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Long-Term Sobriety from Opioid Use: An Interpretive Phenomenological Analysis

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Long-Term Sobriety From Opioid Use: An Interpretive Phenomenological Analysis

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Finally, I would like to acknowledge former clients I've worked with that struggled with substance use and their families. I invite you to see this study as hope for the future. Recovery is possible.

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Abstract

Opioid addiction is a current health crisis in the United States. According to the National Institute on Drug Abuse 1.7 million Americans were addicted to opioids in 2017 (NIH, 2020, para 2). According to the Centers for Disease Control and Prevention, 130 Americans die every day due to an opioid overdose (CDC, 2019, para.1). Those in treatment are 60% more likely to relapse within the first 90 days post-treatment (Weich, 2010). Marriage and Family Therapists may often work in treatment settings addressing addiction and recovery. This study utilized a Solution Focused Brief Therapy lens to seek to understand the life experiences of individuals with at least 10 years sober from opioids and what factors assisted them in achieving long-term sobriety. This study also aims to contribute to further defining long-term sobriety as it relates to opioids. An Interpretative Phenomenological Analysis design was used to examine the life experiences of individuals with at least 10 years sober to identify factors that contributed to their long-term sobriety. The results of this study offer individuals, families, and therapists a look at the many, inter-related factors that support long-term sobriety with suggestions for future research.

Keywords: opioids, recovery, long-term sobriety, interpretative phenomenological analysis

CHAPTER I: INTRODUCTION

Now, more than ever, there is a dire need to provide resources like access to treatment and innovative approaches to treatment for individuals struggling with an addiction to opioids. According to the Centers for Disease Control and Prevention, "on average, 130 Americans die every day from an opioid overdose" (CDC, 2019, para. 1). The opioid crisis is not only affecting the active users but their families as well. In the United States "7.5 million children reside with at least one parent who abuses drugs" (Chopra & Marasa, 2017, p. 196). Opioid use and deaths reached such an alarming rate that the President of the United States declared a national public health emergency for the opioid crisis in 2017 (Blendon & Benson, 2018).

With the rise of deaths related to opioids, its impact on families, treating an addiction to opioids may feel hopeless. I explored the experiences of individuals, who were at least 10 years sober from opioids, to identify the strengths and resources that made it possible for them to achieve long-term sobriety. Existing literature is mixed in defining long-term sobriety. This study is intended to contribute to defining long-term sobriety and serve as a resource for individuals struggling with opioid use and clinicians working in recovery settings.

A fundamental component of Solution Focused Brief Therapy (SFBT) is focusing on strengths. SFBT was developed by Insoo Kim Berg and Steve de Shazer and is based on discovering strengths, exploring context, and identifying resources of clients to approach their current problem (de Shazer, 1991). I employed an SFBT lens to answer what made it possible for an individual to obtain at least 10 years sober from opioids.

Definitions

Opioids. Before going any further, it is important to keep in mind several definitions and background understanding of opioids and the world of recovery. Opiates are derived from the natural opium poppy and can often contain synthetic compounds (Darke, 2011). Along with heroin; morphine, codeine, methadone, oxycodone, fentynyl, and carfentanil are all considered opiates and a part of the narcotics drug class. An in-depth look into research on this topic will continue in chapter II.

Substance use. The Diagnostic and statistical manual of mental health disorders (DSM) 5th edition uses the term Opioid Use Disorder to imply an addiction to opioids via diagnostic criteria (American Psychiatric Association, 2013). Throughout this study I state substance use disorder implying the individual struggles with an addiction to opioids. Substance use, in it's current meaning, goes beyond recreational drug use (American Psychiatric Association, 2013). Chapter II discusses how the DSM has changed over time and no longer distinguishes between *use* and *abuse*.

Sobriety. Sobriety is defined as "sparing in the use of food and drink" and "not addicted to intoxicating drink" by the Merriam-Webster Dictionary (2019, para 2). Narcotics Anonymous (NA) (2008) defines sober as "life without drugs" (p. 10). Within the Narcotics Anonymous Basic Text, sober is referred to as "clean." I will refrain from using the word *clean* and maintain the language other researchers use as *sober* or *sobriety*.

Narcotics Anonymous (2008) advocates; "Our disease can only be arrested through abstinence" (p. 16). The American Society of Addiction Medicine (2005) defines sobriety as "comfortable abstinence from alcohol and/or other dependency-producing

drugs" (p. 1). Within the medical community, the word remission is often used to describe the disappearance of symptoms (National Cancer Institute, 2019). Similarly, remission and sustained remission, when discussing opioid use disorder, suggests long term sobriety from substances (Chopra & Marasa, 2017).

Research Gap

The research on the length of time defining long-term sobriety is mixed. The Diagnostic and Statistical Manual of Mental Health Disorders (5th ed) (DSM-V) identifies opioid use disorder, with a specification of early remission, as "at least 3 months" and sustained remission as "12 months or longer" (American Psychiatric Association, 2013, p. 541). Galanter & Dermati, 2013; Gubi & Marsden-Hughes, 2013; Luciano et al., 2014; Nosal, 2002 suggest between one and five years is considered long term sobriety. Only one other study, at the time of this study, identified 10 years as the length of time defining long-term sobriety (Pagano et al., 2009). Existing research on length of time defining long-term sobriety as it relates to opioids is inconsistent.

10 years is also significant within the medical community. When studying cancer remission rates, specifically breast cancer, survival and remission rates are measured in five and 10 years (Bender et al., 2017). One study on epilepsy proposed changing the criteria for full remission in epilepsy from five years to 10 years to increase confidence for full remission (Sillanpaa, Schmidt, Saarinen, & Shinnar, 2017). This study intended to further contribute to defining long-term sobriety for opioids as there is a need for a consistent length of time.

Significance of the Study

According to existing research, long-term sobriety from opiates is hindered by the highly addictive nature of opioids and high relapse rates. Opioid use disorder is considered chronic and relapsing-remitting (Chopra & Marasa, 2017). Weich (2010) found that "34% of the patients relapsed to heroin use within three days, 45% within seven days, 50% within 14 days, and 60% within 90 days" (p. 76). Furthermore, Chopra and Marasa also suggested that individuals struggling with opioid use disorder face a 91% relapse rate (2017). Darke (2011) states heroin use is associated with increased dependence over time and with the lowest remission rates of medical diseases. Opioids 91% relapse rate is relatively high compared to other substances. Witkiewitz, Litten, and Leggio (2019) suggest that individuals who struggle with alcohol have a 78% relapse rate. In a seven-year longitudinal study, researchers found that methamphetamine use had a 60% relapse rate (Wang et al., 2018). The DSM-V reported that only about 20% of individuals struggling with opioid use disorder obtain long-term sobriety (American Psychiatric Association, 2013).

The question of how to achieve sobriety and remain sober is difficult to answer and highly sought after. Opioids entered into American culture on a large scale in the early 1990's. The CDC (2020) identified three waves of opioid use. The first wave started in the early 1990's as a result of increased prescription opioids. The second wave emerged in 2010 with the increase in presence of heroin. The third wave identified by the CDC began in 2013 with the rise of synthetic opioids like fentanyl (CDC, 2019).

Prior to the 1990's the Vietnam war was a conduit for the use of opioids. American soldiers fighting abroad were introduced to potent, cheap, and abundant heroin

and then subsequently became addicted (Baker, 1972). Stanton (1976) reported that "one in five of the enlisted troops were addicted at some time during their tour" (p. 557). It became so much of a problem that President Nixon enacted the "War on Drugs" to address the Vietnam opioid use as well as drug use in the United States. This enforced strict drug testing rules before the soldiers could come home and a seven-day detox for soldiers who tested positive for opiates (Baker, 1972). This resulted in some soldiers stopping their use of heroin. "95% of those who were addicted to heroin in Vietnam did not become readdicted" (Stanton, 1976, p. 567). Stanton (1976) noted that the lack of continued addiction rates suggesting that the addiction to heroin in Vietnam was "neither as persistent nor as untreatable" (p. 569) as previously thought. Stanton identified factors like a supportive environment, employment, and family involvement contributed to the soldiers remaining sober from opioids. Stanton stated that "a case was made for the importance of the environment in addiction and also for the importance of non-physiological factors (e.g., economics, family) in the maintenance of addiction" (1976, p. 569). This phenomenon paved the way for existing research to continue identifying factors in obtaining and maintaining sobriety from opioids.

Best et al. (2012) studied 205 individuals, 98 of them in recovery from heroin and identified factors that contributed to positive quality of life in recovery. Their study found that an increased number of peers in recovery in an individual's social network contributed to a higher quality of life. They also reported that increased engagement in meaningful activities, like volunteering, contributed to a higher quality of life. Laudet and White (2010) recruited participants with varying lengths of time sober and identified what factors contributed to recovery. They reported that in addition to peer support and

volunteering, factors like employment, education, and housing are top factors that contributed to higher quality of life for individuals in recovery. Laudet and White (2010) suggested that employment is a top priority as it provides resources and a "respected role in society" (p. 7) with education being a conduit. Housing was found to be important, once abstinence has been reached, due to participants engaging in healthier lifestyles and moving away from previous drug using environments. Laudet and White (2010) also noted that there is a "growing recognition that recovery from substance use in its chronic form is a process that often takes time and continues to unfold long after abstinence has been reached" (p. 7). Chapter II further discusses the existing literature on factors that contribute to long-term sobriety from opioids.

Researcher's Relationship to the Study

Over the years, while working in treatment centers, I have experienced the deaths of several clients from opioids. One particular client comes to mind. He was shy, kind-hearted, and desired to pursue his life dreams. He had a full-time job and was also going to school. He loved his father and wanted to make him proud. As a child he experienced sexual and emotional abuse. We worked together for over a year on addictions to Xanax and alcohol. He had just celebrated one year sober and graduated from the treatment center. A few weeks later we were informed that he had died, from a heroin overdose. He had relapsed on alcohol and then tried heroin for the first time, which led to his death. The days after learning of his death made me ask myself, "how did this happen? He was doing so well. He just celebrated a year sober! Why did this happen? Is there really any hope for people to recover?" I was struggling with feelings of hopelessness about recovery and everything the entire staff and I had worked so hard to help him achieve.

This story is like many other stories of individuals having time sober, relapsing, overdosing, and then dying. This is why I believe it is vital to explore how individuals achieve long-term sobriety with the intention of providing hope to those in early recovery.

Purpose of the Study

The purpose of this study was to address the gap in the research and explore the experiences of individuals who have obtained at least 10 years sober from opioids and what factors made this possible. I used interpretative phenomenological analysis (IPA) to illuminate these factors. Interpretative phenomenological analysis seeks to "explore in detail how participants are making sense of their personal and social world" (Smith & Osborn, 2004, p. 54). IPA is largely focused on the meaning individuals attribute to these experiences (Smith & Osborn, 2004). IPA data is collected by using structured and semi-structured interviews, transcribing the conversations, then identifying themes that speak to the meaning of the experience (Smith & Osborn, 2004). Further details of IPA methodology and data analysis will be discussed in Chapter III.

Summary

This chapter identified the research question, purpose of this study, the current research gap, and the researcher's connection to the research topic. Chapter II explores the existing research on opioids, how they effect the brain, and forms of opioid treatment, in addition to how MFT models make sense of treating substance use, as well as exploring the existing literature on factors that sustain long-term sobriety. Chapter III discusses the chosen methodology to answer the research questions of what made it possible for individuals to obtain at least 10 years sober from opioids.

CHAPTER II: LITERATURE REVIEW

Introduction

This chapter provides a review of the existing literature on opioids; what they are and how they affect the brain, treatment options, how marriage and family therapy theories view the treatment of substance use, and factors that sustain sobriety.

Opioids

Papaver somniferum, or the opium poppy, is a flowering plant with fruit seeds (Dittbrenner, Mock, & Lohwasser, 2009). Opium is known to grow naturally in parts of Asia and the Middle East, as well as South America (Brownstein, 1993). The use of opiates dates back as far as Greek mythology, where it was used in religious rituals. Opium use for medical purposes began in the 1500s to soothe crying children, alleviating stomach issues, and reducing pain. In the 1850s, doctors began using morphine as an anesthetic for surgeries (Brownstein, 1993). Morphine and other opioids are known to cause sedation, euphoria, and most notably, pain relief (Bryant & Knights, 2011). In 1946, methadone, a synthetic opium derivative, was developed as a pain reliever that is not considered as addictive as morphine (Brownstein, 1993). More recently, scientists have developed synthetic opioids such as fentanyl.

Currently there are two uses for growing opium plants, medicinal and food production. Opioids for medical purposes require a high content of alkaloids (Dittbrenner et al., 2009). Food production requires a low content of alkaloids (Dittbrenner et al., 2009). One commonly known low alkaloid opioid is the poppy seed, which are commonly found in poppy seed bagels. Alkaloids are naturally occurring organic compounds, morphine being the dominant alkaloid in opium, in addition to codeine and papaverine (Bryant &

Knights, 2011). Researchers have found that alkaloids target specific opioid receptors in the central nervous system. The central nervous system is comprised of the brain, spinal cord, and gut. The specific opioid receptors are "μ (m; mu), κ (k, kappa), and δ (d, delta)" (Bryant & Knights, 2009, p. 290). Research has also recently identified a new receptor called opioid-receptor like-1 (Pergolizzi, LeQuang, Berger, & Raffa, 2017).

Opioids are divided into three classes: opioid receptor agonists, partial agonists, and opioid antagonists (Pathan & Williams, 2012). Opioid agonists bind with a receptor, most often the μ (m; mu) receptor, which then prompts a specific physiological response (Vallejo, Barkin, & Wang, 2011). While there are many different types of opioids, the following are some of the more popular and commonly known opioid agonists: morphine, codeine, methadone, hydromorphone, tramadol, oxycodone, dextropropoxyphene, fentanyl, and heroin (Pathan & Williams, 2012). Opioids are known for producing the following effects: analgesia (pain relief), depression, euphoria, physical dependence, and respiratory sedation (Vallejo et al., 2011).

Morphine. Morphine is considered the gold standard for pain relief due to its potency (Trivedi, Shaikh, & Gwinnut, 2007). It is used to treat severe, chronic, and acute pain. It is often used in epidurals and anesthesia. Morphine was named after "Morpheus, the Greek god of sleep and dreams" (Bryant & Knights, 2011, p. 290). Codeine is considered a weaker opioid and is most often used for mild pain, cough suppression, and treating diarrhea (Trivedi et al., 2007). Methadone is often used in maintenance treatments for opioid dependence, as it takes longer to metabolize (Bryant & Knights, 2011)

Hydromorphone "is a semisynthetic opioid with a faster onset but a shorter duration than morphine" (Bryant & Knights, 2011, p. 296). Tramadol, a relatively new synthetic drug, that binds to the mu-opioid receptor and is known for its mild effects and decreased likelihood for misuse (Trivedi et al., 2007). Oxycodone is a potent synthetic opioid with a high likelihood for misuse (Bryant & Knights, 2011). Dextropropoxyphene is a synthetic opioid related to methadone and is not often used as a medication due to its dysphoric effects and cardiotoxicity (Bryant & Knights, 2011).

Fentanyl. Fentanyl is a highly potent synthetic opioid, used for severe pain, and is often used in anesthesia (Bryant & Knights, 2011). Fentanyl has also become popular with illegal drug users. "National overdose deaths attributed to fentanyl began to rise in 2013" (Ciccarone, Ondocsin, & Mars, 2017, p. 146) and is likely due to fentanyl's potency and difficulty in identifying when mixed with other substances. "Fentanyl deaths increased 520% from 2009 to 2016" (Manchikanti et al., 2018, p. 309). Researchers have found that illegal fentanyl is often mixed into heroin, making an overdose more likely (Carroll, Marshall, Rich, & Green, 2017). Researchers suggests that fentanyl is 50 to 80 times more potent than heroin (Ciccarone et al., 2017).

