A Phenomenological Research Study on the Treatment Experience of Opioid Addicts: Exploring the Intrapersonal and Interpersonal Conflicts that Opioid Addicts Face During the Treatment Process

Nicole Marie Ouzounian

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A Phenomenological Research Study on the Treatment Experience of Opioid Addicts:
Exploring the Intrapersonal and Interpersonal Conflicts that Opioid Addicts Face During
the Treatment Process

by

Nicole Ouzounian

A Dissertation Presented to the
College of Arts, Humanities, and Social Sciences of Nova Southeastern University
in Partial Fulfillment of the Requirements for the Degree of
Doctor of Philosophy

Nova Southeastern University
2018
Nova Southeastern University
College of Arts, Humanities, and Social Sciences

This dissertation was submitted by Nicole Ouzounian under the direction of the chair of the dissertation committee listed below. It was submitted to the College of Arts, Humanities, and Social Sciences and approved in partial fulfillment of the requirements for the degree of Philosophy in the Department of Conflict Analysis and Resolution at Nova Southeastern University.

Approved:

Date of Defense
8/31/18
Claire Michèle Rice, Ph.D., Chair

Neil Katz, Ph.D., Committee Member

Elena Bastidas, Ph.D., Committee Member

Date of Final Approval
11/12/18
Claire Michèle Rice, Ph.D., Chair
Dedication

I dedicate this research manuscript to all of the addicts struggling with drug and/or alcohol addiction. There is not a day that goes by that I am not inspired by those who I am blessed to work for. Watching individuals fight for their lives, giving everything they have to transform their souls is a powerful reminder of just how strong we can truly be. I have great respect and admiration for those struggling with addiction and am honored to be fighting the fight with you. For me, this study was more than just an academic opportunity. My hope is that the voices of those representing recovery speak to the world about the underlying potential of what addiction has the potential to unveil for those who are on the recovery journey. I love you all!
Acknowledgments

This dissertation would not have happened had it not been for the love and support of my mother, Laura Toggweiler, who talked me out of many dark times when I wanted to give up. Words cannot express the gratitude I have for what you have done for me through this long process. You are not only my mother, but you are also my best friend. I love you.

I would like to thank my step-father who introduced me to Nova and informed me of the Open House where I made the decision to go back to school. Our intellectual conversations were not only stimulating but also helped me believe that I had knowledge that needed to be shared. To my father who was the calming force throughout this process, never feeding off my anxiety while always providing words of encouragement. Watching Jag together cleared my mind more than you know. I love you both.

To my kick boxing friends who gave me the forum to expel physical energy and exhaust me to the point where I could not think anymore. I needed that. To my friend Amy who made me get out of the house when I wanted to isolate. It is rare indeed to find a friend who gives but does not expect anything in return. You are a gem.

I would also like to thank my dissertation Chair, Claire Michèle Rice, Ph.D., and my committee members, Neil Katz, Ph.D. and Elena Bastidas, Ph.D., who allowed me the opportunity to fulfill an academic dream. Thank you all for your patience and understanding when I needed extra time to complete this part of my journey.

I would like to thank my boss and my mentor Wendi Rabucha. Watching you at work inspired me daily. Your passion and dedication to the clients we serve taught me a great deal about the power of love. I cannot tell you how grateful I am to you for
allowing me the time to work on this manuscript. To the staff that I am so blessed to work with, thank you for taking over the house when I had to write, and a special thank you for being patient during my sassy times.

Finally, thank you to my Lord Jesus Christ of which none of this would have been possible. You have moved mountains in my life to allow this to happen. I love you.
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Abstract

Opioid addiction is a physical, mental, and social issue. The insidious habits and behaviors acquired while living an addictive lifestyle are more powerful than human comprehension, and the training required to release these strongholds are extreme to say the least. Capturing the lived experiences of this process is needed to increase understanding of the development that leads to transformation from active addict to addict in recovery. This phenomenological research study on the treatment experience of opioid addicts used a qualitative approach to gain understanding of this phenomenon. For this study, 15 research participants were selected. Their ages ranged from 21 to 30-years-old and they all successfully completed an adult substance abuse treatment program. All participants must have been in active recovery for a minimum of one year. The central question for this study is: what are the intrapersonal and interpersonal conflicts opioid addicts are presented with during their treatment process? By means of conducting and analyzing interview questions and utilizing the conflict resolution theories of human motivation, social identity theory, coordinated management of meaning theory, and relative deprivation theory, this study revealed that the overall essence of the treatment experience is the journey of identity transformation from active addict to addict in recovery through conflict management. The need to manage conflict in five specific areas was uncovered. They include identity formation, stigma, interpersonal relationships, group structure, and conflict styles. The participants’ shared experiences provide insight into identifying conflicts that need to be managed and resolved so recovery is achieved and sustained.
Chapter 1: Introduction

We are living in a time that allows one to be susceptible to all kinds of addictions. With the internet and social media technologies leading the way in creating a culture that perpetuates an instant gratification mindset (Tulipano, R., 2015), it should come as no surprise that many Americans chose quick fixes to alleviate physical, mental, or social dysfunctions. Leading the way in this modern mindset is the field of medicine. If there is something ailing you, there is a prescription medication that will provide instant relief. From minor headaches to chronic back pain, there is an opioid designed to reduce or even diminish the pain (WebMD, 2017). Unfortunately, the costs of taking opioids do not always outweigh the benefits and many of our nation’s people are struggling with the intense consequences of living a life that includes medications originally designed to give one comfort from intense chronic pain. Some of these consequences include increased tolerance to reach the desired effect (WebMD, 2017). Tolerance increases at a rate that does not allow the original number of opioid pills within the prescription to ease pain. In addition, physiological withdrawal occurs when the body does not receive the appropriate amounts of the opioid (WebMD, 2017). The withdrawal symptoms can be so painful, that it requires illegal tactics to obtain new prescriptions from multiple sources. Behaviors that one would never do, become doable in moments of desperation. The costs for prescription pain management may include but are not limited to physiological withdrawal, social dysfunction, and psychological deterioration.

Opioid addiction has reached epidemic proportions in the United States. According to the Substance Abuse and Mental Health Services Administration (SAMHSA, 2015), 1.9 million individuals in this country were afflicted with drug abuse
disorders because of prescription opioid pain medications in 2013 and 517,000 experienced a heroin use disorder. Fiorentino (2017) reports that opioid prescription medications have the potential of becoming the gateway drugs for substances like heroin when the prescription runs out or are no longer affordable.

According to federal data, 89 percent of people who met the criteria for substance abuse treatment did not get treated in 2015 (InRecovery, 2017). The reasons described have included denial that one has a problem, embarrassment due to the stigma attached to addiction, treatment being too inconvenient to enter, and uncertainty about the costs of treatment and what is covered by insurance. Historically, the profile of an individual who struggles with drug addiction was very stereotypic, born into a specific demographic. An addict was depicted as someone coming from a low socioeconomic environment surrounded by immoral behaviors that influenced immoral behaviors (White, 1998). A criminal with low morality and few ethics viewed as a problematic member of society not deserving of proper care and treatment. These ancient belief systems, although ancient, still seem to attach themselves to a disease that does not discriminate and although some people continue to ignore the prevalence of this problem, the epidemic proportions of which this disease is affecting make it difficult to ignore.

In 2001, Winona Ryder was charged with shoplifting and a prescription of narcotics were found in her possession. In 2003, Rush Limbaugh, 66-years-old, announced that he was addicted to Oxycontin and checked himself into a treatment center in Palm Beach County, Florida. Cindy McCain, wife of Republican Politician Senator Jim McCain, developed an addiction to Oxycontin after she was prescribed the medication to decrease pain following two spinal surgeries for ruptured discs and to
alleviate emotional difficulties (Ranker, 2017). The above mentioned are the lucky ones who have not yet allowed this disease to destroy them.

Chris Farley, age 33, died of an accidental cocaine and morphine overdose in 1997. In 2007, model Anna Nicole Smith, age 39, died of an overdose of Methadone and four different drugs used to treat mental disorders like depression and anxiety. Actor Heath Ledger died of a drug overdose in 2008 at 29-years-old. Oxycodone was found in his system. In 2009, Singer and songwriter Michael Jackson, age 50, died of an overdose of propofol and benzodiazepine intoxication. Actor Cory Monteith from the show Glee, died at 23 from an accidental overdose of heroin and alcohol in 2013. In 2014, actor Philip Seymour Hoffman, age 46, died as a result of a lethal combination of heroin, cocaine, and benzodiazepine use. Singer and songwriter Prince died of an accidental fentanyl overdose in 2016 and joined the growing list of entertainers not exempt from this disease.

Had these celebrities entered treatment, would they have followed the same path? And for those who attempted treatment, why did it not work? People like Robert Downey Jr. had multiple treatment attempts and many relapses, but his last reported drug use to date was in 2003. What worked for Downey Jr.? Why was he successful in treatment when many are not? Downey shared that he was able to stop using drugs utilizing the 12 Steps of recovery, practicing yoga, and implementing meditation into his daily routine (Drugabuse.com, 2017). Many treatment centers offer similar modalities to treat drug use. So why do some individuals recover, and some do not? This dissertation will explore the intrapersonal and interpersonal conflicts that opioid drugs addicts face when they enter residential treatment.
According to the Centers for Disease Control (CDC) and Prevention (2016), nearly half a million people died from an opioid overdose from 2000 to 2014 and “91 Americans die every day from an opioid overdose” (para. 1). The CDC (2016) continues its article by reporting that the number of heroin related deaths more than tripled between 2010 and 2015, with 12,989 deaths due to heroin alone.

We know that overdoses from prescription opioids are a driving factor in the 15-year increase in opioid overdose deaths. Since 1999, the amount of prescription opioids sold in the U.S. nearly quadrupled, yet there has not been an overall change in the amount of pain that Americans report. Deaths from prescription opioids – drugs like oxycodone, hydrocodone, and methadone – have more than quadrupled since 1999. (Centers for Disease Control, 2016, para. 2)

In addition, NIDA (2015) reports that the number of heroin users in the United States went from 404,000 in 2002 to 914,000 in 2014. It appears that the increase in prescription opioids have educated people about not only the medicinal pain-relieving effects of the substances but also the euphoric effects as well. However, severe consequences are overlooked and minimized due to the positive effects that are glamorized.

On May 3, 2017, immediately after the Centers for Disease Control and Prevention announced that the Nation is suffering from a national opioid epidemic, Governor Rick Scott signed an Executive Order declaring a Public Health Emergency throughout the state of Florida. This declaration allowed the state to have access to “more than $54 million in U.S. Department of Health and Human Services grant funds to pay for prevention, treatment and recovery services” (Siemaszko, C, 2017, para. 2).
NBCnews.com (2017, May 4) reported alarming findings that does not allow for our State leaders to ignore this epidemic. The findings reported by NBCnews (2017, May 4) includes:

- In 2015, heroin, fentanyl and oxycodone were directly responsible for the deaths of 3,896 Floridians, according to the most recent Florida Department of Law Enforcement Statistics. That’s about 12 percent of all the 33,000 people nationwide who died that year of opioid overdoses.

- Last year in South Florida, the morgues in Palm beach County were strained to the capacity by 525 fatal opioid overdoses, the Sun Sentinel newspaper reported in March.

- The deadly cocktail of heroin mixed with fentanyl or carfentanil figured in 220 deaths in Miami-Dade County last year, the paper reported. And 90 percent of the fatal drug overdoses in Broward County involved heroin, fentanyl or other opioids. (para. 13)

Opioids are medications that decrease the intensity of both physical and emotional pain by attaching to and activating opioid receptors in the brain, spinal cord, gastrointestinal tract, and other organs (NIDA, 2015). Opioids include but are not limited to oxycodone, hydrocodone, codeine, morphine, fentanyl, heroin, and the infamous carfentanil, which is 10,000 times stronger than morphine. As mentioned previously opioid prescriptions are often over prescribed and are prescribed with minimal information as to how their misuse can produce devastating effects. The powerful effects these medications have as well as the illicit opiate drugs have on the mind and body produce instant gratification that decreases motivation to try other modes of healing that
may require more time and effort. Due to the increased availability of opioids, increased sense of well-being and confidence produced by the opioid, and the decreased ability to handle the pressures of life without the opioid, it appears that the western culture has learned to rely on external quick fixes. The skills required to utilize emotional intelligence and conflict resolution are not needed as a result of the mind-altering substances capacity to numb intrapersonal and interpersonal conflicts when under the influence.

Conversely, when not under the influence, living life on life’s terms becomes difficult for the addict due to the inability to rely on productive and healthy skills necessary to overcome life’s obstacles without taking a pill or using heroin. Frustration of having to obtain the pills or illicit drugs may create a new life style that involves illegal and maladaptive behaviors.

According to Hawkins et. al (1992) violent crimes, unemployment, destruction of families, and societal discord are major consequences of drug use that hit on both personal and societal levels. As a result, addicted individuals create a sense of self based on group identification and social stigmas attached to persons suffering with the disease of addiction. The addiction will ultimately interfere with individuals attempting to change behaviors due to the reciprocal pathologies that the life of an addict creates. Considering the serious consequences of drug use, major efforts have been made to identify effective treatment (Hawkins et. al, 1992).

The addiction field is quickly growing with over 14,500 drug treatment facilities in the US and over 1000 in South Florida (drugabuse.gov), how does one know which program will be best for them? James Hall (2015), an epidemiologist with the Center for
Applied Research on Substance Use and Health Disparities at Nova Southeastern University in Miami, Florida reports key findings identified in 2013 in Florida’s Miami-Dade County and Broward County. His findings report on the high levels of treatment admissions for opioid addicts in publicly funded programs for which the drug of choice reported was opioids. According to the report there were 294 treatment admissions in Miami-Dade County for heroin, accounting for seven percent of all treatment admissions that year. Broward County had 224 treatment admissions for heroin and 181 admissions for opiates other than heroin, totaling nearly five percent of all treatment admissions for the county.

Many treatment centers offer agonist medications that allegedly treat opioid addiction that work through opioid receptors (Stuckert, J, 2016). Unfortunately, most opioid agonists include some of the most addictive medications out there. Suboxone, Subutex, and Methadone are medications used to treat opioid addiction (Stuckert, J, 2016). Most treatment centers are 12-step focused and include Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) as major components in the recovery process. The 12 Step philosophy begins with the idea that all addicts are powerless over their addiction and recovery requires the help of a higher power of the addicts understanding. SMART recovery is a more modern model few treatment centers utilize. SMART recovery does not believe addicts are powerless and the teachings hope to empower those struggling with addiction to find strengths within themselves to stop the addiction.

If agonist medications like methadone, subutex, or suboxone was the answer for successful treatment of an active addict, recovery rates would be increasing instead of addiction rates. Medication alone does not educate on the skills required to handle the
pressures of everyday life when an individual has relied so heavily on a substance to escape from it. Joining a fellowship like Alcoholics Anonymous or Narcotics Anonymous allows for positive group membership and seems to be a powerful solution, but according to US News (2015) Alcoholics Anonymous has an eight percent success rate. Unfortunately, statistics from the Substance Abuse and Mental Health Services Administration (SAMSHA, 2015) have reported low levels of recovery over the past five years, regardless of the amount of treatment centers available as well as the differing models of recovery an opioid addict can choose from. The transformation from addict to a recovering addict is a process that requires skills that allows for the resolution of intrapersonal and interpersonal conflicts as well as awareness of the human factors that promote victimless self-awareness.

**Research Problem**

This dissertation will be researching the intrapersonal and interpersonal conflicts opioid addicts are presented with during residential treatment. The goal will be to determine if there are any similar themes amongst the participants during this process. I chose to include both male and female participants between the ages of 21 to 30. I chose an age bracket that allowed the researcher to understand the more modern issues addicts face in recovery. Some of these issues include treatment centers using questionable practices that allow for enormous amounts of money to be pocketed by those business owners who have lost sight of the physical and emotional healing that was historically expected at reputable treatment centers.

All participants were informed of my position as a Primary Therapist of a substance abuse facility and all were informed of my personal experiences with the
disease of addiction. This was done in an attempt to relinquish any “us” versus “them” attitude allowing for a common bond.

There is a plentitude of research dedicated to exploring predisposing conditions for addiction as well as the negative consequences that result from the addictive lifestyle. Goldstein (1976) suggests that some individuals are born with endorphin defalcations and use opiates as a substitute to make up for these deficiencies. Alexander and Hadaway (1982) write extensively on how many adaptive theorists believe that addiction is a way to cope with inappreciable personalities and how opiate addiction develops “in people whose lives are somehow distressed prior to first drug use” (p. 376). Other researchers have described how opiate addiction is a reaction to violent, harsh, and difficult environments (Garon, 1973; Jacobs, 1977). Alexander and Hadaway (1982) write that drug addiction will eventually create legal, social, and economic deterioration. Hawkins et. al (1992) describe drugs as a major component when it comes to violent crimes, child abuse, and job loss.

Furthermore, many people who struggle with addiction to opioids are also suffering with other mental health disorders. The U.S Department of Health and Human Services National Institutes of Health and National Institute on Drug Abuse (2010) report that the high rate of comorbidity between drug use and mental health disorders calls for a treatment program that can assess the entire scope of an individual’s diagnosis. The report goes on to state the importance of appropriate assessment tools to minimize missed diagnosis (Drugabuse.gov, 2010). However, even in a dual diagnosis treatment center, the primary condition being treated must be the addiction and documentation as well as treatment services must reflect this. If it is determined that the primary condition is a
mental health issue other than addiction, insurance may not pay for treatment and the client would then need to be referred to a primary mental health facility. Unfortunately, most mental health facilities treat individuals who suffer with extreme mental health and dysfunctional cognitions. As a result, the treatment modalities reflect the level of cognition for the population they serve. This limits the addict who is not severely cognitively impaired but may struggle with moderate depression, anxiety, and/ or ADHD. The limited teachings and the over medicating of psychiatric medications make it difficult for an addict to recover in a mental health facility, and the under medicating and lack of mental health attention given to those struggling with comorbidity in a drug treatment center makes it difficult for many to obtain appropriate levels of care (Drugabuse.gov, 2010).

Although this research is important to gain awareness in the drug treatment field, there is limited research that examines the addict’s experience of the intrapersonal and interpersonal conflicts that arises during treatment. Psychological phenomenology was chosen to gain a better understanding of the experience of the addict as well as to obtain information from the perspective of a condition that is difficult to understand unless being lived personally.

**Research Question**

The interview questions follow Creswell’s (2007) recommendation to reduce the “entire study to a single overarching question” (p. 108). The central question for this Phenomenological study is: What are the intrapersonal and interpersonal conflicts opioid addicts are presented with during residential treatment? In order for me to analyze the experience even further with the purpose of identifying relevant themes, horizons,
textual and structural descriptions, and essence, sub-questions were recognized throughout the interview process. These sub-questions were guided by Moustakas (1994) and included:

- Would conflict analysis and resolution training for employees working directly with clients have influenced the participants’ treatment journey?
- What is the shared experience of an opioid addicts’ treatment process?
- What conflicts create resistance to the overall treatment process in terms of remaining an active addict versus one who is in recovery?

To answer the central question while keeping the sub-questions in mind, the researcher asked sixteen interview questions (see Appendix A) during the interview process. The interview questions involved “a series of questions aimed at evoking a comprehensive account of the person’s experience of the phenomenon” (Moustakas, 1994, p. 114). The interview questions were designed to gain knowledge about the experiences of conflicts with staff, peers, and within the self, allowing the participant to answer open-ended questions with open-ended comments.

**Statement of Purpose**

The purpose of this phenomenological study is to describe the experience of opioid addicts’ treatment process, exploring the intrapersonal and interpersonal conflicts they faced while in treatment. The ultimate goal was to determine the strengths and weaknesses of the opioid addicts’ treatment experiences in an effort to improve the treatment environment with the hope of increasing recovery rates. The central phenomena being explored is the overall meaning behind the treatment experience. The intention will be for me to remove personal experiences, so a fresh perspective towards the phenomena
can be investigated (Creswell, 2007). A total of fifteen male and female opioid addicts who have at least one year of recovery were recruited. All participants must have disclosed their drug of choice being an opioid or opiate and they must have completed at least 30 days of a residential treatment program. All participants must have one-year of sobriety post treatment. For all the participants, the researcher will explore intrapersonal conflicts and interpersonal conflicts faced while in treatment. This will be further examined by utilizing sixteen interview questions found in Appendix A.

**Theoretical Frameworks**

This manuscript will explore the intrapersonal and interpersonal conflicts that an opioid addict faces during the treatment process through four theoretical lenses. The theories explain the motivating components that contribute to the beginning stages of addiction, and once dependent on the substance, describe how perceptions of the self are created through identity formation as well as through subjective meanings formulated by communication amongst different groups. In addition, the desire to change one’s identity from addict to a recovering addict becomes difficult when individuals feel deprived when comparing and judging what other individuals have when believing that their situation is unfavorable.

The first theoretical framework discussed is the theory of human motivation. This theory created by psychologist Abraham Maslow (1943) believes that individuals’ must have certain needs met, beginning with the most basic of needs which includes physiological and safety needs, progressing to higher levels of needs that provides a sense of belonging, increased self-esteem, and finally self-actualization. The proposed theory explains five interdependent levels of human needs that must be satisfied. Satisfying
one’s needs is so intrinsically powerful that many individuals go to great lengths, destroying themselves and hurting others in an uncompromising fashion. When the lower, basic needs are not met, individuals will be unable to progress to the higher levels. Seeking the resources that allow for needs to be met will be the main goal of the individual, so they can progress up the hierarchy.

The second theory is social identity theory introduced by Henri Tajfel and John Turner (1979). This theory was originally developed to increase understanding of the psychological phenomenon of intergroup membership and intergroup discrimination. By understanding the behaviors of a group, one gains insight into the behaviors of the individual belonging to that group. Social identity theory proposes that when an individual believes they belong to a particular group, they will act in ways that mimic overall group behaviors. One of the 12 step components’ strengths lies in the fellowship. Identifying with its group members has the potential to guide an active addict to live by the recovery principles of their fellowship. Alternatively, if an active addict continues to socialize with other active addicts, they may never gain new insight into alternate ways of living.

The third theory is coordinated management of meaning theory (CMM), originally introduced in 1976 by Pearce and Cronen. The belief behind this theory is that people who are actively communicating, develop their own social realities and perspectives of the conversation based on interpersonal systems which they created based on previous social experiences. Realities perceived can be interpreted as conflicting or not, depending on the individuals’ meaning making process.
The fourth theory is relative deprivation theory (RD). The premise of this theory is the belief that an individual or group believes that they are being deprived of something to which they feel entitled to. Relative deprivation may occur with individuals feeling discontent when deprived of opioids when they feel they are entitled to them. This concept of RD may allow for further understanding of the attitudes and behaviors an individual exhibits in terms of resistance towards the treatment process.

