recovery, including these statements as part of the back and forth interplay between the data gathered from this research and the discussion about recovery that is ongoing (Glaser, 2011).

As such, and as part of the research, each of the respondents reviewed and commented on each of the definitions. All respondents identified the components that were important to their sense of a recovery and the pieces of each definition that were out of place in their opinion. These reflections on definitions were included in the respondent data that were then to be analyzed.

Data Analysis

A digital audio recorder was used to corroborate the data collected. After data were collected, personal responses and views, as well as descriptions of each interview, were entered into the computer journal. Analyzing the data reflexively allowed the researcher to interpret and analyze before continuing onto the next interview. Through this process, relevant concepts and ideas were determined as well as relationships

between these ideas and concepts. Themes and then categories were extracted from participants' responses and through ongoing analysis of the data, patterns emerged.

To corroborate the data, the researcher triangulated the data using several methods, including audio and visual records, field notes, and reflexive journaling. To improve the trustworthiness, credibility, and plausibility of the data, different forms of data were triangulated in order to ensure accuracy as well as to understand responses. The respondents were asked to verify data as well in order to improve the credibility gathered through the individual semistructured interviews (Flick, 2002; Janesick, 2000).

Open coding was used to identify concepts collected from the interviews and analysis. Open coding includes initial categorization of the data and documentation of the concepts supporting categorization, as well as the properties and dimensions found within the data (Straus & Corbin,1998). Axial coding was used to relate categories and concepts back and forth to each other in terms of their properties and dimensions (Sherman & Reid, 1994) and to describe answers to when, whom, what, how, and descriptions (Straus & Corbin, 1998). Selective coding was used to refine and define the concepts into more abstract constructions (Flick, 2002) and provide insight into what various stakeholders consider the important aspects of recovery outcomes.

RESEARCH FINDINGS

This research project was designed to investigate recovering addicts' definitions of long-term recovery in order to understand the recovery process and to begin to develop an objective definition of the process.

Themes and Patterns

As the interviews of this limited sample proceeded, no variation in responses emerged based on gender, age, sexual orientation, parental status, or relationship status. These results do not mean there are not differences between these demographics; rather, the results are representative only of this sample.

Early in the analysis process, participants were divided into three groups: those who were actively using and not claiming to be in recovery, those claiming fewer than 5 years of recovery (STR), and those claiming 5 years or more of recovery (LTR). The group of actively using (AA) and not claiming to be in recovery seemed to be outside the scope of the questions being asked and as such, these responses were not included as part of the analysis. As the interviews progressed, a fourth group emerged from the 16 participants: those who were using abusable chemicals but not the chemical to which each was addicted. This second form of LTR was labeled Long-Term Recovery–Using (LTRU). The other LTR group was labeled Long-Term Recovery–Abstinent (LTRA). The LTRU and LTRA groups provided an interesting comparison within the LTR group.

Coding

The respondents' responses were then separated and each response was reflected on. These responses were synthesized into codes. The coding and participants' responses were analyzed and further synthesized into six themes to aid understanding: addiction, control, practices, principles, relationships, and identity.

The theme of Addiction related to respondents' descriptions about their use of drugs or alcohol. During addiction, often respondents spoke of failing on their most mundane jobs or responsibilities. One respondent (M#9) said:

> After you know drinking became this self-medication thing, I needed it to function and so for like 6 months really it became my top priority. And looking back that is super painful to think that you know my kids, I went through all the motions, I went to all the stuff but you know really making sure I had some wine on hand for the evening was really part of the day. Like I had to figure out how I was going to make that happen even on a busy day when I should have been focusing maybe on something else and it affected my performance at work and it affected my ability to be really attentive to my kids in a way that I should have been. And it caused me a lot of, a lot of damage, you know they always talk about like the wreckage of your past, you know I didn't pay bills I should have paid on time. I basically lost my job, I mean I was six-figure salary, twenty people team, creating million dollar products, traveling all over, writing speeches for CEOs, and I started to not be as good at that as I had been you know because I just wasn't focused on it anymore and it became clearer at work at a certain point. You know when I had, I think the critical moment was I had to write a speech for the Chief Scientific … I worked for and he was going to be giving this speech in, I think Hong Kong and you know usually I would be there with him to kind of go over it beforehand and stuff. In the past I had been very thorough and the PowerPoint I sent him was clearly just lazy you know. I think that was sort of the point, people had noticed some things and people, rumors had started oh did you hear (M#9) got a DUI? And then you team starts to sort of gossip and disrespect you and anyway so to a certain point the Human Resources department came in and said, hey, would you like to take a really big severance and take a break.

It was clear from the responses categorized as disempowered and themed as addiction that feeling disempowered during addiction was common. Another respondent (M#1) said:

> Being addicted to something makes you feel powerless. It makes you feel like it is dragging your every decision, your every moment, your every move, your every thought, your --everything about you is controlled by this substance and by this want for it, this need, you know, that comes with it.

The theme of Control related to what respondents had to say about their attempts to control their addictions. Respondent M#7 stated:

> Because it's hard. It's a struggle. You're always battling against yourself really I mean in your mind to get passed the urges and the -- the impulses is the hard part, but if you -- you can do it if you have a good structure, if you have good people around you.

During the early process of recovery, the respondents reported putting a considerable effort into controlling what they were doing.

Another respondent (M#3) stated:

> I had made up in my head that I could do this on my own, that I could keep controlling the things that I needed to -- my job, my relationships, my family, money -- all those different things that I could control them myself, and then, ultimately, that would allow me to control the drug and control how much I used or whatever it was, and that wasn't the case.

The themes of Practices and Principles concerned how respondents described their efforts to control addiction or develop and maintain recovery. Principles were general rules used by the person. For example, M#8 stated, “Life is self-directed life -- live a self-directed life and strive to reach their full potential. Everybody wants to reach their full potential even if they're not in recovery or not -- you just want to try to be at your best I feel like.” The idea of living a self-directed life was important. Another respondent (M#4) talked about the principle of honesty this way: “But for me, it's basically coming to terms with it, facing it, being honest, you know, getting honest with myself and everyone around me.”

Practices were behaviors the respondent engaged in as part of their process of

recovery, but not even specific practices. One respondent (M#9) stated, “When I practiced that, it was really powerful for me because it impacted things as small as like just being kinder to the person at the drive through who misunderstands your order or asks you things three times.” Another spoke of holding boundaries (M#6): “You know, there's times that he has asked me what step am I on or how long I've worked it -- how long it's been since I've worked on it, and I told him that's none of his business…That's between me and my sponsor.”

However, based on this sample and their responses, no causal relationship between principles and practices is claimed or indicated. It is obvious from some of the responses that there is a sometimes a connection between practices and principles, but further research must be done to identify what relationship between principles and practices exists.

The Relationship theme related to how respondents described the interactional aspects of recovery: how the respondents acted, engaged within their family, friends, and community. One respondent (M#15) reported:

> Right. Like whenever I was coming back out of it and stuff, you know, I wanted to reach back out to my family and reconnect and stuff and they were compassionate about it and stuff. They recognized it and stuff, you know, and, okay, you know, you're cleaned up and, you know, you're rebuilding your life. And so now we can be part of your life again.

Another (M#6) spoke of the relationship with children:

> I've bettered the relationship with my daughter. I was in and out of her life for 8 years during the course of my disease, you know, of my active addiction. And I have a stable relationship -- trustworthy relationship ... My child is the most important person to me in the world.

The Identity theme was respondent statements related to their developing and maintaining personal attributes. This theme had to do with how the respondents saw

themselves. M#6 stated, “It’s given me back a life that I had before I started using. And I have found out who I really am without that chemical substance in my body.” M#7 said:

> I want to be me. [Laughs] I want to be way more than that; a good mother. I want to work with horses. I love nature. I want to help people and I just want to live my life. I'm pretty simple. I don't want anything extravagant.

As the person continued in recovery, the respondent internalized recovery into a larger personal identity. These 6 themes became the foundation of categories.

Categories

In order to further develop the emerging theory, themes were further reflectively compared to codes. The data indicated the respondents progressed through a three-part process into LTR.

The first category of the process was Disempowerment and seemed to indicate that during the time of addiction, there came a time the respondent realized addiction was affecting their lives more profoundly than intended or wanted. As a result, the respondent recognized the need for change. One respondent (M#5) described her disempowerment as:

> Well, and I say that because when I was using, I was so far gone with using that I didn't have a choice. I had to use to function. I had to use to get my feet out of bed and onto the floor. Before I even got out of bed, I was getting loaded because I couldn't function. So I didn't have that choice. That's the way it felt, is I didn't have that choice.

But not being able to function without chemicals was not the whole story; it was also trauma and crisis that caused this sense of disempowerment. M#5 went on to say:

> I have been able to work through those events and how it affected me and how I felt. I mean, kind of like counseling, but doing 12 steps and working these steps, you work through events that have happened in your life, like being raped or my sister dying. Being abused when I was a kid. Being a child that was seen and not heard when I was a kid. Those were events that I never dealt with growing up, so

> when I got into recovery and I started working my steps, I seen the patterns in my life where this happened and I got loaded, and this happened and I got loaded, and it progressed. And then I seen how I went from alcohol to marijuana to pills to meth, and it was -- oh, I'm not doing that, so I'm good, but I was covering up, substituting one for another.

This need for change started efforts to both control the addiction and the consequences of the addiction. It was characterized by themes of addiction and control.

The second category is called Value Development and is a combination of practices and principles and is the intentional development of a set of behavioral and cognitive rules. Value Development was the time in STR that the individual tried out different principles and practices as the basis for recovery (Prilleltensky, 1996). In the cases of the respondents in this survey, these values were consciously practiced within the person's life. The rehearsal of chosen values was critical to this part of the individual's recovery. One respondent (M#6) stated, "And through my journey of recovery and working the steps and associating myself with other people in recovery, I've learned how to set those boundaries. And they're healthy boundaries." Another respondent (M#9) stated, "A real self-awareness and an awareness to the point that you make decisions based on that awareness, and that you don't fool yourself into you know thinking that you don't have these character defects or that you've overcome these character defects." These values begin to be practiced during STR until they become habitual, when the respondents became LTR. Further research must be completed to identify similarities and differences of principles and practices.

LTR was the demarcation point when the respondent became emancipated or free from addiction. Emancipation does not argue whether the individual remains addicted or whether they are completed recovered from addiction but rather Emancipation denotes

the individual is free to make their own choices despite whatever circumstance in which they find themselves. The individual moved into the category of Emancipation when the rehearsal of values became habitual. Respondent M#16 stated:

> I think the habits of, you know, for me prayer, meditation, self-analysis, maintaining friendships with people in recovery, answering, you know answering the phone you know, inviting friends over or going to friend's houses, meeting people in meetings, going to birthday meetings. Those sorts of things are the things that I do that help me habitually.

Another respondent (M#7) stated:

> It's much more of a principled kind of life than it is about outcomes. You know, people in early recovery seem to be going I need to get sober, I need to get a job, I need to get, get, get... Whereas, people in long-term recovery it's more about who they are, who they're being. The principles of their life, you know. Are they being honest, are they being truthful, are they being trustworthy or loyal? Yeah. No, that -- that is exactly it. I told you how I look up to a lot of people. You know, there's a lot of times in life where I'm sitting there thinking okay what would my dad do right now?

Amongst these LTR respondents, each had an awareness of their chosen values, but the practice of these values seemed to be a habitual component of the individual's life and conscious practice was no longer necessary to maintain the individual's recovery. The three categories of Disempowerment, Value Development, and Recovery are the broader constructs of this recovery theory.

As each individual spoke about their recovery, it was clear that there were rules they lived by, and that there were obvious characteristics about each. M#5 stated people in recovery would, "come in and they have an honest desire, and it's like being pregnant and they have this glow." M#11 felt that his recovery was a chance to get back on track with his life as if his drug habit had not occurred. This respondent said:

> Recovery for me was an opportunity to regain more or less. I, growing up, was always the -- out of my three brothers, the one that was most set up for success, and everyone thought -- if you had asked someone when we were younger who

would be the most likely to get [indiscernible] I would have been the choice.

