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RESEARCH ARTICLE

Multiple relapses into opiate and crack misuse among people in recovery: An interpretative phenomenological analysis

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Abstract

Relapsing multiple times back into opiate and crack cocaine misuse significantly increases the risk for overdose death, of which rates continue to soar worldwide. This study aims to provide an in-depth understanding of opiate and crack relapse from the lived experience perspectives of people in recovery from substance misuse. Semi-structured interviews were held, and interpretative phenomenological analysis was used to analyze the data. Findings revealed two superordinate themes which highlighted the impact of relapse on an individual's sense of self, their conceptualizations of relapse, and their approach to recovery thereafter. The study offers implications and future directions for mental health authorities and addiction professionals.

KEYWORDS

addiction, crack, interpretative phenomenological analysis, opiates, relapse

INTRODUCTION

Relapse into substance misuse remains a global health concern with significant societal and economic implications (World Drug Report, 2021). It is recognized that 75% of people who misuse opiates or psychostimulants, particularly crack, relapse within 3–6 months of exiting treatment (Appiah et al., 2018; Hendershot et al., 2011). Relapse increases the likelihood of drug overdose death (Herlinger & Lingford-Hughes, 2021; Public Health England, 2020), adding pressure to relevant addiction professionals. This is reflected in current data trends which show a significant increase in crack-related treatment re-entries and opiate-related overdose deaths (World Drug Report, 2019; European Drug Report, 2021). Conclusively, those who misuse opiates and crack have an increased risk of relapse, and those who relapse multiple times (i.e., more than twice during their lives) are at an increased

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risk of overdose death. The high turnaround rate of people exiting, relapsing and, best case scenario, re-entering treatment services reflect a limitation in current relapse support strategies.

A recent scoping review of opiate and crack relapse literature (Klein, 2021) highlighted that current relapse support strategies have developed from studies focusing on a medical/clinical treatment perspective (i.e., understanding the prevention or prediction of relapse). For instance, Marlatt et al. (Marlatt & Donovan, 2005; Witkiewitz & Marlatt, 2004) have established valuable theories on indicators which risk and prevent relapse. Their research formed the basis of relapse prevention strategies, which include a combination of cognitive-behavioral and behavioral modification skills to help the individual identify and cope with high-risk relapse situations (Brandon et al., 2007). More recently, scholars have built on this seminal understanding by developing the mindfulness-based relapse prevention model (MBRP; Bowen et al., 2021). MBRP aims to decrease relapse risk through helping individuals gain awareness about their thought, behavior, and emotional patterns (Holas et al., 2021). Since the earliest studies on relapse, only a handful of research projects have explored opiate and psychostimulant relapse qualitatively. These include McAuliffe's (1982) study which tested whether relapse was a result of taking opiates to alleviate the symptoms of withdrawal sickness. After interviewing 40 individuals experiencing opiate misuse issues, McAuliffe concluded that withdrawal sickness was not a cause for relapse. Additionally, McIntosh and McKeganey (2000) interviewed 70 individuals suffering from addiction about their relapse prevention strategies. The authors found that their participants commonly employed two key strategies, which were avoiding old, drug-using communities and building new, nondrug using communities. Another study, conducted by Mullen and Hammersley (2006), explored contributing factors of relapse. Their interviews with heroin-dependent men in Glasgow revealed that old circumstances and living environments were key factors which prevented individuals from staying abstinent. Lastly, a more recent study explored relapse prevention strategies of poly-substance users in Ghana. This evidenced that Ghanaian communities, as well as family members, played a key role in individuals staying abstinent (Appiah et al., 2018).

Taken together, these studies offer invaluable knowledge but lack explorations into relapse which are informed by people with lived experience. A broad and mostly preventative approach to relapse disregards the unique context of the individual. This narrow understanding in the field is arguably reflected in clinical practice by continuously high relapse rates. As such, we propose that exploring the experiences and perspectives of individuals who are most at risk for fatal overdose (i.e., those with multiple relapse experiences from opiates and crack cocaine) is important to inform our understanding of their needs and develop more effective support strategies. As such, our study seeks to address two central questions, which are as follows:

1. What are the lived experiences of relapsing multiple times (i.e., more than twice) from opiate and crack misuse among people in recovery from substance misuse (henceforth, people in recovery; PIR)?
2. How do PIR make sense of these experiences within a recovery context?

By addressing these questions, the study aims to generate an in-depth understanding of opiate and crack relapse, including how multiple relapses impact the individual's psychological well-being as well as their overall approach to recovery. This understanding will have the potential to inform practitioners about tailoring intervention and support strategies more effectively for this vulnerable people group.