Due to the limitations of the theoretical analysis the researcher will be using Moustakas’ empirical, transcendental or phenomenological research concentrating on the description of the addicts’ experiences (Creswell, 2007). The overall goal of this dissertation will be to gain a better understanding of how conflict influences an opioid addict’s treatment experience. Without the appropriate training, an addict may enter treatment, but their chances of relapse will remain high. If the environmental and social factors that perpetuated the addiction are not addressed internally as well as externally, the addict has a high propensity of returning to the addictive lifestyle.

**Research Justification**

Being in the field of addiction for over a decade has allowed me the opportunity to work with a population that our culture has yet to understand. As someone who has had personal and professional experiences with addiction (see “bracketing on page 15), I felt it was appropriate to explore the treatment environment and gain a better understanding of why treatment success rates are so low. The literature review in chapter two investigates a myriad of books and studies that focus on past and present-day treatment modalities as well as current knowledge of the phenomena. However, very few studies have focused primarily on the actual treatment experience from individuals who
have not only completed treatment but have also found long term success. In addition, there are no studies that look at how one transforms from an active addict to an addict in recovery from a conflict analysis and resolution lens. By applying this particular lens, I will be able to determine that addiction is not merely a moral issue that can be stopped by sheer will alone but is a process that encapsulates many different multi-disciplined issues that must be addressed throughout one’s lifetime.

I used a reflective, analytical lens to investigate 15 participants’ experiences to better understand the actual experience of someone who was able to resolve both internal and external conflicts and was able to transform from an active addict to an addict in recovery. It is important to note that I have been a drug counselor for many years and strong professional boundaries were established that did not allow any clinical work to take place during the interview process.

**Bracketing**

The research being conducted is very personal and intimate. I have been surrounded by the disease of addiction since the age of 15. I knew something was a bit wrong with my first boyfriend, noticing high levels of intoxication when we would attend high school parties. His drinking progressed to cocaine and it reached a point where I did not know who he was anymore. A young man who started out as a gentleman turned into a monster from whom I had to get away from. My heart was broken, and I immediately began asking the question, why?

When I went to college I took my first Introduction to Drugs and Alcohol class to gain a better understanding of what went wrong with the man I was going to marry. I was mesmerized and absorbed every detail and lesson that I was learning. Around this same
time, my little brother began exhibiting symptoms that I was learning about in my classes. I was in denial. He was my baby brother. As the months progressed, we discovered that my brother was a drug addict at 13-years-old. By 15 he was shooting heroin and crystal methamphetamine. My parents immediately sent him to treatment but when he completed treatment, he seemed worse instead of better. By 17, he had stolen all my mother’s jewelry, had drug dealers in my parents’ home with loaded weapons, and stole my parents’ credit card information, stealing thousands of dollars. He ran away, and we did not hear from him for 10-years.

During that time, I decided to get a Masters in Addictions counseling and in July 1998, had my first job as a drug counselor in Elizabeth, New Jersey. I continued to work in the field, discovering many faults in the treatment environment. I moved to Florida, the ground zero of treatment, and got married. I should have known what I was getting myself into having all this personal and professional experience, but I ignored all of the red flags. My husband ended up having an addiction to opioids and would try to get me to obtain prescriptions for him. He became angry, verbally and emotionally abusive, and I had to leave him, or I was going to die. Seeing firsthand how addiction effects the family, loved ones, as well as in the treatment field has given me a lot of opinions about what I think is best for treatment. Having this awareness, it will be imperative that I leave my experiences out of the research and apply Husserl’s concept of bracketing, “in which investigators set aside their experiences, as much as possible, to take a fresh perspective toward the phenomenon under investigation” (Creswell, 2007, p.57-58).
Definition of Terms

To increase awareness while decreasing confusion, a definition of terms has been created to expand understanding of specific vocabulary used in the addiction field and conflict analysis and resolution field which are included throughout the literature review.

**Addiction.** The American Society of Addiction Medicine (2011) defines addiction as:

Addiction is characterized by the inability to consistently abstain, impairment in behavioral control, craving, diminished recognition of significant problems with one’s behaviors and interpersonal relationships, and dysfunctional emotional responses. Like other chronic diseases, addiction often involves cycles of relapse and remission. Without treatment or engagement in recovery activities, addiction is progressive and can result in disability or premature death. (para 2)

**Carfentanil.** Carfentanil is a drug so strong that it's used to sedate elephants. It's 100 times as potent as fentanyl, which makes it roughly 10,000 times stronger than morphine. And now it's showing up on the street. (Brodwin, 2016)

**Client.** Word used interchangeably with patient that describes an individual receiving substance abuse treatment.

**DOC.** Drug of Choice

**Fentanyl.** Fentanyl is a powerful synthetic opioid analgesic that is similar to morphine but is 50 to 100 times more potent. It is a schedule II prescription drug, and
it is typically used to treat patients with severe pain or to manage pain after surgery. (drugabuse.gov, 2016, para. 1)

**Higher Power.** Higher power can be anything that an individual believes in from God, to the universe, nature, Buddha, music, love, Allah, humanity or even the fellowship of AA itself. (Recovery.org, 2015)

**Intrapersonal Conflict.** Wilmott and Hocker (2011) describe intrapersonal conflict as “internal strain that creates a state of ambivalence, conflicting internal dialogue, or lack of resolution in one’s thinking and feeling.” (p. 12).

**Interpersonal Conflict.** Folger et al. (2009) explain that interpersonal conflicts I include those between family, spouses, siblings, friends, peers, and roommates.

**Opioids.** The U.S Food and Drug Administration (2016) define opioids as:

Prescription opioids are powerful pain-reducing medications that include prescription oxycodone, hydrocodone and morphine, among others, and have both benefits as well as potentially serious risks. These medications can help manage pain when prescribed for the right condition and when used properly. But when misused or abused, they can cause serious harm, including addiction, overdose and death. (para 1)

**Opiates.** National Institute on Drug Abuse for Teachers (2016) definition of opiates:

Opiates are powerful drugs derived from the poppy plant that have been used for centuries to relieve pain. They include opium, heroin, morphine, and codeine. Although heroin has no medicinal use, other opiates, such as morphine and codeine, are used in the treatment of pain related to illnesses (for example, cancer)
and medical and dental procedures. [O]piates also possess very strong reinforcing properties and can quickly trigger addiction when used improperly. (p. 39)

**Oxycodone.** Oxycodone is an opioid pain medication also referred to as a narcotic. (Drugs.com, 2017)

**Post-Acute Withdrawal Symptoms (PAWS).** American Addiction Centers (2014) explain that as acute withdrawal symptoms fade, post-acute withdrawal symptoms may linger for as long as two years. Post-acute withdrawal symptoms include:

- Irritability and hostility
- Anxiety
- Mood swings
- Depression
- Low energy and fatigue
- Sleep disruption, including insomnia
- Limited ability to focus or think clearly
- Lack of libido
- Inexplicable chronic pain (para. 2)

**Recovery and Sobriety.** The Betty Ford Clinic Consensus Panel’s (2007) established definitions:

**Recovery.** Recovery from substance dependence is a voluntarily maintained lifestyle characterized by sobriety, personal health, and citizenship. Sobriety refers to abstinence from alcohol and all other non-prescribed drugs.

**Sobriety.** Sobriety refers to abstinence from alcohol and all other drugs of abuse.
Relapse. The definition of drug relapse is evolving, making it difficult to explain. Researchers debate whether drug relapse is a process or an outcome in and of itself. The origins of the definition of drug relapse come from a medical model that viewed addiction like a disease: a patient returns to a state of sickness after a period of remission. As the definition evolved, it came to encapsulate the process that leads people in recovery to return to their drug abuse. (Osborn, C.O., 2017, para. 4)

Tolerance. When drugs such as heroin are used repeatedly over time, tolerance may develop. Tolerance occurs when the person no longer responds to the drug in the way that person initially responded. Stated another way, it takes a higher dose of the drug to achieve the same level of response achieved initially. (Drugabuse.gov, 2007, para. 1)

Withdrawal. Drugs.com (2017, para. 2) describes opioid withdrawal as a group of symptoms that occur when you suddenly decrease or stop taking opioids. Withdrawal signs and symptoms may start within 6 to 16 hours after you stop taking opioids. The symptoms usually last for days but some symptoms may be present for months. According to Drugs.com (2017, para. 2) symptoms include:

- Runny nose
- Yawning
- Nausea or vomiting
- Diarrhea
- Chills or goosebumps
- Muscle aches or cramps
- Anxiety or irritability
- Overwhelming craving for the medicine or drug
Summary

Chapter one explained the intense need for exploring the intrapersonal and interpersonal conflicts that an opioid addict faces while in residential treatment. The increase of individuals addicted to opioids and opiates and the high levels of overdoses has reached epidemic proportions, having no discrimination of who will fall victim. What was once thought to be a moral issue can no longer be the justification of why one becomes an addict as we are discovering individuals addicted to opioids who are productive members of society. This major national problem is not only affecting those who struggle with addiction, but is affecting our country as a whole, gaining the attention of our politicians. Unfortunately, academia and the behavioral health field have yet to discover a solution to this growing problem.

To gain a better understanding of this phenomena chapter 2 will examine literature that focuses on different treatment modalities, what treatment styles were found to be successful, and what issues interfere with the transformational process from addict to addict in recovery. The literature being reviewed encompasses mixed methods and utilizes both European and American studies. Included in the literature review will be explanations describing the prevalence of opioid addiction and why an individual takes the path of addiction from a sociological and psychological perspective. It will explain how an individual comes to identify themselves as an addict and how and why society contributes to the reported low recovery rates. In addition, it will attempt to explain what is needed to change one’s identity from that of an addict to one in recovery. Theory of human motivation, social identity theory, coordinated management of meaning theory, and the theory of relative deprivation will be discussed in the literature review providing
a theoretical analysis with the purpose of acquiring a more robust understanding of the intrapersonal and interpersonal conflicts an opioid addict faces in the transformational process from active addict to recovery.

Chapter three explains various phenomenological methods reiterating on why I chose the particular methodology I chose. In order to gain a better understanding of what intrapersonal and interpersonal conflicts are present when an opioid and heroin addict enters a treatment center, transcendental or psychological phenomenology was chosen. A phenomenological research concentrating on the description of the experiences (Creswell, 2007) was determined to be the best method. Due to the personal and professional experience of this researcher bracketing was included (see page 15).

Chapter four reports the findings of the answered interview questions applicable to the research question: what are the intrapersonal and interpersonal conflicts opioid addicts are presented with during their treatment process? Five thematic categories were identified while keeping in mind the three sub-questions mentioned on page 10. The five thematic categories include identity formation, stigma, interpersonal relationships, group structure and conflict styles, each describing corresponding sub-categories.

Finally, Chapter five discloses the essence of the phenomenological study of the lived experiences and explains how conflict analysis theories are incorporated in the data analysis through collaboration of existing literature with the five thematic categories and corresponding sub-categories identified. In addition, Chapter five discusses the limitations of this study as well as the practice related contributions.

This phenomenological study cannot change the stigma attached to individuals struggling with addiction and it may not decrease the level of addictive potentials within
our Country, but it will hopefully add a new perspective on this epidemic that we as conflict resolution professionals can offer. Both clients and therapists will benefit from this research by gaining a better understanding of the intrapersonal and interpersonal conflicts an individual faces during treatment. By expanding the knowledge of the behavioral health field to include conflict analysis and resolution, therapists and staff members working in the field can increase their understanding of what is required to help people suffering with addiction. Gaining awareness of why addicts partake in the behaviors they do while living an addictive lifestyle may increase the compassion and empathy of the specialists working in the addiction field. This in turn may help clients feel safe enough to disclose personal information and release belief patterns that no longer serve them.
Chapter 2: Literature Review

For decades national and international organizations like the National Institute on Drug Abuse (NIDA), the Substance Abuse and Mental Health Administration (SAMSHA), and the Centers for Disease Control (CDC) have been implementing programs and funding research in an attempt to understand the cause of addiction. Cutting edge figures in the addiction field like Stanton Peele, Ph.D., author of the infamous book Love and Addiction, Dr. James West, former medical director of the Betty Ford Clinic, and Gordon Marlatt, Ph.D., Director of the Addictive Behaviors Research Center at the University of Washington have all contributed greatly to the idea that addiction is not a moral condition, but stems from biological, psychological, and social factors. However, the components that enable an addict to move from active addiction to recovery, from a conflict resolution perspective, has not been exclusively researched.

The literature reviewed encompasses mixed methods research integrating qualitative and quantitative methodologies both in and outside of the United States. In addition, multi-disciplined scholarly articles and books that report on past and current knowledge of the phenomenon being explored were used. The goal of the literature review is to provide an overview of historical and present-day treatment modalities, providing the statistics of present day recovery rates. Data on the prevalence of opioid addiction is highlighted while providing a contextual framework of the intrapersonal and interpersonal strongholds developed throughout an addicted individual’s life. The literature review will examine four theoretical lenses that includes theory of human motivation, social identity theory, coordinated management of meaning theory, and theory of relative deprivation.
With the increasing use of opioids, there has been an increase in treatment admissions, specifically for opioids and heroin addiction. According to the National Institute on Drug Abuse (2015), the number of “people receiving treatment for prescription opioid addiction rose from 360,000 in 2002 to 772,000 in 2014” (NIDA, 2015, p. 1). NIDA (2015) reports that the number of heroin addicts in the United States went from 404,000 in 2002 to 914,000 in 2014, accounted for 18 percent of the admissions for drug and alcohol treatment in the US (International Statistics, 2016). The U.S Food and Drug Administration (2016) reports three out of four people who used heroin in 2014 to mid-2015 misused opioids first and seven out of 10 people who used heroin also misused opioids.

According to American Addiction Centers (2018), success rates of opioid addiction treatment is very hard to track. They explain that because treatment is confidential, many refuse to participate in the studies since it could breach confidentiality. In addition, some individuals in recovery might not want to admit relapsing (American Addiction Centers, 2018). Not only is the goal of treatment to stop using drugs, but it is imperative that the recovering addict unlearns everything they learned while living the life of an active addict. Excerpts from chiverichards.com are listed in Table 1. This table provides an explanation of the polarizing differences in the thinking and behaviors of an active addict versus an addict in recovery.

The National Institute on Drug Abuse (2011) reports that treatment provides a venue to offset addiction’s adverse influences on the brain and helps addicted individuals re-establish control of their lives; however, the habitual nature of addiction allows professionals in the field to understand that relapsing will be very likely. Treatment must
address not only the biological addiction, but the psychological, and social addictions as well.

Figure 1. Addiction (Chiverichards.wordpress.com, 2016)

**Overview of Treatment History**

Addiction treatment in the United States began in the mid-19th-century due to changes in alcohol and drug consumption and the professionalization of American medicine (White, 1998). Dr. Benjamin Rush known as the Father of Addiction Medicine, combined his beliefs on science, morality, and colonial psychology and his many ideas dominated medical thinking for nearly 100 years (White, 1998). During a time when the nation was celebrating its freedom, Rush noticed the levels of intoxication the American soldiers were displaying and blatantly stated “a nation corrupted on alcohol can never be free” (White, 1998, p. 3). One of his initial treatment recommendations was that opium replace alcohol as a medicine. He believed that opium caused less deterioration and was
less addictive. This radical treatment modality with treating one addiction for another is still used by some treatment centers today who incorporate agonist medications to treat opioid dependence (See page 7 in the Introduction).

Rush and his colleagues introduced the notion of addiction and the concept of it being a disease, but people of that time were not ready for this modern medical way of thinking. In the book, *Slaying the Dragon* by William White (1998), the history of how drug and alcohol use was treated is explicitly described. It explains the progression of the naiveté of early professionals who believed they had the answers to treat the disorder, but only manifested more negative intrapersonal and interpersonal issues. Access to hospital beds was restricted to individuals who were perceived as worthy and admission was usually denied to those suffering from alcoholism and drug addiction (White, 1998). In addition, White (1998) explains that the medical care for people struggling addiction included interventions like sedation, utilizing instruments to enforce bleeding, electricity machines, and restraining devices. The high levels of stigma attached to individuals suffering with addiction led to harmful medical interventions, and the abhorrent means of medical treatment was the answer to what the medical field did not understand.

Once the medical field began recognizing that the above medical interventions were not working, the emergence of asylum treatment modalities was created in an attempt to gain social control (White, 1998). Access to medical hospitals continued to be denied by those they believed to be morally unworthy (White, 1998). With evolving approaches emerging in the 1900s, some social groups began recognizing the idea that drug and alcohol addiction may not be a moral issue but may be a disease that manifests
as a result of biology, psychology, and sociology, an idea that began years ago with Dr. Benjamin Rush.

In the late 1880s, cocaine was recommended for almost all medical issues. In 1889 Dr. W.H. Bentley advocated the use of cocaine for the treatment of morphine addiction believing that cocaine was the premier remedy for the morphine habit that was so prevalent at the time (White, 1998, p.146). By the early 1900s, the stigma for opiate addiction became so bad that those addicted would hide their addiction and attempt to stop in secret in their own homes. According to White (1998) there were 3 approaches used to treat opiate addiction in the early 1900s: 1) Immediate cessation 2) Titration of the substance quickly; 3) Slow withdrawal, utilizing a gradual decrease of the drug over a long range of time.

By 1914, the Harrison Anti-Narcotic Act was passed, which many consider to be the beginning of the war on drugs. The purpose of this act was to force taxes on the sale, distribution of cocoa leaves, opium, and any form of products obtained by these products (USLegal, nd). The act allowed the narcotic to be prescribed for medicinal purposes but not to treat addiction (USLegal, nd). As a result of this new federal law, physicians who continued to supply narcotics to large numbers of addicted patients were being arrested. Physicians of the US Public Health Service continued to deny responsibility for this particular population, but something had to be done. Morphine Maintenance Clinics began opening but were closed by 1925, creating a thriving illicit drug market, as they increased the prices of narcotics by as much as 50 percent (White, 1998). Throughout this time physicians remained quiet as it was known how their part played a role in the development of this problem due to their intemperate management of narcotics.
With the prohibition of alcohol in the 1920s and the depression in the 1930s, it was a time of great reform. Most institutions designed to treat addiction were gone and the escalation of alcohol and drug addiction could not be ignored. In the 1930s the Oxford Group, a Christian organization led by Frank Buchman emerged, holding house parties at various locations around the world (White, 1998). The Oxford Group was guided by four standards and five procedures (aaagnostica.org, 2013, November 3). The four standards include: 1) Honesty 2) Unselfishness 3) Purity 4) Love (para. 27). The five procedures are as follows: 1) Give into God; 2) Listen to God’s direction; 3) Check guidance; 4) Restitution; 5) Sharing – for witness and for confession (para. 29).

A man by the name of Bill Wilson, struggling with alcoholism attended an Oxford Group meeting, getting his first experience of the power of fellowship and the importance of one alcoholic helping another. Wilson soon discovered that he could not stop drinking on his own and he needed others in the fellowship to maintain his sobriety.

In 1935, Bill Wilson and a man named Dr. Bob collaborated and created what is today known as Alcoholics Anonymous (AA). This 12 Step Model focuses on intrapersonal issues as well as interpersonal connections and ascribes to the idea that following the 12 Steps will change the active addict to one who is in recovery. Table 1 lists the 12 steps as they are listed in the Alcoholics Anonymous book. The steps are designed to change the way someone thinks internally as well as how they behave externally. Each step is a process and they are completed one at a time and are designed to be worked together with a sponsor.
Table 1

*The 12 Steps, Alcoholics Anonymous, 2001, p. 59-60*

| 1. | We admitted we were powerless over alcohol – that our lives had become unmanageable. |
| 2. | Came to believe that a Power greater than ourselves could restore us to sanity. |
| 3. | Made a decision to turn our will and our lives over to the care of God as we understood Him. |
| 4. | Made a searching and fearless moral inventory of ourselves. |
| 5. | Admitted to God, to ourselves, and to another human being the exact nature of our wrongs. |
| 6. | Were entirely ready to have God remove all these defects of character. |
| 7. | Humbly asked him to remove our shortcomings. |
| 8. | Made a list of all persons we had harmed and became willing to make amends to them all. |
| 9. | Made a direct amends to such people wherever possible, except when to do so would injure them or others. |
| 10. | Continued to take personal inventory and when we were wrong promptly admitted it. |
| 11. | Sought through prayer and meditation to improve our conscious contact with God as we understood Him, praying only for knowledge of His will for us and the power to carry that out. |
| 12. | Having had a spiritual awakening as a result of these steps, we tried to carry the message to alcoholics, and to practice these principles in all our affairs. |

The 12 Traditions pertain to the life of the fellowship itself. They explain how fellowship members maintain their unity with the means of connecting to the world. They listed as written in The Twelve Steps and Twelve Traditions in Table 2. The 12 Principles listed in Table 3 go along with each step and is the link between staying sober and one’s moral character. It narrows down the philosophy of the 12 steps into one word while explaining in more detail the specifics of each step. In the end, the steps, the traditions, and the principles are all designed to transform one’s soul from the inside out. They assist in guiding an addicted individual to a life that embraces acceptance, forgiveness, and the belief that something bigger than the self can restore one to sanity.
Narcotics Anonymous (NA) emerged from AA in the later 1940s and became official in 1953 (Narcotics Anonymous, 2008). NA’s 12 Steps, traditions, and principles are similar to AA’s. The only difference is that the words alcohol and alcoholic are
replaced by the word addiction. The development of NA was cofounded by Jimmy Kinnon and was created for people suffering with drug addiction.

Like AA, NA focuses on the importance of acceptance into the fellowship as an essential component for the program to work. The message of The Twelve Steps and The Twelve Traditions has spread throughout the world and it is a resource being used in present day treatment facilities. Connecting with a positive support system and a sponsor to help guide throughout the process are key elements in this program. Unfortunately, as mentioned previously research has shown that AA has about an eight percent success rate (Sederer, L., 2015).

Understanding the history of addiction and recognizing the historical mistakes we have made in the evolutionary process of treatment might have one believe that we have learned from our mistakes. In many instances, it appears that the drug and alcohol field is beginning to learn about the predisposing factors that increase the chances of becoming an opioid addict as well as the criteria that keeps individuals stuck in this toxic lifestyle. However, due to the shift in the pharmacology world, the demographic of what constitutes an opioid drug addict is no longer what one would expect. Much more research is needed as this field has been briefly touched by the academic world.

In the next section, this research manuscript will explain the importance of fellowship, feelings of self-worth, recognizing and forgiving the behaviors of the self and others while providing relevancy to the intrapersonal and interpersonal conflicts opioid addicts face when in treatment. It will also explain the stigmas that continue to be attached to individuals struggling with addiction and why this interferes with recovery. In addition, a new emerging stigma will be revealed that is now being placed on treatment
facilities due to the criminal activities presently occurring in the treatment field which includes insurance fraud, enticement, and unethical clinical practices (NBCnews, 2016). The contextual framework will attempt to elaborate on the above aforementioned utilizing mixed methods research integrating qualitative and quantitative methodologies, multi-disciplined scholarly articles and books, and the analysis of four theoretical perspectives.