One LTRU (M#9) stated, “and so, you know recovery is the years that we have where we're able to be productive and the service to others and feel you know feel productive.” M#9, in regards to recovery, spoke of a recent death of a famous recovered heroin addict:

> And in the world in which I live where you know I suffer this, you know, this fate worse than death where I can't stop smoking crack and I've had reprieve for multiple years now. I consider it, you know, just beautiful that he was able to have the reprieve and was able to produce what he did and the years that I've had you know sober been able to do what I've been able to do are just, it's just. You know, the times over is the beautiful thing and the time in recovery is a more beautiful thing and the big picture is that, you know I should have died years ago and I didn’t. He should have died years ago and he didn't and everything beyond that is great.

There was a sense of satisfaction and pride among the LTR group about achieving recovery.

Summary of the Findings

Three categories of recovery were identified in the analysis of the data: Disempowerment, Value Development, and Recovery. The following sections describe the reflective process of the researcher by category.

Disempowerment

According to the responses of these participants felt powerless while active in their addiction. One participant (M#1) indicated:

> Being addicted to something makes you feel powerless. It makes you feel like it is dragging your every decision, your every moment, your every move, your every thought, your—everything about you is controlled by this substance and by this want for it, this need, you know, that comes with it.

All of the respondents spoke of their addiction as distinct and separate from

themselves. They reported thoughts, feelings, and behaviors that arose from the addiction that were uncomfortable and painful, including suicidal ideations and behaviors. Each responded while in active addiction, because of this discomfort, being numb or being able to immediately change one's feelings were a necessity. One (M#3) reported:

> I'm sick of the constant cycle of abuse and recognition, recovery, treatment—all of that cycle. I'm just tired of trying to numb everything. I want to be OK with the way things are and be able to enjoy that.

Another said, "I think you become numb, kind of, in a way." This powerlessness was an ongoing feature of participants' description of addiction.

Many participants reported issues related to traumatic events earlier in life. Their use of the chemical seemed often to be efforts to cover up real-life issues.

> No, the major events, yes, they were mountains and I covered them up. So here I have all this stuff inside me that I have never dealt with like a normal person would deal with it; like you get raped, you go to counseling. I got raped, I got loaded, which just covered it up. It was still there because I never dealt with it. My sister was killed in a car accident…at the hands of a drunk driver and I couldn't deal with it. The rest of my family did without getting loaded. (M#5)

In the throes of their addiction, each of the participants struggled with making sense of the world and what occurred. They reported they did not know how to deal with emotional pain without the substances in their system. In the midst of these behaviors, there were self-destructive thoughts and feelings. One (M#2) stated, "My addiction has brought out definitely suicidal thoughts."

Often, participants mentioned in the midst of their addiction that it would be a life-long struggle against being controlled throughout their lives. In their state of addiction, they felt helpless and victimized in a chaotic world. M#1 went on to say:

> feel that disconnect of not being controlled anymore, you know,

> and the power that comes with freedom—personal freedom, not anybody else's or whatever—just my personal freedom I guess from that drug and that addiction, it makes you feel like you're in control instead of a slave. Slave to control is completely different.

In addition, many respondents reported being unable to make changes on their own. One (M#3) stated:

> I had made up in my head that I could do this on my own, that I could keep controlling the things that I needed to -- my job, my relationships, my family, money -- all those different things that I could control them myself, and then, ultimately, that would allow me to control the drug and control how much I used or whatever it was, and that wasn't the case.

All of the participants came to a point where they decided changes had to be made, and they made the decision to take control of the consequences the chemical brought to their lives. They made efforts to control what happened as the result of their use:

> Well, just like, you know a treatment center is something that is—you know, as I went through a treatment center, came home, and thought that everything was under control and, ultimately, relapsed and tried to live life with the mindset that I could control the drug (M#3).

Often this control of the drug failed reinforcing the belief that outside force must be involved to keep control, although the goal remained controlling the drug and its consequences. M#3 stated:

> I needed that outside influence that, you know, another treatment center. I needed to be able to really go in and have an outsider's view of my life and my struggles and my pain and all the things that I couldn't handle on my own to be able to point out things that I was too closed-minded to see.

Value Development

There came a point in each of the LTR respondents' life while they were in STR that they began consciously exploring and developing behaviors and cognitions to

support them in a recovery lifestyle. For some, this took place in a treatment program. For others, it came of searching among friends and relationships for what worked and what did not.

Principles

All of the LTRU and LTRA had developed values in their lives they maintained in order to have recovery as they saw it. The principles the participants spoke of were very personal and sometimes very emotional for the individual. Each had a list of articulated principles that they strived to understand and put into practice. The LTR respondents personally measured their recovery based on their compliance with the principles and practices they chose. Participants made it clear that authenticity and integrity are foundational to recovery. One (M#13) stated, "I don't have to be manipulative or a chameleon or wear a bunch of different hats in a different group or around different people." This participant (M#13) stated, "I can be me in recovery." Another (M#6) stated, "There's a lot of self-respect involved in recovery." Other principles they referred to were humility, resourcefulness, acceptance, recognition of problems, honesty, respect, and self-respect. Participants had a set of principles that led them to practices of recovery in their lives. Some of the participants used programmed principles and practices. The main programs were 12-step programs, which have a predetermined set of values in order to facilitate recovery. Other participants developed programs of their own to maintain recovery. Regardless, all of the participants had specific practices and principles that were integral to their recovery. However, it should be noted that there is no causal connection between principles and practices in this research.

One participant (M#6) stated, “I hate change, and today I feel that some changes are good.” M#6 also said, “very respectful of other people and …tend to be honest.” Another practice connected to principles was stated by M#6, “I am financially responsible today. You know, I pay my bills on time, I have a house, you know, I am a productive member of society today when before I wasn't.” Participants focused on taking on life events as part of a principled way of doing things. The LTRU and LTRA participants spoke of living a life based on clear principles they had chosen as important in their life. The process of choice was varied: That is, some came from a religious point of view, some from a 12-step point of view, and others from a perspective of personal experience and the consequences of past behaviors. One participant (M#13) stated:

> There’s some addicts that they don’t have a program like I do. They can abstain and they’re OK. And they turn to religion and they’re OK, and I’m not religious. And so there’s a huge difference there for some people. But for me, like I have a service position and I have a home group and I do those things, and I know that like if I’m not going to my home group meeting or I’m not attending enough meetings, like I’m just comfortable in this routine of the same meeting, the same group. I need to maybe change that and get some diversity in my recovery because I could stop going because I’ve done that before. You know, like I can stop this, I’m OK. So maybe a different service position.

Another (M#15) talked about her life in her recovery group this way:

> Oh, no. I mean, we're very open and honest about it and stuff, and, you know, we try to be helpful when we can. We normally don't shy away from it, you know, let us be an example that you can get out of it and stuff and you can stay and maintain a relationship, a long-term relationship.

Religion and Spirituality

Some kind of spirituality was important for all of the participants in LTRA and LTRU. A participant (M#5) said, "I've learned that that’s OK because ultimately, what I’ve learned is it doesn’t matter what your Higher Power is. It doesn’t matter what you

call it. There is something greater than ourselves that's taking care of us." This participant also stated:

> So to turn that around and actually believe in something was huge and all of a sudden, I felt like a huge weight was lifted off my shoulders and I didn't have to do this by myself, and if I relied on my Higher Power to take care of me and I did the footwork, I was going to be OK. And my first spiritual experience, you could say spiritual awakening, I'll share with you. I was in a sweat lodge, and I was being very impatient. And the way we did the sweat lodge at the time is you went around in a circle and prayed and you basically had to wait your turn. Well, I was being so impatient, and I wanted it to be my turn. And if you start feeling light-headed or dizzy or can't breathe, you're supposed to put your face down towards the edge of the sweat lodge, and I swear I wasn't going to do that. I was tough. And I started getting tunnel vision and light-headed and I just didn't feel well. And it became my turn and the instant I started praying, it all went away. And that was when I truly believed that there was something greater than myself that was taking care of me, and after that, I didn't have a hard time believing in something.

While living out the addictive lifestyle, most of these participants struggled with the concept of a God or the practice of religion. Many respondents stated that religion was uncomfortable for them but most developed values in their recovery of a spiritual nature. So they separated the religious from the spiritual in their lives. M#5 described his evolution of belief this way:

> But I didn't believe it. I didn't believe the things that they taught, and I sure didn't believe that I had to go to a building to show what I believed in. And when I got clean, people would talk about God in meetings and I would shut down because I didn't want to hear anything they had to say. But there is a difference between—huge difference—between religion and spirituality. The fellowship that I go to is a spiritual, not religious, program, and it took me a long time to define spiritual principles. And because [of] the feelings I had towards God, it took me awhile to define that belief. The program teaches us that your Higher Power can be anything you choose as long as it's loving, caring and forgiving.

Choice

This idea of choice was critical to most of the participants. One participant who was in the STR (M#1) individuals stated:

> Another principle that I think that—my personal recovery, I feel freer every day. Like I'm in control. Like, I get to control who I am and what I am and what I want to be and what I want to go. So I think that long-term recovery, for me, it's—I know they say, you know, it's not going to be hard work your whole life. It's something that you have to be aware of constantly, things like that. But for me, I feel like it's more of a sense of freedom that I feel in myself instead of feeling like I'm a slave to something or a slave to someone. You know, I feel in control, which is incredibly polar opposite.

Another participant (M#5) stated, "Uh-huh. I use it [choice] on a daily basis every morning when I wake up."

Self-Improvement

The respondents felt it was important to continue to grow and to improve things in their lives. One addiction professional (M#7) stated:

> And I never want to be stagnant, and, you know, every time I do a treatment center, I learn something new. And that's what excites me new things, creating them, but recovery it looks like progress and it's where people's lives that used to be just a mess, just start coming together. They may not be perfect, but they're getting closer to coming together.

One (M#13) participant stated, "Yeah, and you don't want to—I don't want to be like that. Like for me, I have to work on myself on a daily basis." Another participant (M#12) stated, "Well, of course you're not going to get better if you tell yourself every day you're not going to get better." M#12 went on, "Successful recovery, there again, is taking the unmanageable and making it manageable, being able to live a daily—live day to day, minute by minute, second by second, and year by year be able to plan." Thus, the participants' values are part of their daily life and effort to work on their personal improvement.

In talking about self-improvement, M#12 stated:

> So I think that the day-by-day model is very, very true in a lot of ways, but I also believe that, you know, you can't just say, well, I've got to cling to this moment

> because I don't know what's going to happen. When I have to enjoy this moment, I have to make the best of this moment, I have to understand this moment or I have to accept this moment. But I don't have to have this—it's not the only moment in my life; it's the only moment in my life right now. I don't know what's going to happen. I could fall out this window. But, you know, recovery is about I think being happy in your own—and I hate that term, being happy in your own skin but being able to live in your own skin. I do get anxiety, and when I do get anxiety, I have a prescription for benzodiazepine, so I take a half of one and I take one before I go to bed. The VA monitors that very closely. I've never abused it, and there's a lot of times I don't use it at all. There's sometimes I use it before I go to sleep because, if I don't, I'm not going to sleep. And that's something I don't know if that anxiety is a byproduct of my prior use. I don't remember being anxious. Well, I did methamphetamine; that was my drug of choice, so there was times I was anxious, but not for the right things or about what was going to happen next.

One LTRA (M#4) was asked about life and responded:

> Smells and colors and relationships and the true—feelings, you know. I think you become numb kind of in a way. You know, you get used to pushing away, and for me, being recovered, I don't necessarily—I believe that I will be looking at life through—it won't be through rose-colored glasses anymore. It'll be clear, you know. It'll be focused, and it'll be from my heart and not addiction, you know what I mean?

Practices

Practices often went hand in hand with principles. These tended to be things learned in treatment or in early recovery. M#6stated, "It's a lot of pen to paper for me. For me, I'm really having a hard time with something, I will write hate mail. And then I burn it." M#1 said:

> I feel like I am learning really good habits and patterns here. I feel like I'm starting to learn who I am and who I want to be, and I don't think I've ever asked myself the question of who am I because I've let people tell me who you are and who you're supposed to be. So I think it's about learning who I am.