METHODOLOGY

Design

Given the interpretive and phenomenological direction of our questions, we chose a qualitative research design to enable participant experiences to reveal themselves in the data (Creswell &

TABLE 1 Participant inclusion and exclusion criteria

Inclusion criteria	Exclusion criteria
A history of class A drug misuse (e.g., opiates, crack cocaine) Aged 18 years or over	Identify as having relapsed mainly from alcohol or other drugs apart from opiates and crack
Not currently in treatment but moved on to aftercare or recovery support groups (e.g., AA/NA)	Currently in maintenance-drug treatment (i.e., on a methadone script)
Abstinent from any presenting drugs, apart from nicotine and caffeine, for at least 3 months at the time of the interview Having relapsed, as identified by them, at least twice from opiate or crack in the past Able to communicate verbally using the English language	Currently identifying as dependent on alcohol or other nonopiate drugs (i.e., cannabis)

Creswell, 2017). In alignment with our belief that reality is something to which each person attaches their own subjective meaning, we approached this study from a relativist ontology (Moon & Blackman, 2014) and specifically situate this study within recovery-informed theory (RIT; Brown & Ashford, 2019). RIT provides a stance for a continuum-based model of addiction and argues for the centrality of the lived experience perspectives in understanding and exploring recovery. RIT posits that recovery from addiction is not a binary outcome (abstinent vs. nonabstinent) but can be conceptualized as a transformation toward wellness which is captured in people's various "life spheres," including intrapersonal factors (relationship with self), interpersonal factors (relationship with others), and ecological factors (context, environment, society). This multifaceted view on addiction aligns with our professional understandings and was therefore used to guide the research. When analyzing the data, we remained conscious of each of these life spheres but also remained open to others not yet included in this theory. Given the theory's emphasis on the lived experiences as well as our overall aim to explore how PIR make sense of their lived relapse experiences, we chose interpretative phenomenological analysis (IPA; Smith, 2011; Smith et al., 2021) as best fit for the explorations in this study.

Sample

IPA is underpinned by idiography, meaning that it emphasizes an in-depth and case-by-case data analysis. As such, samples in IPA are typically small and range from one to 10 participants (Smith, 2011). The aim of IPA sampling is to gain access to a homogenous group of people who all have lived experience of the phenomenon of interest (Larkin & Thompson, 2012). Participants were recruited voluntarily upon response to a study flyer which was circulated in aftercare groups of five voluntary sector (i.e., no-for-profit) drug and alcohol treatment centers across England. These included outpatient treatment centers (e.g., walk-in clinics or community-based day treatment centers) as well as inpatient treatment centers based in the North, South-West, and central England. Seven participants (one woman, six men) volunteered to take part in the study. All participants were consenting adults who had relapsed from opiate and crack misuse at least twice throughout their lives. Participants were also required to be abstinent for at least 3 months at the time of the interview as this is the point at which UK addiction services consider former clients a "closed case" and in aftercare. The inclusion criteria are outlined in Table 1. An overview of participants' background information can be found in Table 2.

Data collection

We generated data through individual, semi-structured interviews using MS Teams. In alignment with conventional IPA research, we developed a semi-structured interview guide. In developing the guide, we kept relevant, reviewed literature in mind and formulated questions openly yet topical enough

TABLE 2 Participant demographic overview

Pseudonym	Age	Gender	Location (part of England)	Dominant drug of misuse	No. of relapses
Jack	26	M	SW	Heroin, crack	6
Toby	38	M	N	Heroin, crack	5
Trish	43	F	N	Heroin, crack	>10
Tristan	43	M	C	Heroin, crack, methadone	>10
Rick	39	M	C	Heroin, crack	4
Bryn	56	M	N	Heroin, crack, methadone	>10
Jonathan	56	M	SW	Crack, zopiclone	>10

to create structure. Participants were asked about their feelings, thoughts, and physical sensations during relapse as well as how these feelings and thoughts varied with each added relapse. Additionally, participants were asked how these relapse experiences impacted their perceptions of, and attitudes toward, recovery. As is good practice in IPA, the first author piloted the interview schedule with one participant to ensure that questions were easy to understand and produced the desired data (Smith & Osborn, 2015).

Prior to any interview, we presented all potential participants with a study information sheet which outlined the study aims, the interview process, and how their interview data would be managed. Interviews lasted between one and a half and two hours each. The first author recorded each interview on a password-protected recording device. Each interview was subsequently transcribed and anonymized by the first author. As such, any subsequent references to participants will relate to their pseudonyms, not their real names.