**Contextual Framework**

There is a large amount of literature that supports the consequences of drug use. However, the literature is lacking in providing a conflict resolution framework for understanding the factors involved in opioid addicts’ treatment process. The internal and external consequences of living a drug addicted lifestyle makes the recovery process very difficult. Opioid addicts themselves would be a direct source of information that would enable a better understanding of the conflict barriers that interfere with treatment (Jordan, C.M. & Oei, T.P.S, 1989; Tsogia, T.S, Copella, A., & Orford, J, 2001) According to Hawkins et. al (1992) violent crimes, unemployment, destruction of families, and societal discord are major consequences of drug use that hit on both personal and societal levels. These consequences create an understanding of the self that creates a self-fulfilling prophecy, creating a lack of confidence or motivation to change behavioral patterns. Internal conflicts create external conflicts that perpetuate the addictive lifestyle. Group identification, personal and social stigmas, and high-risk factors will be reviewed to further understand this phenomenon in order to increase understanding of how these factors influence the treatment process.
Identity and Group Identification

At its core, a major source of intergroup conflict lies in the primary need for identity (Folger et al., 2009). Folger et al. (2009) writes that a quintessential source of identity stems from an individual’s perception of a particular social group that they believe they belong to or are a part of. These connections are so powerful that the individual may even lose sight of who they really are before they are aware of being influenced by the group. This includes taking on the group’s values and beliefs, even if the individual does not agree with them. This need promotes social categorization which is a primitive social process that includes defining oneself by identifying with the group they believe they belong to as well as defining groups they believe others belong to (Folger et al., 2009, p. 92). Social theorists believe the group an individual associates with will take on the characteristics of the group thereby creating an identity of the self-based on their groups’ characteristics. Many researchers have argued that the preliminary stage of the transformational process from active addict to recovery begins with management of a “spoiled identity” (Waldorf and Biernacki, 1981; Waldorf, 1983; Biernaki, 1986). According to Biernacki (1986) the decision to stop an addictive lifestyle begins when the active addict identity begins to conflict with other identities of the individual, unrelated to drug use. According to Biernacki (1986):

[T]he key to the recovery process lies in the individual coming to an understanding that his or her damaged sense of self has to be restored together with a reawakening of the individual’s old identity and/or the establishment of a new one (McIntosh & McKeganey, 2000, p. 1503).
Lee Robbins (1983) researched extensively on American servicemen who developed opiate drug addictions during the Vietnam War. Upon their return to the United States after the war, Robbins discovered a significant reduction or a complete abstinence in their illegal drug use. He believed that their relocation and change of social structures, in which drug use was highly discouraged, was an important deterrent and highlighted the significant influence social factors play in the development of drug use and its cessation (Robbins, 1993).

Buckingham, Frings, & Albery (2013) explain in their article that social identity theory and self-categorization theory explains the significance of how addicted individuals use group membership as a means to create identity (this will be further discussed in the theoretical analysis). By changing one’s group, one can change their identity. For individuals suffering with the disease of addiction, Buckingham et al. (2013) investigated how fellowship membership in Alcoholics Anonymous or Narcotics Anonymous can create new social identities compared to the social identity of an active addict. They stress the idea of how an individual internalizes the qualities of their group members and often define themselves in terms of the social group they belong to. This social identification allows the addict to have a sense of belonging within the group they belong to. The findings suggested that addicts who change their social group from the addicted group to the recovery group, will increase positive beliefs about the self and may alter negative behaviors (Buckingham et al., 2013). A successful renegotiation of identity occurs as a result of new social expectations.

The identities acquired by people suffering with the disease of addiction in which their addictive behaviors are a major part of their self-concept presents core identity
issues for them to solve (Koski-Jannes, A., 2002). When attempting to stop addictive behaviors it is imperative that the first identity-related task will be to secure a self-concept that agrees with the new orientation (Koski-Jannes, A., 2002, p.184). As mentioned previously, Biernacki (1986) believes that when an addict decides they want to stop taking drugs there is an addict identity conflict. This occurs as a result of the reawakening of old identities or possibly because of the formulation of new ones (McIntosh, J. & McKeganey, N., 2001). Intrapersonal conflicts may develop as a result of deep-seated beliefs the addict has about the self. Establishing new identities based on new social and community connections poses a difficult challenge within residential treatment due to the population the centers serve.

In 1954, The American Society of Addiction Medicine (ASAM) was founded and has since evolved into a professional society which includes over 5000 physicians and professionals in the field (ASAM.org, 2017). The society developed the ASAM patient placement criteria that assesses a client on six different dimensions (see appendix B) to determine which level of care a client would need, ranging from Outpatient Care to Medically Managed Intensive Inpatient Services. In order to be admitted into a Residential Level of Care, a client would have to meet specific criteria within the six dimensions. It is not uncommon for clients to be experiencing high levels of Post-Acute Withdrawal Symptoms (PAWS), to have extensive legal histories, minimal family involvement, multiple treatment attempts and failures, financial discord, medical issues as well as emotional and mental health issues (ASAM.org, 2017). Many have poor coping skills, poor anger management, and poor problem-solving skills. Most clients are suffering on many different levels but struggle with letting go of old identities no matter
how miserable they are (Buckingham, Frings, & Albery, 2013). Connecting to each other while in treatment, utilizing their addicted identity to feel a part of the addicted group may be the only emotional reprieve during a time when nothing else makes sense.

Professional staff are hired to work in these facilities tasked with the incredibly difficult challenge of helping clients change their perceptions of the self and truly influence the healing process utilizing group and individual therapy. One of the barriers to this healing process is the reality of group differentiation. Folger et al. (2009) writes that group differentiation is the internal process of separating groups thereby believing in the negative stereotypes of the other groups triggering conflict. This perpetuates an “us” verses “them” attitude between the client and staff as well as staff and the client. As a result, intergroup ideologies create the belief system that the “us” group is favorable and the “them” group is not (Folger et al., 2009). The depth of these ideologies will be based on how emotionally and psychologically invested the person is to the group they are identifying with. If strongly invested transformation may be more difficult (Koski-Jannes, A., 2002).

Equally important is limited availability to change group membership while in residential treatment due to limited outside networking, making it extremely difficult for addicts to associate with individuals and groups who have significant recovery time. Clients have no choice but to spend a great deal of time with other clients. The one thing that they all have in common is their drug addiction. For many, they continue identifying with their spoiled identity (see page 31) because this is the only way they can relate to the others in the group. The term “war stories” is used throughout the treatment world that describes the glamorization of the drug lifestyle that is discussed amongst clients while in
treatment. In treatment, behavior may no longer be the primary root of identity formation but maintaining a narrative may become the principle element in their continued addict identity (Giddens, 1991). Anthony Giddens (1991) believed that a large component of establishing an identity are the stories people tell themselves and others about the self, believing that these stories are more powerful than actual behavior. Reissman (1994), a researcher who also stressed the importance of how narratives or telling stories allows individuals to construct who they are by linking the past, present, self, and society.

Many researchers claim that one of the central components of maintaining an addictive lifestyle or transforming to a lifestyle in recovery is dependent on how one identifies the self and the groups they identify with (Buckingham et. al, 2013; Koski-Jannes, A., 2002; Giddens, 1991). Expanding on this concept are the personal and social stigmas attached to addiction and how the power of these stigmas keeps people sick. In addition, a new more modern stigma attached to treatment must be discussed due to the corruption and abuse that has risen in the drug treatment industry.

**Personal and Social Stigmas**

Cultural and community stigmas associated with addiction may perpetuate negative thoughts about the self which impedes on the sense of belonging to those that do not suffer from addiction (Luoma et al., 2008). Terms like junkie, dead head, dope fiend, and dirty have been used by families, health care practitioners, and the general public to describe individuals suffering with the disease of addiction throughout history. These words are filled with metaphors and symbolism that help subscribe to stigmas based on their judgmental tones. They are symbols or concepts which have the capacity to create perspectives and realities about the self and others. In addition, these words may
unintentionally categorize individuals and fail to recognize individual autonomy in regard to the decision-making process with treatment and recovery (Broyles et. al, 2014).

Ervin Goffman, a pioneer in the work of social stigma defines stigma as an “attribute that is deeply discrediting” and reduces individuals “from a whole and usual person to a tainted, discounted one” (Goffman, 1963, p.3). Link and Phelan (2001) take from Goffman’s definition and believe that stigma occurs when “elements of labeling, stereotyping, separation, status loss, and discrimination occur together in a power situation that allows them” (p. 377). Those who are stigmatized and marginalized may be negatively affected through the process of self-stigmatization (Luoma et. al, 2008). Luoma et. al (2008) believes that individuals who identify with a stigmatized group may serve as a barrier to the recovery process due to the negative ideologies society holds on the idea of addiction.

These negative thought patterns may deter an addicts’ motivation to change group affiliations due to the shame and fear of being affiliated with the stigmatized group. Luoma et al. (2008) explains how the implementation of an acceptance based treatment for self-stigma may decrease negative thoughts about the self. It describes the harm that can be caused when a substance abusing individual stigmatizes themselves as a result of their addictive lifestyles.

Stigmas are developed because of an individuals’ identification with a particular group. The research suggests that negative beliefs about the self has the potential to become barriers to the overall recovery process (Buckingham et. al, 2013; Koski-Jannes, 2002; McIntosh, J. & McKeeganey, 2001; Luoma, 2008; Room, 2005). Luoma et al. (2008) utilized different instruments in their research to gather data from 88 participants.
who were involved in six-hour work group workshops that focused on mindfulness, acceptance, and values work concentrating on self-stigma. Results showed that some areas of stigma decreased but more research is needed to determine long-term effects.

Criminal activity, family discord, loss of meaningful friendships, unemployment rates for those dependent on drugs and alcohol, and social inequality has the potential to exacerbate negative feelings and perpetuate negative behaviors and negative beliefs about the self (Buckinghan et. al, 2013). Room (2005) explains how drug and alcohol use is heavily moralized by society and how this results in stigma and marginalization. Room (2005) talks about stigma as a form of social control and how public policies continue to marginalize addicted individuals that only perpetuate their addictive lifestyle. The negative effects of stigma and current public policy initiatives send messages about what is and is not tolerable. In addition, social inequality is a reality for low socioeconomic communities (Room, 2005). Not only are individuals from low socioeconomic communities stigmatized, but they also lack many of the appropriate resources to obtain the necessary skills to choose alternate lifestyles (Room, 2005). Lack of resources for individuals growing up in low socioeconomic neighborhoods and policies that enforce strict consequences on drug and alcohol offenders, provides minimal opportunities to change pathological patterns. Once identity has been established and group identification has been determined, the foundation of how one perceives themselves and how others perceive a particular group are extremely difficult to alter (Mitchell-Yellin, B., 2018, February 2).

A new emerging stigma is now being placed on treatment facilities due to the criminal activities presently occurring in the treatment field which includes insurance
fraud, enticement, and unethical clinical practices. What was once a place that created hope and possibility, has now become a venue for the extremely unethical and money driven. There are many reputable and principled treatment programs where thousands of individuals have found sobriety, unfortunately state and federal authorities have discovered that expanded insurance coverage for addiction treatment combined with limited regulation and oversight have created an infrastructure of corruption (NBCnews.com, 2017). State Attorney Dave Aronberg, Palm Beach County’s top prosecutor reported, “There’s no incentive in sobriety …. The money is in relapse” (NBCnews, 2017, para. 2).

Since the summer of 2017, state and federal law enforcement have been focusing on drug treatment centers in South Florida arresting owners, CEOs, and sober home operators for patient brokering. According to Palmbeachpost.com (2017, July 11), Florida has now made it illegal for anyone to pay or receive monies of any kind when an individual is referred to a drug and alcohol treatment facility. Unfortunately, the drug treatment industry has grown so lucrative that treatment centers have found creative ways to make and receive illegal payments to ensure a steady flow of clients. Pathways to Recovery in Boca Raton, Inspirations Recovery in Greenacres, Acceptance Recovery Center and Good Future both in Delray Beach, and Whole Life Recovery in Boynton Beach are just five out of many treatment centers targeted by The Palm Beach County Sober Home Task Force (Palmbeachpost.com, 2017, July 11). This Task Force has made 41 arrests on charges of patient brokering and insurance fraud since October 25, 2016 (Palmbeachpost.com, 2017 & Sun-sentinal.com, 2017).
As horrible as patient brokering and insurance fraud is, the deeper reality is much worse. South Florida is known as the rehab capital of America and has earned a reputation where addicts are bought, sold, stolen for the insurance policies, and many are coerced into sex (BuzzFeed.com, 2016). Otherwise known as “marketers”, “body brokers”, and “junkie hunters”, these individuals are hired by treatment centers and are able to spot young homeless addicts and ask them if they need a place to go. Buzzfeed.com (2016) reported in their blog how these marketers hang out in specific locations, praying on active addicts, offering them money and drugs to get them into detox facilities. So, the incentive is to keep addicts relapsing, cycling through detox and treatment, which can cost insurance companies about $1000 per day per patient. This does not include the added costs of drug screens, medical services, and/or ancillary services.

One of the most dangerous drug treatment center owners, Kenneth Chatman, pleaded guilty in March 2017 to “conspiracies to commit money laundering, health care fraud, and sex trafficking” (Mypalmbeachpost.com, 2017, March 15, para. 1). According to Mypalmbeachpost (2017, March 15) Chatman would encourage prostitution and would pimp out his clients on websites like craigslist.org and backpage.com, taking the money as payment for them to reside at his sober living facility. Many clients died in his care due to drug overdoses and as many as 90 percent of his patients were using drugs in his facility (Mypalmbeachpost.com, 2017, March 15). All of this taking place as Chatman and his wife lived in a million-dollar home in Boynton Beach, Florida, receiving about 25 million dollars (Mypalmbeachpost.com, 2017, March 15).
The media has done a wonderful job reporting these horrible individuals and organizations that use the dark side of addiction to their advantage. Educating our country about this enormously important issue is essential so individuals struggling with the disease of addiction and their families know the truth. Unfortunately, the media attention may have the power to affect the reputation of treatment centers who make ethically sound care a priority, utilize evidence based criteria, and hire educated therapists and medical staff. As a result, centers providing high quality care may be prejudged as the idea of the treatment “world” is generalized.

For centuries, cultural and community stigmas associated with negative perceptions of individuals struggling with addiction appeared to be a major roadblock in the treatment world (Buckinghan et. al, 2013). Unfortunately, this has expanded to include the actual treatment world itself. Not only are individuals struggling with negative stigmas associated with having an addiction but now the treatment associated with rehabilitating the individual has become stigmatized. For people seeking help, trusting the help you are receiving is imperative. The conflict within the self as well as with professionals may impede on the transformational process, and unfortunately with the opioid epidemic and increase in overdoses mentioned in Chapter 1, working through these stigmas must be a priority so therapeutic alliances can occur.

As mentioned in the introduction, there is an overwhelming number of people using opioids, some for medicinal purposes, some for recreational, and many for both. These pills are in many American homes, placed in medicine cabinets or bedside tables, allowing for easy access for children and/ or young adults. Where at one time drinking beer and smoking a “joint” was considered bad behavior at high school parties, our young
generation has evolved to crushing oxycodone pills and snorting them intranasally, possibly accessing them from their parents’ medicine cabinets or being prescribed the medication themselves due to sports injuries and the like. The next section, High Risk Factors, attempts to explain what factors may be contributing to the opioid epidemic. Transformation begins with awareness.

**High-Risk Factors**

Research over the past two decades have attempted to understand the causes of addiction and why individuals continue their addictive lifestyle. The consequences that result from the disease of addiction produces costs in lost productivity, produces extreme family discord, causes death, and reduces connections that hold society together (Hawkins et. al, 1992). Much effort has been made to identify effective prevention and treatment interventions. However, the reinforcing principles of opioid and heroin addiction are themselves strengthened by patterns and behaviors of interpersonal connections. For example, many studies have suggested that poor family relations, lack of parental supervision, parental separations, and overall family conflicts increases an individual’s potential to engage in drug abusing behavior (Loeber, R. & Stouthamer-Loeber, M., 1986; Wright, K.N. & Wright, K.E., 1994). The Mayo Clinic in their December 2015 report states that a family history of addiction, peer pressure, and lack of family involvement are specific factors that can increase the potential of developing and maintaining an addiction.

Returning to neighborhoods associated with high levels of drug use post treatment places recently recovering addicts in an environment that are inundated with triggers for relapse (Chandler, et. al, 2009). Without financial and community resources, it is
difficult for addicts early in their recovery process to establish supportive environments to maintain their recovery. According to Bandura (1997), risk factors must be addressed in the treatment process. Enablement factors that teach recovering addicts the skills necessary to engage in resilient coping mechanisms when they are presented with negative intrapersonal beliefs as well as intrapersonal and environmental challenges is imperative if sobriety is to continue (Bandura, 1997). In general, most people have biological and psychological factors that have the potential to enable one to be more susceptible towards an addictive lifestyle. Relationships, communities, and societies are three environmental factors that SAMHSA (2015, October 2) believes have major influences in effecting behavioral health issues.

Alcohol or drug dependent parents, physical, mental, or verbal abuse of a child, and insufficient supervision of a child, all increase the risks associated with a higher likelihood for negative outcomes to occur (SAMHSA, 2015, October 2). In communities, risk factors include residing in neighborhoods with increased crime and high levels of illegal drug use. In addition, inadequate housing and high unemployment rates are listed by SAMHSA (2015, October 2) as factors that increase the risk of developing troublesome pathologies. SAMSHA (2015) reports that “[i]n society, risk factors can include norms and laws favorable to substance use, as well as racism and lack of economic opportunity” (SAMSHA, 2015, 2 October, p. 2).

The State of Hawaii Department of Health: Alcohol and Drug Abuse Division (ADAD, 2017) focuses on the prevention and treatment of addiction for the Hawaiian Residents. Their research reports on factors that contribute to an individuals’ drug and/ or alcohol use and they include:
• Curiosity
• Belief that drugs improve physical and mental performance
• Belief that drugs are not harmful
• Depression
• As a coping mechanism for traumatic experiences, e.g., childhood sexual abuse, school failure, etc.
• Sensation-seeking behavior
• Substance use by family members
• Peer pressure
• Community norms
• Exposure to pro-use message in mass media
• Access and availability (para. 4)

Risk factors can have an effect throughout an individual’s entire life span. Even though an individual moves out of a low socioeconomic environment or away from abusive parents or relationships, internal conflicts may follow unless resolved in an appropriate and healthy way. Intrapersonal conflicts are just as powerful as interpersonal conflicts and when left untreated, may increase conflicts in ways that only increase drug use as the individual attempts to decrease negative feelings in a toxic, life-threatening way. The next section analyses four theories that help explain why individuals struggle with living life on life’s terms while unable to utilize productive and healthy coping skills necessary to overcome life’s obstacles without taking a pill or using heroin.
Theoretical Analysis

If opioid treatment was as easy as just ceasing the use of the substance, treatment would not be a billion-dollar industry and the nation would not have classified this issue as an epidemic. Completing a detoxification for opioids is not enough as it only addresses the physiological symptoms, not the psychological or the social. Treatment is a biopsychosocial process that must address conflicts between the addict and those around them (Griffiths, 2009). These internal and external conflicts usually begin at a young age as children begin creating patterns that allow for the manifestation of negative behaviors when their realities create stress and contention within the mind (SAMHSA, 2015, October 2). As these children grow into adulthood, habitual patterns of thought create specific attitudes, which consequently may lead to negative behaviors. Theories that suggest intrapersonal and interpersonal conflicts by opioid addicted individuals that create barriers to recovery includes: theory of human motivation, social identity theory, coordinated management of meaning theory, and theory of relative deprivation.

Theory of Human Motivation

Abraham Maslow’s (1943) theory of Human Motivation describes five basic needs universal to all individuals. Maslow’s needs include:

- The physiological need for food, shelter, air, and water;
- The need to feel safe and secure which includes but is not limited to financial security and having an overall need to feel safe;
- The need to feel love and have a sense of belonging;
- The esteem need or the need to feel respected while believing one has some control over their lives;
• The need to self-actualize or believe as though there has been personal growth.

As mentioned previously, Maslow’s (1943) five basic needs are universal as all individuals have a general understanding of what they believe their life should be like. This is purely subjective, but if an individual is convinced that they are not performing at a level they should be, they will feel discontent (Maslow, 1943).

Figure 2 depicts Maslow’s hierarchy of needs diagram. According to Maslow (1943), if one of the basic needs are not met, it will be impossible for the individual to advance to the next within the hierarchy. If this occurs, intrapersonal conflict and/or psychopathologies may manifest. According to this theory, the connection between the individual and the group they align themselves with, is what ultimately determines the power of a particular need and the conflicts that will manifest if a particular need is not met (Maslow, 1943). To understand the impact these needs carry, one must recognize the individual person and how their intrapersonal conflicts may be connected to intergroup conflicts.

![Maslow's Hierarchy of Needs](image)

*Figure 2. Maslow’s Hierarchy of Needs (Finkelstein, 2006)*
The first stage is the physiological need. This is what Maslow (1943) termed as the starting point for motivational theory. This stage deals with the upkeep of the human body to sustain survival. The need for water, food, sleep and air are just a few of the needs mentioned mandatory to begin the uphill climb for overall satisfaction of life. Addiction to illicit and prescribed opiates creates life threatening health concerns. Nabipour et al. (2014) believes the nutrition needed for the human body to remain healthy are disregarded by opiate addicts due to the preoccupation with their addiction and lack of appetite for food. Opiate addicts usually ignore many of the basic physiological needs of life that include food, water, sleep, and shelter due to their obsession with obtaining their next high (Nabipour et al, 2014). Most of them become undernourished, dehydrated, and have poor sleeping schedules, staying up for days on end before the inevitable nodding out, or loss of consciousness due to a high dose of opiates. In addition, severe organ failure and the slowing down of the using individual’s respiration results; and in many cases, breathing ceases (Nabipour et al., 2014).

It’s difficult for non-addicts to imagine a substance so powerful, that people are willing to give up the very first basic need for continued use. Entering treatment may provide a stabilization process whereby an individual suffering with dehydration, malnutrition, and sleep deprivation are corrected, while decreasing the chances of respiratory failure. Unfortunately, once stabilized due to satisfying the physiological needs, many clients leave treatment against medical and clinical advice, unable to meet the next need (American Addiction Centers, 2018 April 20).