Heroin. Heroin is a highly potent illegal opioid. Heroin mainly comes in two forms; powdered (white or various shades of brown) or in tar form, known as black tar (Mars, Bourgois, Karandinos, Montero, & Ciccarone, 2016b). When consumed, heroin "is rapidly converted in the liver to morphine" (Bryant & Knights, 2011, p. 296). This makes heroin a popular choice for experiencing a fast rush of euphoria. When heroin is consumed, individuals may notice a euphoric feeling, sense of relaxation, as well as slowed breathing (respiratory depression) (Mars et al., 2016a). Intravenous injection "is

the most concentrated and efficient way to introduce opiates into the bloodstream" as compared to other ways of consuming opiates, like smoking or snorting (Mars et al., 2016a, p. 44).

As with all opioids, regular use of heroin leads to an increase of tolerance. According to DSM-V, tolerance is defined as "a need for markedly increased amounts of opioids to achieve intoxication or desired effect or a markedly diminished effect with continued use of the same amount of opioid" (American Psychiatric Association, 2013, p. 541). Researchers suggests that opioid tolerance is especially complex. Individuals may build up a tolerance to the respiratory effects of heroin and develop a tolerance to the euphoric effects at a different rate, thus increasing the likelihood of over-use (Mars et al., 2016a).

Partial agonists bind to the same opioid receptors but are only partially effective (Vallejo et al., 2011). Partial agonists are less effective and have less severe withdrawals than opioid agonist (Bryant & Knights, 2011). Buprenophine, a partial agonist, is used for moderate to severe pain relief and in treating existing opioid dependence (Bryant & Knights, 2011).

Opioid antagonists bind with the receptors to reverse the effects of opioid agonists (Bryant & Knights, 2011). Naloxone and Naltrexone are "used to reverse the adverse or overdose effects of opioid agonists" (Bryant & Knights, 2011, p. 297). Naloxone, also known by its brand name, Narcan, is fast-acting and often given when an opioid overdose is suspected to reverse the effects. Narcan is often used by first responders and medical staff. There are several community programs that provide Narcan to individuals actively using opioids to help in cases of suspected overdose (Drainoni et al., 2016). The sooner

an individual receives Narcan during a suspected overdose the more likely they are to survive (Drainoni et al., 2016).

Naltrexone is long-acting and often used as maintenance treatment of opioid dependence (Bryant & Knights, 2011). Naltrexone comes in three forms: a pill consumed daily, a shot received once a month, or an extended release device surgically implanted (Sigmon et al., 2012). When Naltrexone is used, an individual will not feel the effects of opioids if they attempt to use them. Naltrexone is used as a treatment modality to promote sobriety. Researchers suggests that Naltrexone has a 53% efficacy rate in maintaining sobriety (Sigmon et al., 2012).

Diagnostic and Statistical Manual of Mental Health Disorders. Opioid related disorders have been present in each of the five DSM editions. The first edition of the DSM was released in 1952; it's formal name in the DSM-I was "Acute Brain Syndrome, drug or poison intoxication", where opiates were listed among bromides and barbiturates (American Psychiatric Association, 1952, p. 15). Also, within the first edition addiction was identified as a personality disorder, specifically, drug addiction and alcoholism.

The second edition of the DSM, published in 1968, drugs/opioids were still considered a brain disorder but had the names of psychosis with drug or poison and non-psychotic organic brain syndrome with drug, poison, or systemic intoxication (American Psychiatric Association, 1968). Also, within the second edition there was a specific diagnosis for "drug dependence of opium, opium alkaloids and their derivatives" (American Psychiatric Association, 1968, p. 10). In this edition the diagnostic criteria for this diagnosis included "evidence of habitual use or a clear sense of need for the drug" (American Psychiatric Association, 1968, p. 45); it also went on to exclude prescribed

medication. Unlike the first edition, the second edition made distinctions between the substances such as, cocaine, cannabis, barbiturates, and hallucinogens (American Psychiatric Association, 1968).

The third edition of the DSM was published in 1980. With this edition substance use disorder emerged as its own category, not as part of another category as in previous editions (American Psychiatric Association, 1980). Opioid abuse and opioid dependence emerge as their own diagnoses, along with opioid organic mental disorders (American Psychiatric Association, 1980). This manual identified the specific diagnostic criteria for opioid abuse, which states:

> A. pattern of pathological use: inability to reduce or stop use; intoxication throughout the day; use of opioids nearly everyday for at least a month; episodes of opioid overdose (intoxication so severe that respiration and consciousness are impaired). B. Impairment in social or occupational functioning due to opioid use: e.g., fights, loss of friends, absences from work, loss of job, or legal difficulties (other than due to single arrest for possession, purchase or sale of the substance). C. Duration of disturbance of at least one month (American Psychiatric Association, 1980, p. 172).

After the third edition the American Psychiatric Association published a revised edition in 1987 (DSM-III-R) which further elaborated on substance use disorders and renamed the class, psychoactive substance use disorders (American Psychiatric Association, 1987). This edition removed the specific diagnostic criteria for each disorder of substance use and made one general criteria.

The fourth edition was published in 1994. Between the third and fourth editions, there was an increase in number of substances included in the substance use disorder category. In 2000 APA published a revised fourth edition (DSM-IV-TR). With each edition, the DSM increased the specificity of the features, specifiers, inclusion criteria, and diagnostic criteria. The fifth edition appears to be the most comprehensive edition in regard to research on the patterns associated with opioids as it identified at length the history of each disorder. The DSM-V (2013) has complied a set of 11 diagnostic criteria to identify opioid use disorder. The following is taken from the DSM-V.

> 1. Opioids are often taken in larger amounts or over a longer period than was intended. 2. There is a persistent desire or unsuccessful efforts to cut down or control opioid use. 3. A great deal of time is spent in activities necessary to obtain the opioid, use the opioid or recover from its effects. 4. Craving, or a strong desire or urge to use opioids. 5. Recurrent opioid use resulting in a failure to fulfill major role obligations at work, school, or home. 6. Continued opioid use despite having persistent of recurrent social or interpersonal problems caused or exacerbated by the effects of opioids. 7. Important social, occupational, or recreational activities are given up or reduced because of opioid use. 8. Recurrent opioid use in situations in which it is physically hazardous. 9. Continued opioid use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance. 10. Tolerance, as defined by either of the following: a. A need for markedly increased amounts of opioids to achieve intoxication or desired effect. b. A markedly diminished effect with continued use of the same amount of opioid. 11. Withdrawal, as manifested by

> either of the following: a. the characteristic opioid withdrawal syndrome. b. opioids (or a closely related substance) are taken to relieve or avoid withdrawal symptoms (American Psychiatric Association, 2013, p. 541).

An individual must experience at least two of the previously stated above during a 12-month period (American Psychiatric Association, 2013).

Effects on the Brain

As stated above, when opioids are introduced into the body, they produce a euphoric, relaxed, depressed, and a pain free experience. Researchers also suggested that opioids have other effects on the brain. Kosten and George (2002) stated that opioids trigger "the same biochemical brain processes that reward people with feelings of pleasure when they engage in activities that promote basic life functioning, such as eating and sex" (p. 14). The researchers stated that opioids activate the brain systems responsible for releasing dopamine, a chemical which releases feelings of pleasure, emotion, and motivation (Kosten & George, 2002). Researchers identified that the experiences of pleasure led to the creation of memories about the pleasurable experiences along with the environment and context in which they occurred. The researchers identified these memories as conditioned associations that contribute to the drug cravings (Kosten & George, 2002).

The chemical reactions in the brain have also been identified as influencing addiction. Kosten and George (2002) stated "particularly in the early stages of abuse, the opioid's stimulation of the brain's reward system is a primary reason that some people take drugs repeatedly" (p, 16). The researchers identified repeated consumption of opioids and increasing dosages, alters the brain's ability to function at a normal capacity

(Kosten & George, 2002). Researchers stated that the brain functions "more or less normally when the drugs are present and abnormally when they are not" (Kosten & George, 2002, p. 16); this is described as tolerance.

Tolerance occurs when the opioid receptors become less responsive to the presence of opioids and more opioids are needed in order to produce the same response (Kosten & George, 2002). Dependence also includes the brains ability to increase its production of certain chemicals when opioids are present, thus creating a new normal level of chemicals in the brain. When chronic opioid use is discontinued, an individual will experience symptoms of withdrawal as the brain readjusts to functioning prior to opioid consumption. Symptoms of withdrawal include jitters, anxiety, muscle cramps, diarrhea, vomiting, mental confusion, insomnia, dilated pupils, and possible seizures (Kosten & George, 2002).

Short term and long-term opioid use. As previously stated, when opioids are consumed the brain adjusts to the new influx of chemicals. Shortly after stopping the consumption, the brain has to re-adjust, often resulting in an over or under production of chemicals previously suppressed by the opioids (Krosten & George, 2002). Researchers suggested that due to the changes in the brain, activities like eating and sex, that once brought the individual a sense of pleasure, may no longer do so (Krosten & George, 2002). It is suggested that after chronic opioid use the brain functions abnormally when the substance is no longer present in the brain (Krosten & George, 2002); this triggers jitters, anxiety, muscle cramps, and diarrhea (Krosten & George, 2002). The DSM-V identified that withdrawal symptoms may begin to emerge within six to 12 hours after the final dose of opioids and may take two to four days to fully emerge (American

Psychiatric Association, 2013). In addition, the DSM-V stated that withdrawal symptoms from heroin "usually peak within 1-3 days and gradually subside over a period of 5-7 days" (American Psychiatric Association, 2013, p. 548). Other withdrawal symptoms, identified as chronic, include anxiety, dysphoria, anhedonia, and insomnia may last for weeks to months after the final dose (American Psychiatric Association, 2013). Withdrawal effects are often perceived as so uncomfortable that individuals continue to use to avoid withdrawals (Mitchell et al., 2009).

Krosten and George (2002) suggested that individuals can withdraw and detox from opioids and no longer be dependent on them but the addictive qualities of the drugs, in combination with the activation of the reward system in the brain, may have significantly longer lasting effects. Long-term effects of opioids may result in neurocognitive deficits. Bolshakova, Bluthenthal, and Sussman (2019) noted that these deficits include "impairments in verbal working memory, impulsivity, and cognitive flexibility (verbal fluency)" (p. 1109).

Cravings may also play a role in the short term and long-term effects of opioids on the brain. Craving is defined in the DSM-V as "a strong desire or urge to use opioids" (American Psychiatric Association, 2013, p. 541). Craving is also one of the identified diagnostic criteria for opioid use disorder.

Current Crisis

The opioid epidemic is considered the "most consequential preventable public health problem in the United States" (Manchikanti et al., 2018, p. 309). In 2016 "the United States accounted for 92% of the world's consumption of hydrocodone, 81% of the world's consumption of oxycodone and 60% of the world's consumption of

hydromorphone" (Bolshakova et al., 2019, p. 1107). Researchers, physicians, and other health care professionals noticed an increase in opioid use and addiction in 2000, but the factors contributing to the current crisis started many years prior with the emergence of pain as the fifth vital sign.

In 1980 a one paragraph letter to the editors appeared in the New England Journal of Medicine. This letter supported expanding the use of opioids. The authors of the letter stated that, according to their records, "only 4 of 11,882 patients who had pain and were given opioids became addicted to them" (Rummans, Burton, & Dawson, 2018, p. 345). As a result, this letter was referenced over 600 times in support of using opioids for expanded treatment of pain (Rummans et al., 2018). Beginning in the early 1990s, pain emerged as the fifth vital sign and with this there was an increased pressure on doctors to treat pain (Bolshakova et al., 2019). Also, around this time, Purdue Pharma, a private company owned by the Sackler family, a family of physicians, released the drug, OxyContin, used for treating pain. OxyContin was marketed to physicians as safe and non-addictive (Bolshakova et al., 2019, Van Zee, 2009). Part of Purdue's marketing of OxyContin included sales representatives bestowing gifts to physicians, tracking physician prescribing patterns, all-expenses paid trips to drug conferences, often at lavish resorts, and free samples to patients (Van Zee, 2009).

> One of the cornerstones of Purdue's marketing plan was the use of sophisticated marketing data to influence physicians' prescribing. Drug companies compile prescriber profiles on individual physicians—detailing the prescribing patterns of physicians nationwide—in an effort to influence doctors' prescribing habits. Through these profiles, a drug company can identify the highest and lowest

> prescribers of particular drugs in a single zip code, county, state, or the entire country. One of the critical foundations of Purdue's marketing plan for OxyContin was to target the physicians who were the highest prescribers for opioids across the country. The resulting database would help identify physicians with large numbers of chronic-pain patients. Unfortunately, this same database would also identify which physicians were simply the most frequent prescribers of opioids and, in some cases, the least discriminate prescribers (Van Zee, 2009, p. 222).

As stated above, Purdue Pharma implemented a free sample marketing strategy to patients. “Through the sales representatives, Purdue used a patient starter coupon program for OxyContin that provided patients with a free limited-time prescription for a seven to 30-day supply. By 2001, when the program was ended, approximately 34,000 coupons had been redeemed nationally” (Van Zee, 2009, p. 223). As a result of the combined marketing efforts, sales of OxyContin rose from $48 million in 1996 to $2.4 billion in 2012 (Bolshakova et al., 2019).

In 1998 Purdue Pharma claimed that only 1% of individuals taking OxyContin would become addicted. It was later found that the two studies Purdue Pharma used to make this claim were not replicable and the existing research about the potential addictive tendencies of OxyContin was ignored. (Bolshakova et al., 2019). By “2004 OxyContin had become the leading drug of abuse in the United States” (Van Zee, 2009, p. 221).

In May of 2007, Purdue Pharam and “3 company executives pled guilty to criminal charges of misbranding OxyContin by claiming that it was less addictive and less subject to abuse and diversion than other opioids. And will pay $634 million in

fines" (Van Zee, 2009, p. 226). In 2010 OxyContin was reformulated to Oxycodone ER (extended release) and be more difficult to abuse. Researchers noticed an increase in Heroin use around this time (Manchikanti et al., 2018). In 2016 pain was removed as the fifth vital due to its connection with big pharma sales and implications in the rise in opiate addiction (Manchikanti et al., 2018).

Brian Mann reporting for National Public Radio (NPR) reported in September of 2019 that Purdue Pharma, owned by the Sackler family, tentatively reached a deal that would fine Purdue Pharma about $3 billion dollars for its role in fueling the current opioid crisis. While details are still being finalized, it was suggested that "future revenue from the sales of OxyContin would go into a trust designed to help communities struggling with the opioid epidemic" (Mann, 2019, para. 6). The article also stated that in March of 2019 Purdue Pharma and members of the Sackler family "agreed to pay $270 million settlement and to pay legal fees to Oklahoma to avoid a trial over the company's role in the opioid crisis in that state" (Mann, 2019, para. 23).

It has been suggested that in addition to the false and unethical marketing of OxyContin, lack of consensus regarding appropriate dosing standards, lack of medical tests for pain, as well as prescription of opioids for minor injuries, all contributed to the rise of opioid over-prescribing and subsequent addiction (Bolshakova et al., 2019). According to Manchikanti et al., (2018), researchers, physicians, and law makers have now started to regulate opioids. Prescriptions for acute pain are now limited to a maximum 10-day course. There has been an increase in public education programs on the dangers of opioids and illicit drugs. Lawmakers partnered with pharmaceutical companies to reduce or eliminate co-payments for non-opioid pain management options.

First responders and medical staff are now equipped with an increased availability of buprenorphine, an opioid antagonist used to reverse the effects of opioid overdoses. Physician's have also engaged in an increased training and education on prescribing opioids, as well as educating patients upon receiving an opioid prescription.

Ratycz, Papadimos, and Vanderbilt (2018) suggested that historically medical school curricula "do not adequately cover or spend substantial time covering addiction medicine and that most doctors fail to identify or treat patients with substance abuse problems" (p. 2). The researchers suggested more training in "identifying patient risks including familiar, occupational, and economic factors, recognizing signs and symptoms of opioid and heroin abuse" as well as "following proper opioid prescription guidelines, and identifying systems-based practice for referrals of patients who are addicted, and proper Naloxone administration" (Ratycz et al., 2018, p. 3).

It is important to explore alternative perspectives of contributing factors to the current opioid crisis, not just the actions of Perdue Pharma. Rummans, Burton, and Dawson (2018) suggested that in a supply and demand economy, Purdue Pharma was the supply and individuals created the demand. The researchers called for an increase in education programs, legal options to address the influx of illegal opioids, and an increase in treatment options for individuals struggling with an opioid addiction (Rummans et al., 2018).