Data analysis

IPA provides an analytical protocol to investigate the individual's lived experience with the overall aim to interpret what these experiences mean to the individual. As such, an important and explicit feature of the analysis is the analyst's interpretation of participants' accounts, also referred to as double hermeneutics (Larkin et al., 2006). We analyzed the data following Smith et al.'s (2009) six-step guide, which required a line-by-line coding process of each individual transcript. We coded descriptive, linguistic, and contextual elements in each transcript with the overall commitment to understanding the participant's point of view. In alignment with Larkin et al.' (2006) recommendations, we identified codes by focusing on people, places, or events which mattered to the participant (i.e., objects of concerns). Next, we focused on identifying the meaning that participants attributed to these (i.e., experiential claims) and what participants' stances toward these meanings were. We followed this protocol for each individual transcript before moving on to producing a thematic account of all seven transcripts combined. Lastly, we identified similarities between each transcript and grouped these into superordinate themes (Smith et al., 2009). We organized data on a spreadsheet, including all codes, interpretive themes and participants' quotes.

Given the interpretive nature of IPA, we sought to engage with this project reflectively (Finlay, 2008). This meant that we critically discussed how our own values, experiences, and dispositions could influence our interpretations of the data. The first author kept a research diary throughout the study in which she recorded her thoughts and experiences after each individual interview. This diary was useful for bracketing purposes, as the first author was mindful to record her initial assumptions and thoughts before reading the transcript for analysis. Throughout the data collection and analysis, the first author maintained an audit trail, consisting of researcher notes, transcripts, coding maps,

theme spreadsheets, and final findings (Morrow, 2005). Further, authors two and three conducted independent credibility checks by reviewing the codes and themes to ensure the validity of coding procedures and to identify any biases or assumptions about the data. This was possible as authors two and three were the research supervisors and practitioners themselves and were therefore able to identify any themes which may have been informed by the first author's assumptions and biases. After independently checking, all authors critically discussed any potential issues and provided the first author with recommendations for the development of themes.

Ethical considerations

Prior to commencing this research, we received ethical approval from the host university's Social Science Research Ethics Committee. We identified a gatekeeper at each recruitment site to help identify potential participants. For this, we emailed each gatekeeper an electronic study information sheet, outlining the study aims and objectives as well as the expectations of the interview process. The information sheet clearly outlined that participation is voluntary and that participants have the right to withdraw their data from the study at any point without providing a reason for doing so. Lastly, the sheet outlined that participants were not obliged to answer any interview questions if they did not feel comfortable to, and that we would provide participants with details of support services in their area, should they become upset during the interview (Bernard, 2013).

We requested each gatekeeper to forward this information sheet to any potential participant and to encourage people who expressed interest in participating to contact the first author directly. Upon agreeing to participate, we emailed further information to participants, including a consent form. On the day of the interview, the first author reviewed the study information sheet with the participant and reassured participants about voluntarism. All participants gave informed consent before the research began, which the first author recorded by initialing on a separate consent form.

RESULTS

Two superordinate themes emerged from the data: "The Relapse Experience" and "Recovery after Multiple Relapses." Each of these superordinate themes is accompanied by individual subthemes, which demonstrate nuances in participants' lived experiences. An overview of themes is presented in Figure 1. In this section, we present each theme using verbatim quotes of participants as a guide.

Superordinate theme one: The relapse experience

This first theme highlights the emotional and psychological experience of relapse in four subthemes: "From Self-Mistrust to a Sense of Powerlessness," "Conceptualizing Relapse as Location, Multipartite and Movement," "Thankfulness and Avoidance toward Relapse," and "Reducing Risk for Relapse through Self-Efficacy, Vulnerability, Purpose, and Commitment for Change."

From self-mistrust to a sense of powerlessness

This first subtheme captures how each relapse was experienced as a process leading participants to feel a sense of powerlessness. This process consists of three feelings (self-mistrust, shame, hopelessness) which consequently result in feeling disempowered. The first feeling, self-mistrust, was referred to as an internal incongruency which, following multiple relapses, degraded participants' ability to trust in themselves. Jonathan described this incongruency as a tension in his head:

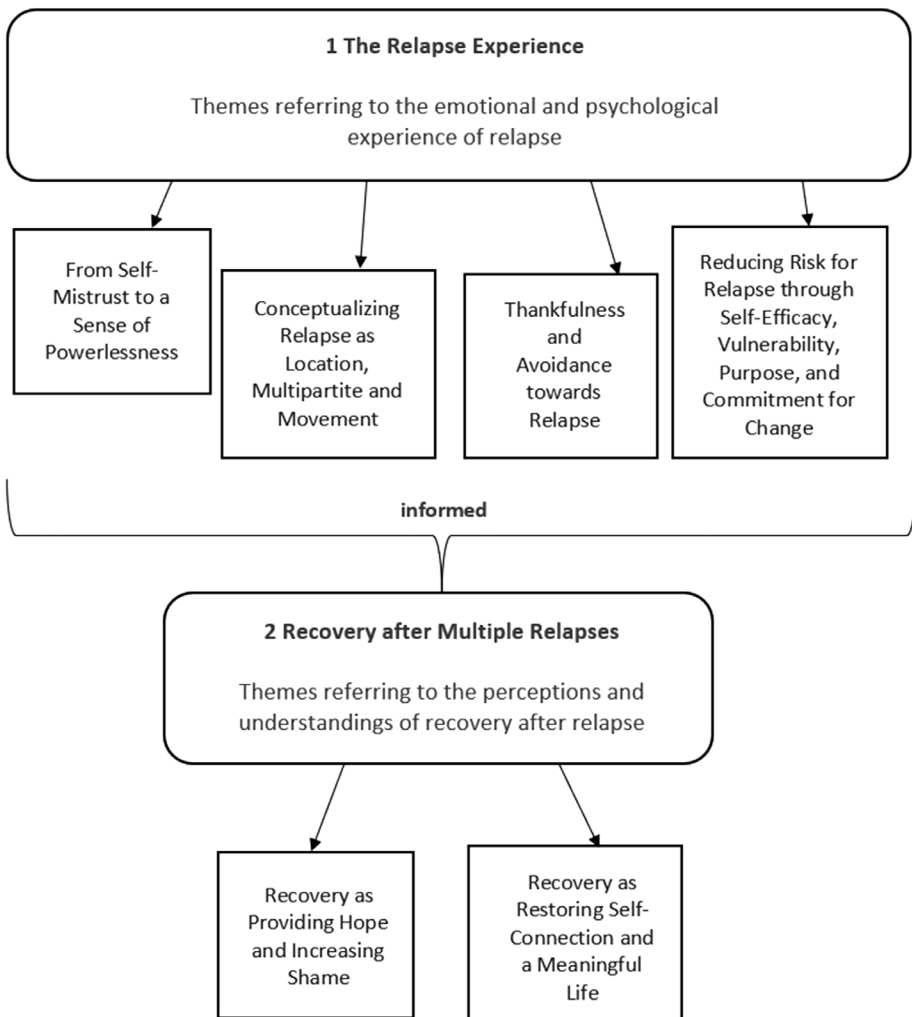


FIGURE 1 Overview of themes

My head starts saying to me, “you know, you shouldn’t do this. You know, it’s the wrong thing to do.” But then the turmoil is that the other part of me is saying, “well, but, you know, you need to do this [use drugs] to escape.”

Here, Jonathan reflected on what relapse feels like in his mind; one part of him judges his drug-taking part, while his drug-taking part justifies relapsing. Other participants shared this internal argument. For instance, Toby reflected that it “(...) feel[s] like there’s two different people.” Bryn, another participant, compared this internal argument to excruciating pain. “It’s like torture of the mind,” he said. With each additional relapse, these feelings of incongruity developed further. All participants voiced that they could not trust themselves anymore to make good decisions. This internalized belief of self-mistrust then became a confirmation bias; participants used any additional experiences to confirm their belief that they would relapse again. For instance, Jack explained that “it’s like you can’t fully trust yourself (...) part of you has told yourself ‘you’re never gonna do that again and then something over rails that.’” As such, every additional relapse led participants to develop an

internal belief system of being untrustworthy, thereby decreasing their self-confidence and overall autonomy.

Participants described how this decrease in perceived autonomy over time led to shame, the second feeling in the process leading up to powerlessness. Jack shared that “[his] inner feeling is bad (...) there is something bad about it. It’s wrong. It’s broken.” In Jack’s account, shame manifested itself in a belief that he was incapable of change, even if he desired it. Several other participants shared this sense of shame. For instance, Tristan compared this feeling with “a broken record saying it over and over and over.” Additionally, Toby conveyed that shame was also triggered by other people’s reactions:

You feel bad enough about what you’ve done, but you[‘ve] got then [to] explain to somebody else and then take home what they’re going to feel about it.

As such, there was a connection between participants shaming themselves and feeling shame because of other’s comments. By unpacking this further, relapsing multiple times fosters a sense of hopelessness. Toby explained that his repeated relapses have led him to feel “stuck in that hole.” As such, each added relapse can “normalize” this inability to change or move forward.

This normalized hopelessness made up the third element in the process to feeling powerlessness. Participants highlighted an intensified doubt in their ability to change and sustain their recovery, as was captured by Jonathan:

I’ll never be able to do this [recover]. And this is going to be a situation of recovery, relapse, recovery, relapse is going to affect me for the rest of my life. I don’t know what I’m going to do differently this time. How is it going to be different?