The second stage is the safety need. To satisfy this need, one must feel safe and secure from harm. As mentioned in the previous section of High Risk Factors,
relationships, communities, and societies contribute to the level of risk increasing the potential for drug taking behavior (SAMHSA, 2015, October 2). If an individual does not feel safe, this need will not be fulfilled. As a child, the lack of family involvement, parental abuse or neglect, and high levels of family stress are indicators for negative behaviors to occur. In Dina Redman’s (2008) mixed methods study, two thirds of the 68 participants said they used drugs as a means to cope when having a history of sexual and/or physical abuse. One of her participants reported on the abuse he received from his mother sharing how she would beat him daily with extension cords and sticks when he was a child. He shared that his mother would beat him until he cried and would then beat him more for crying, creating an environment of fear setting the stage for his addiction to manifest (Redman, 2008). If this intrapersonal need for safety and security are not met, it will follow the individual into adulthood and create new high-risk factors for the children they bare.

Drug addiction is a major factor in violent crimes, unemployment, and neglect of children (Hawkins et al., 1992). All of these factors have a high potential to create fear and the need for security may be so high, one will do anything to obtain it. In addition, with the new emerging stigma mentioned on page 41, many treatment facilities may not necessarily provide an environment of safety and security, yet give off the impression that they do. As mentioned previously, what was once a place that created hope and possibility, has now become a venue for the extremely unethical and money driven.

Opioid addicts are well aware of the corruption taking place and it is usually through communication amongst clients that corruption is disclosed. Just this month, a former client forwarded me a text message that he received from a peer offering him over
$1000.00 to fly to California and transfer to the treatment facility he was working for. In addition, he offered my client a plane ticket to get there, rent free sober living, cigarettes, money for food, a job, and free prescription medications. The text message used words like “my team will make you feel comfortable” and “we will take care of everything.”

This message is filled with the idea of satisfying the safety and security need for individuals who have been seeking it for many years, some for a lifetime. Unfortunately, treatment centers who utilize this method of recruitment create a foundation of sobriety that is filled with lies and manipulation, thereby creating a deeper darker mental place for the addict after the money has been spent and the insurance company no longer authorizes treatment due to multiple treatment attempts.

The third stage is the belonging need or social needs which is discussed in greater detail in social identity theory. This need stems from a tribal nature. This is the need for belonging, love, and affection that allows for fulfilling relationships through family, friends, and/or a group. Maslow (1943) describes it as follows:

He will hunger for affectionate relations with people in general, namely for a place in the group, and he will strive with great intensity to achieve this goal. He will want to attain such a place more than anything else in the world and may forget that once, when he was hungry, he sneered at love. (p. 376)

Psychology Today (Hall, 2014) describes a sense of belonging as being the most important in finding value in one’s life. There seems to be a comfort in knowing that others are going through similar trials and tribulations and the idea that one is not alone has the capacity to empower. On the reverse, when one feels alienated from a group or even from society, Maslow (1994) believed that this created the perfect storm for the
most severe cases of maladjustments and psychopathologies. Redman’s mixed methods study (2008) reported on the experience of an African American man who attributed his heroin use to growing up in a racist society and feeling as though he did not belong. Her participant explained his struggles with not feeling a part of the society he grew up in. Redman (2008) reported how her participant expressed feeling excluded and worthless, not belonging to the very society he resided in. These feelings of alienation are what Redman (2008) believed contributed to her participant’s continued addiction.

Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) are not considered actual treatment. Although, most treatment centers today utilize the 12-step modality and fellowship during the treatment process. The power of the fellowship utilized in AA and NA provides social support for addicts and/or recovering addicts. It is a resource for advice and information, it allows a venue for emotional support, feedback and appraisal from other members, and it allows all struggling with addiction to be a part of a group without judgment or ridicule (aa.org, 2018). Utilizing the fellowship until other interpersonal conflicts are resolved may help the individual feel less alone while validating their existence with others who have struggled or are struggling with many similar issues. This will be discussed further in social identity theory.

The fourth stage is the esteem need, or the need to have a stable, high evaluation of the self which includes not only self-respect but also the respect of others (Maslow, 1943). The University of California created a document titled Self-Esteem (2017) that provides a clinical definition of self-esteem that highlights how self-esteem is the internal mechanism human beings use to create value within ourselves. This internal mechanism affects how we relate to our interpersonal relationships with others. Having a low self-
Esteem can be a crippling condition that hinders individuals from recognizing their potential. Some symptoms of low self-esteem include but are not limited to perfectionistic attitude, not trusting others, having a victim mentality, feeling unloved, fear of being judged or ridiculed, and having an overall negative view of life (Self-Esteem, 2017).

On the reverse, satisfaction of this need leads to feelings of confidence and feeling like a productive member of society. The idea is that one’s negative behaviors when active in their addiction will not allow individuals to have a positive idea of the self; therefore, they will be unable to satisfy this need. In order to progress to the next phase of the hierarchy, the ability to recognize the need to have self-confidence and becoming aware of how helpless people behave must occur (Maslow, 1943). Changing destructive life patterns to establish positive meaningful relationships where one is perceived as being respected should be one of the objectives of treatment. Obtaining employment and becoming financially independent while learning healthy coping mechanisms that one can be proud of are all esteem issues that may have the potential to make or break the recovery process.

The last stage is the need for self-actualization, or the development of the self and realization. Maslow (1943) believed that an individual will feel discontent and restless unless they are doing something that brings meaning into their life. In essence, it is about becoming the best “you” that you are capable of becoming. Maslow (1943) expounded on this idea and elaborated on his explanation of self-actualization writing:

It refers to the person’s desire for self-fulfillment, namely to the tendency for him to become actualized in what he [or she] is potentially. The specific form that
these needs will take will of course vary greatly from person to person. In one individual it may take the form of desire to be an ideal mother, in another it may be expressed athletically, and still another it may be expressed in painting pictures or in inventions (p. 382-383).

One of the philosophies of the 12 steps of AA and NA is the idea that wisdom is knowledge, but virtue is applied knowledge (12stepphilosophy.wordpress.com, 2018). In active addiction, the lower level needs will be unmet thereby never allowing one to reach the final need. Fortunately, if one decides to get sober, the needs for material, emotional, social, and relationship security has a high potential to be met. Through treatment, the fellowship, and working the 12 steps listed on page 30, negative perceptions of reality can be altered, acceptance of self and others occurs, opinions and views of culture and environment no longer yield the power as it once did, focus and goal centered thinking becomes a priority, gratitude versus entitlement emerges, and interpersonal relationships are based on love and service thereby creating purpose and self-fulfillment (12stepphilosophy.wordpress.com, 2018).

Opioid addiction has the potential to interfere with every stage of Maslow’s theory. It is highly likely for an active opioid addict to fulfill even the first basic need when involved in an active addictive lifestyle (Nabipour et al., 2014). That being said, the desire for the addicted individual to meet the lower level needs continues, albeit in a highly toxic way that is very short lived. The longer an individual is involved in the addictive lifestyle the shorter the “high” becomes, and in extreme cases, high levels of the substance are needed just to feel some sort of relief from the internal and external disappointments faced as a result of the chosen lifestyle (Drugabuse.gov, 2007). With
every “high” there is a “low”. It is usually due to the extreme lows when addicted individuals become sick and tired of being sick and tired. Some of these “lows” includes overdosing, running out of resources, incarceration, and institutionalization. It is the hope that these “lows” bring the individual to a place of surrender, so the journey to achieve the healthy fulfillment of each need can begin. Once the physiological need is met, the next two, safety and belonging, have a lot to do with who the individual surrounds themselves with.

**Social Identity Theory**

Social Identity theory was introduced by Henri Tajfel and John Turner in 1979. The nature of this theory believes that individuals obtain their identity from those who they interact with and they define themselves by the roles they play within the group(s) they are a part of. Tajfel and Turner (1979) believe that this sense of identity creates a feeling of belonging to a larger social group. This need fosters social categorization or the social process whereby people obtain their identities by the groups they and others belong to (Folger et al., 2001). When people accept these social categories, they begin to act in ways that reinforce their beliefs, creating a pattern that allows the preservation of these beliefs about other social groups to continue.

As illustrated in Figure 3, personal identity, or the definition of self, is formulated by the social identity of the group one feels they belong to. This allows the individual to categorize themselves as being a part of the group they believe themselves to be in. This categorization places the individuals in what they depict as the in-group while others not belonging to their group are considered the out-group. The in-group is therefore considered favorable where-as the out-group is considered unfavorable.
The initial treatment process involves incredible amounts of stress and discomfort. The general human predisposition is to alleviate any painful physiological and psychological symptoms as much as possible by avoiding the uncomfortable situations (Mitchell, 1981). Once admitted into treatment, it is the individual’s opportunity to choose a group within the treatment community to align with. The three main choices generalized usually includes; those that want recovery, those that do not, and those that are undecided. Habitual patterns of behavior are likely to emerge sooner than later, so the speed of which one aligns is a key factor of the overall treatment experience (Anderson, 1994).

Identifying with a group usually involves the individual’s self-image and he or she will undoubtedly connect with the group they see themselves as in order to gain a better sense of security in an otherwise unfamiliar place. Their self-image guides them of what to do and what to expect when socializing with others (Anderson, 1994). Social
identity theorists believe that social identification precedes group behavior (Spears et al., 1997). Mitchell (1981) explains group identification as a common psychological practice that involves the process of seeing one’s own group as good, justifying their group’s ideas and behaviors while believing the other groups to be inferior and unprincipled in behavior.

Goffman (1963) further describes the process and reports that those who do not meet the presumptions of the chosen group will fall into another group. Thomas Scheff (1967) called this pluralistic ignorance, meaning that each group’s interpretation of another’s group is wrong, but neither believes that they are. These assumed interpretations initiate polarization that creates stereotyping of other social groups promoting an “us” versus “them” attitude or an in-group and out-group. Intergroup ideologies are created that point out the differences between groups that present one’s own group in a positive way, justifying their perspective in conflict situations (Folger et al., 2001). When new members join the group, they are taught the belief system of the group and eventually view the other group in terms of the ideology.

Due to the opioid epidemic, this process is literally life or death. The group that the client aligns with will either take them back out into the addictive world or ground them in the recovery process. It appears that the treatment field has learned the power of social identity theory. Merging NA and AA into the treatment field was historically a taboo and frowned upon. The fellowship and the recovery world were deemed separate and attendance at AA or NA meetings historically began after the treatment process due to the anonymity of AA and NA members. In an effort to introduce clients to positive support networks, treatment has begun introducing AA and/ or NA philosophies as part
of the treatment experience (aa.org, 2018). The positive benefits of social sober support appears to be reliant on the level of “which those providing support are perceived relevant, similar and connected to the self” (Best et al., 2016, p. 112).

To change one’s identity from an active addict to one that is in recovery is a powerful determinate in recovery. Biernacki (1986) stressed this point stating that people struggling with drug addiction must create new identities and belief systems about the social world around them while stripping the old addict identity. The ability to connect with addicts in recovery helps individuals make sense of their substance related behaviors while reinforcing a new social identity (Best et al., 2016). Best et al. (2016) believes that the development of this new social identity has the potential to strengthen an individual’s sense of belonging thereby creating new norms, values, and beliefs about the self and about the over-all recovery process.

When we interact with other groups and individuals we do so in the context of how we perceive ourselves and those that we are communicating with (Folger et al., 2001). Not only do we interpret meaning from interactions through the norms and values of the groups we identify with, but also through our own intrapersonal system. The combination of our intrapersonal and interpersonal systems create a perspective that allows us to manage our reality and will either create a successful recovery process or tempt an individual to relapse. Managing meaning of a situation, especially one that involves changing an identity involves learning new ways of interpreting social cues. Coordinated management of meaning theory builds off of social learning theory by recognizing that meaning is not only determined by the interaction between those that are communicating, but also by the members of the group the communicators come from
Coordinated Management of Meaning Theory

Originally introduced in 1976 (Pearce, 1976) Coordinated Management of Meaning Theory (CMM) believes that individuals construct meaning on the bases of exchanging rules. This theory developed by Pearce and Cronen “is concerned with how individuals organize, manage, and coordinate their meanings and actions with one another” (Folger et al., 2001, p. 205). The idea is that individuals in a social situation attempt to perceive what is happening and apply learned practices to figure it out. This figuring out transpires as a result of interpretations based on conversations and messages between different groups which ultimately shapes how an individual sees themselves within the context of their culture and how they ultimately will view others (Folger et al., 2001). CMM theory offers a foundation when explaining how individuals bring meaning to messages, conversations, relationships, and how groups establish their meanings and actions through conversations (Folger et al., 2001). Folger et al. (2001) believed in the enormous importance behind meanings because they are the predictors of the actions individuals will take or avoid.

Coordinated management of meaning theory suggests that individuals organize meanings in a hierarchy, which includes six levels of meaning, each level feeding off the next to establish meaning on another level (see Figure 4). The levels include (rdillman.com, 2018):

1. Content, or the words spoken aloud.
2. Speech Act, or speech that intends to make contact with the receiver or alter the behavior of the receiver. Content is needed to complete this.

3. Episode, or the setting of where the communication takes place. The episode plays a part in deciding the speech act to be used, and the speech act helps to define the episode.

4. Relationship, or how the communicators know each other and the roles they have within each other’s lives and their own social group. The relationship interconnection works together with the episode, the speech act and the content.

5. Self-concept of the communicator and the receiver as well as of each other will affect how the content is presented, received, and reciprocated.

6. Cultural Patterns, or the cultural values of the society and social group we align with plays a part in determining the communication flow.

Figure 4. Coordinated Management of Meaning Theory (rdillman.com, 2018)

This process demonstrates the layers of meanings we integrate to allow for understanding when interpreting specific messages and actions. It also provides a picture of how the perceptions of history influence the parties’ ideologies and analysis of a conflict situation (Folger et al., 2001).
Coordinated management of meaning theory allows for a better understanding of how differing histories between groups affect their interpretations of a conflict. When looking back at the history of addiction mentioned in chapter two and the social stigmas attached to treatment and to those struggling with opioid addiction, it is not surprising as to why recovery rates are so low. Social identity processes work at a cultural level affecting an individual’s expectations of how their life should be and how it will develop. West and Turner (2000) summarize three main points of this theory which includes: humans communicate; humans simultaneously create their social realities; information activities depend on intrapersonal and interpersonal meanings. How we perceive content from another, depends on intrapersonal perceptions that are based on past and present interpersonal relationships.

Repeatedly being called a junkie, dead head, dope fiend, criminal, or looser by families, and the general public affect the communication process between parties on all six levels. In order to survive on the streets while managing an expensive heroin or pill addiction, one must have a certain mindset and a strategic way of being that is culturally ingrained in many of the opioid addicts entering treatment. The speech act between staff and client becomes difficult due to the different cognitive processes that takes place when living the life of an illicit drug user. Mitchell (1981) uses the term cognitive consistency. The main concept of cognitive consistency is the human ability to ignore or reject conflicting details about the world that does not fit in with an already existing belief system. This ignoring or rejecting of details enables the individual to live in an environment creating a world that allows for acceptable amounts of psychological stress (Mitchell, 1981). As a result of cognitive consistency, selective perception, or the
filtering out of information to prevent conforming to the environment takes place (Mitchell, 1981). The ability to conform to the rules of the treatment program becomes very difficult for the addict, and the belief that non-addicted individuals actually care about the well-being of someone suffering with an active addiction is hard to embrace for many clients when they enter treatment due to cognitive consistency.

Utilizing CMM theory within the treatment world may present as something like this. *Content* may be misinterpreted from the very beginning due to clients already being uncomfortable and physiologically affected due to the cessation of the drug(s) when entering treatment. Post-acute withdrawal symptoms may be high as well as the neurological abnormalities because of the toxic effects of the drug. This may alter interpretations of communication to a point where non-communication may be the best form of communication until the physiological symptoms subside. Compassion coming from a therapist may come across as sarcastic or fake creating a hostile environment where actual violence could occur. Due to the subjectivity of the levels, the content is what will eventually give meaning utilizing the other five levels.

During the *speech act*, staff attempts to alter the clients’ way of thinking in an environment that does not allow active use or addictive behaviors. When a client enters a residential level of care or a partial hospitalization program with community housing, some of the environmental changes that occur includes limited access to the outside world, rooms must remain clean and all clients must shower daily, conversations amongst patients are closely monitored with 24 hour supervision, and daily structure of group meetings, medical appointments, and clinical sessions are enforced (Drugabuse.gov,
For many illicit opioid and opiate addicted individuals, this is a completely different way of life than what they are used to.

The actual environment of the treatment setting, or episode adds stress. Rules that must be enforced on the streets by an active addict in order to survive are no longer tolerated and may warrant a discharge because they are in direct correlation of the new rules enforced by the facility. In addition, the relationship is already predetermined before verbal communication takes place because of the differentiation of power between staff and client. Information has already been exchanged as a consequence of each person’s history, culture, and group identity. “Previous relational history between parties affect the contract level” (Folger et al., 20010, p. 206). If staff is perceived as the “them” the intention of the communication may be perceived in a very negative way based not only on the client’s history, but also on their past treatment experiences.

If a client does not view themselves as anything but an active addict, it will be extremely difficult to change their self-concept. As a result of cognitive consistency, addicts entering treatment have developed a repository of psychological defense mechanisms that keep their self-concept in check, avoiding the truth of the situation. Drugabuse.com (2018) lists five universal lies addicts tell themselves to rationalize their lifestyle choices and minimizes the severity of their addiction and they include:

1. My addiction doesn’t affect anyone else.
2. I’d never be able to manage my problems without drugs/alcohol.
3. I’m in control of my substance abuse; I can stop whenever I want to.
4. But I’m not like so-and-so...he/she’s really in bad shape.
5. I don’t care about my life and I don’t care if my addiction kills me.
If the belief system followed by staff is that the client will never change, or the client believes that they are going to die with a needle in their arm, the interaction between the communicators within the context of society will generate messages that will not promote healing and transformation.

Coordinated management of meaning theory allows individuals to interpret meaning by using one level in the hierarchy to aid in the interpretation of another level. This interpretation ultimately leads to action. Actions are determined based on what Pearce and Cronen (1976) call regulative rules, or rules formed by one’s culture, self-concept, relationships, experiences, and intentions. Regulative rules will determine the course of action a person will take in a conflict situation. Folger et al. (2001) writes that intergroup differences may influence conflict because of social categorizations and stereotypes becoming solidified as a result of rule guided behaviors. Once learned, these rule guided behaviors will impact how an individual will respond to another. In the end, the need to begin shifting the addict’s cultural pattern is the goal of the overall treatment process. This is much easier said than done.

Addictive thinking is inundated with justifications and rationalizations on an individual and group level. On the individual level, it is an unconscious action to help explain behaviors that are unacceptable while manifesting logical reasons to make it acceptable (Mitchell, 1981). On the group level, it is a process by which individuals preserve his or her image of the group as being moral and ethical while avoiding information that may dispute this positive image (Mitchell, 1981). The need to justify unacceptable actions are not only powerful for the individual but also for the group they
represent. Justifying “good reasons” for not so good communication styles and behaviors is an attempt to decrease guilt and shame and alleviate both intrapersonal and interpersonal conflicts (Mitchell, 1981). It is a coping mechanism within an illegal opioid addicts’ lifestyle. What one must do to continue the lifestyle so withdrawals are minimized and the euphoric effects are maintained creates a reality that is inundated with an altered perspective, giving these rationalizations and justifications validity. The last theory within the theoretical analysis provides an explanation as to why criminal thinking and behaviors as well as entitlement continues to occur when one’s life appears to have hit rock bottom.

**Relative Deprivation Theory**

The fourth theoretical lens is relative deprivation (RD). Sociologist Samuel A. Stouffer and his colleagues are attributed with the development of relative deprivation theory. The initial understanding of RD is simple: “persons may feel deprived of some desirable thing relative to their own past, another person, persons, group, ideal, or some other social category” (Walker & Pettigrew, 1984, p. 302). Skocpol (1979) believes individuals become angry when they are unable to obtain things they value or are not given opportunities they feel entitled to. Figure five helps to further illustrate why an individual may feel deprived when comparing and judging what other individuals have when believing that their situation is unfavorable. As a result, the individual may become involved in deviant behaviors, justifying their behaviors as appropriate.
People who struggle with active opioid addictions are flooded with intrapersonal and interpersonal conflicts that create perceptions about life from an altered state of mind. Taking personal responsibility for one’s life and well-being is very difficult when one believes that life without the drug is a form of deprivation. In addition, the “us” (the client) versus “them” (the staff) attitude created by group identification has a high propensity to generate an initial foundation of the treatment process that is riddled with frustration and resentments associated with the resistance of incompatible interests as mentioned in social identity theory. Treatment may seem like a prison term as the client may feel as if they are being deprived from the one thing that they believe will make them feel better. In regard to RD, Pruitt and Kim (2004) believe the root of conflict is not necessarily actual deprivation, but rather conflict manifests as a result of the deprivation in comparison to what others have that they believe they should have.

In South Florida, home to hundreds of treatment centers, addicts have learned that many treatment centers profit off their insurance. On the reverse, many treatment centers profit off the vulnerability of the addicts. When addicted individuals enter a treatment center that focuses on recovery and not on monetary gains, they may struggle with what they believe they are entitled to due to previous experiences they have had when enticed

*Figure 5. Relative Deprivation Theory (assignmentpoint.com, 2018)*
by monetary focused facilities. Many addicts are enticed by material things in exchange for their insurance information. Cell phones, free rent, groceries, and cash are just a few of the incentives offered (Buzzfeed.com, 2016). An individual who does not want recovery or is not willing to do what it takes to live a life of recovery is going to struggle with the rules and standards of an ethical, treatment focused establishment.

Fraternalistic deprivation is more specific in terms of intergroup attitudes and how the social comparison process can lead to group behavior. According to the CDC (2015) individuals ages 18 to 25-years-old are at the highest risk for heroin addiction. It appears that millennials currently comprise the primary age bracket of individuals struggling with addiction. “Addiction is a disease that afflicts primarily young people between the ages of 15 and 35, and all those are millennials at the moment” (Rass, 2018, para 3). Millennials consist of people born from 1980 to 2000, so the group is mostly comprised of late teens to early 30s. At around 80 million, they are one of the largest age groupings in United States history (Stein, 2013, May 9). Each countries millennials are different depending on their culture but due to globalization and social media, millennials worldwide are more similar than they ever use to be (Stein, 2013). That being said, millennials are growing up during a time in the United States when illicit and prescription opioid use are becoming normalized, are over prescribed, and are poorly regulated (see Chapter 1).