Often, a practice component of recovery started in STR. For example, M#9, in talking about providing some form of service, said:

> Yeah I mean I think it is partially just doing those things but it's also being in

> service, being of service especially to you know the people in recovery, sponsees and just other folks that I've kind of you know gone through the process with that I'm close with that you know that I've shared my faults with. When those people call or I call them and we reach out to each other. That process seems to help me get back to it.

Future Orientation

For most of the participants in long-term recovery, a future-oriented mentality was necessary. A participant (M#13) stated that within recovery, goals are critical, "Goals, just having a job or making—a vacation, just something to look forward to. Just some type of goal." M#13 also said, "Well, I had daily goals, you know. Like last time it was get the kids up, get ready, get the house cleaned, you know, make everything look good on the outside was the goal." Participants' vision of themselves in their environment was critical to their recovery. She (M#13) wanted to have "a home. I have a job. I have goals, you know, as far as management with my job. I'm in management now. I'd like to move up in management and vacations and those types."

Their goals weren't just long-term goals but also a daily and weekly plan. M#15 stated,

> All right, I know that that's where I want to be, and I've got to get from A, B, and C to get there. What is my plan, you know? I think coming from a military background helps with that.

M#15 stated that part of recovery was "knowing how to create steps and goals for myself." It was important to the LTR participants that they plan ahead. "Not worrying about how I'm going to pay for my next meal or my next room to stay in or something. Basically it was just getting down to getting myself to a sense of orderly routine." These practical steps of planning, both long-term and short-term, were made to maintain a sense of security and order.

For some of the respondents, part of the process of planning was development of a future orientation value, where the individual plans for the consequences of current choices. One respondent (M#7) stated, "I refused to think that addiction is all there is for me." The STR group worked on developing this focus while the LTR groups seemed to have made this process more habitual and part of their planning process. One respondent (M#2) when asked what your life would be like in recovery stated:

> I will most likely be working and a house that I've always wanted, you know, and hopefully kids, married, back in school. Definitely back in school. That's the big thing right there. That's part of what's keeping me alive.

Respondent M#7 said:

> But once I bought into it, I was like I'm recovered. I don't need drugs. I don't use drugs. I don't crave them. I'm done. And it just propelled me forward. And so I truly believe that there is an end point to recovery where okay, you're healed.

Abstinence

One issue consistently discussed by respondents was the principle and practice of abstinence. Not all respondents practiced abstinence; however, each had an opinion concerning it. Abstinence is the practice of avoiding chemical use of all kinds. One respondent's (M#12) principle of abstinence was more nuanced than a simple black and white definition:

> I think abstinence plays a major part of it in recovery, but … as a recovery community … I think that we've kind of looked at it half-assed for years and years because abstinence means—to a lot of people abstinence means no fun and no anything that's going to alter anything. No wine with dinner, no beer with lunch, no beer on Saturday, not have a cocktail when friends are around …To me recovery is about not doing what you were doing and making your life better. And if you're not doing what you were doing and you're making your life better, and along the way you have a drink or in the state where it's legal you take a toke of pot or if you have a prescription for pot or if you have a broken back and you have a prescription for pain meds and you use them as prescribed, I don't think you're not in recovery. I think you're very much in recovery. Are you doing your

> pain pills as prescribed? Yes. Are you doing heroin on the side? No. Are you doing methadone on the side? No. Are you doing methamphetamine on the side? No. Well, is your medication prescribed to you and you're being medically managed? That to me is not, not being in recovery.

Another respondent felt that abstinence was critical to recovery. M#15 stated, "Well, I think characterized by sobriety, definitely yes." The individuals in this group indicated their abstinence choices were based on principles they developed during their STR time.

During the interviews, the STR group felt that abstinence was necessary. The LTR group broke into two types, LTRA and LTRU. For the LTRA group, any mind altering substance use was not acceptable. However, for the LTRU group, use of drugs or alcohol was acceptable as long as the individual's drug of addiction was not used.

Principles May Inform Practices

The principles can lead to practices. For example, the principle of honesty was often talked about (M#6):

> I'm very honest...Very...Sometimes it's hurtful honest, and then sometimes I have to put my hand in my pocket and put the shut up button on because I'll catch myself going to say something mean or just right down ugly like I used to. And like, you know what, I'm not going to let them go there. You need to give me a time out so I can recollect my thoughts to finish talking to you.

And these daily practices begin to permeate the individual's life and planning. M#5 said:

> And it's learning how to ride the rollercoaster on a daily basis and getting through those situations, and when I -- it was right before my eight years when I didn't want to do it anymore, and again, my Higher Power has a funny sense of humor and put a police officer in my life. And he pulled me over because I was speeding and asked me where I was going and I was going up over Trappers , and I was like, I was going to go up there and go off the edge and roll my truck. He was like, what? I said, well, you asked. And he's like, well, you know, he says I really should take you in if you're going to do bodily harm to yourself, and I says, dude, I said, I can't go to jail, I've got to work tomorrow. And he just looked at me. I can't go to jail because I have to work tomorrow, but I was going to go kill myself.

Going to and being at work was such a part of this individual's life that she couldn't act on her impulses and risk going to jail or the hospital. This was an almost automatic response to dealing with the consequences of behaviors. The practice of having to be at work was a necessary part of her recovery. It's not even thought out by the individual. It begins to color their perspectives, language and behaviors.

Practices May Inform Principles

M#5 said:

> I have almost 11 years clean and I attend at least two meetings a week. I am of service. I give my time freely to the program. I'm actually on the convention committee, so I helped put on the biggest convention in Utah. I'm a part of that and I'm a sponsor, and if somebody calls me up and says, hey, you know, I need some help, I'm there. So it's a daily thing. And if I don't pray on a daily basis, things in my life just start not going right, so I know that I need to pray on a daily basis.

M#5 committed to a set of practices and as a result developed principles by which she lived.

Relationships

Value Development was also relevant to romantic, familial, and associative relationships of the individual. Choosing to be part of larger groups was an important part of recovery for these respondents. Participants reported a constant focus on developing the self in relationship to their community. M#6 found people who fit certain criteria and then followed them, "They're committed, yeah. And when they're committed, those are the people I want to be around. Those are the winners that I want to surround myself with."

Most often, as LTRU and LTRA individuals moved into the second category of

recovery, respondents would speak of family as being an important value in recovery. Family and relationships became a priority in the lives of LTRU and LTRA group members:

> I have people I look up to in my life. I look up to my dad. I look up to my—my—all of my brothers…I look up to just the strength to say you know what, I know I work at a treatment center, here's what's going on …That takes big "cojones," you know, but to see if someone's in recovery, it's about watching progress and all their areas of life. And so if you know someone was an addict, went through treatment and they're "clean" and you watch them. If they're truly in recovery, all of their life will be progressing, you know, and that's not to say there's not financial problems every once in a while and relationship problems. The healthiest people in the world have relationship problems, and so, but it's a general—it's kind of like you can't watch it every second. It's kind of like OK, over the last, you know, 4 or 5 months, look at that, they got a new job, they got a promotion, they paid off three things on their credit score, whatever. They're staying home with their kids. And so it's an overall feeling of progression. And I think that's why I keep like going from one center and opening another and another. It's like I just want to make progress. I just want to make sure that my life keeps moving forward (M#7).

One participant (M#7) stated, "My family is—my—my children especially keep me from getting miserable." When asked if being a father was part of the recovery process, the participant (M#7) responded, "It's a huge chunk. You know, they got taken from me and that's why I went to treatment the last time and really decided, OK, I'm going to do this or kill myself." He (M#7) said: "You know, you've got—got three little lives and smiles and hopes and dreams of the future and it's hard to be miserable around them. I get—I get somewhat miserable when I'm away."

> One STR individual (M#4), when asked about recovery, stated:
>
> To me, I think it's—for me, success in recovery, I kick the habit. I kick the drug. I don't want it anymore. That's gone out of my life. That bad influence, that bad—and the people that go along with it … Being secure in my family, by having a family that is tight-knit like it was when I was growing up, you know. I mean, having—you know, to me—for me personally, kicking my feet under the dinner table every night. Never had that. Seventeen and a half years since I've been in the oil field, I've never had that opportunity without driving a lot of miles to get

> to that. It's putting my feet under the table. I don't have to do it all the time, but I would like to be there doing homework with my kids, to, you know, playing tetherball or watching my daughter swim or watching my 4-year-old son, you know—he's riding horses now. He's out starting to rope and doing little things like that. Being there for him, you know. Building fence with my kids, teach them trades that my folks taught me, being productive—a productive father and a good husband—a good, loving, caring husband.

He (M#7) stated:

> One or the other. And—and really you think about all the—I do I have a lot of responsibilities, but they all are miniature compared to those three little kids and it's weird too, and I know this is off topic…When I was using and DCFS was getting involved and people were telling me you're picking dope over your children, you don't love your children. I did love my children. I did with all I was capable of. Every year I get sober, every day I get sober, it's amazing the depth of love that you're able to reach when you're sober. It's like crazy amounts of love, and sometimes I feel sorry for people who've never had the chance to be an addict. I know that sounds weird, but then to feel the difference it's like you don't know—you don't know joy until you feel pain.

For both the LTRU and the LTRA, family responsibilities became critical components of their recovery. The relationship theme was particularly focused on family and connecting with parents, partners, and children. One participant (M#11) said:

> And like I—we had clawed and climbed our way out of where we were to now we have two boys that we're raising. My mother now lives with us, and our life is immensely more fulfilling to both of us now.

When asked if reaching out is part of being in recovery, 1 participant (M#6) answered:

> Yes, because it's about—also about mending and rebuilding relationships with those people that are important to you, your family, really good close friends, mentors, whatever they may be. I mean, because it's not only good for me to have reestablished that connection to my past life; it's also uplifting I would think to them, and they were proud and happy to see I was able to pull myself up.

Each of the LTR participants also seemed to feel that personal boundaries were critical. One (M#6) stated, "You know, I respect myself first. I come first before anybody else comes first. It's me and my recovery, and it's not your recovery or you to work my

program or me to work their program." This participant (M#6) also made the comment that this respect meant relationships were a choice: "Sometimes I've totally walked away from people, like, even in the rooms. I completely walked away from this one person."

Citizenship

One of the individuals (M#12) interviewed said:

> I worked. I think that citizenship is definitely a part of it. I think that, you know, we should be responsible for our own actions, and I think if we're doing something that makes our actions unacceptable that we need to step up and stop doing those for the good of the citizenship. So yeah, I'd say that… Directing yourself in a positive, yeah, I mean, freedom of choice or self-determination, yeah…And I think that's something we should all do. I mean, not just people in recovery, everybody. And of course, I think some of the—that's one of those things that other people have taken for granted because they've already been doing it, you know, that we addicts haven't been. So I don't know why we're so proud that we all of a sudden started doing that; it's just part of living.

Respondents indicated that they needed to deal with their families and communities in a different way in recovery than they did when actively using. This respondent indicated an awareness of community makeup after recovery and the impact of addiction on this community. In addition, there were new ways of understanding the consequences of behaviors on the community. As a result, they developed new ways of being in a family and community during recovery.

Identity

The respondents were asked about the Betty Ford, SAMHSA, and White definition of recovery (Betty Ford Institute, 2007; SAMHSA, 2011; White, 2007). One respondent (M#9) stated, "The first two definitions are sort of saying, well if you're living a self-actualized life then you're in recovery, but I wouldn't say that that's really captures what is unique to recovery." All M#8 wanted to say is that "I'm a better person, and I can

care about people and see things more clear now." Another (M#5) stated that people that were in recovery would, "come in and they have an honest desire, and it's like being pregnant and they have this glow."

One respondent (M#11) said: "Recovery for me was an opportunity to regain, more or less. I, growing up, was always the—out of my three brothers, the one that was most set up for success, and everyone thought—if you had asked someone when we were younger who would be the most likely to get [indiscernible] I would have been the choice."