Jonathan derived his sense of hopelessness from past experiences, which then framed how he viewed his future experiences (i.e., in recovery). Similarly, hopelessness was intensified through comparison with previous users who have not relapsed. Trish highlighted this by explaining how comparison triggered her belief that life for her will never change: “you think why [are] people around me getting it and I’m not (...) I just can’t seem to stay clean (...) I was using against my will every day (...) I just couldn’t stop.” Similarly, Jack expressed powerlessness over relapse by stating: “[relapse] is bigger than I am.” The use of expressions such as relapse “came out of nowhere” (Tristan) or active language such as “it almost made me kill myself” (Rick), participants attributed control and power to relapse. In Rick’s case, his use of active language illustrated that he blamed his relapse for his suicidal ideations, and perceived relapse as having the power to “make” him do something.

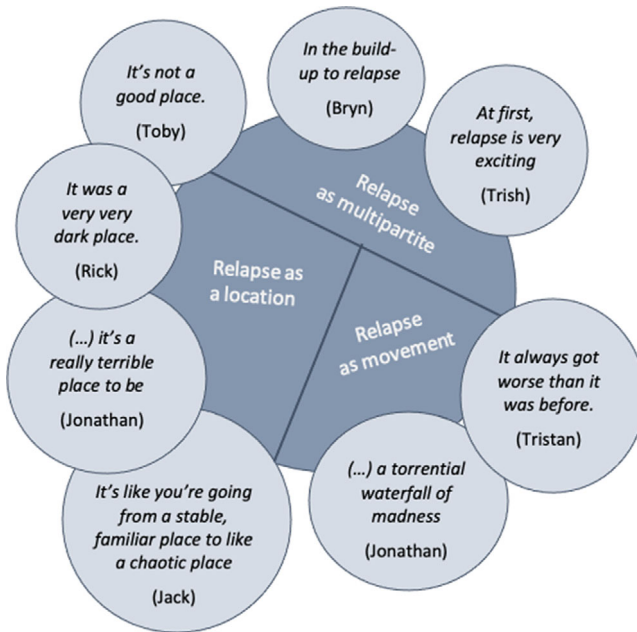
Conceptualizing relapse as location, multipartite and movement

This theme refers to how participants conceptualized relapse (see Figure 2). Some referred to relapse as something to be “in”—like a place, season, position, stance, stage, state, phase, or another reality. Others understood relapse as including multiple parts. A last conceptualization related relapse to something which had movement. As shown in Figure 2, the conceptualization of relapse as a location was shared by most participants. Jack provided insight into what it felt like to be in this place:

Like when you are a kid and you have a bad dream or something and then you wake up and you’re kind of in your home, but everything feels a bit different.

Here, he portrayed relapse as an alternative reality in which everything looked the same but felt “different.” By comparing relapse to a kid’s nightmare, Jack seemed to indicate that relapse was a place or state that felt scary and confusing.

FIGURE 2 Concepts of relapse



The second way in which participants conceptualized relapse was as something which included multiple parts (see Figure 2). This was highlighted by participants' use of numerical language to describe the experience. For instance, Trish used the words "at first" and Bryn used "the build-up to" when describing relapse. These descriptions also highlighted that some participants conceptualized relapse as a gradual rather than an instant experience. By contrast, other participants described feeling suddenly plunged into a chaotic place.

The last way in which participants conceptualized relapse was as something with movement or progression. For instance, Jonathan shared: "I went straight back onto the coke and the crack and things deteriorated quite rapidly from there (...) a thousand times worse." The choice of words here signal that Jonathan perceived each repeated relapse as more intense and unpleasant. Jonathan went on to compare relapse with a waterfall (see Figure 1) and further with "(...) a washing machine, you know, that is on cycle 1000. I can't stop it." In both analogies, he related relapse to something that was moving with force, and which felt intimidating. In other words, he emphasized that he understood relapse as both, forceful and unstoppable.

Thankfulness and avoidance toward relapse

This theme refers to how participants positioned themselves toward relapse. Most participants drew meaning and value from their relapses and viewed relapse as something to be appreciated as it facilitated recovery, as captured by Jack:

It's not saying that people who haven't gone through that [multiple relapse] can't self-actualize. But I think in a way it can sort of force you to deal with yourself in a way that perhaps ... otherwise you wouldn't. Potentially you could live a much better life than you could have if you hadn't been forced to really take a look at yourself.