Traditional Forms of Treatment

Researchers suggests that only 10% of individuals struggling with an opioid addiction receive treatment, leaving thousands to struggle on their own (Rummans et al., 2018). There are five levels of care in the treatment of addiction. The American Society

of Addiction Medicine (ASAM) has defined each level of care on a continuum with specific criteria the individual may or may not meet in order to determine placement. When an individual addicted to opioids decides to enter treatment, they usually start with medically managed intensive inpatient services also known as detox (Mee-Lee, 2013). Detox is recommended in order to stabilize the withdrawal symptoms the individual may be experiencing. Trained medical staff oversee the detox process 24 hour per day in case any complications arise (Mee-Lee, 2013). Individuals in detox are typically confined to the medical facility with minimal contact with the outside world, for the duration of their stay. In this level of care counseling is offered 16 hours a day to attend to the psychological effects of withdrawal and sobriety (Mee-Lee, 2013). Withdrawal symptoms usually begin 8 hours after the last use of opioids and can last up to a week (Burma, Kwok, & Trang, 2017). Researchers suggests that withdrawal comes in two phases, early and late, both impact the nervous system (Burman et al., 2017). Early withdrawal symptoms include muscle aches, insomnia, anxiety, agitation and sweating (Burman et al., 2017). Late phase withdrawal symptoms include nausea, vomiting, diarrhea, and cramps (Burman et al., 2017). The researchers also state that the withdrawal symptoms can often be so uncomfortable that individuals are then motivated to use opioids again to avoid the withdrawal symptoms (Burman et al., 2017).

In detox, individuals are often given pharmacological support to lessen the significance of the withdrawal symptoms. The researchers suggest that current practice in withdrawal management is to engage in replacement therapy instead of an abrupt cessation (Burma et al., 2017). The researchers suggest prescribing replacement methods that are longer acting and less euphoric, compared to the fast acting and euphoric drug of

choice. This includes methadone and buprenorphine/naloxone (Suboxone), as well as non-opioid methods (Burman, et al., 2017).

Partial Hospitalization Program. After the withdrawal symptoms have been managed and stabilized, the individual will then enter partial hospitalization program (PHP) level of care. PHP level of care is a structured environment that is usually about 30 days long and includes intensive treatment and therapy. Individuals in PHP usually receive at least 20 hours or more of service each week. This includes group therapy, educational groups, family therapy, individual therapy, occupational and recreational therapy, as well as, psychiatric, medical, and laboratory services (Mee-Lee, 2013). The purpose of PHP level of care is to provide structure, stabilize symptoms, and help the clients learn coping skills.

Intensive Out-Patient. If an individual chooses to continue with formal treatment he or she then enter into intensive out-patient (IOP) level of care. IOP level of care consists of 9 hours per week of services like group therapy and individual therapy (Mee-Lee, 2013). Here the individual will likely began assimilating back into life. They may obtain a job, return to school, be able to attend outside NA meetings, and visit home (Mee-Lee, 2013). Relapse prevention strategies are often discussed and implemented at this level of care.

Relapse Prevention, a technique developed by Alan Marlatt and Katie Witkiewitz aims to prevent and manage relapses while teaching the individual strategies to make better informed choices and to avoid specific factors (Witkiewitz & Marlatt, 2004). Based on the cognitive behavioral therapy model, the relapse prevention approach has been successful in teaching clients about specific high-risk areas and behavioral skills.

This includes people to avoid, places to avoid, and events to avoid, in addition to coping skills (Witkiewitz & Marlatt, 2004).

Outpatient. Once the individual has completed IOP level of care they may continue to engage in outpatient (OP) services. Outpatient services are defined as less than nine hours of service each week (Mee-Lee, 2013). The main focus on OP level of care is to monitor progress and continue engaging in life tasks without the use of substances (Mee-Lee, 2013). Individuals in OP level of care may live in their private residence or live in a sober living home. One of the more well-known sober living homes is known as the Oxford House. Established in 1975, the Oxford House is a community-based peer-recovery residential setting (Jason et al., 2007).

> Each house is rented, multi-bedroom dwelling for same-sex occupants, located in low-crime, residential neighborhoods, and each operates democratically by majority rule and residents govern by electing house officers. . . houses are not over-crowded and rarely are there more than 12 people in a house. Similar to AA, they are financially self-supported and there are no professionals involved. However, unlike AA, there is no single, prescribed course for recovery that all members must follow (Jason, et al., 2007, p. 804).

The researchers also state that this supportive environment is an important factor in sobriety (Jason, et al., 2007).

Medication-Assisted Treatment. Medication-assisted treatment (MAT) is the use of methadone and/or buprenorphine, in low-doses administered by a physician, to regulate the presence of opioids in the body in order to avoid withdrawal symptoms. Over time the doses are reduced to eventual cessation. (McElrath, 2018). Medication-assisted

treatment is also suggested to lower the likelihood of overdose (Bell & Strang, 2020). The researcher suggests that currently buprenorphine is the preferred choice over methadone treatment (McElrath, 2018). Research in support of medication-assisted treatment suggest it is more effective than short term treatment or no treatment (Bell & Strang, 2020). This suggests medication assisted treatment programs are useful in reducing relapses and maintaining sobriety. While methadone an opioid agonist, and burprenorphine, a partial agonist, Naltrexone, an opioid antagonist, is also used in treating opioid use disorder. As previously stated, Naltrexone is used to block the effects of opioids in the nervous system (Bell & Strang, 2020).

Narcotics Anonymous. DeLucia et al., 2016 states that Narcotics Anonymous (NA) is considered an evidence-based form of treatment and accessible option to many individuals struggling with addiction. Founded in 1953, NA is a community based, peer-led, mutual help group specifically for people who self-identify with a substance use problem (DeLucia et al., 2016). Powerlessness is at the core philosophy of NA, as stated in the Basic Text "We are powerless over addiction and our lives are unmanageable" (Narcotics Anonymous, 2008, p. 15). Prior to admitting one's powerlessness over addiction, the individual must first identify and embrace the addict identity. This is embraced at the beginning of every meeting where attendees introduce themselves and identify as an addict (DeLucia et al., 2016). Narcotics Anonymous suggest that acceptance of powerlessness, identity as an addict, and reliance on their higher power are the keys to recovery. Individuals who subscribe to NA follow the twelve steps which are as follow:

1. We admitted we were powerless over our addiction, that our lives had become unmanageable.
2. We came to believe that a Power greater than ourselves could restore us to sanity.
3. We made a decision to turn our will and our lived over to the care of God as we understood Him.
4. We made a searching and fearless moral inventory of ourselves.
5. We admitted to God, to ourselves, and to another human being the exact nature of our wrongs.
6. We were entirely ready to have God remove all these defects of character.
7. We humbly asked Him to remove our shortcomings.
8. We made a list of all persons we had harmed and became willing to make amends to them all.
9. We made direct amends to such people whenever possible, except when to do so would injure them or others.
10. We continued to take personal inventory and when we were wrong promptly admitted it.
11. We sought through prayer and meditation to improve our conscious contact with God as we understood Him, praying only for knowledge of His will for use and the power to carry that out.

12. Having had a spiritual awakening as a result of these steps, we tried to carry this message to addicts, and to practice these principles in all our affairs (Narcotics Anonymous, 2008, p. 17).

According to Narcotics Anonymous suggest the philosophy of change occurs through the process of engaging in the twelve steps and following the recommendations. Narcotics Anonymous advocates for working with a sponsor; a person who has time sober and has gone through the steps themselves (DeLucia et al., 2016). Research suggests that consistent engagement in NA is associated with positive outcomes (DeLucia et al., 2016). Criticism of Narcotics Anonymous highlight the duplicity of identifying as both a disease model approach and a moral failing approach to addiction. Szalavitz (2016) stated "while 12 steppers claim that addiction is a disease, they don't treat it like one. Imagine a psychiatrist telling a depressed person to surrender to God and take a moral inventory—of better yet, imagine thing being proposed to treat cancer" (p. 184). Relapses are also seen as a moral failing.

Systemic Approaches

Solution Focused Brief Therapy. Developed by Insoo Kim Berg and Steve de Shazer, solution focused brief therapy (SFBT), is a strength based, relational, evidence-based approach that focuses on the following eight main assumptions:

> "change is constant and inevitable; small changes result in bigger changes; …concentrate on the future; people have the resources necessary to help themselves: they are the experts, every human being, relationship and situation is unique; everything is interconnected; every problem has at least one exception;

> therapy is not the only way people change, there are many things that are therapeutic" (Simon & Berg, 1999, p. 118).

The therapeutic relationship is central to SFBT and needs to be established before diving into any therapeutic change. Solution focused brief therapy is built on a collaborative relationship between the therapist and client. A significant amount of time is spent connecting, joining, understanding context, and validating the client Simon & Berg, 1999). Therapeutic connection and joining are fundamental to Carl Roger's (1992) Common Factors, specifically through the use of empathy.

> To sense the client' private world as if it were your own, but without ever losing the "as if" quality—this is empathy. To sense the client's anger, fear, or confusion as it if were your own, yet without your own anger, fear, or confusion getting bound up in it (p. 829).

Validation and understanding of the client's context and problem comes from *formulation*. "Formulation, in the therapeutic context, occurs when the therapist summarizes what the client said and this summarization demonstrates that therapist's attention on the client' perspectives" which helps facilitate the therapeutic relationship (Reiter & Chenail, 2016, p. 2).

It is important that SFBT therapists work within the client's perspective. As with all strength-based family therapy theories, SFBT therapists view the client as the expert in their own lives. "A solution-focused therapist works under the assumption that the client has the answer to his or her own problem and the skills and resources needed to carry it out" (Berg et al., 2000, p. 1). Identifying the client as the expert of their own lives is an idea based on the influence of social constructionism. Social constructionism

"maintains that people develop their sense of what is real through conversation with and observation of others" (Berg & De Jong, 1996, p. 376). Through a social constructionist view change often emerges through the process of exploring new perceptions of reality.

The role of a SFBT therapist is to collaborate with the client to identify solutions. According to Berg and De Jong (1996), solutions are "changes in perceptions, patterns or interacting and living, and meaning that are constructed within the clients frame of reference" (p. 377). A solution focused brief therapist is often focused on exceptions; times when the problem was not a problem. While SFBT therapists do not often explore the past, they will do so in order to identify 'what worked' and how this can be incorporated into current solutions (de Shazer, 1985). Solution focused brief therapy stated that change is constant and the result of doing something different. (de Shazer, 1985). Berg and Miller (1992) suggested that in order to facilitate change, goals need to be relevant to the client, as well as small, concrete, specific, and observable. Hope is also a fundamental principle of solution focused brief therapy. Hope in therapy is the assumption that situations will improve. Reiter (2010) suggested that hope is intertwined with the expectation of change.

Solution Focused Brief Therapy has been applied to addiction in several notable works. In the book, *Working with the Problem Drinker* (1992), Insoo Kim Berg and Scott Miller apply SFBT to their work with individuals struggling with addiction. The authors stated, "the clients strengths, resources, and abilities are highlighted rather than their deficits and disabilities…rather than looking for what is wrong and how to fix it, we tend to look for what is right and how to use it" (Berg & Miller, 1992, p. 3). The authors also suggested that SFBT therapists work from the premise that healthy patterns already

exist. As a main principle of SFBT, identifying exceptions is a conduit to identifying solutions. Exceptions may be times when the client did not drink or use drugs in a situation when they previously would have. This is in contrast with the Alcoholics Anonymous and traditional psychotherapy approach to addressing client's problems where discovering the root of the problem is considered success (Berg & Miller, 1992). Berg and Miller also differ in their ideology that change needs to be on a large scale for the clients. The authors state "a small change in one area can ultimately result in profound differences in many other areas" (1992, p. 10). Solution focused therapists may not directly address substance use in a client's life with the assumption that small change in one area may lead to change in other areas. Solution focused brief therapy also differs from the traditional approach to treating addiction and the Alcoholics/Narcotics Anonymous approach on the views of change. AA and NA believe change can only happen when the individual fully acceptances the "addict identity' and surrenders to their higher power (Narcotics Anonymous, 2008). Whereas SFBT view change as naturally occurring and "so much a part of living that clients cannot prevent themselves from changing… oftentimes then, therapy becomes a matter of simply identifying those naturally occurring changes and then utilizing them in brining about a solution" (Berg & Miller, 1992, p. 11).

Solution focused brief therapy view the role of the family as crucial in working towards change. According to Berg and Reuss (1998) solution focused therapists involve the family in substance use treatment as a source of information, strengths, and potential solutions. This is in direct contrast to the traditional approach to families in addiction treatment, where families are often seen as contributors and enablers to the substance use.

In fact, Berg and Reuss (1998) believe that telling family members they are enabling their loved one can be damaging to the relationship. Instead, solutions focused therapists view family members as having an "enormous capacity to tolerate frustration with unlimited patience and undying hope" (Berg & Reuss, 1998, p. 27). A solution focused therapists goal is to elicit strengths from the family while also exploring their solution attempts as potential sources of information for new solutions (Berg & Reuss, 1998).

Lutz (2017) suggested when working with individuals that are struggling with an addiction to opioids, it is important to explore "what clients are good at, what they enjoy, and how they learned these skills, they will need to use these attributes to help them overcome their addiction" (para.4). The author also suggested that even when an individual has a difficult time identifying strengths and resources, they often have many untapped skills for maintaining their drug use (Lutz, 2017). The author stated "one client responded that she is good at using, buying, and selling drugs. Complimenting her entrepreneurial spirit, ability to make connections, and courage were all skills that could be re-directed towards positive means" (Lutz, 2017, para. 4). The author identified the importance of complimenting the loved ones and families of those struggling with addiction. Family members are often scared and feel helpless when their loved one is struggling with addiction (Lutz, 2017). "Complimenting loved ones on their efforts to get their loved ones into treatment and how they accomplished this often uncovers tremendous resources on the part of the family" (Lutz, 2017, para. 4). In line with SFBT the author suggested using "for you statements". Lutz suggests that for you statements may be helpful for clinicians and family members in building emotional agreement as well as validation and acknowledgement. An example of a for you statement may be how

scary it is for you to see your child struggling with heroin use or it must be so difficult for you to be forced into treatment (Lutz, 2017).

Narrative Therapy. Developed by Michael White and David Epston, Narrative therapy views stories as the tool in which people use to make sense of their lives and experiences. White and Epston suggested that people derive meaning from their stories that help shape their perspective and identities (White & Epston, 1990). White suggested that when problems arise this often leads people to internalize the problem, seeing it as something within themselves (White, 2007). Narrative therapists seek to explore and develop alternative narratives or stories to the problem saturated ones (White, 2007). Therapists do this by exploring unique outcomes which are "experiences that would not be predicted by the plot of the problem-saturated narrative" (Freedman & Combs, 1996, p. 67).

As it relates to addiction, Narrative therapy takes the approach of viewing addiction through a social lens. White suggested that we live in a "culture of consumption", identifying how society contributes to over consumption in many ways (White, 1997, para.1). In regard to treatment, White suggested that individuals will be disappointed if their goal is to stop consumption all together. He suggested instead changing the individual's relationship to consumption (White, 1997). This is done in part by normalizing and acknowledging the possibility of 'turning back' or 'back to square one' on the journey. He also suggested sharing "maps of the journeys made by others" (White, 1997, para. 6). This can provide a roadmap for what has helped others and sense of community. Narrative therapists may also explore externalizing conversation which

challenge the idea that the problem is located within the person. This is commonly referred to as, the person is not that problem, the problem is the problem (White, 2007).

A fundamental goal of narrative therapy is to explore and develop alternative narratives that are less socially constraining. This may be problematic when individuals refer to themselves as "an addict". A narrative therapist may identify and understand how this label may be limiting. A narrative therapist may work with an individual to explore the implication of these labels, challenging them and inviting new ideas if the label becomes problem saturated.