The internet is a global system that provides a variety of information interconnecting networks using specific protocols. In modern society, to see a person under the age of 30 not staring down at their cell phone is rare indeed. Millennials were born in a world that promotes technology (Stein, 2013). Accessing illegal information is not a difficult task. Pornography, gambling, prostitution, and illicit drug dealings can all
be found on-line, appearing legal and harmless. A new communication portal has evolved known as the darknet markets. These cites tempt millennials with attractive looking people plastered on their websites while promoting special deals (drugs-center.biz, 2018):

In addition to on-line accessibility, modern day movies and music promote, glorify, and normalize drug use. The Wolf of Wall Street tells the story of an opiate addict who becomes financially wealthy, regardless of his addiction. Trainspotting, is a dark comedy that romanticizes heroin use and shows the euphoric effects associated with heroin use. Pineapple Express, a film fan favorite. Even though the main drug solicited is marijuana, the movie does not encourage people to stay away from drugs, if anything, it encourages the use of drugs. Movies like The Hangover, Animal House, and Beerfest glamorize a party lifestyle that involves excessive drinking and drug use using humor to deter from the truth about the risks taken when partaking in this lifestyle.

According to data from a jointly conducted survey by Entertainment Retail Association and the British Phonographic Industries, Millennials reported listening to about 3.1 hours of music per day (Resnikoff, 2016). While songs about excessive partying are nothing new, access to different kinds of music are much more available utilizing music streaming services like Pandora and Spotify. Many studies have shown that music represents a major source of exposure to the positive side of drug use and has a big influence in identity development (Parker-pope, 2008).

The popular hit song No Limit by G-Eazy lyrics are filled with references to money, “bitches”, and “Always lit, yea I’m never sober”. A popular song released in
2018 by Blackbear tilted So High glorifies the effects of getting high with the repeating chorus rapping the lyrics:

I like to get high
With my friends all the time
Don't got nothing on my mind,
I'm good I'm good
(you make me so high)I'm good
(you bring me alive, so high)
I'm good (so high)

Reading the lyrics to this song was horrifying. Knowing that it was released in 2018 during an opioid epidemic is terrifying. Even the titles of songs are sending messages. F*ck How It Turns Out by Turk featuring Lil Wayne & Kodak Black that talks about the wonderful effects from drinking lean, a slang term for prescription-strength cough syrup that includes opioids.

By normalizing and minimizing the consequences of addiction and glamorizing the addictive lifestyle, young people may be conditioned to believe that drugs promote power and that taking mind-altering substances to make one feel better is normal. The decision to believe that “getting high” is normal may be based on the messages received from music, entertainment, and social media which promote a mindset that follows what others say they deserve. In addition, these media venues paint a picture of what society deems as normal specifying what anybody in their circumstances should get (Pruitt & Kim, 2004). These intergroup attitudes lead to intergroup behaviors, and when threatened, will almost always promote conflict.
Clients receiving treatment are given opposite messages of how to live their life. Defiant behaviors are not uncommon when a client enters treatment (drugaddictiontreatment.com, nd). Entitlement is also an issue that needs to be addressed as most clients believe they should be rewarded in material or medicinal ways due to their insurance paying thousands of dollars for them to be treated. Many clients are confused and angry when informed that they will not be prescribed certain medications to ease their post-acute withdrawal symptoms or will not be given certain luxuries (i.e. cigarettes, food cards, access to computers) for entering treatment (drugaddictiontreatment.com, nd). To live a life of recovery means to live a life of integrity, humility, faith, forgiveness, and action (see Figure 1). These principles conflict with the addictive lifestyle and mindset due to the intergroup attitudes and social comparison concepts previously learned.

Crosby (1976) recognizes the importance of egoistic RD but specifies social outcomes that seem to relate more to fratenalistic RD. She attempts to explain the hasty preconditions that may lead to quarrelsome behaviors by outlining five preconditions that are needed for a person to be in a state of RD. The five preconditions include a person desiring something that another has, the person wants this something, the person feels entitled to this something, the person believes it is feasible for them to attain it; and finally, the person does not take responsibility for not having it (Walker & Pettigrew, 1984). Crosby (1976) believed that if all five of these conditions are met, conflict is sure to ensue.

The five necessary preconditions that Crosby defines are clearly evident in terms of why an addict may be experiencing RD. Through social media, music, movies and the
normalization of drug use and the materially promoted lifestyle, young people are conditioned to believe that they can live a life of instant gratification while attaining material success. Through social media platforms like Facebook, Twitter, Instagram, and Google, the realities of people who our culture deems successful may be misinterpreted. Perceptions about what it takes to be the ideal self is highly influenced by societal and environmental influences. People believe that a certain way of life is the norm based on the messages they are receiving. When life doesn’t turn out the way they believe it should, based on what they have learned, victimization may occur (drugaddictiontreatment.com, nd). The victim mentality prevents the addict from taking personal responsibility for their lack of success blaming others for their misfortunes while creating intrapersonal and interpersonal conflicts that only exacerbates the addiction (drugaddictiontreatment.com, nd).

According to Crosby (1976), the effects of RD will be affected by three factors. They include; where the projected blame falls for not having X, level of emotional control by the particular group or person, and finally, the actual perceived opportunities to change the situation to make it more favorable. Basically, the ultimate goal of RD theorists is to provide an explanation as to how feelings of deprivation over money, strong belief ideals, power, status, etc., may encourage individuals and/ or groups to create conflict situations as a way to influence social change. As mentioned previously, the main focus of treatment should be to help guide the addict in unlearning everything that he or she has learned about the self, others, and society as a whole. Perceptions of what constitutes success and happiness needs to change from an entitled state of being to one of being grateful.
Conclusion

The information obtained in the literature review is used to aid in describing the intrapersonal and interpersonal conflicts an opioid addict faces pre-treatment and throughout the treatment process. Using a conflict analysis and resolution perspective to describe the experiences of transitioning from an active addict phase to one who is in recovery seems quite significant in terms of understanding why an individual chooses an addictive lifestyle and why it is difficult to change that lifestyle. Literature on identity and group identification, personal and social stigmas, and high risk factors are mentioned throughout the literature review for the purposes of providing a conflict resolution framework for understanding the factors involved in opioid addicts treatment process. The four theories described in the literature review provides an understanding of why people may become opioid addicts as well as what contributes to the escalation of the addiction through the eyes of a conflict resolution practitioner.

Unfortunately, the existing literature does not explain the experience of transforming from active addict to one who is in recovery through the addicted individual’s viewpoint, and it fails to provide a clear picture of how psychological conflicts within the self as well as social conflicts within groups exacerbate the reciprocal pathologies that are maintained throughout their addiction. Due to the limitations of the theoretical analysis, I developed a Phenomenological research study that focuses on the intrapersonal and interpersonal conflict opioid addicts’ face throughout their treatment process. The next chapter focuses on the Phenomenological methodology used and why it was chosen to explain this phenomenon.
Chapter 3: Research Methodology

Research Method

The theories mentioned above not only enables professionals in the field to gain a better understanding of why individuals may become addicted to opioids and heroin but also provides clues as to why the recovery process is so challenging from an intrapersonal, interpersonal, and environmental perspective. However, to gain a better understanding of what intrapersonal and interpersonal conflicts are present when an opioid and heroin addict enters a treatment center, transcendental or phenomenological research concentrating on the description of the experiences (Creswell, 2007) was determined to be the best method.

Addiction is a touchy and often misconceived issue in our society. With the growing number of people in our culture struggling with opioid addiction, it is no wonder that the addiction field is gaining attention. The purpose of this research was to focus on this growing population utilizing interviews that allowed the participants to share their transformational stories and how they continue to transform in their recovery process. Because addiction affects individuals in a personal way, a qualitative methodology was determined to be the best mode of research versus a quantitative methodology.

“[Q]ualitative research allows researchers to get at the inner experience of participants, to determine how meanings are formed through and in culture, and to discover rather than test variables” (Corbin & Straus, 2008, p. 12).

Qualitative methodology has five qualitative methods. These methods include – ethnography, narrative research, phenomenology, grounded theory, and case study. When determining the methodology, I drew upon personal experience and the diversity of the
addicts I have served over the years. While working in the field of addiction, I discovered that no two addicts have ever presented the same and their perceptions about their reality are quite unique. Phenomenology was chosen as the best qualitative methodology because according to Moustakas (1994):

The aim is to determine what an experience means for the persons who have had the experiences and are able to provide a comprehensive description of it. From the individual’s descriptions general or universal meanings are derived, in other words the essence or structures of the experience. (p. 13)

Phenomenology has a heavy philosophical component and was strongly influenced by Edmund Husserl. “Husserl’s intention was to study consciousness and how phenomena in the world are constituted by human consciousness” (Davidson, A.S, 2013, p. 320). Husserl believed that researchers should not let their own preconceived ideas and theories determine our experiences but instead, allow our experiences to formulate our theories (Davidson, 2013). Husserl is also known for introducing the concept of epoche or bracketing “in which investigators set aside their experiences, as much as possible, to take a fresh perspective towards the phenomena under examination” (Moustakas, 1994, p. 59-60). Expanding Husserl’s original ideas about phenomenology were Heidegger, Satre, and Merlaeu-Ponty (Moustakas, 1994), each bringing their own philosophical argument.

Phenomenology has multiple schools of thought that includes: empirical, hermeneutical, heuristic, and transcendental or psychological phenomenology. Empirical phenomenological research is possibly the most often used of phenomenological research (Moustakas, 1994). This approach involves two levels which Moustakas (1994) describes while utilizing Giorgi’s (1985) descriptive levels of the approach specific to empirical
phenomenology. Level I involves collection of data compiled from naïve descriptions retrieved from open ended interview questions. Level II involves the researcher describing “the structures of the experiences based on reflective analysis and interpretation of the research participant’s account or story” (p. 13).

Creswell (2007) describes hermeneutical phenomenology as an interpretive process whereby the “researcher makes the interpretation” (p.59) by “interpreting the ‘texts’ of life” (p.59). Again, as a result of the researcher’s personal and intimate connection to the research, hermeneutic phenomenology was not chosen due to the researcher’s involvement in interpreting meanings. Heuristic research only addresses the co-researchers experience and does not include how outside forces influence the experience (Moustakas, 1994). Analysis of outside forces are a primary component of what this research is trying to discover. Therefore, this was not the method utilized.

For the purposes of this research, transcendental or psychological phenomenology was chosen. This method takes from the Duquesne Studies in Phenomenological Psychology and the data analysis approaches of Van Kaam (1966) and Coulaizzi (1978) (Creswell, 2007). This method focuses “less on the interpretations of the researcher and more on the description of the experiences of the participants” (Creswell, 2007, 59). According to Moustakas (1984) “Husserl espoused transcendental phenomenology, and it later became a guiding concept for Moustakas as well” (Creswell, 2007, p. 237). Moustakas (1994) believed that four core processes are needed to obtain or develop knowledge: Epoche, Transcendental-Phenomenological Reduction, Imaginative Variation, and Synthesis. It was due to these four processes that solidified this methodology of choice.
**Epoche or Bracketing**

Epoche involves the processes of bracketing out the researchers own experiences to get a fresh perspective of the phenomenon being researched. “In the Epoche, no position whatsoever is taken; every quality has equal value” (Moustakas, 1994, p. 87). Epoche is discussed in greater detail on page 79.

**Transcendental-Phenomenological Reduction**

The second step in the process is Transcendental-Phenomenological Reduction which allows for each experience to be considered unique, in and off itself (Moustakas, 1994). No generalizations or judgments about experiences of the phenomenon are made as the researcher takes the position of an open self. Moustakas (1994) focuses on the investigator setting aside all preconceived ideas of their own experiences as much as possible, so the participants’ experience under examination can be analyzed individually, openly, and objectively. According to Moustakas (1994) “Phenomenological Reduction is not only a way of seeing but a way of listening with conscious and deliberate intention of opening ourselves to the phenomena as phenomena, in their own right, with their own textures and meanings” (p. 92). By looking and describing and looking again until looking again is finally exhausted, a reflective process materializes, intended to understand the entire scope of the phenomenon (Moustakas, 1994). The reduction will aim at providing a textural and structural synthesis of meaning to reveal the essences of the phenomenon being examined (Moustakas, 1994).

**Imaginative Variation**

The purpose of imaginative variation is to determine a “structural differentiation among the infinite multiplicities of actual and possible cognitions, that relate to the object
in question and thus somehow go together to make up the unity of an identified synthesis” (Husserl, 1977, p.63). This allows for a structural description of the meanings to be attained while producing descriptions of the circumstances that triggered an experience so that the precipitating factors can be connected (Moustakas, 1994).

According to Moustakas (1994):

The task of imaginative variation is to seek possible meanings through the utilization of imagination …[t]he aim is to arrive at structural descriptions…in other words the ‘how’ that speaks to conditions that illuminate the ‘what’ of experience (p. 98).

Moustakas (1994, p.99) lists the steps involved with Imaginative Variation and they include:

1. Systemic varying of the possible structural meanings that underlie the textural meanings;

2. Recognizing the underlying themes or contexts that account for the emergence of the phenomenon;

3. Considering the universal structures that precipitate feelings and thoughts with reference to the phenomenon, such as the structure of time, space, bodily concerns, materiality, causality, relation to self, or relation to others;

4. Searching for exemplifications that vividly illustrate the invariant structural themes and facilitate the development of a structural description of the phenomena.

In the end, these structural descriptions of the Imaginative Variation are ultimately combined with the textural descriptions of the Transcendental-
Phenomenological Reduction so that textural and structural synthesis of meaning can be determined (Moustakas, 1994)

**Synthesis**

The final process in the phenomenological research process includes the converging of the textural and structural descriptions into a linked, consolidated statement that explains the overall essences of the experiences as a whole (Moustakas, 1994). With this in mind, it is imperative to understand that essences of an experience are never constant. Perception is infinite and the synthesis of the structural and textural synthesis “represents the essence at a particular time and place from the vantage point of an individual researcher following an exhaustive imaginative and reflective study of the phenomenon” (Moustakas, 1994, p. 100).

There are numerous quantitative studies that provide statistics of addiction, relapse, and recidivism rates. In addition, there are numerous books that explain what an addiction is, the symptoms, and the behavioral patterns of an addict. However, there is limited qualitative research that explains the intrapersonal and interpersonal conflicts an opioid addict faces while in treatment utilizing a transcendental phenomenological research methodology. This phenomenological study examines data by interviewing 15 adult opioid addicts who completed a minimum of 30 days in treatment. All participants must have been minimum one year in recovery post-treatment. The transcendental phenomenological study conducted utilizes steps outlined by Moustakas (1994) and Creswell (2007) and they include: 1) bracketing, 2) sampling and recruitment, 3) data collection and analysis, 4) ethical issues, 5) protection of human subjects, 6) credibility and validity, 7) writing the final analysis.
Bracketing

Epoche involves the processes of bracketing out the researchers own experiences in order to get a fresh perspective of the experiences being researched. As mentioned in the Bracketing section in the introduction, addiction has been an integral part of my personal and professional life. Providing therapy for opioid addicts for over a decade as well as having an ex-husband addicted to pain pills has guided my own ideologies about addiction and the intrapersonal and interpersonal conflicts an opioid addict faces both in and out of treatment. This process was imperative for me to utilize so “the everyday understandings, judgements, and knowings [could be] set aside, and phenomena [could be] revisited, freshly, naively, in a wide open sense, from the vantage point of a pure transcendental ego” (Moustakas, 1994, p. 33).

Providing a fresh mindset on the phenomenon being researched doesn’t allow my personal experiences to alter the experiences of the participants. By keeping preconceived ideas about what I think should be addressed in treatment, opens my mind to the infinite possibilities that comes from new information. This process allows nothing to be proposed, introduced, or suggested. “In the Epoche, no position whatsoever is taken; every quality has equal value” (Moustakas, 1994, p. 87). The Epoche process allowed me to stay mindful of just how subjective I am in the field of addiction and alerted me to my ego and the realization that my mind was not as open as I had originally believed it to be in regards to this this issue.

Sampling and Recruitment

Creswell (2007) suggests starting with locating a sight and “determin[ing] which type of purposeful sampling [would] be best to use” (p. 118). The most important criteria
in determining whom the participants should be is that they all must have experienced the phenomenon being researched while having the ability to explain their own experience. Once I obtained approval from the Nova Southeastern University Institutional Review Board (IRB) recruitment of participants began. The term participants were used due to them deserving to be treated “with the highest standards of consideration and respect” (Chalmers, 1999, April 24, p. 1141). Keeping in mind that the participants recruited for this study had been stigmatized for years, it was imperative that I made sure all those involved felt comfortable and received the appreciation they deserved. I wanted all involved to understand the importance of what they agreed to be involved in and how their participation could in fact increase recovery rates of fellow addicts.

For this study, 15 research participants were selected. In order to meet criteria for involvement specific inclusion criteria needed to be met. Male or female participants had to be between the ages of 21 to 30-years-old and all must have successfully completed a minimum of 30 days in an adult substance abuse treatment program. All participants must have been in active recovery for at least one year. All participants must have reported their drug of choice to be an opioid or opiate based drug. Table 4 reports on the demographics of the participants as well as their drug of choice and length of sobriety.

Exclusion criteria included any clients I had ever treated or provided therapy for in the past or present. In addition, exclusion criteria included any staff member of whom I was the direct supervisor to. Individuals who reported any kind of alcohol and/ or drug use within a year of when the interview process took place were excluded. Participants were excluded if they reported opioid use but did not report it as their drug of choice. Participants were excluded if they remained abstinent due to 12 step involvement and
fellowship participation without the 30-day treatment experience. Minors were excluded due to the vulnerability of this population. Adults over the age of 30 were excluded to encapsulate a more modern treatment experience with current issues. There were no exclusions based on number of treatment attempts, location of treatment experience, location of participant, race, gender and/or religion.

Table 4

Demographics of the Participants

<table>
<thead>
<tr>
<th>Participant’s Pseudonym and Gender</th>
<th>Age at the Time of the Interview</th>
<th>Drug of Choice</th>
<th>Geographic Location</th>
<th>Length of Sobriety</th>
</tr>
</thead>
<tbody>
<tr>
<td>Henry: Male</td>
<td>29-years-old</td>
<td>Opiates/ Heroin</td>
<td>Florida</td>
<td>5-years</td>
</tr>
<tr>
<td>Mary: Female</td>
<td>26-years-old</td>
<td>Heroin</td>
<td>Florida</td>
<td>2-years</td>
</tr>
<tr>
<td>Sue: Female</td>
<td>30-years-old</td>
<td>Heroin</td>
<td>Florida</td>
<td>2-years</td>
</tr>
<tr>
<td>Jan: Female</td>
<td>28-years-old</td>
<td>Heroin</td>
<td>Florida</td>
<td>5-years</td>
</tr>
<tr>
<td>Jake: Male</td>
<td>26-years-old</td>
<td>Opiates/ Heroin</td>
<td>Florida</td>
<td>3-years</td>
</tr>
<tr>
<td>Albert: Male</td>
<td>27-years-old</td>
<td>Oxycontin</td>
<td>Florida</td>
<td>2-years</td>
</tr>
<tr>
<td>Emily: Female</td>
<td>27-years-old</td>
<td>Opiates/ Heroin</td>
<td>New Jersey</td>
<td>2-years</td>
</tr>
<tr>
<td>Angie: Female</td>
<td>24-years-old</td>
<td>Heroin</td>
<td>Florida</td>
<td>1.5-years</td>
</tr>
<tr>
<td>Carl: Male</td>
<td>28-years-old</td>
<td>Heroin</td>
<td>Florida</td>
<td>3-years</td>
</tr>
<tr>
<td>Randy: Male</td>
<td>24-years-old</td>
<td>Heroin</td>
<td>Florida</td>
<td>1.5-years</td>
</tr>
<tr>
<td>Cole: Male</td>
<td>26-years-old</td>
<td>Oxycodone 30s</td>
<td>Florida</td>
<td>2-years</td>
</tr>
<tr>
<td>Amy: Female</td>
<td>25-years-old</td>
<td>Heroin and Crack Cocaine</td>
<td>Florida</td>
<td>2-years</td>
</tr>
<tr>
<td>Bob: Male</td>
<td>28-years-old</td>
<td>Heroin and Cocaine</td>
<td>New Jersey</td>
<td>1.5-years</td>
</tr>
<tr>
<td>Cody: Male</td>
<td>27-years-old</td>
<td>Heroin</td>
<td>Florida</td>
<td>4-years</td>
</tr>
<tr>
<td>Ben: Male</td>
<td>29-years-old</td>
<td>Heroin</td>
<td>Florida</td>
<td>9-years</td>
</tr>
</tbody>
</table>

The objective was to recruit fifteen participants who met all the required inclusion criteria. However, one of the original participants relapsed on heroin and another stopped responding to my phone calls. The goal was to collect the data within a 6-month period of time, which was attained. The interview process took approximately 60 minutes with no follow-ups needed.

The fifteen participants were recruited through referral sampling that utilized gatekeepers and personal contacts. In addition, snowball sampling was used, which
allowed participants to recruit other participants from among their acquaintances. A research study flyer (See Appendix C) was provided to referrals and personal contacts who were interested in the research, providing a brief description of the study as well as the inclusion criteria. The Executive Director of the treatment center I work for provided the permission I needed to utilize the center as the location to conduct my interviews. The Site Approval Letter (see Appendix D) was signed and submitted to Nova Southeastern University Institutional Review Board and was approved. Once staff learned that I was conducting research that focused on improving the treatment process of opioid addicts, I was referred to over 20 possible participants.

**Data Collection and Analysis**

The purpose of this research study is to investigate intrapersonal and interpersonal conflicts opioid addicts face while in treatment as they embark on learning how to resolve personal and intergroup conflicts that exacerbated over their drug using history. The purposed theories mentioned in the Literature Review includes Maslow’s Hierarchy of Need, Social Identity Theory, Coordinated Management of Meaning Theory, and Relative Deprivation Theory. These theories help to explain the psychological and social influences that perpetuate addictive behaviors, but a qualitative research analysis is needed to gain more insight into just how powerful these influences effect the process of transformation from one living an addicted lifestyle to one living a life of recovery.

To enhance this insight utilizing opioid addicts’ experiences throughout the treatment process, sixteen interview questions were asked that focused on the central phenomenon of the experience (see Appendix A). “The phenomenological interview involves an informal, interactive process and utilizes open ended comments and
questions” (Moustakas, 1994, p. 114). The purpose of the interview questions was to obtain “rich, vital, substantive descriptions of the co-researcher’s experience of the phenomenon” (Moustakas, 1994, p. 116). The opioid epidemic has affected millions of individuals in our nation that includes but is not limited to the addict themselves; however, the actual conflicts that need to be addressed to alter internal perceptions so external behaviors shift, have been minimally researched.