Here, Jack explained that his repeated relapses ultimately led him to a greater awareness of himself and a level of self-growth which he would not have reached "otherwise." When looking back on his

past, he added that “it’s not something that I regret necessarily cuz it all needed to happen uhm you know to get to where I am now.” Relapse, from this perspective, is seen as facilitating recovery by being a stepping-stone for self-development and self-growth. Further, Jack expressed that the experience of relapse meant that he could reach a state of “self-actualization,” implying that relapse was a meaningful and valuable experience for him which helped him realize his full potential. This positive positioning of relapse was also shared by Toby. “My relapses have helped me to understand myself on a deeper level (...) without those relapses, I wouldn’t have experienced that,” he explained. In addition, Jonathan expressed gratitude. “I’m grateful that my pain has led me to a greater understanding of myself (...) I don’t know if I would change anything.”

While some participants positioned themselves as thankful learners, others took the stance that relapse was hindering their recovery. Tristan, for example, sided with both, a positive attitude toward relapse by stating that “[he] had to relapse to basically learn,” as well as holding a cautious attitude. “People think that relapse is part of recovery but (...) it’s not (...) I strongly believe that (...) if I relapse, I’m dead,” he explained. As such, Tristan drew value not from experiencing relapse, like Jack or Jonathan, but rather through avoiding/preventing it. This zero-tolerance position was also expressed by Trish who stressed that “relapse actually fills [her] with fear today.” In other words, relapse was seen as encapsulating only pain or fear.

Reducing risk for relapse through self-efficacy, vulnerability, purpose, and commitment for change

Several participants identified the importance of building self-efficacy, or self-belief about their ability to recover. As someone who had experienced multiple relapses and the accompanying feelings of self-mistrust and shame, Jack explained that he “(...) was struggling to believe then, (...) how much things can change.” He viewed building self-efficacy as a gradual process. “The longer you are around people who have what you want (...) the more you start believing that it’s possible,” Jack said. As such, the belief that recovery was possible (even after multiple relapses) was derived from witnessing other people in recovery. In his interview, Jack identified that witnessing others provided him with powerful evidence. However, other participants highlighted that being around people in recovery in between their relapses made it more challenging for them to re-enter treatment. As such, participants alluded to another strategy for reducing the risk of relapse which served to support re-entry into treatment, namely, vulnerability. For example, Bryn explained that vulnerability offered him a clear conscious. “If I carry that shame and guilt [of not telling people] with me, relapse is in the pipeline because I can’t handle that shame and guilt no more,” he said. A third strategy for reducing the risk of another relapse was identified by Bryn:

When my grandson was born (...) it’s like the Stevie Wonder song, “for once in my life, I have somebody who needs me” (...) so me attitude changed.

Bryn believed that he previously had no purpose in life or a motivation to change his drug use, which seemed to contribute to repeated relapses. However, after his grandson was born, Bryn felt like he was needed by his family; that he mattered and belonged. This shift in perspective was powerful enough to have led him to commit to his recovery, and thus minimized the risk of another relapse. Lastly, several participants felt that relapse risk can be reduced through commitment and readiness for change. For example, Trish shared: “My heart wasn’t in it.” Toby added that “[he] obviously wasn’t ready at that time.” However, Jack stressed that change itself was not enough and that there was a right and wrong type of change. “I hadn’t made the right changes. I was kinda scratching the surface,” he said. His statement indicates that only a “right” kind of change can reduce the risk for relapse and facilitate recovery.

In summary, this first superordinate theme offered insights into how relapsing multiple times felt (i.e., the felt experience). This felt experience of multiple relapses informed how participants cognitively made sense of their recovery.

Superordinate theme two: Recovery after multiple relapses

The second main theme captures how relapsing multiple times has affected participants' perceptions and understandings of recovery. It is reflected in two subthemes: "Recovery as Providing Hope and Increasing Shame" and "Recovery as Restoring Self-Connection and a Meaningful Life."

Recovery as providing hope and increasing shame

This subtheme highlights that participants perceived recovery as a double-edged sword; as having both, favorable and unfavorable consequences. On the one hand, recovery was seen as providing encouragement and motivation. "Because I had been through treatment and got a taste of recovery (...) that gave me the motivation to push through and grab it (...)," said Tristan. As such, the time spent in recovery and the awareness gained through it, offered Tristan protection from another relapse. He felt an impulse to reach out for help again. Bryn added to this positive outlook by reflecting that "once you[ve] got a taste of recovery (...) you've got that little seed in the back of your head saying, 'there's a way out of this.'" Bryn highlighted that previous time spent in recovery or treatment can provide hope during/after a relapse. In other words, every time he chose to pursue recovery after relapse has created the belief that because he had recovered before, he could recover again.