M#9 speaking of a recent death of a famous recovered heroin addict:

> And in the world in which I live where, you know, I suffer this, you know, this fate worse than death, where I can't stop smoking crack and I've had reprieve for multiple years now. I consider it, you know, just beautiful that he was able to have the reprieve and was able to produce what he did. And the years that I've had, you know, sober, been able to do what I've been able to do, are just, it's just. You know, the time's over is the beautiful thing, and the time in recovery is a more beautiful thing. And the big picture is that, you know, I should have died years ago and I didn't. He should have died years ago and he didn't, and everything beyond that is great. And so, you know, recovery is the years that we have where we're able to be productive and the service to others and feel, you know, feel productive, you know, because not everybody maybe is like making you know Broadway plays or directing Broadway plays… But I think whatever, whatever anybody is doing in their own life to sort of be doing a little bit of art is better than just [the] selfish draw of addiction.

Recovery

Each of the participants' values had an effect on their self, romantic, familial, and associative relationships and led directly to their recovery. As a result of this recovery, a change in the perspective of the person occurred and changed the motivation for the respondent from controlling the addiction to developing a lifestyle of recovery. Respondent M#5 stated:

> Well, and I say that because when I was using, I was so far gone with using that I didn't have a choice. I had to use to function. I had to use to get my feet out of bed and onto the floor. Before I even got out of bed, I was getting loaded because I couldn't function. So I didn't have that choice. That's the way it felt, is I didn't have that choice. When I was done and I chose to quit using with the help of the police…because I had nine days in jail, and that nine days was long enough to stop using and be like -- because when I went to jail, I was like, yes, thank you. Because I wanted to stop; I just didn't know how. I didn't have the tools in front of me to be able to stop.

Recovery became important in relationships. Respondent M#6 stated:

> I've bettered the relationship with my daughter. I was in and out of her life for eight years during the course of my disease, you know, of my active addiction. And I have a stable relationship -- trustworthy relationship -- with my child. My child is the most important person to me in the world.

Recovery gave meaning to one individual (M#3) who stated,

> Something that I get purpose and meaning out of in life. Something that gives me a real sense of wanting to be the best person I can be in order to benefit, you know, whatever it is, if it's a relationship, if it's a job or a career—something that I get that satisfaction out of and having that be held to such a high standard that I want to be the best I can be in order to fully expound on that.

One (M#1) other saw recovery as a holistic process of change and stated,

> It means I'm healing. Mentally, Physically, Emotionally…I feel like I am learning really good habits and patterns here. I feel like I'm starting to learn who I am and who I want to be, and I don't think I've ever asked myself the question of who am I because I've let people tell me who you are and who you're supposed to be. So I think it's about learning who I am.

Another (M#12) in talking about community and family said:

> And what I think it did is it gave them a better understanding of who they were dealing with as a whole and gave me a lot better understanding of what impact I was having on society.

According to this research, recovery should not be thought of in arbitrary terms of long-term (over 5 years) or short-term (under 5 years), but the development of habitual practices and principles guiding the person in recovery and whether the practices and principles have become habitual. The respondents seemed to not wonder about a

temporal definition but whether the practice had moved beyond simply following the rules and consciously practicing behaviors. The Recovery category represented individuals who were now responding habitually to issues with certain practices and principles as opposed to the Practices and Principles category where the practices were more conscious and planned.

One respondent (M#7) stated:

> You know what -- what I try and do is I try and copy successful people and so if you look at ex-addicts that are now successful, not many of them are drinking or smoking marijuana because it wasn't their drug of choice. They stay completely abstinent, and so I copy those people.

In recovery, the individual shifts from the category of disempowerment through the development of practical attitudes and values into recovery. Participant (M#1) stated, "It's more of a mental healing for me I think because I have this notion of who I am."

Participants stated that recovery was also more than just being themselves; it was also connecting to a larger relational circle. One participant (M#6), who is an addiction professional, stated, "I have a sponsor, and when I'm struggling and I have that, the I-want-to-give-up days and just go get loaded, I contact my people that I trust in the rooms and I surround myself with people in recovery." Another participant (M#6) explained recovery as follows, "That you're willing to have to work through your issues and not have to pick up. For instance, I've gone through two deaths in 9 months—or 8. No, three in 18 months." This participant (M#6) stated:

> We know that drugs and alcohol sort of damage us. They damage the brain. But they more importantly damage our, you know, our ability to heal and to sort of live guilt-free and shame-free and therefore be able to be useful against others … the wound is always kind of there and the more, you know the more that we're actively managing the healing of it, the more likely we are to live a healthy, productive life.

M#6, stated:

> I'm not a fan of residential recovery near as much as I am of a criminal justice-based or a long-term, very focused, very, very intense recovery program where you—not only are you in recovery and not doing what you've been doing to make your life unmanageable, but you're making the rest of your life manageable by managing, by actually getting out there and doing, by going to work, by paying your bills.

The participant went on to say that recovery is about "maintaining those changes you've made and accepting more changes … and still being in the process of change."

Another (M#5) stated that recovery is:

> actively managing their continued vulnerability to such problems, I mean, that's—you're working on your recovery every day … To heal the wounds inflicted by that, by working the steps, you learn to heal those mountains instead of cover them up. But the process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential, that's the goal of being in recovery because that's really what you want to do. So once you get the hang of not using, then you go to the process of change.

Many talked about the new beliefs they had incorporated into their lives: M#6 said that "It's OK to ask for help," and "I don't have to be manipulative or a chameleon or wear a bunch of different hats in a different group or around different people" (M#11). When asked is not doing drugs part of a real recovery stated:

> Yes, because I—it helps with my self-esteem, knowing that I am able to live a happy life. And now I know that I have a much happier life now, not like waking up either incredibly feeling like my body has just collapsed or, you know, looking, OK, where am I going to get some more drugs?Oh my God, I don't have drugs, you know. That's not a life to me.

Another (M#7) stated,

> Allowing people to be individuals and who they are individually is huge; especially for addicts because I think that—I think that we are a little bit different. I don't know if we're wired different. I don't know if we're more sensitive. I don't know… All I know is that a common thing that I have observed and even heard from other people in my life that have suffered from addiction is they don't conform to the norm. And if they're going to be a way, they have to choose that

way. We're kind of more of a "fightier" sort, I guess.

One participant (M#10) stated, "I want to be me. I want to be way more than that: a good mother. I want to work with horses. I love nature. I want to help people and I just want to live my life." Another (M#15) defined recovery as follows: "In a sentence, getting my life back." Thus, recovery for many of the participants is simply a return to a normal pathway of life.

Comparison of Findings by Participant Grouping

It is important to realize that recovery without an addiction is unnecessary. So as the respondents talked about recovery, they also compared their recovery to their addiction. Wanting to obtain a life was a common long-term goal of the STR individuals.

As they developed practices and principles, the STR still talked about feeling helpless in the face of their addiction. Respondents in the LTRA and LTRU groups talked about their goals in early recovery as being able to get back on track with their lives, as well. They spoke of a desire to go back to school, and to have a family and a home. However, among the respondents and during their disempowerment time, the drive to use was so strong and pervasive that this individual felt there was no hope of achieving these goals. While they were in STR, this drive was also pervasive, but the values help to stall the urges for the chemicals.

Short-term Recovery

The STR participants seemed to talk of their recovery in terms of obtainable concrete objectives and goals: "not using the drug," abstinence, getting a job, and getting back to or engaging differently with their significant others. These goals and objectives

were not out of the ordinary in terms of a normal life development. This meant not so much "getting a life" but dealing more effectively with what was going on. This group had goals they were working on, and they were focused on the objectives that would lead to this goal.

The STR participants spoke of their recovery experience in terms of the treatment they had received and what goals they were working on at the moment. They were able to clearly discriminate between acceptable and unacceptable behaviors in pursuit of their goals. They had a clear set of specific objectives and goals, as well as hope for a recovery lifestyle. They spoke of abstinence as their primary accomplishment and a necessary objective. One participant (M#8) stated that recovery was "definitely getting over the addiction, not using the drug." There was a sense from some that they were focused only on abstinence. These participants were attending treatment programs, attending meetings of some kind, or just trying to quit on their own. This subgroup was made up of those who had a short duration of recovery, usually a few months, or who were in and out of a recovery lifestyle. These abstinence-focused participants tended to be early in their recovery, approximately 0–2 years along.

Their motivation was to change themselves or circumstances by obtaining these objectives and goals in their pursuit of avoiding consequences of behaviors. The STR seemed to believe that recovery was a goal to be obtained. As originally indicated, the long-term goal of recovery was neither well defined nor operationalized for any of the STR participants, other than by abstinence. As a result, their view remained focused on achieving recovery objectives. The STR participants seemed to believe recovery was the result of abstinence, participating in treatment objectives, and participating in a social

support network.

Long-term Recovery

Those in long-term recovery groups, both LTRA and LTRU, spoke more of meaningful principles and processes of recovery, along with their immediate social network, rather than an object to be achieved. In this sense, their principles involved more abstract beliefs about right or wrong actions. These principles tended to be either personal or cultural, depending on how the participants had developed their principles. There was no generalized set of principles that were consistent between individuals. However, all LTR participants indicated that some set of principles guided their individual choices.

The four LTRU individuals seemed to have an emotional foundation for their principles, similar to the STR and AA individuals, where as the LTRA individuals seemed to have a more objective view of their principles. The LTRA individuals spoke of their emotions less dramatically than the LTRU individuals:

> I've seen people that have multiple years clean that walked away from the 12-step program and realized that their behaviors and their actions—and they were like a dry drunk basically because they weren't doing anything to maintain that recovery, and they'd come back in the rooms and they're just as miserable as they were when they were using (M#5).

The four LTRU individuals seemed to correspond with the LTRA individuals in all other aspects. Each individual in the LTRA and LTRU groups spoke of recovery as a basic process that focused on the principles of recovery. Service, work, and responsibility were often identified as integral to their individual recovery. The LTRU participants, rather than focusing on achievement or obtaining of things, spoke of development as an individual within their relationships. One participant (M#6) stated, "I've regained

relationships with my family that I didn't have before." This participant (M#6) also stated:

> I've bettered the relationship with my daughter. I was in and out of her life for 8 years during the course of my disease, you know, of my active addiction. And I have a stable relationship—trustworthy relationship—with my child. My child is the most important person to me in the world.

Participants discussed developing the ability to create and hold boundaries. One participant (M#6) stated, "Before it did. I'm like, how do I get this person to stop treating me this way?" M#6 further discussed boundaries:

> I—for instance, there was a really good friend of mine who continued—I had suspicions. I mean, this person was my best friend. We've been through this journey from the first day we got clean, and we were always together. And I had my suspicions that he was using and lying constantly. And when I found him in the dope house, I set that boundary, and I told him I'm done. I'll love you from a distance, and it's going to take time to rebuild our relationship…He's come back, and he's respected my boundaries and—because he called me from jail and …he called to talk to me.

Another participant (M#1) stated, "Holding boundaries and setting boundaries is two different things." When M#1 was asked if she was able to set boundaries before but could not hold them, she stated, "No. It was a combination of both. I would set boundaries and not hold them, and then sometimes I just wouldn't set boundaries because I was afraid of what that person would think of me." Thus, for many in recovery, boundaries became an important part of their development. One participant (M#6) stated, "You know, I respect myself first. I come first before anybody else comes first. It's me and my recovery, and it's not your recovery or you to work my program or me to work their program." Another participant (M#11) indicated that setting and holding these boundaries were critical:

> I broke down a couple times before. I've always been a fairly determined individual, even when I was growing up…And I had gotten really lost, and I

> could see that objectively that I was physically a mess. The last time we got evicted I think was the final slap in the face. I was staying on a friend's couch and stuff, and I just—I just—I knew it was time. I was like this is—I cannot live my life this way anymore. And it was the second time we had been evicted in the course of I think 3 years. And I knew it was more than just, you know, paying for rent. I just—I could not stand the way things were anymore. And my partner and I talked, and I told him, I said it's time for me to get clean and I want you to go with me, but if you don't I'm going anyway. And thankfully he went with me and our relationship has survived.

One participant (M#13) illustrated the process of drawing boundaries with active addicts:

> Well, people—there's partying and then like in the sense of getting loaded and then there's partying and not getting loaded. Does that make sense? The difference, you're calling and you're making connections and you're…can you get me this, can you get me that, and you're meeting up.