For the purpose of this study, open-ended interview questions were administered that focused on conflict analysis and resolution themes. Investigating the experiences through this lens provided an opportunity to view opioid addiction not just as a biological or physiological condition, but from a psychological and sociological condition that, if addressed and treated appropriately, could yield positive outcomes. The sixteen questions attempted to guide the interview process to obtain information that focused on internal forces as well as external forces that shaped the participants’ overall treatment experience. This method also provided a venue of “service” or “giving back” to the participants just by their involvement in the study, which the twelfth step in the 12 steps of AA and NA promotes. The twelfth step is all about action in the recovery process. “Here we experience the kind of giving that asks for no rewards” (Twelve Steps and Twelve Traditions, 1981, p. 106).

The central question of this research study aims at understanding the intrapersonal and interpersonal conflicts opioid addicts are presented with during treatment. Obtaining answers from individuals who have actually lived the experience would provide professionals in the field evidenced based information so the structure of the treatment environment as well as the group curriculum could address the issues reported. As
mentioned previously, there are a number of Quantitative Research that attempts to explain addiction but minimal Qualitative Research. The interview questions that were used to ultimately answer the central question gave the participants a voice. This voice hopefully empowered them to continue down their path of healing, possibly giving them an opportunity to provide hope for those who are presently struggling with active opioid addiction.

Recruitment for this study was not as challenging as I originally thought it would be. Being the Program Director of a drug and alcohol treatment center provided numerous resources. Working side by side with Mentors, also called Behavioral Health Technicians (BHT), provided the initial access I needed for snowball sampling to occur. The BHT’s role is to assist therapists by providing support services to clients in treatment. Many are in recovery themselves and have established positive support networks with other recovering addicts. In addition, our program utilizes guest speakers every other Friday, who volunteer to come to the center and speak to our clients about their recovery process. I made it a goal to meet with them after their testimonials and provided them with the Research Study Flyer (see Appendix C). Once word got out that I was involved in a study that promoted positive change to the drug and alcohol field, recovering opioid addicts were asking if they could be involved. Once contact was established, the following steps occurred.

Potential participants were assessed, needing to meet all of the inclusion criteria. This process was done exclusively on the phone. Once inclusion criteria was met, I reviewed the purpose of the study with them, informing them that participation was strictly voluntary and would not provide any financial compensation. I discussed any
potential risk factors and explained to them that they could retreat from the study at any time. In addition, clients were informed that if they needed to speak to a therapist due to possible triggers and/or cravings resurfacing, they would be referred to one immediately. Potential participants were asked to contact this researcher within 48 hours if interested, and when verbal confirmation was established, an appointment was scheduled to review the consent form. Due to the interviews being held at a treatment center, appointments were scheduled after clinical hours to maintain confidentiality of the clients in treatment as well as the potential participants. Prior to beginning the interview process, the informed consent was reviewed and signed by both the participant and myself. A copy of the signed consent form was provided for the face-to-face participants. All thirteen participants agreed to the location of where the interviews were going to be conducted.

Two of the potential clients were from out of state, so the informed consent was emailed to them. After the informed consent was signed and sent back to me, I scheduled the interview appointments, via phone interviews, making sure to meet the scheduled needs of the participant.

Working as a therapist in the field of addiction for fifteen years had its pros and cons during the interview process. Corbin & Strauss (2008) believe:

When we share a common culture with our research participants, and sometimes even if we don’t share the same culture, we, as researchers, often have life experiences that are similar to those of our participants. It makes sense, then, to draw upon those experiences to obtain insight into what our participants are describing (p. 80).
This insight did allow me the advantage of understanding certain recovery lingo, but I had to be very mindful to keep my therapy hat off and truly utilize the Epoche, and bracket my personal opinions based on my own experiences.

To gain understanding of the internal and external conflicts opioid addicts present with while in treatment, appropriate questions needed to be asked and mindful, active, and reflective listening needed to occur. I had to be very careful not to lead the interview or make the interview a therapeutic session. Utilizing certain motivational interviewing techniques helped create a supportive and non-judgmental environment. All of the participants had worked extensively with counselors and therapists in the past, answering probing questions for years, usually providing answers that they assumed their therapist wanted to hear. I did not want this experience to be anything like that for them. The questions asked were focused on their truth of the experience, not the researcher’s truth. Because of the conflict focused verbiage used in some of the questions, I explained that they could stop the interview at any time if they did not fully comprehend the question. As soon as the participant verbally stated that they were ready to begin, the recorder was turned on.

The interview questions for this phenomenological study start with a topical question or general open-ended question that asks for a brief description of themselves and their experience of when they believe their addiction started. As the interview progressed, the researcher progressed to “a series of questions aimed at evoking a comprehensive account of the person’s experience of the phenomenon” (Moustakas, 1994, p. 114). Interview questions designed to gain knowledge about the experiences of conflicts with staff, peers, and within the self were asked that allowed for the participant
to answer open-ended questions with open-ended comments. Understanding that perspectives of the treatment experience may be perceptually altered due to the continued internal and external recovery process that continues when one leaves treatment. One of the researcher’s goals was to allow for the client to feel comfortable in discussing any resistance they may have had when in treatment and why they believed they experienced resistance. This allowed the participants to provide their insights on what was beneficial for the recovery process and/or what may have created roadblocks in their recovery process.

The final question asked the participants if they had anything else they would like to add in reference to their experience. This provided an open forum to share how they believed the conflicts they experienced either created a process of personal evolution or decompensation and gave them an opportunity to speak candidly to the academic and treatment field. The interview questions used are as follows:

1. Please tell me about yourself and when your addiction started?
2. What were your drug or drugs of choice?
3. What does it mean to be an addict?
4. What does it mean to be an addict in recovery?
5. Please explain the relationships you had with your peers while in treatment?
6. Please explain the relationships you had with the staff while in treatment?
7. What contexts or situations typically influenced or affected your experience while in treatment?
8. What conflicts did you have to face during your treatment experience?
9. How did you manage these conflicts?
10. What have you found to be your best treatment experience(s)?

11. What have you found to be your worst treatment experience(s)?

12. What exercises or practices helped you or was the most effective with your transformational process of active addict to being in recovery?

13. What exercises or practices were the least effective with your transformational process of active addict to being in recovery?

14. Have you noticed any change in your own personality as a result of treatment?

15. How have you stayed sober after your treatment experience?

16. Is there anything else you would like to add with reference to your experience?

Throughout the interview process, I was very mindful of the responsibility to create an environment in which the participants felt at ease to ensure the most honest and comprehensive answers possible (Moustakas, 1994).

Creswell (2007) describes the data collection, data analysis, and report writing processes as interrelated, working simultaneously throughout the research process. Once each interview was completed, the interviews were transcribed. Creswell’s (2007) Data Analysis Spiral depicted in Figure 6 was used to analyze the qualitative data, which allowed the research to move “in analytical circles rather than using a fixed linear approach” (p. 150).
Figure 6. The Data Analysis Spiral (Creswell, 2007, p. 151).

The transcribed data were placed into password locked computer files in my home. The researcher’s personal experience on the phenomenon was disclosed using bracketing so a fresh perspective of the phenomenon being researched could evolve (see Page 15). The analysis process continued as the transcripts were read several times so the researcher could immerse herself in the details before breaking the data into their perspective parts (Agar, 1980). Memos were written in the margins of the transcriptions so key concepts or codes could be highlighted. This allowed the data to be organized in a way that the researcher could focus on larger thoughts presented and initial categories of the data could be determined. This horizontalization step highlighted how the participants experienced conflicts, so meanings could be developed. “This process consisted of moving from the reading and memoing loop into the spiral to the describing, classifying, and interpreting” (Creswell, 2007, p. 151). Detailed themes were developed as data was reviewed multiple times to reduce and combine themes. Creswell (2007) suggests reducing the amount of themes to five or six. The clustered themes and meanings provided the content to develop textural descriptions, or the “what”, and structural descriptions or the “how” (Creswell, 2007; Moustakas, 1994). The last step involved
giving meaning to the textural and structural descriptions, so the essence of the
phenomenon could be revealed.

**Ethical Issues and Protection of Human Participants**

Working in the field of addiction allowed me the opportunity to have access to
many potential participants. In addition, many people who are in recovery thrive by
helping others find their recovery and are more than willing to volunteer their time to any
efforts made to enhance the addiction field. For the purposes of this research study ethical
procedures were implemented. Possible participants knew I was a therapist in the field, so
it was very important that I made my researcher role very clear. Participants were
informed that the interview session would not be a therapy session, and I had to be
mindful to keep the interviews focused on the interview questions.

Clear agreements were discussed and must have been accepted by the
participants. Participants were briefed about the purpose of the research and understood
the possible risks that they may face due to being part of the research. Participants were
informed that if any emotional reaction occurred or if they were triggered by a memory,
they would be given the name and phone number of a therapist who would help them
address any lingering issues that may surface. Participants were notified that they may
drop out of the research at any given time without any consequences.

“Human science researchers are guided by the ethical principles on research with
human participants” (Moustakas, 1994, p.109). An informed consent was reviewed and
signed by all participants. Participants were told all information would be confidential,
and all data and transcripts would not contain personal identifiers. For this research
manuscript, participants were assigned a letter and a number to protect their identity. In
addition, all data and interview transcripts are protected on a personal password locked computer, of which only I use and know the password to. As mentioned previously, due to the belief that addiction is never cured but can only be treated, adequate referral resources would have been provided for those who needed it. None of the participants reported feeling negative emotions during the interview process and none of them reported that they were triggered as a result of the interview questions; therefore, none of them needed to be referred to a therapist.

A digital voice recorder was used to record the interview. I did not take notes during the interview but did note important non-verbal body language for the participants who interviewed face-to-face. For phone interviews as well as face-to-face interviews, different font colors were assigned for pauses, escalation in tone, and rapid speech during the transcriptions. After completion of the study, the recorded interviews and written transcriptions will be saved for three years before being destroyed using the terms stated in the IRB protocol.

Establishing a supportive, non-threatening environment, while remaining culturally sensitive without establishing stereotypes and/or labels allowed the opportunity for participants to disclose their experiences of the phenomena as openly and honestly as possible. Interviews were conducted in a large office that provided comfortable chairs, with easy access to a rest room. Bottled water was provided. As mentioned previously, face-to-face interviews were scheduled after 4:30pm Monday through Friday to protect the confidentiality of the participants and the clients attending program at the center where the interviews were conducted. Phone interviews were scheduled when the participants were available. Interview sessions lasted about 60
minutes. Participants were not given their transcripts for review because I wanted to make sure all participants were emotionally well when disclosing their treatment histories. Providing the transcript for participant review may have placed the participant in an emotional situation that may have increased the risk of negative emotions or trigger exacerbation of symptoms. The safety of the participants with minimal risk was important to me.

**Credibility and Validity**

Qualitative research is subjective research open to differing interpretations. I have attempted to make it very clear throughout this manuscript that I have been exposed to addiction for many years and have been a therapist in multiple treatment facilities for about fifteen years. Bracketing in Chapter 1 disclosed some of these experiences and hopefully exposed some of the biases that may present throughout this research manuscript. In addition, before each interview, I made sure to meditate and clear my mind, focusing on removing any preconceived ideas that I had as a result of my own experiences. Reflective listening is a skill that is taught to all well rounded therapists. Even though I was not doing clinical work during these interviews, the ability to reflectively listen while showing compassion and empathy provided participants a safe, non-judgmental environment. Reading and re-reading the manuscripts to ensure that the essence of the participants’ experience was captured was necessary so accurate information could be disclosed. The goal is to shift some of the ancient stigmas and treatment modalities, so an appropriate evolution can take place in the treatment field.

The data analysis from the interview transcripts combined with the literature review and theoretical analysis provides reliable information and raw data with the
purpose of enhancing the knowledge of those suffering with the disease of addiction. In addition, it has the potential to enhance the knowledge of those working in the treatment industry. Very little qualitative data has been completed that focuses on the treatment experience of opioid addicts. With new information being disclosed that shows the dark side of treatment, more needs to be disclosed about what methods increase recovery rates and what methods decrease recovery rates in the treatment process. The individuals struggling with addiction clearly are in conflict with themselves, one side wanting to resume their addictive lifestyle versus the other wanting to find a new, healthy way of life.

**Summary**

To gain a better understanding of what intrapersonal and interpersonal conflicts are present when an opioid and heroin addict enters a treatment center, transcendental phenomenological research concentrating on the description of the experiences (Creswell, 2007) was determined to be the best method. This psychological phenomenological study utilizes 16 interview questions obtained from six female and nine male participants totaling fifteen participants. Throughout the recruitment process, mandatory signed consents, confidentiality disclosures, data collection methods, and data analysis IRB protocols were followed with the main purpose of protecting all participants involved utilizing ethical procedures by Moustakas (1994).

The hope of the study will be to increase academic as well as non-academic literature on the intrapersonal and interpersonal conflicts opioid addicts face while in treatment. For an actual addict, the idea that one can just stop getting “high” is absolutely absurd without specific, life altering techniques as well as a “will” that is ready to
transform the soul. The process of altering one’s lifestyle requires information from people who have lived it. By discovering common themes from those who have lived the experience, this study will hope to highlight areas within the treatment field that have not been explored or have been minimized as a critical component within the recovery, transformational process.
Chapter 4: Data Analysis and Findings

Chapter three explored the methodology and the methods utilized to orchestrate the research. Chapter four reports the findings that answers the question: What are the intrapersonal and interpersonal conflicts opioid addicts are presented with during their treatment process? The analysis of the answered interview questions applicable to the research question will be reported where relevant. To determine the overall theme of this phenomena, the steps of Transcendental-Phenomenological Reduction were incorporated.

The initial process involved transcribing the interviews which created an overall theme of the phenomena. The second step included reading and re-reading the interview transcripts to develop textural experiences creating horizontalizations of each participant. Significant statements were then obtained for the purpose of finding meanings. The fourth step separated the meanings into five identified thematic categories, each describing corresponding sub-categories. Figure 6 illustrates the format of the radial Venn diagram used to depict the thematic categories and shows how the themes overlap and interconnect in terms of the overall experience. The fifth step reports on the patterns of the participants’ statements that correspond to each thematic category. The participants’ verbal responses are shared verbatim in an effort to reproduce the patterns of the actual lived experience. The final step involved illustrating the textural experiences found in Appendix E. These were created through horizontalization and they embody the descriptions of the phenomena through the mind of each participant.

Each participant presented to the interview process with their own ideas of what they hoped to get out of treatment. In order to gain some insight into the diverse personalities, a brief profile of each participant is important to disclose to gain a better
understanding of the individuals who have beat the statistics and are overcoming a phenomenon that has plagued our country.

**Brief Profile of Participants**

Participant Henry is a 29-year-old male from Florida whose drug of choice was heroin. He began his addictive behaviors as young child when he would steal his best friend’s toys and sell them. The use of mind altering substances began around the age of 13 when he started smoking cigarettes, progressing to marijuana and alcohol. At 16, Henry tried both cocaine and heroin when introduced to these substances by a girlfriend. This is when his life changed paths and the drugs became a priority, destroying many aspects of his life for over a decade. After multiple treatment attempts, Henry has been sober for five years now. He is married and has a 2-year-old son who he adores. He is working in Orlando, Florida at a five-star hotel and continues to attend meetings while helping other addicts searching for recovery.

Participant Mary is a 26-year-old female from Florida whose drug of choice was heroin. She began using around 16, but she started experimenting and using recreationally at 12-years-old. Mary talked about always feeling awkward and believing that the people in this world were “scary”, using drugs to feel more comfortable in an uncomfortable world. She shared that she would tell herself she got high because she “hated” herself and what is the point of getting sober if “I don’t like who I am”. When Mary realized that it was not physically or emotionally possible for her to feel any worse than she did, and when she recognized she had no more fight left in her, she made the decision that she wanted to get sober. Mary has been sober for two years. She works in a
treatment center in Florida and is a powerful sponsor in AA helping many struggling addicted women.

Participant Sue is a 30-year-old female from Florida whose drug of choice was heroin. Her addiction started around the age of 20, the same time she met her future husband who she quickly learned had stage four cancer. He was being prescribed opiates for pain, and she would steal them occasionally to numb the pain of watching her husband slowly dying. He was given six to ten years and ended passing away on the sixth year. She shared that she became addicted to opiates because it numbed the pain of her reality. She explained that once her body became addicted to the drug, she became powerless over using it. Unfortunately, the opiates became too expensive, so she turned to heroin to get a more intense high that was less expensive.

After four treatment attempts, Sue embraced recovery and has been sober for two years. She has a beautiful one in a half-year-old daughter and is getting married to the father of her child in May 2018. She works in the treatment field and is a very active member of AA, mentoring struggling women who suffer with drugs and/ or alcohol addiction.

Participant Jan is a 28-year-old female from Florida whose drug of choice was heroin. She shared that she does not have many memories of her childhood but believed her addiction began when her brother passed away. She was in college at that time and went straight to heroin, admitting that there was no progression of less intrusive drugs. Jan spoke of how her body quickly became dependent on the substance and she used it to cope with the depression and anxiety she was feeling at the time. Having over 15 treatment attempts, she shared that the transformation shifted when the perspective about
herself shifted. She shared that treatment was a “stepping stone” for her and her recovery would not have been possible without it. Jan has been sober for five years and works in the treatment field in Florida with the specific task of placing addicted individuals in treatment.

Participant Jake is a 26-year-old male from Florida whose drug of choice was opiates. He shared that his addiction started when he was 15 after being prescribed Vicodin for a concussion. He admitted to immediately liking the way Vicodin made him feel and quickly began abusing it. Once his body became addicted to the substance, he believed he had no control over its use and the power of choice was removed. Jake reported two treatment attempts, the first was a state-run facility and the second a private treatment program. Being ready and wanting treatment is a huge factor in gaining recovery according to Jake. He believes that one must commit and commit daily to their recovery. Jake has been sober for three years and is working in the field of addiction in Florida helping struggling addicts find the help they need.

Participant Albert is a 27-year-old male from Florida whose drug of choice was Oxycontin. He started his addiction around the age of 13 when he stole Tramadol from his father. He shared that he liked the way they made him feel but had no idea that they were a synthetic opioid and was not aware of the short or long-term effects that would soon take place. He eventually progressed to Oxycontin which ultimately became his drug of choice. He was in denial for a long time trying to stop on his own. He was admitted to 45 detoxes and has had four treatment attempts. He shared that he did not like himself and was trying to hide the fact that he was ashamed at what he had become. Albert admitted that he does not know if he could say his sobriety is a direct result of
treatment and believes working the 12 steps with a sponsor and going to meetings is what transformed him. Albert is a grateful recovering addict who has two years of sobriety. He continues to attend AA meetings, has sponsees, and speaks regularly at treatment centers telling his story to addicted individuals all over Florida.

Participant Emily is a 27-year-old female from New Jersey who began her addiction at 15. Her drug of choice was opiates, mainly Oxycontin. She shared that she always struggled with anxiety and the drugs helped her cope throughout high school. Prior to her addiction, Emily reported that she was a cheerleader and a dancer but always felt like there was something missing. As a result of the numbing feeling the substance provided, she began taking more of the substance until she was unable to control her use. By about 16, Emily dropped out of cheerleading and dance and began using daily, until she was arrested. Emily reports one treatment attempt believing that leaving New Jersey to come to Florida would not have happened had she not been arrested. She is one of two out of the 15 participants who is no longer attending AA or NA support groups. Emily is two years sober and is a computer technician for a treatment center in New Jersey.

Participant Angie is a 24-year-old female from Florida whose drug of choice was heroin. She shared that her addiction started around 13, when she had her first sip of alcohol and started hanging out with the wrong people. She shared that she was bullied in school and this completely put her in an emotionally dark place. Angie admits to sniffing her first bag of heroin at 14, going from recreational alcohol use to heroin use quickly. She shared that she did not care. She was struggling with body issues, resentments towards her mother and would party every weekend. This lifestyle sent Angie on a journey that included over 15 treatment attempts. Angie shared that after her first three
weeks of staying sober at her last treatment center she obtained a sponsor and began working the 12 steps. After she completed her 12 steps, Angie shared that she began to sponsor young women, and this helped give her a purpose and provided meaning in her life. At the time of this interview, Angie had been clean and sober for one and a half years. She has since relapsed and is living in Connecticut, homeless and actively using heroin.

Participant Carl is a 28-year-old male from Florida whose drug of choice was heroin. He explained that he began smoking marijuana and drinking alcohol at the age of 11. He shared that he sniffed his first bag of heroin at 18 and was using this substance intravenously by 21. Carl could not recall the amount of times he went to treatment estimating about ten attempts. He shared that the experiences and relationships he had with staff and peers changed drastically between his first treatment attempts to his last. The power of interpersonal relationships between staff and client is what enabled Carl to continue with his sobriety. Carl expressed strong feelings against the stigma that has been placed on addicts when talking about how addicted individuals get treated by society and how this enables struggling addicts to stay sick. Carl has been sober for three years. He lives in Florida and is working full time at a treatment center.

Participant Randy is a 24-year-old male from Florida whose drug of choice was heroin. He reported growing up in a loving home receiving everything he needed and shared he had a great relationship with his family. He shared that he started with alcohol and marijuana as an early teen but realized he was an addict around the age of 21. He shared that he recognized he could not stop using heroin and was unable and struggled with feeling emotions. Randy reported five treatment attempts. He shared that by the last
attempt, he realized that treatment was about getting him off the streets, so he could clear his head. He shared that not everyone in treatment wanted treatment and a big part of his motivation relied on the peers he aligned with. Randy reported that working the 12 steps and being a part of a fellowship is what got him sober and what has kept him sober. He shared that he has transformed in multiple ways because of his treatment experiences. Randy believes that treatment was necessary for him because it pulled him from the streets and away from society. Randy has been clean and sober for one and a half years. He is very involved in AA and is working with sponsees, guiding them with their recovery process.

Participant Cole is a 26-year-old male from Florida whose drug of choice was Oxycodone. He reports feeling “different” throughout his childhood and never felt that he was accepted. He shared that he began his addiction at 14-years-old. Cole shared that he felt accepted aligning with other addicts due to the stigma addicts had in the southern state he grew up in. He shared he found comfort in the opiates because they numbed his feelings and allowed him to continue with his addictive behaviors. Cole explained that his body could not handle the toxins he was ingesting, and he almost died, believing that this was the catalyst that enabled him to decide to change his life. Cole reported one treatment attempt. He shared that when he entered treatment he surrounded himself with people that could help him think differently. Participant Cole has been sober for 2-years. He works as a behavioral health technician at a treatment center in Florida. He is very involved in the AA community and sponsors men who are struggling with addiction.

Participant Amy is a 25-year-old female from Florida whose drug of choice was heroin. She shared that she never really felt like she fit in and began experimenting with
marijuana and alcohol around the age of 13. She reported that she began taking opiates around 14 and progressed quickly to heroin. Amy made it clear that she never intended on becoming an addict. She expressed that once her body became addicted she could not stop. Believing she had a problem was a conflict Amy struggled with for a year. To resolve this conflict, Amy would mentally convince herself that she was not like other addicts. Creating separation internally and externally from her peers kept her sick by denying the severity of her circumstances. Extensive legal history, extreme family conflict, and inability to communicate effectively is what convinced Amy she was ready to change. After multiple treatment attempts, Amy has been sober for 2-years. She is an active member of AA and sponsors many women struggling with drug and/or alcohol addiction. She speaks all over Florida sharing her testimony to other addicts. Amy works at a treatment center in Florida and visits her family in New Jersey often.