On the other hand, recovery was seen to also have negative consequences. Some participants felt that recovery could increase feelings of shame and ultimately increased the risk of a fatal relapse. For instance, Jack explains that "the guilt and the shame is more because you worked so hard to get to that point." This interestingly highlights that length of time spent in treatment may lead to increased expectations regarding recovery, and ultimately to an increased sense of shame in the event of a relapse. This was underlined by Toby, as he explained that "[if] you've kind of been through treatments, then it feels more significant if you relapse." Further, participants expressed that the increased shame experienced as a result of having been through numerous treatments could lead to an increased amount of drug dosage during the next relapse. For instance, Trish explains:

The more knowledge you have about recovery and knowing what you need to do, the harder you relapses get because (...) you know how to stay in recovery, and you end up using even more to block those thoughts and feelings out.

This is significant as it demonstrates that time spent in recovery may contribute to a higher risk of fatal relapse. This understanding further informed what meanings participants attached to their recovery, as presented in the second subtheme below.

Recovery as restoring self-connection and a meaningful life

This subtheme refers to what recovery meant to survivors of multiple relapses. The meanings included a feeling of self-connection and creating a meaningful life. Firstly, participants expressed that recovery meant restoration of trust in themselves. "Recovery (...) has been to trust my inner feeling again," Jack said. Additionally, for Jonathan, recovery meant restoring self-compassion: "[recovery is] a way for me to accept my wholeness, my negative and positive [parts of] myself, all of the different facets of myself." Toby supported the idea that recovery means self-compassion, as he stated that "[recovery

means] standing in your own truth and not being ashamed to talk about it.” Like Toby, Jonathan, and Jack, Bryn felt that recovery involved respecting oneself. “Recovery means to me in a way love [and] freedom of the mind,” he explained. Not only does recovery mean for Bryn to feel free from the internal dilemma mentioned in the first main theme, but it also means feeling self-love.

Secondly, participants expressed that recovery meant having a meaningful life. Trish explained that for her, recovery involves creating “a life that’s worth living more than the life [she] had when [she was] using.” Recovery means to adopt changes which support a drug-free lifestyle. Other participants identified that recovery includes re-connecting with “(...) everything that you’ve lost i.e., friends or family,” as Tristan shared. For Bryn, this also includes other aspects, such as hobbies or fitness. “Playing golf is recovery; being with my grandson is recovery; drinking orange juice in the morning is recovery,” he highlighted. These statements revealed that recovery means much more than not using drugs; it also means to re-connect and engage with both, mundane and meaningful aspects of everyday life.

DISCUSSION

This study explored the lived experience perspectives of multiple relapses into opiate and crack misuse among people in recovery from substance misuse (PIR) in England. As the first study to ever have explored multiple relapse through interpretative phenomenological analysis, the generated findings hold significance on both national as well as international level. Findings revealed that participants identified as relapse survivors, whose multiple relapses significantly shaped their psychological well-being, sense of selves and overall dispositions toward recovery, all of which substantially enriches the existing, qualitative literature reviewed earlier.

Survivors’ narratives highlighted that shame leads to relapse and relapse leads to further shame, a cycle which ultimately creates a sense of disempowerment within them. Lack of agency and feeling inferior were expressed as consequences which could risk relapse propensity. Survivors clearly stated that each added relapse decreased their belief of being capable of making choices which maintained recovery (self-efficacy) and increased feelings of inferiority toward themselves. This finding is consistent with Marlatt and Donovan’s (2005) relapse prevention model, which remains the dominant approach for relapse prevention in addiction treatment services. The model conceptualizes the attribution of relapse to internal factors, such as lack of self-efficacy, as the abstinence violation effect (AVE), which suggests that such individuals are more likely to relapse. The prominent solution of the model is to help individuals regain their self-efficacy. Common psychological approaches to increase self-efficacy include intentionally setting and approaching difficult tasks until they are mastered and overcome (Hyde et al., 2008). Given this understanding, individuals who have relapsed multiple times (should) have higher self-efficacy. In other words, because they have done it before, this increases their belief that they can do so again. However, this is inconsistent with the findings of this study. Apart from a few survivors, most accounts revealed that, the more survivors relapsed, the more self-doubt was created, all of which further decreased their overall self-efficacy. These nuances suggest self-connection, not self-efficacy to be the defining factor for individuals to prevent relapse. As such, a review of Marlatt’s model might be useful to account for these nuances.

One of the startling aspects of the findings was that survivors expressed greater relapse risk behavior during long-term, rather than early, recovery. In other words, individuals who have been exposed to treatment and recovery many times before may experience a greater sense of shame and self-judgment when relapsing. Depending on their physical health and tolerance level, this could mean an increased risk for these individuals to overdose during their relapse. This finding contrasts with those treatment approaches which view long-term recovery as a period of maintained abstinence. Here, we propose a less rigid outlook on relapse which does not count relapse as absent from, but as present within, long-term recovery, all of which could significantly reduce shame, and, possibly, overdose risk in survivors.