This participant (M#13) indicated that people in addictive relationships were "like business partners, really." Another stated, "Even the people you're just hanging out with getting loaded with, it's part of a business process. They're getting you stuff, you're getting them stuff, and it's all—you may connect with somebody, but it's not sincere." She went on, "Even the people you're just hanging out with getting loaded with, it's part of a business process. They're getting you stuff, you're getting them stuff, and it's all -- you may connect with somebody, but it's not sincere."

M#13 talked about differences in friendships between active users and those in recovery:

> Yeah, but they aren't friends. You're using each other. You're using each other for something. In that type of lifestyle, you're using each other. It's what do you have, what can I get from you. You're manipulative. You—it's all abusive.

There was an expectation that problems of life had to be dealt with individually usually because of a lack of trust in others ability to help without wanting something in return. When asked about needing help, participant (M#13) said, "I tried to deal with stuff

myself. I thought that I was supposed to. I was taught, like, you're supposed to be able."

Friendships in recovery became supportive and responsive. Several participants, when asked how he dealt with the discomfort of real life in recovery, stated, "I call somebody but indicated that the call wasn't about a transaction or *quid pro quo* action." One participant (M#13) stated, "Yeah, if I get to that point. I think that's good though for me. I used to not, and it was a difference between the two recoveries, too … It's OK to ask for help." This was a change for most of the participants. One (M#11) stated that there was a change in an intimate relationship when they both decided to get sober:

> But as far as our relationship goes, you know, it's been really strong, but I knew that there were things that were—well, due to drugs I know in part, suspicions and things like that were intensified. But, you know, like we kind of just had to lean on each other because we were staying on his mother's futon couch in her living room when we first left. And so we had to keep each other honest and relearn each other to some degree as sober individuals. Thankfully, that has worked out.

But also there were losses of relationships due to the change from active addition to a recovery in any form, to STR.

> I've lost them just because they pushed me away, and I had to accept that…It hurts still. It's not something I'm happy about. I have made amends with a few, but it's not—our friendship is still not where it was. And I definitely—I never went through a 12-step program or anything, but I knew for me I needed to reach out and tell them that I was sorry and thank them for not writing me off. Or if they did, you know, that I understood, that it was ok and I had a few that responded positively, and I had a few that didn't respond at all (M#11).

Abstinence was a question asked about in all interviews. For the STR group, the goals centered on abstinence, with one (M#1) stating, "Abstinence—yeah. Abstinence in substances is absolutely going to be a part of long-term recovery, yeah." Another participant (M#7) said, "I just in my case abstinence from everything is the smart thing to do." Another (M#4) said,

> Well, that's the root of the issue is using, right? So if you don't want to—if you

> want to be recovered and you want to be healthy—you know, you got cancer, it's probably a good idea to quit smoking, you know what I'm saying? You don't keep feeding the disease with, you know, a carcinogen. You just—you need to quit.

For LTRA and LTRU, abstinence seemed to be more part of their recovery process rather than the end point of recovery. The practice of abstinence was different in each group. There was awareness in the LTRU and LTRA that chemical use is still part of current culture and that as long as the individual was being responsible and principled, chemical use was not a problem. For some, remaining aware of the dangers was part of a recovery lifestyle. Another participant (M#9), when asked if she could use chemicals and stay in recovery, stated:

> I haven't really been able, I've tried many times and I have for periods of time. But then it just, for me so far it's always ended up sort of escalating to—I think my body for [one] thing acclimates really quickly to needing it to the point that you know, if I didn't drink for 3months but then I drank three nights in a row fourth day, I would a little withdraw and a little like my body is so. I have just noticed it so fast to you know do that. That makes me think I should take the abstinence road you know. And my need for how much you know, what a half a glass of wine can do one night isn't the same by the next week and it just escalates really, you know.

One participant (M#7) stated:

> But once I bought into it, I was like I'm recovered. I don't need drugs. I don't use drugs. I don't crave them. I'm done. And it just propelled me forward. And so I truly believe that there is an end point to recovery where okay, you're healed.

Not all of the LTR participants felt that complete abstinence was necessary. For all groups though, recovery did include abstinence from the drug of choice. However, there was some awareness that chemical use is necessary at times. M#9 stated:

> There is a sense in which, you know, like for me, first several years abstinence was like essential because if I didn't have abstinence then I had guilt and then I had shame, and then I had social withdraw and then I had selfish behavior, and then I had you know the whole gamut of all of these things that you would have to call relapse or you'd have to call drug use, but over time I've started to I guess

> you know because I've had a couple of surgeries where I had to take opiates which weren't exactly my drug of choice but certainly I could tell that they put me in a place where selfishness could have run rampant without keeping it in check. So you know, even those times when I was on opiates at least I felt like I was in recovery because I was a want to be involved in recovery behaviors at least some of the time.

As a result, chemical use for a surgery still brought up feelings and behaviors that needed to be managed. These were not situations that required a panicked response but a managed reaction with choices and support.

One (M#7) LTRA stated that abstinence did not have to be "100%. There are some people that are recovered, recovering and might have a slip up every now and then. You know, recovery has more to do with quality of life than anything." He was clear that having a normal life without addictive behavior consequences was more important than abstinence. The LTRA and LTRU focused more on living a principled life rather than chemical use.

Others in the LTRU group reported that abstinence was integral to the process of recovery M#7 said:

> I'm fully opened to the fact that there might be some people out there [who think] that using illegal narcotics is—is better in life than their life outside of it. I haven't met those people yet I don't think, but I'm totally open to the fact that that might be the case. In my life I realize that total abstinence is the important piece because I get kind of crazy kind of fast.

In both the LTR groups, though, abstinence was not the focus but a side effect of the changes they had made in how they viewed the world and how they were in their lives. The participants talked about principles of living rather than achievements. These principles seemed to be critical to their recovery. Volitional principles helped them make choices and drove their decisions rather than being outcome oriented. This does not mean the LTR individuals were not looking to achieve or obtain goals. Each had goals and

outcomes they were working on, but their recovery was based in articulated values. One LTRA (M#6) stated: "And I am financially responsible today. You know, I pay my bills on time, I have a house, you know. I am a productive member of society today when before I wasn't." Another (M#15) spoke of "compassion from other people is part of recovery, yes." There were many statements about the principles that LTRU and LTRA both accepted as being necessary for their recovery.

Process versus Outcomes

The analysis of interview transcripts seems to indicate a clear differentiation between STR and LTR respondents. The STR respondents talked clearly about outcomes and goals. Abstinence, maintaining clean time, and repairing relationships were often an important theme in their responses. Their beliefs indicated that they expected recovery to be about an outcome that could be achieved.

In contrast, the LTR respondents focused more on the process of living, focusing on daily practices that were part of an attitude and value set. This set of values was not focused on outcomes but on the processes of living a principled life. These principles were not necessarily religious in nature but were, in most cases, self-determined. Even when the principles were not self-determined, they were selected from a treatment program as being important to the individual. LTR respondents referred to abstract patterns and themes beyond just personal goals and targets that could be defined concretely. It became obvious their view was more about abstract principles of living and more about the process of recovery than positive outcomes. In addition, the behaviors and beliefs seemed to be much more natural than intentionally practiced. Practices are behaviors based upon principled choices and are often no longer conscious but habitual.

The LTR group interviewed viewed principles and practices more about the process of recovery than the outcome. Positive outcomes were not the foundation of a LTR recovery but rather a byproduct of living their chosen recovery lifestyle.

Habits

In this research, unconscious and habitual behaviors and feelings seemed to drive all three groups of respondents (STR, LTRU, and LTRA). Each respondent seemed to be dealing with either developed habits (LTRA, LTRU) or developing habits (STR).

In the normal human processes, habits are automatic responses to improve well-being. They are an autopilot system that does not require conscious attention. Habits can be acquired in terms of behaviors, thoughts, physiological response, or feelings. Any habit consists of three parts: a habit trigger, the habit ritual (behaviors, physiological responses, thoughts or feelings), and reinforcement (King, 2012).

The trigger of a habit is anything that will alert the biochemical habit system in the brain about opportunities that are worthwhile to perform the habit. The executive system of the brain then can consider and modify these estimates of worth based on context and environment. This process is called volition. However, compared to the habit system, the volition system is slow (King, 2012).

The ritual of a habit can consist of behavior, physiological responses, thoughts, feelings, or any combination (rituals) of these four. The habits will happen in order to have an immediate gratification opportunity or reinforcement.

These rituals happen automatically and with a minimum of energy wasted. To stop them from occurring requires a higher expenditure of energy. Reinforcement occurs in an affective change to a less uncomfortable state. This does not mean that the person feels

better, but simply his sense of well-being has changed from a less comfortable to a more comfortable feeling (King, 2012). This change in the state of well-being reinforces the habit ritual. All habits give immediate positive change in the state of well-being.
In the STR group, the chemical still remained the focus of their rituals but the individuals focused their attention on remaining abstinent. Recovery choices did not seem to be principle driven but behaviorally driven.

In the LTRU and LTRA groups, the drug of choice was not an option for them. The significant difference between these two groups was whether the individual was abstinent from substances that were problematic for them. The individuals in this group indicated their life style choices were based on values developed during STR time.

Defining Recovery

The respondents reported a change in personality and expectations as the disempowerment proceeded. As the disempowerment progressed, there were attempts to control the consequences of addiction: trying to maintain the positive consequences while avoiding the negative consequences. There was a sense that they could use their chemical and avoid anything that would be damaging.

Considering quitting seems to be the first step in STR. The 1 participant identified as STR was active in trying to decide how to go forward. This individual had determined the drugs were a problem, but the habit was still overwhelming the determination to stay away from drugs.

This movement into STR did not necessarily mean that the change was made but only that change was initiated. It also initiated a change in the attempted control of the addictive behaviors. However, during disempowerment, a different motivation begins to

emerge as the individual addicted begins to attempt control of addiction and its consequences. As the individual enters into recovery, the individual begins working on practices and principles that the individual hoped would lead to a recovery. The development of self in terms of the addiction is part of this process where the individual begins to understand the nature of the addiction and how it has affected them

There were rules that this respondent developed and consistently lived by. This person was able to identify specific processes that were involved in his recovery and was very proud of his accomplishments in recovery. In the STR phase, the addicted individual begins identifying practices that are recovery oriented. A set of principles was developed as well. For STR respondents, the principles were not as critical to the individual as the practices were in keeping with their program. However, there was articulation of principles in defense of the practices.

Practices and principles would focus on development of a changed identity, with limits, boundaries and goals. These limits, boundaries, and goals stayed in the forefront of the STR individuals mind. Often the primary goal was abstinence with some efforts at relational and individual changes being made. The individual would make commitments to chosen ideals and attempt to maintain these ideals. These chosen ideals became the foundation of continued meaning and purpose for the individual.

Finally, the individual would cross the line, into Long-Term Recovery. There were two types of Long-Term Recovery identified in this research. The first type of LTR was LTRU, which were individuals who claimed to be in a recovery but were using chemicals. The second type was the LTRA or abstinent individuals who claimed to be in recovery. The first and second types are not identified in an order but only describing two

types of LTR groups.

A noteworthy difference between the STR and the LTR individuals was the development of a focus on relationships, practicing identity principles and attempting to change for the better. These individuals were focused on maintaining current progress related to self, improving self, and providing service of some kind to their community.

DISCUSSION

The results of this study show that during addiction, when the respondents became aware of the problems associated with their chemical use, and moved into STR, each had a sense of disempowerment. The sense of disempowerment encompassed a loss of self-efficacy and significant negative consequences as a result of the addictive lifestyle.

Based on this research, recovery is a process through which the individual feels empowered through practicing their chosen values and in their own sense of self within their chosen community. As a result of this sense of empowerment, the addict sees him or herself as being capable of self-determination and responsible for their own behaviors, thoughts and feelings. This recovery process is ongoing and based on preferred values that become habitual to the individual (Groshkova, Best & White 2012; Laudet 2008; Laudet & Humphreys, 2013; Medina 2014).The study respondents agreed with Shinebourne and Smith (2010) that their involvement in their recovery group with its values was fundamental to their success. Individuals in long-term recovery focus on an effective journey of recovery rather than simply achieving recovery, supporting the idea that recovery is an ongoing process rather than a goal to be achieved (Betty Ford Institute, 2007; Laudet, 2007, SAMHSA, 2011; White, 2007).