Structural Family Therapy. Most notably developed by Salvador Minuchin, views relationships and families through the lens of structure, boundaries, patterns, rules, and systems (Minuchin & Fishman, 1981). The rules that govern interactions are created and maintained by the members of the family (Minuchin & Fishman, 1981). According to Minuchin (1974) "family members relate according to certain arrangements, which govern their transactions" (p. 89). Structural therapy focuses significantly on boundaries. Boundaries are defined by three categories: diffuse, ridged, or clear (Minuchin, 1974). "Ridged boundaries have difficulty or lack in communication and maintain overly structured, restrictive interactional patterns and can lead to disengagement" (Gehart & Tuttle, 2003, p. 25). "Diffuse boundaries are apparent when the behavior of one member in the system immediately affects the entire system leading to enmeshment" (Gehart & Tuttle, 2003, p. 25). Clear boundaries "define 'normal' relationships and appropriate family functioning. Clear boundaries are well defined and allow the members of the system to function with levels of independence" (Gehart & Tuttle, 2003, p. 25).

From this framework, substance abuse is a reflection of dysfunctional family structures, specifically as it relates to boundaries, patterns, family rules, and communication (Reiter, 2019). Attention is often focused on how family members organize around the addiction. Stanton and Todd (1982), pioneers in structural therapy and addiction, would suggest that a dysfunctional family system interact in repeated patterns thus perpetuating the dysfunction. Structural family therapists may explore challenging family assumptions, challenging the existing structure, and addressing boundaries when working with addiction.

Strategic Therapy. Developed by Jay Haley and Cloe Madanes with influence from Gregory Bateson, Milton Erickson, and Salvador Minuchin, Strategic therapy explores how symptoms shape family interactions. Haley (1976) stated "treating an individual for symptoms is like assuming a stick has one end" (p. 155). Strategic therapy identify symptoms and problems within the context of the family system (Haley, 1973). Strategic therapy view symptoms as the family's way of maintaining the status quo while solutions tend to disrupt the equilibrium (Haley, 1976). Strategic therapy view relationships through the lens of hierarchy, the organization of power within the system (Haley, 1976). Madanes (1981) defined hierarchy as the "repetitive sequences of who tells whom what to do" (p. 145). Strategic therapy view problems or disruptions to the natural hierarchy when an inappropriate hierarchical position occurs (Haley, 1976). For example, when a child is in a higher hierarchical position than the parent(s).

Strategic therapists also emphasize life cycles individuals and families experience. Haley, drew from studies of natural and animal behavior, identified six stages: the courtship period, marriage and its consequences, childbirth and dealing with the young,

middle marriage difficulties, weaning parents from children, and retirement and old age (Haley, 1976). Haley suggested that problems and symptoms arise when there is a disruption in the cycle or during a transition period (Haley, 1976). The goal in strategic therapy is to disrupt the inappropriate hierarchical relationships and return them to the status quo (Haley, 1976).

As it relates to addiction, a strategic therapist may explore the factors and family interactions that are maintaining the addiction. It has been suggested that addiction arises out of the transitional period in the family life cycle. At each various stage in the family life cycle, the individual may turn to substances to cope during the transition due to failure to adapt (Reiter, 2019). A strategic therapist may then use metaphors, paradox, and, directives to encourage behavioral change.

Natural Systems Theory. Also known as Intergenerational family therapy or Bowen family systems, was pioneered by Murray Bowen. Natural systems theory "is based on the assumptions that the human is a product of evolution and that human behavior is significantly regulated by the same natural process that regulate the behavior of all other living things" (Kerr & Bowen, 1988, p. 3). Bowen's research and ultimate theory intended to identify "basic relationship processes that operate in the background in all families" (Kerr & Bowen, 1988, p. 4). Bowen's research resulted in eight main concepts: differentiation of self, triangles, nuclear family emotional process, family projection process, multigenerational transmission process, emotional cutoff, sibling position, and societal emotional process (Kerr & Bowen, 1988; Reiter, 2019).

Differentiation of self is "the lifelong process of striving to keep one's being in balance through the reciprocal external and internal processes of self-definition and self-

regulation" (Freedman, 1991, p. 140). An individual's level of differentiation of self is related to anxiety. Kerr and Bowen (1988) see anxiety as either acute, a response to real threats, or chronic "a response to imagined threats and is not experienced as time-limited" (p. 113). One's level of differentiation is often thought of as on a continuum of the feeling system and thinking system (Reiter, 2019). According to Reiter (2019)

> those who are better able to choose which process they are operating from tend to function higher on the scale of differentiation. Those who cannot choose and are governed by their feeling process rather than their own thinking process are considered to be functioning toward the lower end of the differentiation scale (p .419).

According to Bowen, triangles describe "the dynamic equilibrium of a three-person system" (Kerr & Bowen, 1988, p. 135). Kerr and Bowen (1988) also stated that triangles are influenced by anxiety. When anxiety is low two people can comfortably maintain a relationship. When anxiety increases the two-person system may be unstable where an additional person is introduced, as a way to manage the anxiety. The third person may be a friend, child, family member, or substance like drugs and alcohol (Reiter, 2019).

Kerr and Bowen (1988) described alcohol or drug use as a chronic symptom. A chronic symptom develops as the result of an attempt to return the system to equilibrium. For example, Kerr and Bowen (1988) explored how a poorly differentiated husband and wife's two-person system was disrupted after childbirth. As an attempt to manage the anxiety and system disruption, the wife develops a significant drinking problem. "The reactivity of the parents to one another precludes reduction of anxiety through support

provided by the marital relationship. In lieu of the relationship, drinking can provide some relief from anxiety" (Kerr & Bowen, 1988, p. 114).

When working with addiction, a Bowen therapist may use the eight concepts as the lens to view and make sense of addiction in the family system. Additionally, a Bowen therapist has two goals: "(a) reduce the level of relationship anxiety in the family system and (b) introduce increased abilities to think about how the family operates as an emotional system. Highlighting, understanding, and reducing the automatic emotional reactions people have to one another help move people to a different level of understanding themselves" (Burnett, 2013, p. 69).

Existing Research on Sustaining Sobriety

According to Laudet, Savage, and Mahmood, "one of the most important single prognostic variables associated with remission from addiction is having something to lose" (2002, p. 309). The authors found that the median length of sobriety of the individuals in their study was 12 years. Most of these individuals discussed hitting bottom and losing everything as a turning point in their recovery process (Laudet et al., 2002). The authors suggested that during the process of recovery an individual rebuilds their life (i.e., employment, housing, health, relationships, and self-esteem) which leads to the influence of anticipated consequences of loss if sobriety is not maintained (Laudet et al., 2002).

Leclair et al. (2020) categorized factors of recovery into five domains: functional, physical, clinical, social, and existential. The functional domain includes obtaining employment, education, and securing housing. Physical includes addressing physical concerns and improving physical health through recovery. Clinical refers to addressing

the individual's mental health symptoms. Social addresses the individuals peer-support, relationships, and sense of community. The existential domain refers to rebuilding self-esteem, gratitude, hope, resiliency, and spirituality (Leclair et al., 2020, Witley & Drake, 2010). Best et al., (2013) refered to these domains as recovery capital.

Employment can often make a significant difference in one's recovery. Eddie et al., (2020) suggested that employment is a buffer for relapse due to employment providing "structure, purpose, meaning, income, and greater knowledge" (para. 1). The authors also suggested that employment is necessary in recovery as it provides access to health insurance, ability to live independently, and financial security (Eddie et al., 2020). The authors found that individuals in recovery who obtain and maintain employment are less likely to relapse and achieve sustained remission (Eddie et al., 2020).

Housing is an important factor in sustaining sobriety. Housing is often divided into two categories; sober living and independent living. Oxford Houses are well known and international sober living homes. Sober living is often peer to peer support and not part of a treatment or recovery center. Sober living homes are also abstinence based and self-supporting (Mericle, Miles, & Way, 2015). Independent living is living on one's own. Leclair et al., (2020) defined stable housing as "living in one's own room, apartment, or with one's family, and expecting to remain in this residence for at least 6 months or having tenancy rights" (p. 476). A supportive living environment was shown to increase sobriety and functioning in quality of life (Leclair, 2020).

Education has been identified as an important factor in supporting and sustaining long term recovery. Eddie et al., (2020) suggested that education is important due to building new skills and increasing the individual's access to resources. Crutchfield and

Dominik (2019) suggested that education and vocational achievements allow for alternative perspectives to the addict identity and support long term sobriety. The authors study found that "those who have achieved an advanced certification, license, or degree since getting clean report almost twice as much clean time as those who did not" (Crutchfield & Dominik, 2019, p. 370).

Health is identified as one of the five important domains in sustaining recovery. Substance use disorders have been shown to increase the risks of a variety of health concerns: liver disease, cardiovascular disease, diabetes, pulmonary disease, lowered immune functioning, HIV, and hepatitis C (Jeynes & Gibson, 2017). The authors suggested that drug use often lead to nutritional deficiencies. Drug use has been "shown to impair the body's ability to access nutrients" (Jeynes & Gibson, 2017). The authors suggested nutritional education and a nutritionally balanced diet are important factors in quality of life and sustained recovery (Jeynes & Gibson, 2017). Fitzgerald (2017) looked at the influence of exercise on recovery. Participants in his study identified as being in recovery engaged in yoga, strength training, or cardio exercise. Fitzgerald found that exercise increased confidence, positive body image, self-efficacy, and decreased anxiety contributing to sustained remission in substance use (2017).

Clinical health is the third domain outlined by Leclair et al., (2020) in sustaining recovery. Co-occurring disorders, substance use and a mental health issue, are common among individuals struggling with substance use. Bergly, Hagen, and Grawe (2015) identified 41% of individuals sampled in their study had co-occurring disorders in treatment for substance use. Timko et al. (2017) suggested that mental health treatment is vital in sustaining sobriety. The study found that individuals who received mental health

services in addition to substance use treatment had higher rates of sobriety at the three month post-treatment period. Mental health support in the form of psychotherapy, medication, group therapy, and psychoeducation was found to increase self-efficacy, motivation, and increase coping skills (Timko et al., 2017).

Peer support and relationships are a part of the social domain in sustaining recovery according to Leclair et al., (2020). Pettersen et al., (2019) stated that in order to "reach or maintain abstinence, it is crucial to maintain positive relationship and to engage self-agency to protect oneself from being influenced by negative relationships" (Pettersen et al., 2019, p. 5). The authors stated that the relationships in the individual's life must not be a source of shame or guilt. The authors identified that the role of a 12-step program and sponsor is "a crucial factor for initiating abstinence" (Pettersen et al., 2019, p. 6). Also, their study supports the importance of "service providers" or therapist and clinicians as influential in sustaining recovery. Pettersen et al. stated "a caring relationship with a service provider seems to be helpful both for adhering to [substance use disorder] treatment and for promoting successful treatment" (1029, p. 6). This appears to be in direct relation to the family therapy theories, as relationships are central. Therapists often work towards connecting clients with resources, exploring shifts in identity, and encouraging meaningful supportive relationships.

The existential domain in sustaining recovery includes hope, resiliency, gratitude, and spirituality. Shumway and Kimball (2012) defined hope as "a reawakening after despair and the ability to expect with greater confidence" (p. 9). Hope is described as "focused on the internal belief that one will have the energy and will to bring about change, as well as the belief that there are ways or avenues through which change can be

accomplished" (Bradshaw et al., 2015, p. 316). Hope is also influenced by an individual's engagement in meaningful activities. Nordaunet and Saelor (2018) defined meaningful activities as engaging in activities related to personal interests. Best et al., (2013) found that individuals engaged in meaningful activities showed a reeducation in substance use, sustained recovery, and higher quality of life. Best et al., (2013) also suggested that individuals engaged in meaningful activities are more likely to develop positive sense of identity and sense of self.

Hope is a fundamental component of solution focused brief therapy and imperative to change. Berg and Reuss stated "we believe that unless we have absolute hope we cannot inspire hope in others" (Berg & Reuss, 1998, p. 57). Therapists hope often translates to the client having hope for their current problem.

Resilience is defined as "a positive adaptation despite significant adversity" (Rudzinski et al., 2017, p. 2). The authors also suggested that resiliency can be conceptualized as a trait, an outcome, as well as a process. Fletcher and Sarkar (2013) made the distinction between resiliency and coping suggesting that "resilience influences how an event is appraised, whereas coping refers to the strategies employed following the appraisal of a stressful encounter" (p. 13). Rudzinski et al., (2017) found that resiliency directly influences substance use. They suggested that an increase in an individual's perception of resiliency decreases the likelihood of substance use. The authors also suggested that resiliency is intertwined with quality of life factors like employment, housing, access to healthcare, positive social relationships, and peer support, as these factors directly influence resiliency.

Gratitude is defined "as a valuable emotion that improves the individual's subjective well-being, a character strength that promotes coping strategies for dealing with stress, and an attitude toward life that fosters prosocial behavior" (Chen, 2017, p. 120). Gratitude has been linked to greater life satisfaction, positive affect and optimism, lower depressive symptoms, and greater overall well being and emotional health (Chen, 2017). Chen (2017) found that gratitude is linked to prosocial behaviors including "strengthening social bonds and friendships. Grateful people are less likely to engage in hostile or destructive behavior, are more empathetic, generous, and supportive to help others" (p. 122). Chen (2017) found that "the more one expressed gratitude the less likely one is to engage in negative coping styles including substance use" (p. 123).

Spirituality is a part of the existential domain in recovery but also relates to the social domain in connecting with others. Spirituality can be defined in many ways. Ghadirian and Salehian (2018) stated spirituality is the "search for the sacred, a process through which people seek to discover, hold on to and, when necessary transform whatever they hold sacred in their lives" (p. 75). The authors also suggested that spirituality is one of the most important factors that ascribes meaning to our existence and influences overall quality of life. Ghadirian and Salehian (2018) and White and Laudet (2005) found that individuals with higher degrees of spirituality were less likely to consume drugs or relapse. White and Laudet (2005) stated that "there is growing evidence that spirituality can serve as an antidote for substance use disorders" (57). Spirituality and a connection to a higher power are main components in Alcoholics Anonymous and Narcotics Anonymous. Ghadirian and Salehian (2018) suggested that twelve step programs are essential to the process of recovery in their search for meaning.

The authors stated that involvement in religion and spirituality fosters empathy, forgiveness, acceptance, and a positive attitude. Involvement in religious or spiritual activities also fosters community connection and social relationships, all of which have been found to decrease substance use (Ghadirian & Salehian, 2018).

Summary

This chapter identified a basic understanding of opioids; where they came from, the difference between them, and how they affect the brain and body. This chapter also identified the factors contributing to the current opioid crisis in the United States. An in-depth look at solution focused brief therapy illuminated the researcher's theoretical orientation and lens to viewing the research question. Additional theories provide context and offer how other MFT theories view substance use. Factors identified by existing researchers highlighted factors that sustain sobriety. Chapter III discusses the chosen methodology for this study as well as the participants in the study.

CHAPTER III: METHODOLOGY

Introduction

In this chapter, I have explored the use of qualitative research, specifically interpretative phenomenological analysis (IPA) to explore what made it possible for individuals to obtain at least 10 years sober from opiates? To answer this question, I interviewed individuals in recovery to share their stories and experiences. In this chapter, I explored the justifications for selecting qualitative research, specifically interpretative phenomenological analysis for this study. Finally, I describe the rational for the selection of participants, data collection and analysis, as well as quality control including ethical considerations.

Qualitative Research

Qualitative research is often used in the social sciences to illuminate meaning, descriptions, and experiences (Creswell, 2007). Denzin and Lincoln (1994) describe qualitative research as the "study of things in their natural setting, attempting to make sense of or interpret phenomena in terms of the meanings people bring to them" (p. 2). Qualitative research is also described as studying the given topic in context (Hays & Singh, 2012). Understanding behavior in context is central for family therapists. Becvar and Becvar (1998) stated "all behavior makes sense, or is logical, within a given context" (p. 19).

In order to answer what made it possible for an individual to obtain 10 years sober from opiates, this study engaged in a detailed look into the experiences and the perceptions of the individuals and their sobriety. This study contributes to the field of family therapy and those struggling with addiction by providing further information as to

what makes recovery possible and to further help define long term sobriety/sustained recovery. Accordingly, this study used a phenomenological approach in order to obtain a detailed description and understanding of the lived experiences of individuals sober from opiates.