Participant Bob is a 28-year-old male from New Jersey whose drug of choice was heroin. He began smoking cannabis and drinking alcohol at the age of 14, progressing to heroin by the age of 20. He shared that he was initially in denial about the severity of his addiction but quickly began to accept that he had a problem when his use progressed. Bob had six treatment attempts believing that gravitating towards the wrong people is what kept him active in his addiction. The relationships he formed with negative peers and relationships he had with female peers distracted him from the work he needed to do so transformation could occur. He shared his life had become so unmanageable and this is when he finally came to the realization that he wanted to get sober. It was after this realization that Bob began taking suggestions. He believed that once he began learning about the 12 steps and living according to the principles, true evolution began. Bob lives
in New Jersey. He is very active in AA and has been sober for one and a half years. He is very involved in the fellowship and sponsors males, guiding them through the 12 steps.

Participant Cody is a 27-year-old male from Florida whose drug of choice was heroin. He reported that his addiction started when he was 14-years-old after being prescribed opiates due to a dirt bike accident. He shared that five years later, he began injecting heroin. The decision to come to Florida for treatment was his decision. He reported internal and external conflicts starting when he got on the plane from Ohio because his parents did not want him to leave. He shared that they were worried because of the bad press coming out about treatment centers in South Florida. He shared he felt guilty about leaving his family and was fearful that treatment wouldn’t work.

Cody had one treatment attempt. He shared that he believed he had no other choice but to get sober. Because Cody entered treatment with the mindset of “I have to do it”, he gravitated towards other clients who were serious about their recovery. He reported that obtaining a sponsor and working the steps is what taught him a new way of life. Cody lives in Florida and is very involved with his family who are now grateful that their loved when went to treatment. He has been sober for four years and continues to attend AA meetings and sponsors men struggling with addiction. He presently works in the treatment field continuing to guide others towards their transformational process.

Participant Ben is a 29-year-old male from Florida whose drug of choice was heroin. His addiction began at 10-years-old when he started smoking marijuana progressing to cocaine and opiates at 12-years-old. By the time he was 14, he was injecting heroin. He admitted that when he first went to treatment he did not want to get sober and went because he was court mandated to go. Due to this mindset, Ben had a
difficult time connecting with the staff and related more to the clients, listening to their suggestions while defying the staff. It was not until Ben was facing long term prison time that he decided to take some of the suggestions that was being asked of him. During his last treatment attempt, Ben went from pre-contemplation stage of change to preparation stage of change. As a result of trusting the staff and the process, he was able to put his guard down and allowed himself to believe he could live a sober life.

After completing treatment, Ben reported that he became very active in the 12-step fellowship. He continued treatment for another four months and lived at a male sober living facility for a year. Ben has been sober for nine years. He continues to attend AA meetings and is actively involved in the fellowship. He sponsors many men struggling with addiction and works in the field of addiction in Florida.

The summaries above allow for the reader to gain a better understanding of the participants by providing a brief introduction to when their addictions began, their drug of choice, and where they presently are in their recovery process. In addition, their length of sobriety, and how the participants are giving back to other sick and suffering addicts was something that all participants mentioned as a part of their recovery journey. Below is an expanded discussion of the themes, beginning with thematic categories of the opioid addicts’ treatment process.
Thematic Categories

The overreaching essence of the treatment experience is the journey of identity transformation from active addict to addict in recovery through conflict management. The essence embodies all of the participants regardless of their socioeconomic background, age, culture, or gender. All participants interviewed had been sober for minimum of a year; therefore, their experiences during their treatment stays were a memory. All participants at the time of the interview were living in accordance with the 12 Step Principles of Alcoholics Anonymous and all were giving back to other suffering active addicts. The conflicts were discussed in the interviews, but their focus was not primarily on the conflicts but the resolutions and solutions they have lived by and continue to live by. Therefore, the essence of the actual experiences depicted in the five themes was reported after the resolution of the conflicts faced, possibly minimizing the intensity of the experiences.

Figure 7. Thematic categories of the opioid addicts’ treatment process.
Theme 1: Identity Formation

The first identified theme is Identity Formation. Participants shared their lived experiences of changing their identity of the self through the treatment process. The theme Identity Formation is divided into three sub-themes (see figure 8). The first sub-theme explains the perception of the self when believing oneself to be an addict. This sub-theme explains the power of how negative views of the self creates intrapersonal conflicts enabling the addictive lifestyle to continue. Separation, the second sub-theme, characterized how the participants needed to be physically removed from their environments, explaining the power of people, places, and things. All of the 15 participants disclosed how they could not have gotten sober had they not left the environment in which they were using drugs.

The third sub-theme is identifying the self as being in recovery. Perceptions of the self can either create intrapersonal characteristics that one can be proud of or not. Participants were very clear about the importance of self-perception and how changing one’s identity will change their external world. The theme identity formation helps to answer the question of how intrapersonal conflicts manifest during an opioid addict’s treatment experience. It also helps to explain the power of changing personal identity from an intrapersonal conflict and resolution perspective.

Figure 8: Sub-themes under Identity Formation.
Sub-theme 1: Addiction. Believing oneself to be an addict does not necessarily mean that individuals are actively using drugs. Many of the participants viewed their problem as being a thinking problem, using opioids as their primary coping mechanism to feel better emotionally. Maintaining an addict identity unfortunately resulted in multiple relapses for 13 out of the 15 participants throughout their recovery journey. The process of altering identity created intrapersonal conflicts that manifested into continued negative behaviors. The statements below explain the numerous ways identifying the self as an addict is portrayed.

I think what it means to be an addict probably is bondage of the mind. It’s feeling like your mind is in prison. To be powerless is bad thinking. All of these things come to mind when I think of being an active addict. (Bob, age 28, DOC heroin and cocaine).

Ben, a 29-years-old male whose DOC was heroin shared his idea of what it means to be an addict and reported:

For me, an addict not only applies to drugs and alcohol, but it applies to everything. It’s a mental thing for me. I can do everything in excess. I was addicted to the gym for many years, two hours a day. But as far as an actual substance, addiction for me, today, I know that if I do any form of substance I’m in trouble because I can’t stop once I start. When I use, I end up doing terrible things. I end up in really worse situations.

Other participants talked about believing they are powerless over their drug use and behaviors. Jake, a 26-years-old male whose DOC were opiates and heroin explained:
I mean, more or less, that I, who is the addict, do not have the choice of whether I use or don’t use. The power of choice is removed from me and everything addiction related becomes priority whether it’s the lifestyle or the using itself.

Henry, a 29-years-old male whose DOC were opiates and heroin addict shared:

Um, for me it was that I had no control over the substance I was putting into my body. Whether it was a substance or action, I believe you could be addicted to anything and to other things besides drugs and alcohol.

Jan, a 28-years-old female whose DOC was heroin mentioned in the following statements:

I became an addict when I couldn’t seem to put it down. Mine is really physical, but it was also very mental for me.

Angie, a 24-years-old female whose DOC was heroin shared:

It’s never enough and there’s something that just keeps you going with it … you can’t stop! There were days when I literally said I’m going to stop, but I just couldn’t stop. Because without the drug, what do you have? You get so far gone that you just keep going. It’s like all or nothing when you’re an addict.

Many participants also shared how prevalent manipulation is to someone believing themselves to be an addict. Bob, a 28-years-old male whose DOC was heroin and cocaine explained:

I was the guy that did everything right in treatment, except I would always break one rule. Whether it was fraternizing, not having food in the facility, not starting a relationship. I always broke one of the rules. This was my form of manipulation.
While explaining her idea of identifying as an addict, Jan shared how her continued identification did not allow her to transform.

The problem was I kept relapsing because I had a big ego. I’m able to build relationships with anyone, so with staff it was good. I was also very manipulative.

I got it down to a science. I did great when I was in treatment, but I still wanted to do things my way.

Identifying as an addict made it difficult for many participants to alter their identities. Avoiding the intrapersonal conflicts by continued use only exacerbated their negative consequences.

**Sub-theme 2: Separation.** All participants separated from the environments that they were using in. Treatment forced the participants to separate from their old environments and actively drug using peers. Half of the participants mentioned separation as an integral component of the identity transformational process. The statements below explain the importance of separating from biological, psychological, and social perspectives:

For me, treatment was absolutely necessary because I wouldn't stop without being pulled out of society. Being put in a facility where I could be safe, not use, and actually clear my mind a little bit. So, for me treatment was a necessity. I would totally recommend treatment. One thing that I've learned is that treatment was good for the physical abstinence from the drugs and alcohol but that's pretty much it was all good for. (Randy, age 24, DOC heroin)

Another participant shared:
I believe in the power of treatment because it's part of my story. I believe in it because it's a benefit to a lot of people. At the very least it gives people an opportunity of a couple months of sobriety and takes them off the street so they can at least think about if they really want to get sober or not. Benefits that come from treatment, I just don't have the experience from the benefits because like I said, I never went into treatment wanting to stay sober. I wasn't ready to be sober. I know at the very least that it allows people the opportunity to make a decision for themselves due to the weeks or months that they're in a controlled environment. So, they can decide if they're going to be ready to put the work in.

(Jake, age 26, DOC opiates and heroin)

After more than six treatment attempts, Jan (age 28, DOC heroin) stated:

To be honest you know the groups aren't that big. Hearing the same things after five or six treatments wasn't that big, but the separation from the drugs and the alcohol was big for me.

Amy, a 25-years-old female whose DOC was heroin and crack cocaine shared how treatment was part of a process that she needed to transform her identity.

Treatment is almost like a little stabilization period. It's like you want the drugs to get out of your system, you get your head straight, and then once you pass that part of it, I think it's what you do after treatment. Treatment like prepares you to go onto the next phase which I think is the most important.

Sub-theme 3: Recovery. All of the participants identified themselves as being in recovery and shared qualities they must live by in order to maintain identifying themselves as being in recovery. The personal perspectives are based on their own
subjective ideas of who they believe themselves to be in recovery as well as the behaviors and social groups with which they align. The following statements explain the participants’ perspective of identifying themselves as being in recovery:

I’m definitely more sincere and humble with things. I think before I lie now.

That’s part of the old addiction. Like before I wouldn’t consider a white lie to be a bad thing. Now, I actually think about it. (Henry, age 29, DOC opiates and heroin)

Sue, a 30-years-old female heroin addict in recovery stated:

Oh wow (laughter), when I came in, I was a little street talking disrespectful lost sad soul, and now I'm really like, I am a woman of integrity. I try to better myself on a daily basis. I'm a family member. I'm a mother. I am living a life that I never knew I had in me. To see where I came from and to see where I am now. I would say that I impact people not only with my testimony, but I'm constantly active with helping women and others, especially women.

Amy (age 25, DOC heroin and crack cocaine) explained how identifying herself as being in recovery is a form of self-actualization.

I don't know how to word it. It's really cool because normal people don't get to experience like these principles. I work AA. People don't get to live by the principles that I get to live by. And then you know, it's like some people don't know that you're in recovery, and they don't know that used to be like this crazy person, and it's like you have this other chance at life.

Wanting to know more about the Principles, I asked Amy what are some of the principles that you have to live by?
Like having integrity, like doing the right thing when no one's around. Being brutally honest with myself and with others. You know, admitting when I'm wrong. Typical things that people would normally not want to do.

Half of the participants explained how identity transformation is a process that does not happen overnight and depends on a high level of self-awareness. In addition, the desire to be a productive member of society is stressed multiple times. Randy (age 24, DOC heroin) shared:

Doing recovery is me becoming the man I'm supposed to be. You know once I started using drugs and started drinking heavily, I couldn't deal with anything in life. I ran away from all my problems. You know; the more I get sober, I feel that I as long as I do the right thing, I'm becoming more of a man. The man I'm supposed to be. Not that I'm a strung-out heroin junkie. So, I mean progressing into a productive member of society. Not being that same person that I once was.

Ben (age 29, DOC heroin) explained his experience:

For me, being in recovery is not just abstinence from drugs or alcohol. For me abstinence is a complete change of life. I couldn’t live the same way while I was using. I just need to be a better person, a better human being, a contributing member of society. I want to be able to help people, and that’s why I think some people in early recovery struggle. The change doesn’t just happen overnight.

Cole, a 27-years-old whose DOC was Oxycodone reported:

Recovery to me (pause) it's like (pause) you're living another lifestyle. When I came down here in my recovery it was like I was born again. I changed my people, places, and things right off the bat. When I came down to South Florida, I
used it as a way to change my thinking. I had to figure out how to go without using a substance so I could live in today's society.

**Theme 2: Stigma**

The second theme intertwines with identity formation by the belief systems the participants held about the self and how these belief systems stagnated or propelled their recovery process. In addition, societal ideologies about addiction only perpetuated the addictive mindset creating barriers when attempting to change identity. When the participants identified themselves as an addict, feeling powerless triggered a victim mentality. Fortunately, conflict is a catalyst for change; however, the direction one chooses to change is up to him/her. Figure 9 divides the theme stigma into two sub-themes: self-stigma and societal stigma.

![Stigma Diagram](image)

*Figure 9: Sub-themes under Stigma.*

**Sub-theme 1: Self.** Fourteen of the fifteen participants reported that their addiction started in their early teens with one participant reporting her addiction starting in her early 20s. All of the participants created negative beliefs about the self that started at a very young age. The decision to enter treatment was the first step that included taking responsibility for their lives. However, beliefs about the self-made it difficult for the participants to break free from habitual thinking patterns that kept them identifying as an
addict. The following statements depict how self-stigma created intrapersonal conflicts that many times led to interpersonal conflicts.

I hated myself and I couldn't seem to grasp what my life would be like without drugs. It was like a constant battle with myself and then on top of that having an enabling mother that wanted to do everything for me because she lost a child to addiction. It was hard for her to say no to money. She was going to get me an apartment under her name. All this stuff. I was just very enabled, and it was just a constant battle between me, myself, and my family members. (Jan, age 28, DOC heroin)

Another participant shared:

The biggest conflict with myself while I was in treatment was actually getting to treatment. I would start thinking about the things that I'd done right before I would get in. I started focusing on damage that I had done throughout my addiction, and it would just turn in my head, and I would feel really bad about myself. That would actually make me want to get high more, which made me resist treatment. I always try to get out of myself and be distracted because I didn't want to face me. So that was the biggest conflict with myself. (Bob, age 28, DOC heroin and cocaine)

Angie (age 24, DOC heroin) shared how her self-stigma started around 14-years-old and it brought her to a place of not caring.

When I was about 14, I sniffed my first bag of heroin. I really went from nothing into everything. With that came a lot of Xanax and Percocet, and I would
do whatever, I just didn't care. On the weekends I would just party. I was barely getting by, and I just didn't care anymore. I felt that that's what life was all about, and I would tell myself why try to be something better. I was like the problem child. I started getting into a lot of bad relationships too and that's when other drugs were introduced and that's when heroin came back.

At 16 things got really bad and that's when I went to my first Intensive Outpatient Program. I didn't really understand what was going on. I just thought I needed a little help to stop. When I was 16 I got alcohol poisoning twice. I didn't realize it was that bad. At 17 it got really bad. It was just rehab and treatment centers, and it got really hard after that.

Mary, a 26-years-old female whose DOC was heroin explained how self-stigma sustained a victim mind-set that made it difficult for her to move forward in her recovery.

If I don't get a job, let's say I go for an interview, and I don't get a job. It's like I'm a piece of garbage, and no one will ever hire me, and a whole slew of this negative perception. Like a normal person might be like, oh you know, I don't need that [job]. Normal people are not so self-loathing.

Conflict is a catalyst for change. Unfortunately, it is up to the individual to decide which path to take. The responses below share how conflict either moves one deeper into the addict lifestyle or brings one to the point of being sick and tired. Henry (age 29, DOC opiates and heroin) explained the following:

Like I had all these goals that were going through my head. The biggest one, if I die right now, my impression on this Universe is going to be nothing.
Like you know, at the time, my 25-years I’ve been on this planet, I’ve accomplished nothing. That was eating me away. It’s like I’ve done nothing with my life other than use drugs and be a low life, and I didn’t want to leave this planet like that. Pushing through was hard, you know like, I, I couldn’t even sleep and that was like my go to thing.

**Sub-theme 2: Society.** Unfortunately, the science and academic world is still trying to understand addiction and the best ways to treat it. Society has it’s own viewpoint on addiction to which addicts are sensitive. Resolving their own stigmas is just part of the transformational process. Resolving their personal reactions to society’s stigmas is another. The influential power of feeling safe and not feeling judged in the environment where they received treatment was expressed frequently. The following statements capture this mindset:

Setting daily goals for myself but really just talking to other people who felt the same way I did really helped. Having someone listen, because coming from my hometown you're either an addict or you're not, and they really treat addicts bad. If you're an addict, there is no help, you just are. It was the label you were going to get for the rest of your life. I think being down here and seeing other people suffer from the same disease, same lifestyle that I did, and they could relate helped … all I ever wanted was to be accepted. (Cole, age 26, DOC oxycodone 30s)

Another participant explained:

I was in a lot of state-run facilities, and they didn't care where we went after
that. They were just there for a paycheck. So that was my first few years of treatment. Until I came down here and was scholarshipped into a private treatment place. That's when I realized that people actually do care. The other places just looked at you like you were going to fail no matter what. (Sue, age 30, DOC heroin)

Like many participants, it took Sue multiple treatment attempts to live a recovery lifestyle. When around caring individuals, the belief about herself changed, because those around her believed in her.

Henry (age 29, DOC opiates and heroin) shared a treatment experience when he believed he was stigmatized by the doctor at the treatment center to which he was admitted.

I couldn’t sleep, and I remember I had like a restless leg, and um you know, every night I had the same problem, and they put [me] on this medication. I kept telling them that I think the medication is giving me this, because before I was on this I never had it. And the doctor was like no, there’s no symptoms of this. No symptoms that it causes this, and you know, telling me to take it and to get over it. It was like I had no input into it. Like you know, take this or suffer. You know, and to me, that’s like a person that just, you know, you go to the doctor cause you have an ailment, and they just prescribe you something and tell you to leave, instead of getting down to the root of the cause.

Participant Mary (age 26, DOC heroin) shared her experience of how she had to overcome societal stigmas and move forward, regardless of what the world thought.
I was like only nine months sober, and I was with my family. I was in a halfway house, and I went to visit them at their hotel, and I fell asleep. And I woke up and my dad was furious. He thought I was high, and he thought I nodded out. I wasn't, and I got so upset, and I went back to my halfway house. This woman said to me that is your burden to bear as an addict. People will always look at you like that even if you have 15 years, people will look at you like that. They will chalk it up to she's weak or she's a drug addict. She said that it was like my job to hold my head up and keep my head up high even if the world wasn't going to.

The theme of stigma was something that all of the participants struggled with during active addiction. Aligning with people who continued to partake in addictive lifestyles limited the interpersonal relationships that had the potential to teach new way of coping and living. Separating oneself from the environments that fed negative thinking was detrimental for all participants so that stigmas no longer held them captive.

**Theme 3: Interpersonal Relationships**

The third theme, interpersonal relationships, explains the importance of how external connections have the capacity to create internal change. Treatment facilities carry a diverse population that have the potential to affect the transformational process from active addict to an addict in recovery. All the participants discussed relationships they had with the treatment staff, their peers, their families, and interpersonal relationships with fellowship members. Some of these relationships influenced positive change and some enabled the addictive behaviors to continue. Figure 10 illustrates the four sub-themes that explain the importance of interpersonal relationships.
Figure 10: Sub-themes under Interpersonal Relationships.

Sub-theme 1: Staff. All the participants had no choice but to interact with treatment staff while in treatment. This sub-theme explains the importance of staff’s role in guiding addicted individuals to see themselves as something other than an addict. Most of the participants struggled with connecting to non-addicts in general so the leadership style of therapists and behavioral health technicians was a primary component in their transformational process. As one participant explained:

The staff, they played a major role the last time I went to treatment. I don’t know how many times I’ve been in treatment, but it’s probably been about 10 times. The last time I went to treatment the staff played a big part. They were people in recovery. The staff playing a role. The ones in recovery. The ones not in recovery. The way they carry themselves. The way they made me feel, accepted and normal, and like I could have a regular conversation whether recovery based or not. They made me feel more at ease and able to open-up my mind a little bit more and feel accepted. (Carl, age 28, DOC heroin)

Sue (age 29, DOC heroin) shared her experience with staff stating:

I was pretty resistant at first; and well, I had a few different therapists. One
of the therapists that I [had] was working with me, you know, she was just
determined to love me until I loved it myself. And she just would constantly
tell me that she sees something in me that I didn't see in myself. She was
more like a coach, more like an encourager. She had a big part in my recovery.

I liked the staff to be honest. I felt safe with them.

Cody, a 27-years-old male whose drug of choice was heroin believed staff played a
significant role in his treatment experience.

My therapist was a big influence. You could tell that he was passionate.
You could tell that he wasn't there for the paycheck, and that he was a
genuine good person. You could tell that he was doing this because he
genuinely wanted to help others.

Mary (age 26, DOC heroin) discussed how her relationship with staff changed as her
desire to get sober increased.

I was never really the rebellious type against authority; that was not one of
my things. I was never like that. So I always got along good with staff
progressively. Really, my disease was just very strong, and I was just
going through a lot of stuff. I was getting more and more angry, and I
started clashing, well not like clashing with staff, but I was kind of
disregarding them. In my last treatment center, at the one I got sober,
those people are my angels. I was there for a long time and after the
initial anger had passed, the staff were amazing, and I would go to
them for everything. That's part of the reason I got into helping others,
because they made all the difference. I really believe that every single
one of them was there for a reason, but I didn't feel that way when I first got there. I love them.

Participant Mary came to recognize that when she began resolving her intrapersonal conflicts, her interpersonal relationships with the staff evolved.

Participants stressed the importance of staff attitude and behaviors. Thirteen of the fifteen participants had over five treatment attempts. That being said, the ability to distinguish between the genuinely compassionate staff versus the non-compassionate was mastered. Ben (age 29, DOC heroin) explained his experience by sharing the following:

I mean staff is different. You have your therapist, you have your case managers, and the relationships are different in each treatment center. It really depends on the staff member. I've had therapist who sit across the desk, and I don't want to say get personal, but for me, I need to know a certain level of someone, so I can open up. As far as like techs and stuff, it was easier to trust them because it's not like I have to go sit in your office. If I only saw a therapist in group settings and like individual sessions, it was hard to relate. But if we were like sitting in the hallway, and they just would come up to me and just like say hi and talk to me and ask me about my day, it showed me more that they cared as opposed to those that literally just sit in the office. I know treatment centers get busy and therapists get really busy with high client caseloads. But just from the clients’ perspective, if a therapist takes the time out of their day and see what the clients are doing, it just seems like they support people. It's like they support more, more than they’re in a position of power.
Cole (age 26, DOC oxycodone 30s) shared his experience of having to sit in a group with a facilitator he felt was not qualified.