Critical Reflections

At the beginning of this research, it became clear that despite efforts to begin without a priori expectations, there was an unexpected personal anticipation that individuals being interviewed would describe recovery in objective ways and there would be a tangible recovery product. The researchers personal expectation that a clear set of steps could be taken by individuals to achieve long-term recovery would be evident. Milestones would be identified that could be measured as individuals progressed from active addictive behaviors to a recovery lifestyle.

However, as the interviews continued LTR would reference more principled and practice oriented themes, while STR individuals saw recovery as achieving goals and objectives that would result in long-term recovery.

Discussion

In this research, the data showed there were general differences that surfaced between the experiences of individuals in the early stages of recovery process (STR) and those with a longer time in recovery (LTR) that is similar to Gubi and Marsden-Hughes (2013) recovery construct.

Gubi and Marsden- Hughes (2013) indicated that LTR involved multiple dimensions with a distinctively individual structure, linking feelings of acceptance with self as a personal state without a distortion of reality. This self is a personal state of developed mastery and competence within the individual's community.

The STR individuals had a sense of disempowerment (Kilian, Lindenbach, Lobig, Uhle, Petscheleit & Angermeyer, 2003; Medina, 2014) but attempted to develop and practice skills related to recovery. In STR, abstinence was often the focus of recovery

efforts but respondents reported the goal was also to avoid negative consequences. The STR respondents believed that when sufficient tools were obtained, recovery was completed.

In comparison, the LTR respondents reported they had repeatedly rehearsed their values until the practices and principles became habitual and became natural for them. In LTR, these habits were not consciously practiced; however, the values can be brought to mind easily. Burkitt (2002) describes habits as lifestyle choices accompanied by practical reasons giving the individual the ability to change or enhance sense of self as well as defining the person's place in the community. Shinebourne and Smith (2010) talk about development of habits within recovery groups as necessary to follow the values recovery groups espouse. In LTR, rather than a sense of trying to achieve the goal of recovery, there was a sense of process and meaning making. Recovery often gave purpose to the respondents' lives and by providing comfort and service to others in their communities. Individuals in LTR spoke of the benefit of being in recovery, despite the effort it entailed (Laudet, 2007; Stecher, 2015) and recovery became part of the individual's sense of self.

This conscious recognition of the recovery benefit for the individual becomes part of the person's identity. The personal understanding of this identity drives the practices and principles of their lives. Deviations from this identity became unthinkable to the person (Laudet 2007). Laudet (2007) called recovery a "process of self-improvement and an opportunity at a new and better life" (p. 12). The LTR respondents in this research each asserted something similar to this understanding of recovery.

Abstinence

In this research, the question of whether abstinence was required for recovery was the only difference dividing the LTRA and the LTRU participants. Gubi and Marsden-Hughes (2013) stated that today in recovery, total abstinence was now superfluous and unsettled. The question of abstinence is still being discussed by stakeholders (Laudet, 2008, Lubman, 2012; Stecher, 2015; Witbrodt, Kaskutas, &Grella, 2014). LTRA participants believed total abstinence was critical to their recovery, in order to avoid any possible consequences of chemical use, while the LTRU individuals felt that abstinence was only related to their drug of choice. The LTRU group felt that being able to choose whether use was acceptable or not was important to their recovery. However, they stated that use of chemicals causing any unwanted consequences was unacceptable. The LTRU individuals reported practicing awareness of any consequences of use more consciously than the LTRA individuals. Often, the use of chemical was based on a cultural or group norm to which they adhered and were seen as external social requirements (Ferrari, Stevens& Jason, 2009; Laudet, 2007; Stecher, 2015; White, 2007).

Each of the individuals in the LTR group set boundaries and adopted attitudes regarding their own life and their recovery (Pagano, White, Kelly, Stout & Tonigan 2007), even when it did not conform to some other groups belief. However, in the LTRA group, the principles seemed to be more habitual and as a result, the LTRA individuals did not seem to watch their consequences as consciously as the LTRU group.

Long-term Recovery

The LTR participants focused more on personally chosen daily practices and principles. This attitude and value set was not focused on outcomes of recovery but on

the processes of living a self-determined and existential self-identity with meaning and purpose for the individual (Medina, 2014). Practices and principles are often no longer conscious but habitual (Shinebourne & Smith, 2010). Positive outcomes happen for LTR individuals but rather as a byproduct of living their chosen identity and lifestyle.

Habits and Disempowerment

The essential difference between the STR and the LTR groups were the habitual nature of the values of the participants. Members of the STR group were consciously focused on developing practices and principles while members of the LTR groups habitually practiced living the principles, as well as their practices. One (M#9) stated:

> I think the habits of you know for me prayer, meditation, self-analysis, maintaining friendships with people in recovery, answering, you know, answering the phone you know, inviting friends over or going to friend's houses, meeting people in meetings, going to birthday meetings. Those sorts of things are the things that I do that help me habitually.

Another (M#5) stated, "And without that structure, like getting up and going to work or actually going to the grocery store, you know, I mean, without those basic responsibilities, then I don't really have a life." Another participant (M#13), when asked what the difference is between people who are miserable in recovery and people who are happy in recovery, stated, "It's that work…It makes you grow. Like that self—because I didn't do a lot of work the first time either. I was really lazy in the treatment program also."

In talking about a return to using, an LTRU individual (M#9) stated, "It's more important that they are there, kind of doing the habits that will get them back to." In normal human processes, habits are automatic responses to improve well-being, like an autopilot system that does not require conscious attention.

The habit system within the person is very fast acting, negating the need for conscious thought. Any habit consists of three parts: a habit trigger, the habit ritual (behaviors, physiological responses, thoughts, or feelings), and reinforcement (King, 2012; Schwabe, Dickinson, & Wolf, 2011). The trigger of a habit is anything that will alert the biochemical and structural habit system about opportunities that are worthwhile to perform the habit (Schwabe & Wolf, 2009).

However, rather than habits being completely in control of the rituals, the executive system can moderate the habit system unconscious decisions, by consciously considering and modifying estimates of worth based on context and environment. This process is called volition. Compared to the habit system, however, the volition system is slow (King, 2012), but the rituals can be modified by choice (Gasbarri, Pompili, Packard, & Tomaz, 2014).

Disempowerment

As the person struggled through the STR phase, the individual faced two themes. The first theme is the sense of feeling helplessly addicted, resulting in a sense of disempowerment and the second theme is the struggle to control the addiction and its consequences.

This sense of disempowerment for these individuals was very real and made the ability to control addiction and its consequences feel insurmountable. This does not discount that for many of these individuals, environmental, biological, and political forces were involved in creating this sense of disempowerment (Kilian et al., 2003; Medina, 2014; Ryan, Baumann, & Griffiths, 2012).

In speaking with each of the STR and LTR respondents, it seemed that there was

a general consensus that during active addiction and in STR, the individual felt they were a passive participant in the process of addiction. They had been disempowered by their addiction, speaking of their 'addict brain' as a separate and objective persona in their lives. As they spoke of addiction, the respondents separated addiction from their identity and identified it as the perpetrator of all their woes. During STR, there was also a focus on the ways other things were causing their problems. Respondents spoke of trauma, family, their brain, or external situations as causing their problems. Without a doubt, when speaking of addiction, respondents described a state of feeling generally disempowered or unable to make a change.

This affective state of disempowerment does not mean the person is actually disempowered, but only feeling disempowered. Several of the respondents came from families that were middle class or higher. However, many respondents reported developing a strong belief that they were unable to affect situations in their lives due to contextual issues, leaving them feeling disempowered. So in a sense, this feeling of disempowerment may not necessarily represent actual disempowerment but only the affective state of disempowerment. While the consequences of addiction were often disempowering in real life, this affective state preceded actual disempowerment. This disempowerment became pervasive and overwhelming for each of the respondents while in the midst of their addictive lifestyles.

In addicts, habits also contribute to disempowerment. These habits tend to maintain long-term unwanted consequences. When the decision to quit was made, the struggle continued until the practices and principles of the individual's recovery became habitual.

With these individuals while they were in the STR stage, they found that they were unable to control whether the negative consequences occurred, and as a result were forced to manage the consequences that occurred. So in addition to controlling addictive use of the chemicals, each of the respondents during STR had to focus on controlling consequences. Each felt the need to increase effort to control the consequences, setting higher and higher expectations. Each respondent reported that while in the midst of their addictive cycle, they could not understand why they could not stop the consequences, with each attempt to control the addiction and its consequences contributing to the sense of disempowerment. However, at some point, each respondent came to a realization that the drug use may be the problem and was connected to the consequences.

Value Development

The effect of this realization is a serious, conscious consideration of the connection between current behavior and avoidable, unnecessary, and uncomfortable consequences occurring. This awareness, by itself, was not sufficient though to complete a change by the addict to seeking recovery. For recovery to occur for these respondents, a commitment to recovery was required as well. When awareness and commitment occurred, the respondents moved into the Value Development category (Boone, Mundy, Stahl, & Genrich, 2015; McKinney, 1975; Nelson, 2004). This does not mean that the person had achieved abstinence but had decided it was time to quit using drugs. In addition, the individual began considering how their personal choices were responsible for these negative effects. This decision seemed to empower the addict toward living a different lifestyle, and was not only self-reinforcing but also supported by the respondent's community as well (Belin, Belin-Rauscent, Murray, & Everitt, 2013;

Friedrich, Wood, Scherer, & Neuper, 2014). Respondent M#5 stated, "So freedom from not using is huge because not using gave me the opportunity to find recovery and learn how to live life the way you're supposed to."

This awareness of personal responsibility for consequence moved the respondent firmly into the STR phase, where the individual began developing and practicing recovery thoughts and behaviors. M#1 stated:

> I think when people use, there's usually a reason behind it whether they're trying to mask something or not feel something or numb something, and that's not being true to yourself. That's hiding or withdrawing, you're isolating. Being true to yourself is facing the hard, facing the pain, facing the emotion and dealing with it appropriately.

Often, the respondent saw reinforcement from these practices and principles and continued to rehearse them. Other times, there was no reinforcement, and as a result, they stopped rehearsing them. As the practices and principles rehearsal continued, a sense of empowerment began to develop in the individual. As the repeating the practices and principles continued, recovery habits began to form, with reinforcements occurring from within the respondents community.

Empowerment

As the values continued to be rehearsed by the respondents, the sense of control became more embedded in the individual. The respondents reported a sense of being an empowered individual, with habits that made for effective living. Effective behaviors and beliefs continued to be practiced until each happened without conscious thought or control (Shinebourne & Smith 2010). However, in the case of the LTR individual, these habitual responses seem to have been consciously chosen for the effectiveness in their life choices rather than through the human learning process. These habitual responses

became a part of the respondents' identity within his or her community. One participant (M#9) stated,

> I think the habits of, you know, for me, prayer, meditation, self-analysis, maintaining friendships with people in recovery, answering, you know answering the phone you know, inviting friends over or going to friend's houses, meeting people in meetings, going to birthday meetings. Those sorts of things are the things that I do that help me habitually.

Recovery as an Empowerment Process

The sense of disempowerment felt by the addicted individual is especially important to the social work field. Social workers are primed by training and ethics to deal directly with the problem of disempowerment. However, there is a problem. The problem is the historical reluctance of social workers to work with addicted individuals (Amodeo & Fassler, 2001; Lightfoot & Orford, 1986). Social workers' inclination to refer chemically dependent individuals to others has gotten in the way of the social work mission to "enhance human well-being and help meet the basic needs of all people, with particular attention to the needs and empowerment of people who are oppressed, vulnerable and living in poverty" (NASW, 2008), especially in terms of addicts being disempowered and vulnerable. However, based on this research and social work values, social workers should focus on the needs of addicts. Social workers have a specific mandate to work with disempowered individuals, and people with addictions who, according to their own beliefs, are disempowered.