Interpretative Phenomenological Analysis

Phenomenological research is the study of "things in their natural setting, attempting to make sense of or interpret phenomena in terms of the meanings people bring to them" (Denzin & Lincoln, 1994, p. 2). Interpretative Phenomenological Analysis (IPA) was selected for this study due to the emphasis placed on the participants lived experience, meaning, and sense making of these experiences. Smith and Osborn (2009) stated "IPA is a suitable approach when one is trying to find out how individuals are perceiving the particular situations they are facing, how they are making sense of their personal and social world" (p. 26). IPA is also interested in how "the researcher makes sense of the participants trying to make sense of their world" (Smith & Osborn, 2009, p. 25) this is called double hermeneutics. IPA research does not claim to make generalizations but rather a statement about a particular population (Smith & Osborn, 2009). There are three key philosophical features within interpretative phenomenological analysis.

Phenomenology

Phenomenology is a "philosophical approach to the study of experience" (Smith & Osborn, 2009, p. 11). As a philosophical idea, phenomenology explores the "rejection of the presupposition that there is something behind or underlying or more fundamental

than experience" (Ashworth, 2015, p. 11). Developed by Edmund Husserl in the early 1900's, this philosophical approach was in contrast with the thinking of the time that was influenced by Freud and Behaviorism (Ashworth, 2015). Behaviorism is the study of behavior and emerged as an observable area for scientific study as compared to consciousness (Ashworth, 2015).

Husserl wanted the social sciences to focus on what is experienced and not assumptions from the researcher (Ashworth, 2015). Epoché is a fundamental component of phenomenology and is described as the researcher setting aside any assumptions of "the cause of that experience, or its motivation, and any claims made in the literature about the nature of such experiences" (Ashworth, 2015, p. 11). Husserl viewed each individual as "a conscious agent, whose experience must be studied from the 'first-person' perspective" to identify their unique understanding and meaning attributed to the experience (Ashworth, 2015, p. 12).

Idiography

Developed by G.W. Allport, idiographic psychology has shaped phenomenological research with his contribution of focusing on the particular individual (Ashworth, 2015). Idiography is the "detailed examination of particular cases, in understanding how particular people have experienced particular events. It does not eschew generalizations but works painstakingly from individual cases very cautiously to more general claims" (Smith & Osborn, 2009, p. 27). Idiography allows the researchers to focus on the precise experiences and understandings of the individual while making some generalizations about the specific population (Smith & Osborn, 2009).

Hermeneutics

Hermeneutics is the theory of interpretation (Ashworth, 2015). Smith and Osborn (2009) stated that "the aim of the interpretative process is to understand the writer, as well as the text" (p. 22). In practice this looks like a grammatical interpretation of what the text means and a psychological interpretation of the author (Smith & Obsorn, 2009). The authors also state that interpretation "is not a matter of following mechanical rules. Rather it is a craft or art, involving the combination of a range of skills, including intuition" (p. 22). IPA uses double hermeneutics, a two-stage interpretation process, "sense-making by both the participant and researcher" (Smith & Osborn, 2009, p. 26). As a result, IPA researchers document and identify their assumptions, biases, and reactions to the data as part of the research process (Smith & Osborn, 2009).

Participants

IPA methodology generally has small participant sample sizes. Smith and Osborn (2009) suggested anywhere from one participant, to six, to as many as fifteen. Participants are selected based on how closely they identify with the defined research group, this is called purposive sampling (Smith & Osborn, 2009). Participants are also selected based on similar demographic and socio-economic status (Smith & Osborn, 2009).

Inclusion Criteria

For this study, participants must meet the following criteria. Participants must identify as in recovery/sober/abstinent from opioids for at least 10 years. The 10 years must not be interrupted with periods of drug use. Participants must also have met the criteria for substance use disorder at some point in their time of use.

Participants in the study must be legal age of consent. The reason for including participants above 18 years of age is that they more likely to have at least 10 years sober from opiates and are legally able to consent to participate in research. This study did not exclude participants for using additional substances during their time of use as long as they self-identified as opioids as their main drug of choice and met the above stated criteria. This study does not distinguish between heroin or prescription pills.

Similar studies reported having higher male participants than female. As well as, more participants that identify as white than other ethnicities (Huser et al., 2015; Ling et al., 2019). The participants in this study all identify as male. Participants are middle aged from the south and south east United States. Participants had access to technology. The inclusion criteria are in accordance with IPA methodology, "IPA researchers usually try to find a fairly homogeneous sample, for whom the research question will be meaningful" (Smith et al., 2009, p. 49).

Participant Recruitment

My first recruitment strategy utilized my friendships and contacts within the recovery community to identify possible participants. I worked as a therapist in a substance use recovery center for several years in south Florida. There I not only worked with the clients but with recovery support staff, which included behavior technicians, intake coordinators, and case managers. I used these relationships as gatekeepers for participant recruitment. The participants are not former clients or the colleagues I personally know, in order to avoid multiple relationships. The gatekeepers distributed my IRB approved flyer to potential participants. Participants contacted me through my university email where I briefly interviewed them to ensure they met the inclusion criteria

for this study. Throughout the interview's participants referred possible participants to me via snowball sampling. The following are the participants in this study.

Chris. A 55-year-old Black male from the Southern region of the United States. Chris reported having 25 years sober from opioids. Chris identifies as Christian. Chris reported multiple substance during times of use, however, identified heroin as the main drug of use.

J.C. A 37-year-old White male from the South Eastern region of the United States. J.C. reported 16 years sober from opioids. J.C. Identified as Christian. J.C. reported using prescription opioids during his time of use.

Joey. A 43-year-old White male from the southern region of the United States. Joey reported having 11 years sober from opioids. Joey identified as Baptist.

Lance. A 41-year-old White male from the north eastern region of the United States. Lance reported 18 years sober from heroin and prescription opioids. Lance identifies as Jewish.

Justin. A 40-year-old White male from the north eastern region of the United States. Justin reported having 18 years sober from prescription opioids. Justin identifies as Christian.

Data collection

Data was collected via video interviews on Zoom. Video interviews were the chosen method given the current health pandemic and to increase participant capture while not limiting participants due to their location. The interviews were semi-structured. Semi-structure interviews are recommended by IPA in order to allow the researcher to fully enter the participants world (Smith & Osborn, 2009). A semi-structured interview

allows for the researcher to ask follow up questions based on the participants responses or probe about something the participant stated that the researcher had not thought of, allowing for a richer narrative (Smith & Osborn, 2009). Smith and Osborn (2009) also suggested that semi-structured interviews allow for rapport building with the participant allowing for the possibility of richer data. The following are the semi-structured interview questions from this study:

1. What was your journey like into sobriety? How did you arrive here?
2. What made a difference in your sobriety?
3. What was the role of relapse in you getting to where you are now?
4. What happened when you hit bottom?
5. How many facilities were you in? What were your experiences there?
6. Did a therapist say or do something that made a difference? Did anything stand out?
7. Did you ever have family therapy?
8. What were your experiences like with AA/NA?
9. What allowed you to orient differently to getting sober?
10. What finally made a difference that you can look back and say ‘that was it’ or if it weren’t for that I wouldn’t be here?
11. At what point in your recovery did you know this was it? That this was different than the previous times? Did you discover this later or did you know when it happened? How did you know?

The interviews were recorded and saved to the researcher’s password protected personal computer, which has up to date malware. The video’s will not be sent or distributed. Once the videos were transcribed and moved to an external hard drive, the

videos were permanently deleted. The transcriptions were de-identified with the participants personal information and the participants were given pseudonyms. The transcriptions were saved to the researcher's password protected personal computer and stored in a locked bag along with the external hard drive.

According to IPA methodology, the entire interview is transcribed. Smith and Osborn (2009) suggested transcribing that transcribing the entire interview is important to engage in semantic transcription in order to capture significant pauses, laughter, the interviewer's questions, and additional information from the interview.

Analysis

The researchers process of analysis within IPA is often described as a cyclical:

> the researcher starts at home-base, in one's office or library, on one side of the research circle, thinking and reading about the topic of investigation. One then moves around the circle and begins to enter into the world of one's participants. As preparation for this, one brackets or puts to one side the knowledge and assumptions one has acquired of the phenomenon being researched. . .one becomes a curious and attentive but 'naïve' listener as the participant unfolds their story in their own terms. After the interview one moves back around the circle to one's home-base and begins the process of formally interpreting what the respondent said (Smith & Osborn, 2009, pp. 28-29).

During this cycle the researcher engages in double hermeneutics-making sense of what the participant said while also exploring the researcher's knowledge (Smith & Osborn, 2009). Smith and Osborn (2009) stated the researcher in IPA moves between "looking at

the part and looking at the whole" (p. 39). This is the process of examining the fine details then analyzing how they make sense as a whole. Smith and Osborn (2009) suggested combing through the transcription multiple times, each with a new lens. Out of this emerges clusters, patterns, and themes thus creating a whole. This process consists of six steps.

My analysis process was as followed, According to Smith and Osborn (2009) an IPA researcher must become naïve to the subject. I did this by engaging in epoche or bracketing via journaling, where I set my biases and assumptions about opioids, sobriety, and recovery aside, viewing each participant as unique (Smith & Osborn, 2009). Next, I got close to the data, going over it line by line analyzing what each participant stated. From here patterns and themes emerged. I noted commonalties and well as divergences. Then according to IPA, I engage in the researcher dialogue (Smith & Osborn, 2009). Here I explored the data and what it might mean. Next, I developed a structure that illustrates the relationship between the themes and subthemes. Once I developed the full narrative (Smith & Osborn, 2009), I engaged in the use of supervision with my chair to test the coherence of my interpretations (Smith & Osborn, 2009).

IPA does not engage in member checking, the process of the researcher circling back to the participants to confirm the accuracy of the researcher's interpretations. Although member checking is common in qualitative research, IPA prioritizes the voice of the researcher and their interpretations (Smith & Osborn, 2009). This is further explained by one of IPA's fundamental philosophical approaches of double hermeneutics. As stated earlier, double hermeneutics is the process of the participants

making sense of their experiences and the researcher making sense of the participants making sense (Smith & Osborn, 2009).

Ethical Issues

Any study involving humans and live data come with risks. As a licensed marriage and family therapist, attention to confidentiality and safety are of utmost importance and top priorities throughout this study. I only began collecting data once I received approval from the Nova Southeastern University Institutional Review Board (IRB). Once participants were recruited, on a voluntary basis, I reviewed the informed consent which explored potential risks of participating in the study as well as answered any questions the participants may have. Participants were also informed that they could withdraw from the study anytime. If a participant wished to end their engagement in the study, I would have immediately ended the conversation, destroyed all data, and thanked them for their time. Participants that agreed to engage in the study were encouraged to be in a safe and private location. The interviews took place over a HIPAA compliant video platform, Zoom provided by Nova Southeastern University. Email correspondence were limited to my university data encrypted email address. I also completed the necessary 15-hour telehealth practices training for my state as well as up to date CITI training.

I anticipated that due to the nature of the conversation about recovery and drug use, participants may be reminded of their past experiences with drug use or difficult times in their lives. While risk of relapse may be low, I attended to this with empathy and connecting them with resources but remained in my role as a researcher and not as a therapist. Ultimately my hope, influenced by the research question, was that the conversations brought about the participant's own resources, strengths, and successes.

Summary

IPA was selected to illuminate rich meaning and description from the participants. This study had five participants that participated in a semi-structured interview to answer, what made it possible for them to obtain at least 10 years sober from opioids. The analysis process helped me identify themes and subthemes that will be explored in Chapter IV.

CHAPTER IV: RESEARCH FINDINGS

Introduction

Opioid use affects millions of people and their families. Recovery may often feel like an up-hill battle full of barriers and setbacks. The individuals in this study shared their valuable perspectives on sustaining long-term sobriety from opioids. This chapter illuminates the primary themes and sub-themes that emerged across the analysis of the conversations with the participants. Table 1 depicts the primary themes and sub-themes. Throughout this chapter I will further expand on the meanings of each theme and sub-theme, supported by direct quotes from the participant interviews.

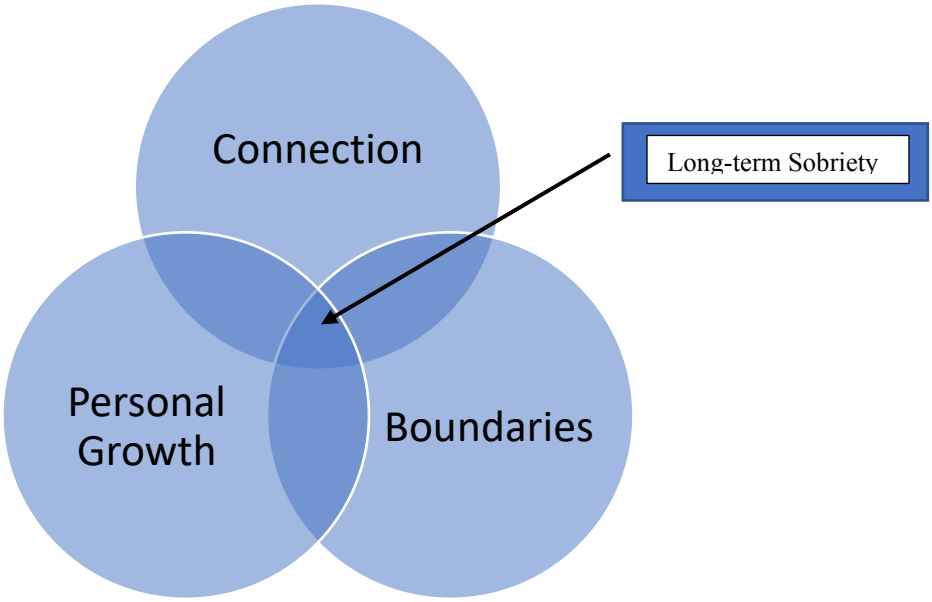
Table 1. *Primary Themes and Sub-themes*

Primary Theme	Sub-themes
Connection	• Active engagement in Narcotics Anonymous • Shared experiences with others • Accountability • Getting involved and giving back • Family therapy
Personal Growth	• Multiple attempts at sobriety • Life outside of substances – "Create a life worth living." • Frequent self-reflection • Spirituality • Employment • Health

	• Goals • Sober fun
Boundaries	• Putting recovery first • Developing a strong “no”

As I went through the interviews with each participant and began the data analysis process, it became clear to me that all of the themes and sub-themes are interconnected. I noticed that there is not a single factor that supports long-term sobriety but rather a myriad of supportive factors that play a significant role in supporting long-term sobriety. As I detail and explore each of the themes and sub-themes the overlap and interconnections will be apparent. For example, all the sub-themes under the primary theme of connection, directly relate and are made up of the participants relationship to and connection with others. The sub-themes in connection are the various ways connection to others manifested in the participants lives. Figure 1. depicts the interconnectedness of the themes.

Figure 1. *Interconnectedness*



Connection

Throughout each of the interviews, the participants overwhelmingly described the importance of connections with others as fundamental to their success in long-term sobriety. Participants highlighted how opioid use robbed them of meaningful connections with others, leaving them feeling isolated. Participants detailed factors that contributed to re-engaging with others and building connections that emerged as sub-themes. Narcotics Anonymous appears to be the initial source of connection for many individuals entering into early sobriety. Participants described the importance of having shared experiences with others, a knowing that others have experienced similar situations, as helpful to alleviate a sense of feeling judged, especially in early recovery. Accountability emerged as having supportive individuals in one's life that promote fidelity to one's goals and new way of living. Getting involved and giving back refers to individuals engaging in acts of service for others, shifting the focus off of themselves. Engagement in family therapy is an additional avenue for individuals to re-connect with their loved ones. Lance stated

> And, you know I think that's my support system has carried me through the toughest times and lifted me up through those tough times, and you know we have each other's backs, no matter what. And that's that carried me through early recovery, and it's helped carry me through to today, so I think that support system it's like pivotal.

Active Engagement in Narcotics Anonymous

Existing literature supports the importance of engaging in Narcotics Anonymous (NA) (Pettersen et al., 2019). Participants in the current study described their participation in NA as a resource, especially in early recovery. J.C. described the experience of attending NA meetings early in recovery as

> Really cool because it threw me into the mix of a lot of guys that had a lot more clean time than I did in the beginning… it just made me feel welcome and connected and I got to really expand my network.