Further, a novel and important insight was gained around survivors' perceptions of recovery after multiple relapses. Survivors saw their role in recovery as either being an appreciative learner or a cautious protector toward relapse. This highlights that using a blanket approach for relapse, either by only focusing on relapse prevention or by only defining relapse as binary outcome (i.e., part/not part of recovery), will not account for the nuances expressed here. A multiperspectival approach to relapse, with evidence derived from different scientific fields, seems to be the way forward. This underscores research from academics in health psychology, who have argued that preparing individuals for the eventuality of a setback (relapse) instead of focusing solely on prevention is more effective and empowering (Wenzel et al., 2020). However, these findings do not frame a mindset of expecting setbacks. The onus here is on helping individuals to feel prepared and accepting toward a setback while maintaining the belief that setbacks are not expected. In practice, this could look like training survivors in the mindset that relapse is sometimes inevitable, which could be combined with MBRP (Bowen et al., 2021).

Lastly, survivors' accounts add crucial evidence to RIT (Brown & Ashford, 2019). For one, the findings on relapse will be useful for situating relapse within a RIT framework, thereby developing important aspects of the theory. As findings revealed, relapse itself was first and foremost an internal experience (i.e., self-mistrust, shame, despair, disempowerment) which could either demotivate or motivate an individual to pursue recovery. As such, relapse must be viewed within the context of the individual who has experienced it, which would situate relapse within the intrapersonal sphere of RIT. Second, the understanding of recovery after multiple relapses further supports RIT. Individuals who have repeatedly relapsed perceived recovery as mainly an internal process of restoring their self-trust, self-belief and, ultimately, self-connection. As such, the understanding that recovery includes an intrapersonal life ecology is thereby confirmed. Additionally, for some survivors, recovery meant creating a balanced lifestyle which included both, treatment-related practices (e.g., attending recovery groups) and treatment-unrelated practices (e.g., exercise or nutrition). This offers important insights into understanding recovery, in light of relapse, within the RIT framework. The finding that recovery may be relapse producing rather than reducing must be acknowledged within RIT and warrants further research.

Implications for clinical practice

This study offers several implications for mental health authorities and addiction professionals. For one, the development of additional trainings, which can prepare PIR, as well as their concerned others, for every eventuality before, during and after relapse, will offer added protection against fatal outcomes. Practitioners could begin to train PIR in psychological interventions which PIR can practice independently of their therapist, and which directly address their need for self-connection, all of which will help PIR feel empowered to maneuver future relapses more successfully. Second, multiple relapses can significantly impact PIR's mental health and denotes long-term recovery as desired goal which protects from relapse in the future. As such, it is advisable for mental health authorities, treatment services as well as educational services to consider equipping and educating clinical professionals who engage with recovery communities specifically, to minimize false expectations in both, themselves and PIR, and to boost support for individuals in long-term recovery.

Limitations and considerations for future research

Some limitations of this study must be acknowledged. For one, gatekeeper involvement in the recruiting process could have caused recruitment bias. Additionally, due to the unprecedented COVID-19 restrictions, the sample was limited to individuals who had the necessary means for a virtual interview (i.e., webcam). However, recruitment involved several sites from across England, which meant the

sample demographics varied. Thus, we are confident that we captured a range of experiences. Further, the limited female representation in our sample must also be borne in mind. This is something which must be considered in future research. Lastly, this study represents the beginning steps of developing a multidisciplinary perspective of relapse to understand the impact of relapse on individuals who can be considered most at risk for overdose death. Further research of this nature, potentially focusing on overdose survivors or addiction therapists, in different locations and across different substance groups, would benefit our collective understanding of this significantly relevant issue moving forward.

CONCLUSION

Understanding opiate and crack relapse becomes ever more pressing in a context where overdose of such substances continues to cost lives. Novel insights were gained about relapse risk environments and the long-term effects of multiple relapses on survivors' mental health. Findings of this study highlight the complexity of relapse experiences and the need for clinical practice to be mindful how relapse can impact an individual's approach to recovery. Importantly, findings of this study conceptualized relapse within the RIT framework, thereby having laid the groundwork for developing a user-informed perspective on substance misuse relapse. We conclude that there is a need for professionals in the relevant field to create a more empathic-informed language and therapeutic space which will not only focus on prevention of relapse but also on empowering individuals to regain agency over relapses in the future.

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CONFLICT OF INTEREST

The authors declare no conflict of interest.

ETHICS STATEMENT

Ethical approval was obtained from the ethics committee of the host University. The procedures used in this study adhere to the tenets of the Declaration of Helsinki.

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