Current Literature Defining Recovery

There continues to be an ongoing discussion of the concept of recovery in the current literature. Much of the discussion is taking place within the realm of mental

health service provision. This discussion is relevant to substance abuse and dependence. A summary of some of these recent articles is presented below.

The definition of recovery that emerged in this dissertation is a process through which the individual becomes empowered through their own values development and in their own sense of self within their chosen community, capable of self-determination and self-responsible for behaviors, thoughts, and feelings. This recovery process is ongoing, based on preferred values. These values become habitual to the individual.

In this dissertation, the process stages of Recovery were Disempowerment, Values Development, and Emancipation. Disempowerment was the sense that one could not affect the world in a specific way. Values Development was the process of learning and practicing specific values in relationship to what was important to the individual. Emancipation was the stage that the individual felt capable of achieving a meaningful and productive life consisting of habitual practices and living specific preferred principles. In this last stage, the addict felt free to be him or herself.

In the semistructured interview format used during the interviews, three definitions were used to instigate thinking about the topic of recovery. SAMHSA (2011) described recovery as "a process of change through which individual improve their health and wellness, live a self-directed life and strive to reach their full potential" (p. 3). In this same description, SAMHSA identified four major dimensions of recovery as being Health, Home, Purpose, and Community (SAMHSA, 2011). This group also identified 10 guiding principles of recovery as being hope, person driven, many pathways, holistic, peer support, relational, culture, addresses trauma, strengths/responsibility, and respect.

This SAMHSA (2011) definition is very similar to the definition that emerged in

my dissertation. In definitions, community, process, responsibility, and striving to reach potential are intimated in both of these definitions. The SAMHSA definition delineates specific values where this current research does not specify values but addresses them in general as preferred value development leading to a sense of self as well as becoming habits of recovery.

White (2007) described recovery as:

> Recovery is the experience (a process and a sustained status) through which individuals, families, and communities impacted by severe alcohol and other drug (AOD) problems utilize internal and external resources to voluntarily resolve these problems, heal the wounds inflicted by AOD-related problems, actively manage their continued vulnerability to such problems, and develop a healthy, productive, and meaningful life. (p. 236)

White's (2007) definition is similar to the definition in this dissertation, sharing the ideas that recovery is a process of personal experiences within a chosen community though the development of values. These values in both definitions define self and begin the process of transcending self into a person responsive to their community. The current research focuses on the individual's habitual responsibility and self-determination leading them to empowerment in the community, but White (2007) focuses on developing a healthy, productive, and meaningful life with a community approach and a focus on symptoms management. There is some crossover in these that is unstated but also a different focus. White (2007) does focus on abstinence as well.

The Betty Ford Clinic described recovery as "a voluntarily maintained lifestyle characterized by sobriety, personal health and citizenship" (Betty Ford Institute, 2007, p. 221). The panel in their article discussed in addition that recovery was a personal multidimensional condition, not a specific method and was maintained ongoing. This research shares some of the components of the Betty Ford Institute (2007) definition in

that the individual is responsible and self-determining in their recovery. This research also agrees that recovery is ongoing, and multidimensional and not related to a specific method but rather focused on individual choices and preferred values. However, in the Betty Ford article, the authors use the term citizenship rather than community and imply a functional set of mores that are necessary, including sobriety and personal health, while this research focuses on the more personal choice of values as critical to the empowerment of the individual.

In Le Boutillier, Leamy, Bird, Davids, Williams, and Slade (2011), recovery is described as promoting citizenship, organizational commitment to recovery, supporting personally defined recovery, and working relationships. Immediately, it must be noted that this article refers to programming a recovery-based treatment protocol and so the focus is on provision of services rather than individual recovery, but recovery can be inferred from the discussion.

From the current research, recovery is volitional, self-determined, and self-responsible, as well as values are personal to the individual within his community. Le Boutillier et al. (2011) implies that autonomy, personal responsibility with self-determination and self-management, is necessary. This articles goes on to say that the individual becomes responsible for their own success and failure, and that the case should go in the desired direction of the individual being treated. In addition, both sets of research indicate that a sense of community is important to the recovery of the individual, that recovery is an ongoing process.

McKim, Warren, Asfaw, Balich, Nolte, Perkins, Sause, and Zakaria (2014) describe recovery as “a positive life affirming strengths focused and hopeful process

including cognitive, affective physical, interpersonal and spiritual elements" (p. 22). In this article, the authors created an interconnected model that included Body, Feelings, Mind, Spirituality, and Support surrounding a holistic point of view. From these can be inferred the components as described in the definition identified by this research but are not explicitly stated.

In Farkas (2007), recovery is described as "possible overtime; represents a multidimensional highly individualized nonlinear process that can be described; may be achieved without professional intervention; has multiple objective & subjective outcome indicators beyond symptom reduction" (p. 70) and consists of a first-person orientation and involvement with the person having self-determination and choice as well as hope. This fits well with this research's conclusion that recovery is the result of a chosen set of values individual practices until able to free themselves from ineffective living styles.

Craig (2008) did not give a definition but described recovery as consisting of the individual becoming adaptable, having a belief in self, having self-confidence, and courage to take calculated risks. Their recovery is based on real experiences and being functional. In addition, the person in recovery is able to make choices and is in control of their life. This represents an empowerment within the individual.

This research compares with Craig's (2008) editorial in terms of individual values but Craig does not talk about the connection with community. Craig (2008) also suggests tempering goals of recovery with financial restraints as well as individuals' needs for self-determination and risk with safety needs of individuals.

Leamy, Bird, LeBoutillier, Williams, and Slade (2011) begin their article by quoting Anthony (1993):

> Personal recovery has been defined as a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills, and/or roles. It is a way living a satisfying, hopeful and contributing life even with the limitations caused by the illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness. (p. 15)

These authors did a systematic review and modified narrative synthesis to create a conceptual framework of recovery in mental health. In this framework, five superordinate categories were developed: values of recovery, beliefs about recovery, recovery promoting attitudes of staff, constituent processes of recovery, and stages of recovery. These five superordinate categories were used to develop a final conceptual framework consisting of three interlinked categories: characteristics of the recovery journey, recovery processes, and recovery stages.

Leamy et al. (2011) described recovery as an active process, that is unique and individual, as well as being nonlinear in nature. They continued to describe recovery as a journey that moved in stages, and was a struggle for the individual. Recovery was a gradual, multidimensional process resulting in a life changing even, supported by a healing environment, consisting of a trial and error course of action. This team of authors also cautioned that recovery is not a cure but can occur without professional help. In addition, Leamy et al. (2011) described the recovery process itself as consisting of connectedness, hope and optimism about the future, identity, meaning in life, and empowerment.

These components described by Leamy et al. (2011) fit nicely against this research, including community, preferred values, self-determination, and self-responsible as well as values development. These authors do not mention the idea of practicing values until habitual and unconscious.

Kaskutas et al. (2015) write about an online survey that was done concerning recovery, specifically about the elements that make up recovery. This team determined five recovery factors: Abstinence, Essentials, Enriched Recovery, Spirituality, and uncommon factors, with a total of 35 elements of recovery. The authors proposed that these elements would give a clear view of what made up recovery. These authors did not define recovery as other than the factor analysis showed and the specific elements of recovery.

Abstinence in recovery referred specifically to substance use, with strong support of no alcohol or illicit drug use. Essentials of recovery seemed to sum up behaviors necessary to maintain changes in substance use. Enriched Recovery is the elements that gave meaning and serenity to a recovery. Spirituality of recovery detailed the concepts of principles and practices to support recovery that were related to spirituality or religion, although a large majority of the subjects of this survey resisted using the terms spirituality or religion. There were also uncommon elements that did not fit into a specific factor and so were combined into a fifth factor. In the current research, these elements would seem to fit well within the description of the Values Development and Emancipation, alluding to Disempowerment during addiction.

In summary, the more recent publications support the findings of this dissertation. In these publications, broader constructs are used in order to give leeway to individual's self-determination in their choices of specific values and from a variety of recovery lifestyles. The specifics of all the articles detail practices and principles of recovery based on philosophical preferences of the authors. In addition, development of a lifestyle of recovery was implicit in all these descriptions. The difference is the idea of emancipation

as the end result of a recovery lifestyle. The respondents in this dissertation spoke of freedom as the result of their lifestyle path. Each indicated that this was an aspect of the choices they made. In the participants view, life did not become easy, and difficult times and things were not avoided, but each of these respondents felt responsible for their life and the consequences of their choices, leaving others responsible for their own.

Recovery

In this research, each of the participants conceptualized addiction as a complex, disempowering process leading to significant psychological, physical, emotional, and spiritual consequences. Although there were immediate mood-related consequences, there were also significant negative consequences. These negative consequences led directly to a sense of being disempowered. This disempowerment became pervasive and overwhelming

Recovery is the process of finding empowerment for the individual through developing a sense of identity as the result of practices and principles. In recovery, the individual continues to rehearse these practices and principles, while maintaining a clear vision of self in relationship to the community. Literally, the individual begins to feel a confident competency in their own lives, structured by principles and lived by ongoing practices, which becomes habitual.

Conceptualizing Recovery

The discussion about long-term recovery is ongoing. Groshkova et al. (2013) stated “recovery is emerging as a new organizing paradigm for policy and clinical practice within the addiction treatment arena in both the UK and the USA” (p. 187). The

UK Drug Policy Commission (2008) defined recovery as "a voluntarily sustained control over substance use which maximizes health and well-being and participation in the rights, roles and responsibilities of society" (p. 6). This fits in well with this discussion about recovery. Recovery is not only looking at reducing symptoms and harm but also in accessing and developing strengths in both the individual abusing drugs and his or her community (Gubi & Marsden-Hughes, 2013; UKDPC, 2008).

This research has been placed among those discussing this question. SAMHSA (2011) has developed a working definition of recovery that stated: "a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential" (p. 1). This change process discussed by SAMHSA gave a broad direction for those working on a substance abuse disorder but did not give specific direction on how to accomplish this task, leaving the task of definition to the personal choices of the individual. The idea of self-determining what constitutes recovery is implicit. In addition, references to living a self-directed, healthy, and well life that strives to achieve potential indicate an understanding that recovery requires an autonomous life disciplined by values in order to obtain a recovery.

The Betty Ford Clinic working group came up with their own working definition of recovery. They stated recovery "a voluntarily maintained lifestyle characterized by sobriety, personal health and citizenship" (Betty Ford Institute, 2007, p. 221). This group was more specific and identified principles driving recovery as self-determination, abstinence, healthy living, and being a functioning part of a larger group.

White (2007) stated in response to the conversation about recovery that:

> Recovery is the experience (a process and a sustained status) through which individuals, families, and communities impacted by severe alcohol and other drug

> (AOD) problems utilize internal and external resources to voluntarily resolve these problems, heal the wounds inflicted by AOD-related problems, actively manage their continued vulnerability to such problems, and develop a healthy, productive, and meaningful life. (p. 236)

White (2007) also implies a series of values to achieve the goals, as being self-determining. In addition, he references health, and functioning in a group. He adds to the definition the idea of actively managing vulnerability and seeking meaning.

The current research supports what these groups stated in their working definitions, in that recovery is a self-determining process of creating an identity within a community that gives purpose and meaning to the individual. This coincides with the respondents in this study indicated. Within the literature concerning 12-step programs, there are values that are encouraged, that the group states will lead to an awakening that will solidify recovery within the individual (Pagano et al., 2013). A significant portion of recovery is the development of an identity of recovery rather than simply abstinence or reduction of substance use (Gubi & Marsden-Hughes, 2013; Medina, 2014; Stecher, 2015).

The three definitions move away from treatment outcomes, as described by Laudet and White (2008), and more toward whole life processes as well as describing the empowerment of the individual addict. The question remains how to define the specifics of these processes while allowing the individual to define their own recovery (Shinebourne & Smith, 2010).

Social Work Mandate

Based on this research, and social work values, social workers should focus on the needs of disempowered clients. Social workers have a specific mandate to work with

disempowered individuals, and people with addictions who, according to their own beliefs, are disempowered.