Participants described the sponsorship relationship as one of the first steps towards connecting with others. Lance stated

> So I got a sponsor and we worked the steps and he challenged me in many ways… Then there was my sponsorship family, you know everyone at the homegroup and my sponsors other sponsee's…my sponsorship family was pretty consistent, and it became the root of my recovery and new earth.

Further along in the participants recovery, NA was a source of connection to others and meaningful relationships. Participants described the accessibility of NA meetings as useful in their recovery. Chris stated

> I've gone to meetings all over the world. In Canada, Brazil, in Spain they had a translator for me, Cancun, Jamaica. You can go anywhere and find a meeting and find our people. And after the meeting everyone still hung around and talked… It's comforting to know recovering addicts are all over. That I've got people all over.

Participants in this study identified active engagement in NA as an important factor that contributed to their long-term sobriety. Participants described the importance of connecting with others through NA in their early recovery as well as a factor to be sustained throughout their recovery.

Shared Experiences with Others

The participants suggested that being around others who have gone through similar situations created an environment for shared understanding and meaning. Participants described this connection as imperative in recovery. Also, as stated above, many of the participants described active substance use as an isolating experience. The interviews suggest that isolation furthered the individual's substance use. For example, Lance stated,

> Yeah, when substances were in my life, it was just about getting the next one, and just about me right, it was about that isolation right…I didn't want to share anything with you. It was all it was all for me. So I didn't have many people in my corner.

Participants described once they decided to stop the substance use, they continued to feel isolated and like they are suffering alone until they found individuals they could

relate with through share experiences. Lance outlined the importance of shared experiences with others in recovery

> I was a part of this Jewish recovery house group. And the theory behind it was that if you put people with like backgrounds together, same religious beliefs and things of that nature, then they'll be better able to relate to each other and support…And that was it. I met some of these guys and we just hit it off. It was the first time I found people in the rooms I could relate to. So instead of reaching out to a bunch of older guys that I couldn't connect with, I ended up connecting with younger people in recovery. And we're still friends to this day… I think that could work for anybody.

In the interviews, participants described an initial fear of getting sober due to having to face their actions in addiction, a challenge to their moral self. J.C. described the comfort in being surrounded by others that have also gone through similar experiences

> I did some pretty messed up things when I was using, things I am not proud of. Knowing that the other guys in my sponsee family had done similar things too, made me feel less awful about the things I had done. And know that my sponsor did messed up things and he still got clean gave me hope.

Participants in this study initially described active drug us as an isolating experience. Participants identified the importance shared experiences with others as an influential factor in connecting with others and contributing to their long-term sobriety.

Accountability

As stated above, accountability emerged as having supportive individuals in one's life that promote fidelity to one's goals and new way of living. Participants in this study described knowing that others will check up on them as an additional factor that helped them sustain long-term sobriety. Participants described the importance of accountability as something needed throughout the entirety of their recovery. Throughout the interviews, accountability took many forms, from motivation to attend meetings, maintaining active engagement in the program, and a presence during times of difficulty. Lance stated

> There were many times when I didn't want to go to a meeting, but I knew the guys would notice I wasn't there. I would sometimes struggle to go to a meeting but never regret it once I was there.

Accountability from others seemed to largely stem from the participants sponsorship family (i.e., sponsor and eventual sponsees, as well as homegroup). All of the participants interviewed saw the value in accountability as a factor in their long-term sobriety. J.C. illuminated the following;

> My wife my sponsor, my sponsees, some of them I've sponsored for a good amount of time. One gentleman for 14 years. So we have known each other through ups and downs and his ups and downs, my ups and downs, and it oftentimes becomes a very mutual relationship where, although I'm their sponsor and they're my sponsee…and often times accountability gets flipped, just as much on my ends, as it would be for them…it has to be someone I trust inherently, who has my best interests at heart too.

Below is an example of how accountability goes beyond connections with others and has a direct effect on sobriety. Justin explored the time he had to have shoulder surgery and was prescribed opioids pain medications. He reported feeling thankful that his doctor was also in recovery.

> I talked about it with my girlfriend at the time, my sponsor and my mom. We had a plan. My mom would hide the pills and only give them to me as prescribed. My doctor also prescribed a really low dose so I wouldn't feel that euphoric feeling. I was really worried about that. But having people to talk to and knowing what was going on really helped.

Accountability, a sub-theme of connection and interrelated factor, emerged from the data as a factor is supporting long-term sobriety for the participants in this study. The participants identified that accountability is relational in nature as it requires the input of others. Participants described how accountability in their early recovery was imperative to them engaging in meetings, finding sponsors, and connecting with their home group. Participants reported that accountability is imperative throughout their time in recovery.

Getting Involved and Giving back

Participants described actively engaging in a Narcotic Anonymous principle of service work as a factor is supporting long-term sobriety. Service work is mostly focused around NA meetings and engaging in a specific task like helping set up the chairs, setting up the coffee, displaying Narcotics Anonymous materials, being the greeter at the door to the meeting or taking a meeting into a jail or hospital. Lance described how his sponsor pushed him to engage in service work and how this shifted Lance's thinking from self to others.

> He made me pick up a service commitment, like greeting people. Where I had to say hello to everyone walking in the meeting. It was so embarrassing at first, but I got to know people. And then later on these people where there for me.

Lance ultimately saw the value in engaging with others at meetings. For him, and other participants, this led to further connections and relationships with others. From these relationships a network is formed. Chris stated "it's important to not just think about yourself. Drugs make you only think about you and your next hit. Once you can see the value in helping others you start to think big and see all the possibilities."

As Chris, Lance and other participants stated, getting involved and giving back became a central part of their recovery. Like the other themes and sub-themes getting involved and giving back is also a form of connecting with other, creating shared experiences, promoting accountability, and shifting the focus from self to others.

Family Therapy

The participants described at least one interaction with formal treatment like in intensive outpatient treatment programs. Several of the participants stated that they engaged in family therapy while in treatment. J.C. described the significance of family therapy and Al Anon.

> The one thing I can attribute my recovery to is my mom being a part of family therapy and going to al anon meetings which was huge. She learned that the word 'no' was a complete sentence and she learned what enabling is, and you know I would get bailed out often. They would bail me out of jail or they give me a new car or help pay my rent so on and so forth, so when I called them from the hospital, when I was in Florida. She explained to me that I shouldn't call her

> anymore until I had about a year clean. And that, if I get hungry dunkin donuts puts their old donuts out at midnight, and I could have as many free donuts as I want….I have two little girls, I mean they're young so God forbid that I'm ever in the same situation but I couldn't imagine how difficult it was for them and at the time I was very angry at them. But then in hindsight it was the best thing that ever happened to me and I respect her very much for doing that. It didn't give me the same out that I had before, so the consequences started adding up.

Both quotes appear to approach the substance use treatment from a systemic lens, addressing not only the individual struggling with substance use but also the involvement of the family. Addressing and exploring the existing patterns in a relationship or family system is needed to identify contributing factors to disruptions.

> I didn't have family therapy in my program, this was many years ago when treatment was really expensive and not covered by insurance, but I tell all my sponsee's now, that family therapy is so important. You know, the addict can be away at treatment and work on things and change but the family is still dealing with all the hurt. It is just as important for the family to process and talk things out as it is for the addict.

Addiction can be an isolating experience. Over all the participants described connection to others as the foundation to long-term sobriety. From the data, connection was made up of several sub-themes like active engagement in NA, shared experiences with others, accountability, getting involved and giving back, and family therapy.

Personal Growth

Personal growth emerged as a theme from the participant interviews. Participants described personal growth as active engagement in working on one's physical, mental, and whole self. From this, several sub-themes emerged. Participants expressed the importance of creating a life worth living outside of substances, frequent self-reflection, connection to spirituality, employment, health, responsibility and goals, as well as sober fun, as contributing factors to personal growth. The participants described recovery as not only stopping the drug use but also addressing the whole self.

Multiple Attempts at Sobriety

Each participant described multiple attempts at sobriety. None of the participants maintained sobriety after their first attempt. Participants described feeling discouraged after attempting to obtain sobriety only to return to drug use. While each story is unique, each participant described a pivotal moment in their journey to recovery. Often, the pivotal moment occurred after multiple attempts at sobriety. Participants described the multiple attempts at sobriety and subsequent pivotal moment as a catalyst to personal growth. J.C. (16 years sober): I remember, I was living with my dad and I was all strung out on pills and I went into the kitchen and spilled soda all over this white rug and my dad comes out and just starts going in on me, yelling. And I just had this moment where I was like "what the hell am I doing with myself." And after that I decided to take meetings and recovery seriously.

> Joey (11 years sober): I had been in the hospital several times from overdoses. I was continuing to make these higher risk decisions and at the time I had a wife and our kids that my behaviors were affecting. At this point I had six felony

charges and my kids had gotten taken away. So I was really coming to terms with the realization of my situation…substances at one time provided me this safe place for me to just be okay, even for a brief moment, the weight of everything wasn't on me but then substances were no longer provided me that space. It started intensifying the reality of the situation…my thoughts were bad at the time, like suicidal…I was coming to terms with the results of my decisions that were hurting the closest people to me and that was really scary. And one day, a guy I knew from the rooms invited me to a meeting and I never looked back.

Chris (25 years sober): I had tried a couple of detoxes in Jersey but I never had insurance so I couldn't afford the 30-day programs. But then I caught my second felony and the court ordered me to go. I did the 18-month program but was back out the day I finished. I started with drinking, a little bit of coke then I was back on heroin. Then I got another felony. And felt like man, I can't go on anymore. I was an embarrassment to my mom, my grandma, everyone. So I tried detox one more time. And I realized that I was not living the life I was supposed to be living. I grew up well off and always had nice things, nice cars, new clothes, pretty girls, vacations, good job but then dope took that all away. So I started going to meetings. And once you come into recovery they like embrace you and it felt like I had this big family now. I got involved and never stopped.

Lance (18 Years sober): I guess the beginning of the end was ultimately when I got a DUI. I had tried to stop using a number of times before that. I tried geographical changes, I tried getting off opioids and switching to just marijuana and benzo's and none of that works. When I got pulled over for the DUI I had a

bag of benzo's in my pocket so I swallowed them and had a pretty rough night in central booking. I had to go to court and was put on probation. It was the last day of my probation and my officer asked me if I gave a urine sample yet and I said no. The night before I did some pills because I though tomorrow is my last day, he hasn't given me a test yet. Of course, he gave me one and I failed it. I went back a year later and thanked him for saving my life that day. That was the last time I used. I had to go in front of the judge because I violated my probation and the judge threatened me with serious jail time. So I left the court house and went to a meeting. There I connected with a group of guys and one of them actually testified on my behalf during my next hearing. I had about 6 months clean at that time. And that was the start of my journey because I was able to connect with someone who was clean and sober and was willing to go to bat for me.

Justin (18 Years sober): I had been sober for a year at one point, but then picked up again. It got dark quick. I started using a needle for the first time and speed balling, which is insane, it's like asking for death. I used like this for 6 years. I was like just completely out of control, I was an absolute danger to myself, and it was at that point, I realized one day that this is really me, I am the problem here, nobody else. This is the life I've created for myself. And I was sick and really scared for my life. So I went back to the meetings. Went back to what helped me get that year sober, same sponsor. But this time I got around much healthier guys. Guys that had much more time than me in recovery. And that was like putting my life back together. I started going to school. Started with community college then

went on to get my bachelors and I fell in love with learning and psychology. I ended up getting a masters and then a Ph.D. and having a career.

Life Outside of Substances

Participants described a process throughout their recovery that contributed to more than just substance use, that I defined as creating a life outside of substances. As previously stated by participants, substance use had a tendency to envelop the person and their life. Participants in this study highlighted the importance of minimizing the appeal of drugs with living a full life that often starts with personal reflection and growth. This idea also appears to be inherently systemic in nature, recognizing the importance of not only treating the problem but the whole. Joey stated, "Recovery to me, is just being a better person and trying to love, who we are inherently and not who we want or think we should be or vice versa."

Participants in this study described how exploring the 12 steps was often the starting point in exploring a life outside of substances. Once the substance use stopped the person is left with the rest of themselves. Participants reported drugs interfering with the other parts of themselves. Identifying this and beginning the process often led to healthier relationships, employment, increased physical health, and long-term sobriety. J.C. stated:

> Because when I stop doing things for myself because of drugs and then I get clean, the 12 steps are interesting because it becomes very much less and less to do with using drugs as it does with finding better ways to live. How am I a better husband, how do I become a better father, how am I better business owner, how do I treat employees, how do I do all sorts of different things, and how do I

> ultimately feel good about myself the things that I'm doing. And then ultimately learning, who I am and what I like.

Participants described the significance of engaging in activities that fostered a life outside of substances. For the participants in this study that meant engaging in activities that contributed to their personal growth. Participants also reported that building a life outside of substance contributed to their ability to ward off temptations to use again. J.C. reported "I have too much to loose. I've worked hard to get where I am. It's not worth it."

Frequent Self-Reflection

Frequent self-reflection emerged as a sub-theme participants engaged in around landmark points in time like sober date anniversaries as well as daily reflection. Self-reflection was described as the process of looking at one's behaviors, how they treat others, how they are treating themselves, as well as their thoughts about self or others and identifying what needs to be changed. J.C. described self-reflection as being a process that he worked up to, by first "getting honest" with himself.

> It became very very clear to me that if I do the same things I'm supposed to be doing for my recovery, like being honest, taking an inventory, and being there for others, as I do in my actual life, then potentially good things can happen…hope is the principle behind step two, I mean really all of them, faith, integrity, not lying on the application, diligence, willingness, all these different things that come down to you know how we portray ourselves or act have a big impact on our sobriety and overall life.

From the data, the significance of having people around the individual to help facilitate self-reflection appears to be another component of long-term sobriety.

Participants reported their sponsor, loved ones, and sponsee family or members of their homegroup as the individuals most responsible for helping initiate self-reflection. Lance stated the following

> I always appreciate friendships where we're able to have open communication in a loving way not that they're saying like you're being an asshole but in certain situations they can do it in a loving way to say hey I'm noticing this about you and that I don't know what you're doing but I'm concerned, you should probably take a look at this. And then the hope is that I'm in a place where I can receive that information and even if I get defensive in the beginning and then reflect and make the change.

Participants in this study described the importance of frequent self-reflection as a factor that supported their long-term sobriety. Participants reported the act of engaging in self-reflection helped them maintain their focus on personal growth.

Spirituality

Participants described their beliefs in a higher power other than self, I labeled this as spirituality. Participants explored the role of spirituality in their recovery as being a place for direction, hope, and growth. Joey stated

> Another pivotal thing was really plugging into a church. A place that I could really explore my beliefs. A church that I can show up to and be myself and really feel that grace and mercy. That really helped me feel free from my addiction. Knowing that Jesus forgives.

For Joey, finding a place of acceptance was crucial in his recovery. He reported that throughout life he never felt like he fit in or that he was always different. When

substances where in his life, they provided an escape from the outsider thoughts. Through the process of getting sober and no longer using substances, existing research suggests the importance of spirituality as a perceived safe place. Joey stated how a connection to spirituality provided sources of strengths and resources during his difficult times.

> If I don't keep my recovery first in my life, everything else will fall by the waist side…prayer and meditation help keep me focused. Having a daily like even if it's just sitting by myself for a half hour in the morning, you know, just gathering my thoughts is very important to me…I listen for answers. Sometimes they come sometimes they don't…But I think prayer is very important. Like even just saying the serenity prayer. The first three steps are all about powerlessness right. So surrendering and knowing that you can't control people or places or situations. So like being able to turn that over to prayer has been pivotal for me…It could be whatever like some bad traffic and just not being able to control it and sort of turning it over and not getting angry over it.

Participants in this study used their spirituality as a way to continue exploring their self-reflection. Participants shared how spirituality helped them develop as a person and also provide a place of resources like hope and forgiveness.

Employment

Employment has been shown to increase sense of self-worth and structure in a person's life (Eddie et al., 2020). Participants described how having a job in early recovery helped them have access to money, social support, health insurance, and hope for a better future, supporting existing research (Eddie et al., 2020). Joey described how

actively engaging in employment helped bring structure and a sense of responsibility to his life.

> When I first got clean I started working at Applebee's as a runner and it was awful. I worked really hard. But it wasn't a good place for me. So I told myself, okay I'm only going to be here for 8 months while I can save money and figure out my next step. And it was during that time that I realized that I wanted to work in addiction. So I figured out how everything I needed to do to become a certified addictions specialist and did it. Now I'm the founder and director of this non-profit treatment center which is a fulfilling job. Don't get me wrong, it has its hardships but every day I am reminded of helping people and I have a responsibility to show up for them.

Participants also described how employment led to opportunities as well as education. One participant noted how he found his passion for learning through his job, which ultimately led him to obtaining an PhD. Justin also described how engagement in education and employment influenced his sense of self in a positive way, thus contributing to long-term sobriety.

> Going to school and having a career are the two critical factors for me in my recovery…School was the first positive reinforcement I got. Like if I worked hard at school, I would get good grades and feel good about that. Once I started getting letters behind my name I started feeling really good about that and going to better school. Learning just felt right. It was like I was discovering the world around me. Which then lead me to research and what I do now which is really exciting to me.

Much like the existing research on employment as a supportive factor for recovery (Eddie et al., 2020), participants in this study described how employment contributed to an increase in their sense of self-worth while also contributing to further personal growth and long-term sobriety.

Health

Lance described health best when he stated, **"**clean up the inside through the steps, clean up the outside with exercise, eating healthy, and taking care of your appearance". Participants described the process of once substance use was no longer in the picture, they began addressing the various aspects of themselves. Addressing the most pressing issues first, such as housing and employment, then came physical appearance, exercise, diet and more. Justin reported

> Physically doing something with yourself, so whether that's going to the gym or going to meetings or just going out to eat, something positive. It's about finding some other way to move because the worst thing an addict can do it just sit and stew… And if you think about it, we are putting in so much effort to clean up our life and not use, we need to work on the external as well.

Overwhelmingly each participant cited actively engaging in physical health like exercise and addressing their physical appearance as crucial on the road to recovery. Chris said "if you look good then you feel good. And feeling good about yourself is a big thing in not going back out and using again."

Taking care of one's health as a supportive factor in recovery is supported by existing research (Fitzgerald, 2017) and (Jeynes & Gibson, 2017). Existing research also

supports the connection between taking care of physical health and seeing positive changes in self-esteem and confidence (Fitzgerald, 2017).

Goals

While the goals may be unique to each person, participants of this study all identified the importance of setting goals for themselves. Participants explained how setting goals for themselves help keep them moving forward to avoid complacency. It also appeared that setting goals and actively trying to achieve them carried an implicit sense of self-worth and hope for the individual. Chris had the following to say;

> I had 30 days clean and it felt really good. So I was like yeah, I've got to start setting goals. Then it was 45 days clean. Then I wanted six months clean and I could take a meeting into a hospital and that felt good. Then my goal was one year clean. And when that happened, I called my mom and we started working on things. Then I wanted a new car, so I needed to have a job and save money, so that was the goal. And now I want nice things, like vacations and nice clothes, so I am still setting goals and making these things happen.

Early in his recovery, Chris explained how drugs influenced a change in his identity. Prior to drugs being in his life he reported living a "nice" life, middle class neighborhood, going into the city for shows, college degree, a nice car, vacations, nice clothes, and a corporate job. It appears that when his identity, the way he saw himself, was challenged, this became a motivator for him to regain these possessions and identity. For Joey, setting goals and employment became a conduit to opportunity. During his substance use, he described difficulty obtaining and maintaining a job, which contributed to feelings of worthlessness. Joey describes how goals helped keep him focused and

increase his self-worth. He is now the director of a non-profit substance abuse treatment center.

> For me having goals was crucial to me getting to where I am. I am sort of all over the place so if I don't have a direction, I will wander. Jobs and going back to school helped with that. Helped me get to where I am today.

Participants in this study described how important setting goals has been to their recovery. Participants described how in early recovery the goals were different than the goals they set in sustained recovery.

Sober Fun

The participants described sober fun as activities that did not include substances. Participants identified the importance of engaging in sober fun in early recovery as well as a sustaining factor for long-term sobriety. Chris reported

> I think it gives you something to look forward to. Being able to do nice things, like I like to golf. I've golfed all around Florida and the US. It's something outside and physical that gets me out of the day to day…building a life and having sober fun also help you realize what you could lose if you chose to use again. 25 years clean I've got a lot to lose if I decided to use again.

Participants identified the rich experiences and meaning derived from sober fun. Lance's first attempt at sobriety happened at the age of 16. Lance explored his first attempt at sobriety did not last due to a lack of sober fun. As an adult he reported that sober fun gave him hope for the future as well as a place of connecting with others.

> Recovery kind of has to be fun right, like there's a lot of life ahead of you when you're that young and you're sober when all your friends and kids your age are

> messing around and if you don't find things to do, healthy hobbies things of that nature, it will be bad… The guys I'm friends with now, we'll get together Sunday night we call it guys night…and we get together at somebody's house and we cut it up, we play spades or watch a game. You know, maybe we'll have a cigar or something on someone's back porch deck or something like that. We've gone on vacations together, Vegas, Cancun, all over and it works because we are all on the same page.

Boundaries

A broad term with simple actions, boundaries. Participants described the process they went through learning about, developing, then implementing boundaries throughout their recovery. Participants described this as putting their recovery first and saying no. Boundaries contribute to individuals constructing a life around them that is supportive to recovery.

Putting Recovery First

Recovery can be full of temptation to return to substance use. Participants in this study identified the effort put into long-term sobriety was supported by strong boundaries. J.C. reported the process of learning to put their recovery before all else, even relationships and friendships.

> The reality, the situation is if I drank today, am I going to smoke crack tomorrow or shoot heroin tomorrow, probably not. It may take months it may take a year, it may never happen, I don't know, but the percentage if it was a 1% chance that that would happen. I'm just not willing to take that risk ever, and I also know myself, my life has been built at this point as a person in recovery, it's part of my identity,

> I do have people that rely on me that I sponsor, my wife, my kids and my children never have to see me use ever. And I don't ever want them to. To risk that it's just not worth it, to me, so it becomes very easy, where, if I think about it, you know I just the play the tape out just a little bit, then it becomes pretty clear that it's just a stupid decision and I should not be doing it.

In Narcotics Anonymous, playing the tape through is a common phrase used to describe the process of thinking about the effects of one's actions. What would happen if I did this? Participants in this study described an active engagement and use of playing the tape through. This thoughtfulness allows for individuals to set boundaries. Justin reported

> Saying no and not putting myself in certain situations is survival. Here's an example, if someone puts a plate of cupcakes on my desk or in the faculty room, I am going to be tempted to eat them. In these situations, I just have to play the tape through of how eating that cupcake would affect me and my family. And always at the end of that tape, is the answer of I am not willing to risk everything I have. It's just simply not worth it. And plus, my wife would kill me…I've created a life where I don't affiliate with drugs. I don't go to bars, I don't go to work parties, I don't go out with my friends. I mean my life is completely clean and there's just not an opportunity. I don't put myself in shaky scenarios…But in the moments I've been tempted, I have to reach out to other people, like telling people what's going on if you're feeling tempted. Having a trusted confidant is one reason why sponsorship works really well.

Developing a Strong "no"

In this study, developing a strong no relates to saying no to specific people and situations. Participants reported having to advocate for their recovery by telling others no or removing themselves from situations. It appeared that the Chris feel passionately about saying no and setting boundaries.

> I'm selfish when it comes to my recovery, I'm like yo fuck you guys. I don't care if I like you, I will not jeopardize what I have worked for. I noticed a girlfriend using and I was like, alright you've got to go. I will help you but you can't be in my space. I am not messing around with my clean time. And I've gotten a reputation for that. People know I don't mess around. They don't even invite me to things because they know I'll say no.

It appeared that a fundamental aspect of setting boundaries and long-term sobriety is a level of comfort in saying no to people despite how they might respond, in this moment, putting self-first and others second. Joey reported

> I've got a full-time job with myself. I will be there for someone to help, but only to a point. I can't spend my time trying to convince someone to come back to the rooms and then I don't focus on my stuff. I also don't put myself in situations where I would be tempted. Because yeah sure, the thoughts cross my mind. And I have some friends that are not in recovery. So there's the opportunity. So if I am at a place, like a restaurant and people are drinking, I get a soda and then leave as soon as my stuff is over. I won't hang out afterwards.

Summary

The results of this study support many findings in the existing literature about factors that support sobriety. All the identified themes and sub-themes are interconnected and often overlap. The participants in this study lent their voices to emphasize the importance of connections with others, attention to personal growth, and the significance of setting boundaries.

In Chapter V I will make connections between the results of this study and other current research. I will also identify the strengths and limitations of this study, with sights set on future suggestions to extend it. Finally, I will explore the significance of this study for the field of family therapy.

CHAPTER V: DISCUSSION AND IMPLICATIONS OF THE STUDY

Introduction

The purpose of this study was to explore and identify factors that contribute to long-term sobriety from opioids. This study also contributed to the existing literature in identifying length of time for long-term sobriety with opioids. By interviewing individuals with at least 10 years sober from opioids, I was able to extract valuable information derived from the participants rich stories. The participants in this study shed light on factors that contributed to their long-term sobriety. I conducted this study with the intention of providing hope for individuals currently struggling with addiction or in their recovery, hope for family members, and suggestions for clinicians working with individuals struggling with addiction.

Exploring the Results

The results of this study reinforced existing research on factors that support long-term sobriety, such as supportive relationships, employment, education, health, and spirituality. Yet there are novel findings from this study such as, setting boundaries and the importance of sober fun. In Chapter II, my review of existing literature, I identified previous studies results for factors supporting sobriety. This included five domains presented by Leclair et al (2020), functional, physical, clinical, social, and existential.

Connection

This study further supports the importance of connection to others. Petterson et al., (2019) stated that positive relationships in one's life are crucial in order to reach and maintain sobriety. Insoo Kim Berg and Scott Miller also made sense of addiction as being relational in nature (Berg & Miller, 1992). From the participant interviews, I analyzed

and categorized connection into active engagement in NA, shared experiences with others, accountability, getting involved and giving back, and family therapy. Each of these sub-themes is based on relationships with others. The participants in this study described how active addiction and substance use contributed to feelings of isolation and loneliness. Each participant identified the importance of engaging with people they identified with in early recovery as a factor that contributed to them staying in recovery as well as maintaining these relationships throughout recovery as a long-term sustaining factor.

Active engagement in Narcotics Anonymous has been identified as a supportive factor for sustaining recovery. DeLucia (2016) reported that consistent engagement in NA is connected to higher rates of sobriety. DeLucia also suggested that NA provides a space where like individuals share in experiences. The emergence of technology creates an abundance of opportunities to connect with others. Many participants in this study described how Covid-19 influenced their ability to attend meetings and connect with others. For many, meetings moved online. While this was a shift from their norm, participants described the increase of online meetings as an opportunity to connected with individuals from all over the world. Justin remarked how thankful he was to be able to continue attending meetings during Covid-19.

This study also supports the importance of getting involved and giving back. Derived from NA principles, each of the participants described the process of being in early recovery and "picking up a service commitment". Participants described a variety of possible commitments like being the greeter at the meeting, distributing meeting materials, or bringing a meeting to others, mostly in hospitals or jails. Best et al., (2012)

found that an increase in meaningful activities like volunteering contributed to a higher quality of life for individuals in recovery.

Active engagement in mental health services is a well-established factor of sustaining long-term sobriety (Leclair, 2020). This study continues to support that engagement in family therapy is an additional factor in supporting sobriety. Participants described the importance of including their families and loved ones in their healing process. This is in accordance with my systemic lens and view of change, supported by Solution Focused Brief Therapy (Berg & Miller, 1992). Including the family is also an opportunity to see the strengths and resources the family has and can provide for the individual.

Personal Growth

This study identified personal growth with internal components like self-reflection, spirituality, life outside of substances, and external components like employment and health. Each of these sub-themes overlap and relate to each other. Participants often described a reciprocal process of working on one area and also seeing changes in other areas.

Each participant in this study described a process of multiple attempts at sobriety. None of the participants reported sustained sobriety on their first try. Chopra and Marasa suggested that individuals struggling with opioid use disorder face a 91% relapse rate (2017). Relapses play an important role in an individual's recovery as identified by the participants experiences with multiple attempts at sobriety leading to a pivotal moment. For each of the participants, there was a pivotal moment in their journey that contributed to sustained sobriety. As identified in Chapter IV, each of the participants story and

pivotal moment is different, with no apparent theme other than the individual experiencing a shift of thinking and acting that they arrived at. Participants described well-meaning intentions of attempts at sobriety whether induced by the law or a family members that did not stick but appear to be useful. Contrary to anecdotal experiences, relapsing and "hitting bottom" does not need to be a disastrous event like getting arrested and charged with multiple felony charges but it can any moment that shifts the individual's perspective, like in J.C.'s story of spilling a drink on the carpet.

Spirituality emerged as a sub-theme for sustaining sobriety. While participants identified as being of varying faiths, they each described a relationship with a higher power as a source of strength that helped them through recovery. Participants also identified spirituality as a space to connect and build relationships with others, as existing research suggests (Ghadirian and Salehian, 2018). Participants described their relationship with spirituality as a source to derive meaning and hope, especially in early recovery, as Joey described.

> Another pivotal thing was really plugging into a church. A place that I could really explore my beliefs. A church that I can show up to and be myself and really feel that grace and mercy. That really helped me feel free from my addiction. Knowing that Jesus forgives.

Participants in this study discussed the importance of employment in their early recovery as well as a factor in sustaining recovery. Eddie et al., (2020) suggested that employment provides structure, purpose, and meaning, as well as, independence and financial security. Participants in the current study also identified the importance of education as a factor that sustains long-term sobriety. Participants suggested that

education shifted the way they viewed themselves to a positive perspective, as well as, increased their access to opportunities.

Much like existing research, participants in this study identified the importance of focusing on health in recovery. Existing research suggests that engagement in physical exercise, medical intervention, and a healthy diet are factors supporting sobriety (Jeynes & Gibson, 2017). One participant in this study described health as "cleaning up the inside while cleaning up the outside." I feel this accurately represents health and how a focus on health helps the individual propel themselves further into long-term sobriety. As existing research suggests, an increase in physical activity contributes to increased confidence, positive self-image, and decreased likelihood of remission in substance use (Fitzgerald, 2017).

Novice Findings

The findings of this study expand on existing literature as it relates to engagement in setting boundaries and sober fun. Setting boundaries emerged as a novice factor from existing literature as it relates to opioids. Boundaries have long been discussed and researched in other areas. To Salvador Minchin, boundaries area large part of structural theory (Minuchin, 1974). As stated in Chapter II, a structural therapist would explore setting boundaries with the individual struggling with addiction and their family (Minuchin, 1974). This may further be expanded to situations, places, and people outside of the individual's family. While boundaries are not specifically stated in Narcotics Anonymous 12-steps, boundaries; avoiding people, places, and things, is a well-known principle within the NA community.

Each participant in this study described at length the importance of learning, developing, and setting boundaries. Participants described setting boundaries as something done throughout their recovery. It appears that participants credit boundaries with their ability to withstand temptation. Participants in this study appeared to embrace setting boundaries as a lifestyle. Many participants reported not putting themselves in specific situations as a form of setting boundaries. Participants also identified the difficulty in setting boundaries with others and in relationships. Overall, the results of this study suggest that setting boundaries and developing a strong no are factors for sustaining long-term sobriety.

Engaging in sober fun emerged as a divergent theme from existing literature. Participants in this study described the importance of engaging in sober fun in early recovery as providing hope for the future. Engaging in sober fun in established recovery was a factor that helps sustain sobriety. Participants illuminated how engaging in sober fun also relates to connections with others and relationships. SFBT therapist may view engaging in sober fun as a way to build strengths and resources for the individual. This may relate to the existing literature on meaning making. Laudet et al. (2002) suggested that having meaning in an individual's life is the single most important factor in sustaining sobriety.