From the beginning, substance abuse treatment has been a component of social work (Richmond, 1917). Social workers have found drug and alcohol problems common among their clients (Googins, 1984). Yet social workers continue to reluctantly work with substance use disorders (Amodeo & Fassler, 2001; Suppes & Wells, 1991). In a larger sense, there may be an institutional bias within social work about directly treating drug and alcohol abuse (Googins, 1984). With a clear definition of the goals of recovery, social workers will be able to better guide their treatment, which should improve outcomes in treatment, education, and policy development as well as encourage social workers to work with this problem among their clients. Reconstruction of recovery into an empowerment model would change how treatment was done that would be in congruence with the ethics of social work.

This research implies that by focusing on voluntarily developing values that are supportive of the individual's own vision of self in their community, the addict would continue to improve themselves, to cause no harm to those around them, and provide a benefit to their community.

Definition

Based on this research, recovery is a process through which the individual becomes empowered through their own value values development and in their own sense of self within their chosen community, capable of self-determination and being self-responsible for behaviors, thoughts, and feelings. This recovery process is ongoing and based on preferred values that become habitual to the individual.

Strengths and Limitations of Qualitative Research

Because there is currently no consensus about the outcomes of addiction treatment, the results of this study could contribute to a model of long-term treatment outcomes. Qualitative methodology was used to study the topic and to give direction to further research. Through semistructured interviews, data were gathered and used to quickly revise the direction of the study (Flick, 2002; Sherman & Reid, 1994). Qualitative research can be powerful and compelling because the data are based on the experiences of real people. Therefore, subtleties and complexities emerge as the topic is explored (Patton, 1990; Sherman & Reid, 1994). These subtleties and complexities guided sampling decisions as well as questioning beyond the semistructured survey form.

The strengths of qualitative research are part of the reasons that this type of research can be vital to the knowledge base. With this type of research, fewer cases are used and, as a result, it becomes less problematic to delve into the rich details of the data, making it easier to compare and analyze. Using this type of research, it became simpler to identify context factors within the data as well. Because of these strengths, a researcher can develop tentative theories to explain phenomena (Johnson & Christensen, 2013).

However, qualitative research also has limitations. These data are not generalizable beyond these respondents (Flick, 2002; Patton, 1990; Strauss & Corbin, 1998). In addition, the quality of the research was conditional on the researcher's willingness and ability to fully investigate the subject. The data may have been influenced by researcher bias and quirks (Flick, 2002; Sherman & Reid, 1994; Strauss & Corbin, 1998). The researcher's presence can also influence the responses of the participants and decrease the trustworthiness of the data.

In addition, there are concerns of anonymity and confidentiality in the presentation of the findings (Flick, 2002; Patton, 1990; Strauss & Corbin, 1998). Moreover, maintaining, assessing, and demonstrating rigor is difficult in this type of research (Sherman & Reid, 1994). Qualitative data can be hard to manage, making analysis and interpretation time consuming (Denzin & Lincoln, 2000; Strauss & Corbin, 1998). Finally, qualitative research is sometimes not well understood or accepted within the scientific community (Denzin & Lincoln, 2000; Strauss & Corbin, 1998).

Future Research

This is an exploratory study, and much more research is necessary to help fill out the description of the construct of recovery, especially in terms of the values that are most effective and in what instances. I hypothesize that the idea of practices and principles as a path to a deeper sense of self and community makes up recovery, with recovery being a consistent observation of these practices and principles, which is the main thrust of what was found by interviewing these respondents. More in depth research would lead to creation of both a concrete definition of treatment and methods to arrive at recovery during and after treatment. In addition, more in-depth research of the values might lead to an even stronger taxonomy of recovery, allowing for both specific treatments and measurement of recovery strength. Defining these concepts and constructs would be helpful in developing a clear definition of the construct of recovery and in development of interventions leading to a recovery. Further research might be able to bridge the gap between the spiritual nature of recovery that many of the respondents espoused and more concrete values of recovery.

In addition, further research into the nature of addictive disempowerment and

development of addictive empowerment theory might lead to effective ways to treat addiction. Understanding these processes could also be used to develop more effective ways of prevention.

APPENDIX A

CONSENT PROCEDURES

I am Curtis Watson, and I am a Ph.D. candidate doing research on long-term addiction recovery. Right now, there is not a consensus of what a person in long-term recovery is like. Recovery remains a personal journey. However, this interferes with researchers' and treatment providers' ability to identify, provide, and evaluate addiction treatment outcomes. I would like to ask you some questions about your opinions of long-term recovery.

A definition of long-term recovery must be broad enough to accommodate individual differences but narrow enough to provide guidance to treatment providers, researchers, and policy makers. My research is looking at what individuals with addictions are expecting in a long-term recovery.

All identifying information will be kept confidential. All audio recordings will be kept on a password-protected hard drive. All written documentation will also be kept on this hard drive as well. In all written documentation, names will not be used. The information from the interviews will be analyzed in order to identify concept themes that describe long-term recovery. I will be asking 5 basic questions to explore your opinions about what long-term recovery is. The answers will be explored further during the interview. I expect that the interview will last approximately 30–60 minutes.

I am looking for your opinions, and as such, there are no right or wrong answers. After I complete my individual interviews and analysis the data, I will be having focus groups to discuss my findings and gather further information. I will be using your opinion, in conjunction with others and the discussion at the focus groups, to complete my dissertation. Would you be interested in participating in these groups?

I will be taking written notes and would like to record the interview on digital audio. Would that be all right?

Name: _____

Contact Number:_____

Date:_____

Signature:_____

APPENDIX B

SEMISTRUCTURED INTERVIEW GUIDE

I want to thank you for taking part in this research study about long-term recovery from addiction. You have reviewed and signed the consent document describing what I am asking questions about. If you have any questions during the interview, please feel free to ask. You can terminate the interview at any point as well for any reason.

The purpose of the study is to identify and discuss addicted individual's beliefs about what constitutes long-term addiction recovery.

The study should take approximately 45 minutes to 1 hour to complete. During the interview, you will be asked your opinions about long-term addiction recovery. I invite you to participate in a follow-up interview to ensure your opinions and statements are represented well in the study.

1. What would you like me to call you?
    a. How old are you?
2. Tell me what recovery means for you.
3. Are you in recovery?
    a. Yes
        i. Tell me what that means to you.
        ii. How are you going to maintain recovery?

b. No

i. Have you ever been in recovery?

a. What was different when you were in recovery?

ii. Would you like to be in recovery now?

4. Tell me how you know when someone is in recovery.

a. What does it look like?

5. What is successful recovery from addiction?

6. What do you think of the following definitions of recovery?

a. a voluntarily maintained lifestyle characterized by sobriety, personal health and citizenship" (Belleau, et al., 2007, p. 221)

b. A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential."(SAMHSA, 2011)

c. Recovery is the experience (a process and a sustained status) through which individuals, families, and communities impacted by severe alcohol and other drug (AOD) problems utilize internal and external resources to voluntarily resolve these problems, heal the wounds inflicted by AOD-related problems, actively manage their continued vulnerability to such problems, and develop a healthy, productive, and meaningful life (White, 2007).

7. Is there about any of them that you would include in your definition of recovery?

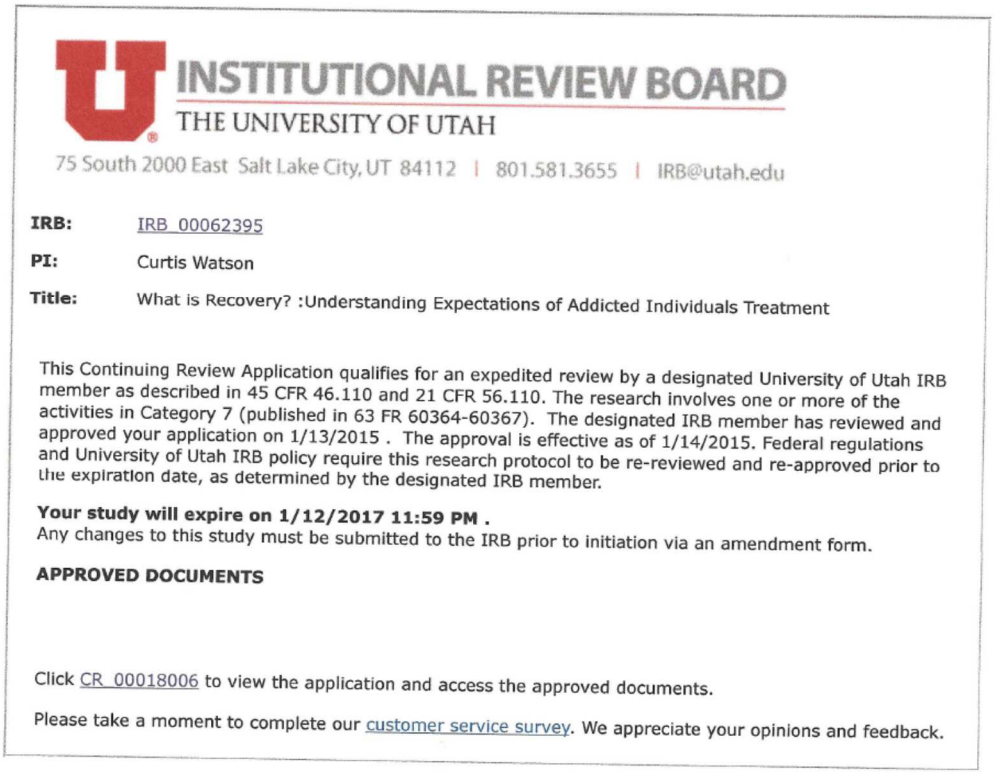
8. Is there anything you would like to add about recovery that we have not talked about?

9. Do you have any questions for me?

   Thank you for participating in this survey.

APPENDIX C

IRB APPROVALS



INSTITUTIONAL REVIEW BOARD
THE UNIVERSITY OF UTAH

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IRB: IRB_00062395

PI: Curtis Watson

Title: What is Recovery? :Understanding Expectations of Addicted Individuals Treatment

This Continuing Review Application qualifies for an expedited review by a designated University of Utah IRB member as described in 45 CFR 46.110 and 21 CFR 56.110. The research involves one or more of the activities in Category 7 (published in 63 FR 60364-60367). The designated IRB member has reviewed and approved your application on 1/13/2015 . The approval is effective as of 1/14/2015. Federal regulations and University of Utah IRB policy require this research protocol to be re-reviewed and re-approved prior to the expiration date, as determined by the designated IRB member.

Your study will expire on 1/12/2017 11:59 PM .
Any changes to this study must be submitted to the IRB prior to initiation via an amendment form.

APPROVED DOCUMENTS

Click CR_00018006 to view the application and access the approved documents.

Please take a moment to complete our customer service survey. We appreciate your opinions and feedback.

INSTITUTIONAL REVIEW BOARD

THE UNIVERSITY OF UTAH

75 South 2000 East Salt Lake City, UT 84112 | 801.581.3655 | IRB@utah.edu

IRB: IRB_00062395

PI: Curtis Watson

Title: What is Recovery? :Understanding Expectations of Addicted Individuals Treatment

This New Study Application qualifies for an expedited review by a designated University of Utah IRB member as described in 45 CFR 46.110 and 21 CFR 56.110. The research involves one or more activities in Category 7 (published in 63 FR 60364-60367). The designated IRB member has reviewed and approved your study as a Minimal risk study on 2/13/2013. The approval is effective as of 2/13/2013. Federal regulations and University of Utah IRB policy require this research protocol to be re-reviewed and re-approved prior to the expiration date, as determined by the designated IRB member.

Your study will expire on 2/12/2015.
Any changes to this study must be submitted to the IRB prior to initiation via an amendment form.

APPROVED DOCUMENTS

Informed Consent Document
Consent doc clean.docx

Surveys, etc.
Semi Structured Interview guide

Literature Cited/References
REFERENCES.docx

Recruitment Materials, Advertisements, etc.
Recruitment Ad.docx
participant ad.docx

Other Documents
CITI completions

Click IRB_00062395 to view the application and access the approved documents.

Please take a moment to complete our customer service survey. We appreciate your opinions and feedback.

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