Strengths and Limitations of the Study

Qualitative methodology allowed me to speak directly to participants to obtain rich descriptions, meaning, and experiences from participants (Creswell, 2007). IPA allowed me to obtain an up-close view of the participants lived experiences and the meaning they give these experiences. An additional strength of IPA is my researcher

understanding of the participants and what they experienced. This allowed me to maintain a unique perspective for interpreting the results. I used my theoretical and therapeutic understanding of substance use and SFBT to identify and illuminate themes between the conversations. While I view this as a strength, I've addressed this possible limitation by including excerpts of the participants transcripts in Chapter IV where the reader can conclude meaning as well as conferred with my Chair as suggested by Smith and Osborn (2009). I feel that this study's small sample size allowed me to closely examine the data from the participants. Smaller sample size is also in accordance with IPA methodology (Smith & Osborn, 2009). A small sample size may also be a limitation as it relates to generalizability. According to IPA, generalizability is limited to the specific population studied and not at the population level (Smith & Osborn, 2009). A limitation to this study is that the participants were all middle-aged males from the south and south east United States. Future research should include women and other individuals to obtain a broad view of factors that sustain sobriety, as well as exploring other regions of the United States. The participants in this study all subscribed to Narcotics Anonymous as a guiding force through their recovery, a limitation of this study. There are a variety of approaches to sobriety that do not focus on NA that future research could explore.

Another limitation is that the results of this study may only be applied to opioids specifically. Participants of this study identified their main drug of choice as opioid. While this is the intention of the research, as stated in the research question, factors that sustain long-term sobriety from alcohol or other substances may be different. Participants of this study were also only interviewed once with no follow up communication. While I

feel that one interview provided an abundance of rich data and provided the whole picture of the participants experience through their recovery, subsequent interviews may have also provided more rich data.

Suggestions for Further Research

Continued exploration on factors that sustain sobriety is likely to change over time. The impact of Covid-19 was minimally explored in this study due to the nature of timing of the interviews. Further research may explore how Covid-19 influenced individuals in sustained sobriety. With the shutdowns and abrupt halt of social gatherings and social engagements, many individuals may have experienced isolation and loneliness. Participants identified isolation and loneliness as factors that thwart progress in recovery. Future research may explore what helped individuals in long-term sobriety remain sober during Covid-19.

Future research may continue to explore the role of relapses in cultivating strengths and resources for the individual. What individuals learn about themselves, triggers to relapse, and what brings them back into recovery may also be factors that help ultimately sustain recovery. Utilizing a learning approach to relapses may also help address the stigma around relapses.

Implications of the Study

My hope for the implications of this study are to reach those individuals struggling with addiction, as well as, families, family therapists, and, other practitioners, educators, and researchers. My intention with this study was to explore the unique experiences of individuals with at least 10 years sober from opioids to further contribute

data to the factors that support sobriety in existing literature. My intention was to also add to the literature in defining long-term sobriety.

Individuals

It is imperative to provide help and hope to these individuals. As previously stated, access to care has grown drastically from years past, however societal views on opioids and addiction continue to waiver. To the individuals struggling with addiction, read these findings and incorporate what worked for others into your lives. My hope is that individuals struggling with addiction will see that recovery is possible. Lance stated "give yourself time, put the bat down, give yourself a shot. Whatever you think you did that is so horrible is not that horrible. Someone else has done it. Addicts don't have to die. There is a better way." Individuals may look upon these participant interviews as a road map for factors that support long-term sobriety.

Families

Family involvement is crucial for recovery. Whether it be one's biological family, loved ones, or chosen family, the individual alone cannot fix this issue. This may mean looking at how families influence the patterns of behavior and how this may contribute to substance use. J.C. identified how his parents no longer providing financial support and "bailing me out" contributed to him figuring things out for himself in a way that ultimately lead to sobriety. J.C. also noted "that must have been the hardest thing for her to do…in hindsight it was the best thing that ever happened to me and I respect her very much for doing that." This is also an opportunity to identify strengths and resources the family possess. Support with unconditional love and to seek services for family members. Participants in this study also described the importance of repairing their family

relationships as supportive factors and connection to others. It is important for family members to hold on to hope and know that recovery is possible.

Family Therapists

My hope is that this study can contribute to therapists' conversations with individuals in inpatient or outpatient services, to help guide them in developing and cultivating the necessary supportive factors in their lives. Therapists and treatment centers may consider the factors identified by this study to incorporate into their programs, specifically the importance of sober fun. While learning about the individual's specific triggers to use, things to avoid, and healthy habits to embrace are all important to recovery, this research has shown the importance of individuals engaging in sober fun.

From my time working at an intensive outpatient treatment center, family involvement was often long-distance due to clients being from out of state. From this study and my own experiences, it is clear that family involvement, in whatever capacity possible, (in-person, over the phone or video) is a significant factor in recovery. While this is likely part of a family therapist's repertoire, other practitioners may find this study as a useful tool for the importance of exploring the involvement of the whole family system.

When the participants described a person, who made an impact on their life and their recovery, one common factor stood out: non-judgment. I urge therapists reading this study to embrace a non-judgmental approach when working with individuals struggling with substance use. Providing a safe space for an individual to come as they are is imperative to recovery.

Further implications of this study for family therapists is a systemic perspective on viewing substance use, addiction, and recovery. A SBFT therapist can view this study as a guide to see the client's strengths and potential resources. One of the eight main tenants of SBFT is that everything is interconnected (Simon & Berg, 1999). I believe this continues to advocate for connections with others. Berg and Reuss (1998) also strongly advocate for involving the family as apart of substance use treatment.

Clients setting boundaries can be viewed at the client being the expert in their own lives, a fundamental SFBT concept (Simon & Berg, 1999). Sober fun can be viewed as an avenue for strengths and meaning building. I believe this would fit into the SFBT concept of "anything can be therapeutic" (Simon & Berg, 1999).

Narrative therapists may view this study as a guide to explore the client's stories and look for unique outcomes. Michael White and David Epston (1990) stated that people derive meaning from their stories that shape their identities. Narrative therapists may explore how a client's story of their journey into sobriety influences how they make sense of their lives. White (2007) also suggested that narrative therapists are interested in creating an "alternative narrative". This may look like focusing on the client's successes throughout their journey into sobriety. Community and connection with others appear to be important to narrative therapists. White (1997) suggested the importance of "sharing the maps of the journey made by others" (para 6) as a part of clients making sense of their own narrative. Narrative therapists may view this study as a road map of what has helped others to incorporate into their conversations with clients.

Concluding Thoughts

When I embarked on this research, I was coming from a place of hopelessness after the death of a client with one year sober. I felt like I was in a never ending up hill battle with opioids. A colleague opened my eyes to the possibility that there are individuals with significant lengths of time sober for opioids. After talking with the participants in this study, I felt my hope renew. The participants of this study have shown me that recovery is possible. I now feel hopeful when talking to individuals struggling in their recovery.

Opioids affect many Americans and their families. SFBT is a lens and strength-based orientation to seeing individuals and their experiences with opioids and recovery. Interpretative phenomenological analysis helped me answer-what made it possible for individuals to obtain at least 10 years sober from opioids. Participants in this study described the importance of connections with others, personal growth, and setting boundaries as factors that support their long-term sobriety. The implications of this study are providing a road map, hope, and a systemic perspective to individuals, families, and family therapists.

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Appendices

Appendix A

Recruitment Flyer

NSU Florida
NOVA SOUTHEASTERN UNIVERSITY

RESEARCH STUDY

Long-term Sobriety from Opioids: An Interpretative Phenomenological Analysis

Nova Southeastern University

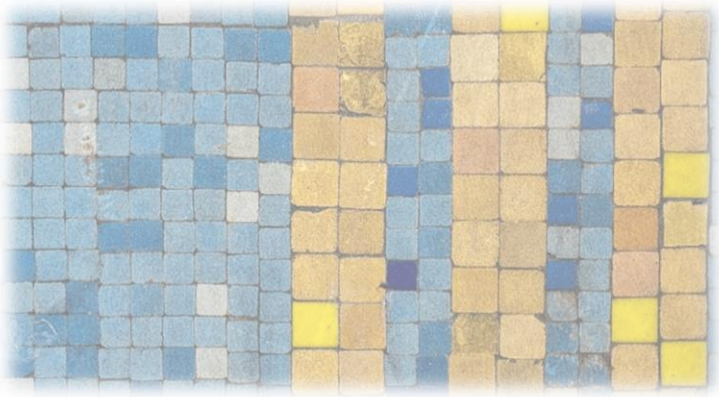
Participants Needed: At least 10 years sober from Opioids, not interrupted by periods of substance use. Participants must have met DSM-V criteria for opioid use disorder at some point during substance use. Participants must be legal age of consent (at least 18 years old) and have access to technology.

The purpose of this study is to explore individual's experiences through recovery and identify factors that contribute to individuals obtaining at least 10 years sober from opioids. Interviews will take place over Zoom for 2 hours at an agreed upon day and time. Participants will not be compensated.

Please contact:

Claire Loucka

CL1425@mynsu.nova.edu



Appendix B

Interview Questions

1. What was your journey like into sobriety? How did you arrive here?
2. What made a difference in your sobriety?
3. What was the role of relapse in you getting to where you are now?
4. What happened when you hit bottom?
5. How many facilities were you in? What were your experiences there?
6. Did a therapist say or do something that made a difference? Did anything stand out?
7. Did you ever have family therapy?
8. What were your experiences like with AA/NA?
9. What allowed you to orient differently to getting sober?
10. What finally made a difference that you can look back and say ‘that was it’ or if it weren’t for that I wouldn’t be here?
11. At what point in your recovery did you know this was it? That this was different than the previous times? Did you discover this later or did you know when it happened? How did you know?

Appendix C

Informed Consent

NSU Florida
NOVA SOUTHEASTERN UNIVERSITY

INSTITUTIONAL REVIEW BOARD
3301 College Avenue
Fort Lauderdale, Florida 33314-7796
PHONE: (954) 262-5369

General Informed Consent Form

NSU Consent to be in a Research Study Entitled
Long-term sobriety from opioids: An interpretative phenomenological analysis

Who is doing this research study?

College: Department of Family Therapy, Dr. Kiran C. Patel College of Osteopathic Medicine.

Principal Investigator: Claire C. Loucka, MFT

Faculty Advisor/Dissertation Chair: Dr. Christopher Burnett, PsyD.

Site Information: Web Based, via Zoom.

Funding: Unfunded

What is this study about?

This is a research study, designed to test and create new ideas that other people can use. The purpose of this research study is to discover what made it possible for individuals to obtain at least 10 years sober from opioids. Opioids are negatively affecting many Americans. Further research is needed to identify factors that sustain sobriety.

Why are you asking me to be in this research study?

You are being asked to be in this research study because you identify as having at least 10 years sober from opioids not interrupted by periods of substance use, must have met DSM-V criteria for opioid use disorder at some point during substance use, are at least 18 years old, and have access to technology.

This study will include 10 people.

What will I be doing if I agree to be in this research study?

While you are taking part in this research study, we will meet one time for two hours via Zoom to discuss your story of recovery.

Research Study Procedures - as a participant, this is what you will be doing:

Researcher will coordinate with the participant to schedule a day and time to meet via video chat for two hours. Participants will receive the video chat link in the email provided. Then on the scheduled day and time the video interview will begin. The researcher and participant will discuss the participants story and process of recovery. Participants will only meet once for this study. Data obtained from this study may be used for further publications and academic/professional presentations.

Could I be removed from the study early by the research team? There are several reasons why the researchers may need to remove you from the study early. Some reasons are: no longer meets inclusion criteria (i.e., 10 years sober interrupted by periods of substance use). If the participants appears to be in danger.

Are there possible risks and discomforts to me?

This research study involves minimal risk to you. To the best of our knowledge, the questions you will be asked have no more risk of harm than you would have in everyday life. While this study will follow all rules and protocols in regard to protecting your privacy and ensure that these conversations are kept private until personal information is removed, there is a risk to privacy. Also, given the topic, you may be reminded of times of past drug use.

You may find some questions we ask you to be upsetting or stressful. If so, we can refer you to someone who may be able to help you with these feelings.

What happens if I do not want to be in this research study?
You have the right to leave this research study at any time, or not be in it. If you do decide to leave or you decide not to be in the study anymore, you will not get any penalty or lose any services you have a right to get. If you choose to stop being in the study, any information collected about you **before** the date you leave the study will be kept in the research records for 36 months from the end of the study but you may request that it not be used.

What if there is new information learned during the study that may affect my decision to remain in the study?
If significant new information relating to the study becomes available, which may relate to whether you want to remain in this study, this information will be given to you by the investigators. You may be asked to sign a new Informed Consent Form, if the information is given to you after you have joined the study.

Are there any benefits for taking part in this research study?
There are no direct benefits from being in this research study. We hope the information learned from this study will provide hope for those currently struggling with Opioid use, that recovery is possible.

Will I be paid or be given compensation for being in the study?

You will not be given any payments or compensation for being in this research study.

Will it cost me anything?

There are no costs to you for being in this research study.

How will you keep my information private?

Information we learn about you in this research study will be handled in a confidential manner, within the limits of the law and will be limited to people who have a need to review this information. Once the video interviews have been transcribed, they will be stored on the researchers external hard drive for the required amount of time. The videos will be fully removed from the researcher's personal computer. The transcriptions will not contain any names or identifying information. Participants will be given a pseudonym or alternative name. This data will be available to the researcher, the Institutional Review Board and other representatives of this institution, and any regulatory and granting agencies (if applicable). If we publish the results of the study in a scientific journal or book, we will not identify you. All confidential data will be kept securely on the researcher's personal password protected computer. All data will be kept for 36 months from the end of the study and destroyed after that time by full removal and deleted from computer and external hard drive.

Will there be any Audio or Video Recording

This research study involves audio and/or video recording. This recording will be available to the researcher, the Institutional Review Board and other representatives of this institution. The recording will be kept, stored, and destroyed as stated in the section above. Because what is in the recording could be used to find out that it is you, it is not possible to be sure that the recording will always be kept confidential. The researcher will try to keep anyone not working on the research from listening to or viewing the recording.

Whom can I contact if I have questions, concerns, comments, or complaints?

If you have questions now, feel free to ask us. If you have more questions about the research, your research rights, or have a research-related injury, please contact:

Primary contact:
Claire Loucka, MFT can be reached at (210) 526-1423 or cl1425@mynsu.nova.edu

Research Participants Rights
For questions/concerns regarding your research rights, please contact:

Institutional Review Board
Nova Southeastern University
(954) 262-5369 / Toll Free: 1-866-499-0790
IRB@nova.edu

You may also visit the NSU IRB website at www.nova.edu/irb/information-for-research-participants for further information regarding your rights as a research participant.

Research Consent & Authorization Signature Section

Voluntary Participation - You are not required to participate in this study. In the event you do participate, you may leave this research study at any time. If you leave this research study before it is completed, there will be no penalty to you, and you will not lose any benefits to which you are entitled.

If you agree to participate in this research study, sign this section. You will be given a signed copy of this form to keep. You do not waive any of your legal rights by signing this form.

SIGN THIS FORM ONLY IF THE STATEMENTS LISTED BELOW ARE TRUE:

- You have read the above information.
- Your questions have been answered to your satisfaction about the research

Adult Signature Section

I have voluntarily decided to take part in this research study.

Printed Name of Participant	Signature of Participant	Date
Printed Name of Person Obtaining Consent and Authorization	Signature of Person Obtaining Consent & Authorization	Date

Biographical Sketch

Claire Catherine Loucka was born in Connecticut and moved to Georgia before high school. From there she attended Georgia Southern University in Statesboro, GA for a Bachelor of Science in psychology. Then Claire went on to obtain her Masters in Family Therapy from Mercer University in Georgia. During her graduate school internship, she was first exposed to substance use treatment centers and there her passion bloomed. A desire to continue learning and developing her skills prompted Claire to purse a Ph.D. in Family therapy at Nova Southeastern University in Florida.

During her time in the Ph.D. program Claire worked as a marriage and family therapy intern and eventual fully licensed therapist at a substance use treatment center in Florida. During this time, she spent several years working with individuals and their families. This time was full of mistakes, learning opportunities, progress made, and unfortunately relapses and loss of clients. Claire hopes to continue exploring ways to support individuals struggling with opioids.

Claire is currently a licensed marriage and family therapist in private practice in Texas as well as an adjunct professor at Our Lady of the Lake University graduate program for Marriage and Family Therapy.