We had one guy that was the tech in the morning groups. And this was one of the things I didn't like. He ran the group, and he talked about himself more than anything. It's nine o'clock in the morning, and we really don't want to be here an hour listening to someone who's not even specialized to run a group, and he's trying to talk to us about it. He said the same story every day. It was actually kind of sad. And then I started thinking well, why are we here if we're not getting the kind of help that we thought we was?

Having been admitted to more than five treatment centers, Jake (age 26, DOC opiates and heroin) summed it up with this statement: “I think a treatment center’s success is going to rely on the staff that is employed there. I think that has been something that I had seen and that defines a treatment center.”

The comments above demonstrates the importance of staff professionalism. The ability to have genuine compassion and empathy may not come as easy for some staff due to their own intrapersonal issues or boundary setting techniques. However, when an addicted individual is motivated to change, interpersonal conflicts may increase self-awareness, thereby changing destructive behaviors.

Sub-theme 2: Peers. Interacting with peers is another unavoidable relationship during treatment. There are both positive and negative influences in any treatment center. The ultimate choice of who one aligns with has the potential to either empower the addict mindset or empower the recovery mind set. Clients are from all over the country having
different cultures, different socioeconomic backgrounds, and different motivational levels. The one thing they all have in common is that they all lived an addictive lifestyle. This is how many of the participants bonded with their peers. Participant Albert (age 27, DOC Oxycontin) explained:

I do remember it being almost like an overnight camp. You know, all of the sudden you take however many people, it is 20 or 40 sometimes and even closer to 80. You have all of these people who never knew each other before, and a lot of people are just coming off the streets or like long term active addiction. Some people have been in and out of treatment a long time. Some people it's their first time. But the only way you can relate to like these people is through drugs. We talked about memories and tails of the street and where you got robbed, when you got arrested, and all of these things. It becomes glorified. I think in treatment, because it's like the easiest way to kind of relate to each other while kind of separating themselves from the staff.

Jake’s statements (age 26, DOC opiates and heroin) mirrored participant Albert’s experience stating:

They were very surface level relationships. I mean there wasn't much to discuss other than the addiction you know what I mean? That's all we really knew at that time that's all we really could like talk about or build a relationship. It was really on whatever addiction that you were coming to treatment with.

Henry (age 29, DOC opiates and heroin) discussed the diversity of individuals who would be admitted to treatment and the power of peer influences.
You find that some of the people in recovery definitely didn’t want to be there, or they’re lying. You know in the beginning when I first started going to treatments, I didn’t want to be there either you know. If there was something there, I would use it. In the end, when I finally had a clear mind I could see, a lot of people were still using in treatment and it affected me, and you know, I finally realized I was one of those people in the past. So, that had a big influence on the type of treatment I would give myself when I was at these places.

Bob (age 28, DOC heroin and cocaine) shared how his gravitating towards peers who were not interested in recovery kept him sick. He shared the following: “I tend to gravitate towards the wrong people. I always seemed to go with the people who weren't really serious about their recovery. I kept repeating bad patterns and relapsing.”

Two participants in particular attended long-term inpatient programs. Both participants began their programs resistant and guarded to all interpersonal relationships. Both mentioned how it took time for positive relationships to manifest. Once interpersonal relationships improved, the transformational process progressed. They shared the following:

The long-term treatment was amazing. It took me like 60 days to even be here and start doing anything. You know, but also, I am there, and we were talking about the feeling of community. I lived with these girls for like six months. We were a real community, and it was really nice. Especially because, like I was saying, I was like the black sheep of my family. Like they all talk, so I felt really accepted by this community. (Mary, age 26, DOC heroin)
I was in long term treatment and I would say 80% of the time I had zero relationships. I took my anger out on everybody. So, it wasn't until a big turning point in my recovery, and I knew people really cared about me that I started formulating friendships. (Sue, age 30, DOC heroin)

For these two participants, the intrapersonal conflicts they had interfered with their interpersonal relationships. Once they began resolving their internal conflicts, positive peer relationships could develop.

**Sub-theme 3: Family.** The interpersonal relationship with family and its impact on the transformational process from active addict to an addict in recovery was explicitly mentioned by eight out of the 15 participants. The resolution of family conflicts was a driving force towards the path of recovery. The following statements depict just how important family involvement was during the treatment process.

My last treatment center is probably the most positive thing. My therapist was kind of big on family interaction. My therapist asked all of my direct family members to write a letter to me and basically, they wrote how I hurt them. That was super impactful. My youngest brother was the one who hit me the most. He was like seven. It was literally just like he wrote I hope you get better. And like scribbled it out and then wrote I just want to see you soon. And it just hit me. It literally hit me that my youngest brother knows that I'm a mess.(Ben, age 29, DOC heroin)

Another participant explained:

I remember when I called my family right before I went to treatment. I called them saying I had relapsed again. When I did do that, I remember my father
freaked out on me, my mother started crying, and my dad pretty much said you're on your own. Don't call us and do what you have to do to get it right. You know, I had a couple phone calls in treatment. I reached out to them, but even though I wasn't the best client I was willing to do whatever it took to get out of treatment and try and stay sober. I did feel that genuine, I'm done. You know, I had to start building that trust back up that came very very very slowly. First couple of conversations with them was like, how are you doing? All right, and I just always said the same thing, but never really put any of the action into it. You know, I would say things like, I think I'm going to stay clean this time; and then, I wouldn't be able to do it. I would say, I know what to do but I would never do it. So that trust, I really had to put in work to build that with my parents again eventually. (Randy, age 24, DOC heroin)

Mary (age 26, DOC heroin) shared her family experience while in treatment.

I hate admitting this, but the family weekend stuff that we did was good. It was awful. Like my mom, dad, and sister crying for three days. But in a family like mine, as it is, me being an addict makes us talk even less. It was probably the only time I will ever hear them and see them be that genuine. It was really good.

Sue (age 30, DOC heroin) learned through family involvement she had more support then she originally assumed. She shared the following:

My biggest thing, I had been alone for a long time, and I really thought that I was in rival with everyone in the world including my family. So, to finally be broke, and to realize my family was there the entire time. You know, I
could establish relationships, and I could accept better than what I was allowing myself to have… The fact that they got my family involved in phone sessions, and when they were in town they always came by. They had a family program. They would stay in a hotel, and they would educate them and help to repair relationships.

The ability to trust her therapist allowed participant Emily (age 27, DOC opiates and heroin) to include her brother in her treatment process.

I kind of bonded with my therapist. He actually reached out to my brother who when I went to treatment, we were really in rocky water. He had him write me a letter, and I started bawling crying in front of the whole entire group. And from that point on, I believe that's when it started.

One participant shared how family involvement was a barrier. Angie (age 24, DOC heroin) had a difficult time involving her mother in treatment explaining the following:

Sometimes when they would get family involved. It was hard because my mom just didn't understand certain things. So, when my therapist would get my mom involved, it would make me kind of want to shut down a little bit. A lot of the problems were stemming from my mom, and my relationship with her from my childhood.

For all participants, including family in their treatment process was a risk. In order to resolve the interpersonal conflicts, the conflicts needed to be identified and not avoided. In addition, forgiveness is an individual choice. One of the goals of family involvement is to resolve family conflicts but, in many cases, resolution may be
extremely challenging due to the severity of the conflicts and the willingness of the clients and their families.

**Sub-theme 4: Fellowship.** All 15 participants were involved in either an AA or NA fellowship during treatment. Ten out of 15 shared that they established a strong connection to the fellowship and give credit to the AA principles and the 12 steps that the fellowship follows. Interpersonal connections to recovering addicts allowed the participants to witness others who had similar experiences, creating strong bonds through social identification. Once the principles were learned and the 12 steps completed, remaining a part of the recovery community is what they report has kept them sober. The following statements explain just how important joining a fellowship is during and after the treatment process to transform from active addict to an addict in recovery.

Meetings was a huge part. Another thing was keeping myself busy with work and with family. Keeping myself around a positive lifestyle. Before I always attracted myself to negative people. I thought I could get something out of them. If they may be using, and it was like a temptation. I would hold on to them so I had someone if I did want to use. This time when I got into the rooms I stayed around people. I saw people living honestly and they were serious about their treatment.

(Henry, age 29, DOC opiates and heroin)

Randy (age 24, DOC heroin) explained the following:

When I look back on it now the things that worked was going to outside meetings. That was a big thing for me because I tried every other way to get sober, but I never really worked a program. But while I was in treatment they would take us to
meetings, and it didn't push me away. It kind of drew me in because it talked about solution.

Jan (age 28, DOC heroin) shared the importance of completing the 12 steps while in treatment.

I made sure that I did the 12 steps before I left treatment and that's when the magic for me happened. I've done a lot of work even in my family. Helping people is really what has kept me sober. I attend two to three minimum AA and NA meetings a week. I picked up sponsees just like when I was using. Instead of picking up a drug, I'll pick up a girl and help her. I'll pick up a book and read it instead of picking up the drug.

Angie (age 24, DOC heroin) believed that an addict cannot be in recovery unless involved in a 12-step program.

To be in recovery for me means to be completely sober from all mind altering substance and to actually work the program. To have whatever be your higher power. It doesn't have to be a God. That's what I tell my Sponsees. Whatever you can use to work the program: To have a sponsor, to work the steps, to go to meetings. To truly be in recovery is to be involved in the 12-step program.

Jake (age 26, DOC opiates and heroin) explained the following:

I mean for me, what changed and what has changed my life is being involved in the 12-step program and being involved in the recovery community. Having a relationship with a spiritual entity. You know being of service. All of the typical things that are expected of being involved in the 12-step fellowship,
and this has given me the opportunity to get sober and stay sober.

Participant Albert (age 27, DOC Oxycontin) credits working the 12 steps and attending AA meetings for his transformational process from active addict to addict in recovery. He shared the following:

I don’t know if I could say if anything is a direct result of treatment because I’ve been out for so long now, but I think most of my personal changes have come more from outside of treatment. Like when I started doing the 12 steps. When I began to deal with life as a sober adult. So, I don’t know if I could say that anything was a direct result of treatment.

Ben and Mary’s statements encapsulates the overall importance of participants’ connection to the fellowship which was shared by more than half of the participants.

The good thing about the fellowship is accountability, the feeling of acceptance. When you’re 21, and you’re a junkie, people are like what are your hopes and dreams? They ask you and you have no idea. AA and NA gave me like a super list of the temporary goals that I could totally do that could change my life. It was like attainable for someone like me. It gave me a lot of self-esteem. It gave me a lot of Courage.

It gave me a lot of connections to really good people. (Mary, age 26, DOC heroin)

I am very active in the 12-step fellowship. I did sober living for almost a year and a half. After treatment, 12-step fellowship was a big part for me. I just have to stay connected to other recovering addicts. (Ben, age 29, DOC heroin)
A big part of the fellowship is guiding active addicts to a life of recovery. By choosing to live a life that is guided by spiritual principles, self-actualization occurred for all participants.

The theme interpersonal relationships were something that all of the participants were exposed to. Cody, a 27-years-old male heroin addict expressed how building relationships was one of the “toughest things for me.” Many of the participants worked with therapists on rebuilding family relationships. In order for this to happen, therapeutic alliances needed to occur to build a relationship of trust. Intrapersonal and interpersonal resolutions of conflict erased resentments, which historically kept many of these participants hostage to their addiction.

Due to the population and diversity of treatment communities, alliances are usually immediately formed amongst peers. It is through these alignments that transformation occurs, unfortunately many participants connected with active addicts during their first few treatment attempts, which kept them coming back to treatment due to relapsing. It was through fellowship connections that participants began believing in a new way of life. Ten of the 15 participants continue to be strong members of the AA or NA fellowship and continue to help other addicts striving to transform from an active addict to an addict in recovery.

**Theme 4: Group Structure**

This theme demonstrates the importance of group structure and how interactions with staff and peers during groups influence the recovery process. The main treatment modality in treatment programs is group work. The aim of this modality is to teach clients about addiction while learning healthy coping mechanisms. Intrapersonal conflicts and
interpersonal conflicts are addressed to educate clients on their personal responsibility to change toxic thinking. Interpersonal relationships with staff and peers force clients to learn their conflict styles with the hope of altering conflict styles suited better for recovery. Figure 11 illustrates the three sub-themes, which fall under group structure.

![Figure 11: Sub-themes under Group Structure.](image)

**Sub-theme 1: Gender.** Making the decision to try and live a life free from drugs and alcohol is not an easy decision. As mentioned previously, not all individuals who enter treatment want recovery. Those who want recovery will have to mentally battle habitual ways of living that they previously learned. Distractions are unavoidable but sometimes a welcomed reprieve when discovering the truth about oneself. Gender specific groups was mentioned frequently as being beneficial during the group process. One participant expressed just how important this was to his recovery process.

Another thing that was very beneficial was that we would have these groups where it was basically just gender groups. The guys and girls would split up, and there would be facilitators leading each group. We touched on topics that nobody really wanted to talk about when the males and the females were combined. So, separating the males and the females helped me a lot too. You know, they always
say that alcohol and drugs are a problem in treatment, but I also had a problem with relationships. One of the things that I had to work on was the rehab romance. When we were in gender groups and talked about that particularly, it really helped me. (Bob, age 28, DOC heroin and cocaine)

Female participant Jan (age 28, DOC heroin) had a similar comment sharing:

I did very well in like gender specific groups. That's another thing, when I really wanted to get stuff out, and I'm just around women, it was perfect because I didn't care how I looked. I could get a lot more out without worrying that I would be judged by a guy.

Amy (age 25, DOC heroin and crack cocaine) was very firm in her tone when she explained the following:

I also think that it's better to keep genders separate throughout treatment. First of all, when you come to treatment, you're already broken and you're shot. So, you're always going to want that validation from whoever. So, I feel that's why you could be more focused on yourself. And groups that were gender specific could let you do that. I would focus more on bettering myself then worrying what the guys thought of me.

Participant Mary shared that she could not get sober in a co-ed treatment facility. In the end, she admitted herself into a female only treatment center. “I can't get sober with guys. I tried. I'm just not my authentic self. Even being just at a woman's meeting, I really prefer that better. The co-ed thing for me is like the worst.” (Mary, age 26, DOC heroin)
Carl (age 28, DOC heroin) a male participant also struggled with co-ed groups stating, “Being in treatment with females, I found myself very distracted. That was a definite issue that I kept running into.”

The comments demonstrate that both male and female participants were able to focus more on themselves when not distracted by the opposite sex. Interactions between clients is inevitable, but many shared how they were not motivated enough during their first few treatment centers to deter themselves from partaking in a rehab romance, believing that the romance would distract them from their intrapersonal and interpersonal conflicts. Two female participants shared that they eventually admitted themselves into an all-female facility and believed that this was detrimental to their recovery process.

**Sub-theme 2: Size.** Another structural component that was mentioned as being a significant factor in the group process was the size of the groups. More than half of the participants shared that they felt more comfortable in smaller groups which did not exceed ten clients.

It was difficult in the first treatment center. The state run, they would put like 25 to 30 adults, 18 to 25 [years-old] in a group room and try to treat them. So, like there was no like individualized treatment. It was like put as many people in a room and try to have a group session. You know what I mean? There was very little that one could get. (Jake, age 26, DOC opiates and heroin)

Another participant explained:

My last treatment experience, we definitely had small number of people. It wasn't just a sea of tons of people. That was really the best is when it was a small group, and I was able to be guided and receive attention. (Carl, age 28, DOC heroin)
Topics discussed in a group setting are very personal and for some participants, they had been distracting themselves from the intrapersonal and interpersonal conflicts for years. When ready to disclose repressed information, some participants became frustrated because they felt they could not disclose with such a large audience. Participant Cody shared his belief about group size stating:

For me, I would say the large groups, when you don't really get much of the individualized therapy, and you just kind of become a number. That would be like the biggest thing, that you don't really get enough time spent on what you really need to work on. (age 27, DOC heroin)

Participant Randy had a similar belief about the size of the groups.

I think for me personally, like some of the bigger groups. Like bigger group activities. It wasn't like a clinical activity, like they had like 30 or 40 person groups. They would do whatever's on the agenda for the day … the bigger type settings of groups did not do me well because I liked to do more of the personal, like individual sessions. Just, you know, talking to people individually and kind of working through things.

Participants expressed a desire to work through their issues but struggled doing this in larger sized groups. Being honest and vulnerable while surrounded by strangers was expressed by the participants as being difficult.

**Sub-theme 3: Topics.** The third sub-theme for the theme group structure is the topics discussed during groups. Groups are facilitated by professionals in the field who come from all different backgrounds having diverse facilitation styles. Holding the
attention of a client during his or her first few weeks of treatment is difficult as Henry expressed:

I don’t know if a lot of people know this, but when you’re first in recovery your mind is racing a mile a minute, you’re thinking about so many different things, and you need something to bring you back down to a normal level. And that was the drug. You need something else. To me meditation and relaxation in some places that I’ve been in really helped me. It took me out of myself. I went into, I think it was in Albany, and it was in a therapeutic community, which is you know very strict, by the book type recovery process. We would sit in the classroom for eight hours, and they would just drill us with statistics and numbers and you know, everything that was taken through analytics. You know, surveys and stuff, and honestly you know that didn’t make me want to stop. That just made me want to pull the hair out of my head and want to leave. I ended up leaving that place because of stuff like that. Um, I don’t know, to me it didn’t work. I mean, if I wanted to be a doctor I would understand. It’s repetitive, but as an addict, it reminded me of when I was in that one class that everybody hated, and you’re waiting for the bell to ring. (Henry, age 29, DOC opiates and heroin)

Amy (age 25, DOC heroin and crack cocaine) shared what group topics had a positive impact on her stating:

We had group on how to communicate with another person. The group on communication was good because I’m not really good at that. I wasn’t like listening and digesting what other people were saying at the time, and so I didn’t really know how to respond to them. I pretty much just didn’t
know how to listen to people. That was a great group that I had during
treatment and that was beneficial.

Amy went on and shared what she believed were non-beneficial group activities:

Sometimes they would make us watch movies that were non-beneficial. I don't
know. I feel like some groups are just put together like we play recovery games,
or we would do arts and crafts. I was like that's not why I’m here. That's not why I
came to treatment. I mean it made the time pass at the time, but I don't necessarily
think that it was beneficial.

Ben shared that he had been to about 20 treatment centers before he became an addict in
recovery. For him, interactive groups produced group discussions that he believed he
learned from the most.

I loved inter-active groups. I hated the normal sitting in a circle let's talk about
things group. Just simple discussions and it didn't even really have to be about
anything. I like to use the whiteboard. I'd like to get up and write stuff on the
board and talk a little about what I knew, and discussions would come out of it
within the group. It got me into the group because you put like one thing up on the
board, and then a peer would be like oh yeah, I relate. Then it would just kind of
make the group get involved. I had been in several treatment centers, so I don't
want to say that it was repetitive, but I can only, I can only hear so many life
stories or go over the same [thing]. You know what to do if you feel like drinking,
or if you get into like the really deep groups about where my addiction started,
you know things like that. Yeah that's great, but I had done that already, and I was
like over it. (Ben, age 29, DOC heroin)
Participant Albert (age 27, DOC Oxycontin) had been to multiple treatment centers as well and shared:

I think the general almost factory-made recovery-based exercises were not helpful, but when you've been in treatment multiple times, and you kind of have, well it's not like new knowledge. I think the most helpful was basic personality stuff. I remember one of my counselors made you pick three people: one person you hated, one person you loved, and one person that you owe an apology to—something along those lines. We all put them on an index card, through them in a pile, and then we had to choose which person it was when we just randomly pick the card. It was more introspective. I think the introspective exercises were more effective for me.

The participants spent most of their time in groups during their treatment experiences. The group topics either captured their attention or frustrated them. In the end, learning how to appropriately deal with frustrations may have been the best lesson. Believing that one knows what one needs to transform from active addict to an addict in recovery is difficult to determine. The intrapersonal and interpersonal conflicts may appear similar amongst this population, but resolutions are attained individually based on the individual’s openness to learn and willingness to surrender to the process.

**Theme 5: Conflict Style**

All the participants spoke of the inability to deal with conflict when they were active in their addiction. Words like “numb”, “shutting down”, and “not good at dealing with” were used to express how conflict was handled. Through the transformational process from active addict to addict in recovery, three conflict styles emerged from the
participants statements. Figure 12 illustrates the three sub-themes which fall under the theme conflict styles.

![Conflict Style Diagram]

*Figure 12: Sub-themes under Conflict Styles.*

**Sub-theme 1: Avoider.** Avoiding intrapersonal and interpersonal conflicts was something all the participants did when they made the decision to use opioids. Using these substances as their primary coping mechanisms did not allow for them to learn healthy conflict resolution skills, only fueling the addiction more. The following statements explain how participants used the conflict resolution style of avoidance. Jan explained how she was avoiding the pain of losing her brother.

For some reason, I kept picking up a drug. It was really because I was numbing myself, and I didn't really want to feel life really. I didn't want to understand what was going on around me or feel the pain of losing him or face the situation. I would instead pick up a drug and then I wouldn't feel anything and that became a whole year of addiction. Like, I didn't allow myself to cope. I didn't allow myself to feel nothing. I just became numb. (Jan, age 28, DOC heroin)

Randy (age 24, DOC heroin) shared how he would use heroin to avoid conflicts with his girlfriend and eventually to avoid life.
I'm going to word this in that I'm not good at dealing with emotions. It could be a bright sunny day, but if I could get high or drunk with my girlfriend I would. She would break up with me and I would get really depressed. I would have self-pity and I would get high. I want to get drunk … You know once I started using drugs and started drinking heavily, I couldn't deal with anything in life. I ran away from all my problems.

Angie (age 24, DOC heroin) explained how she handled being confronted by treatment staff and shared the following: “I think it was also about me and my pride and my ego. I just didn't feel comfortable with that therapist. I just shut down. I literally just shut down.”

It is not as easy to avoid conflict when in a treatment setting. The drugs used to avoid life are no longer available, rules must be followed to maintain the safety of the community, and staff are trained to initiate conflict, so clients learn how to resolve them in a healthy way.

**Sub-theme 2: Competitor.** Half of the participants expressed how their conflict style shifted from avoider to competitor when they no longer had the mind-altering substance available to them. In addition, rules needed to be followed that participants did not appreciate at the time. One participant shared a conflict he was having with his therapist:

My biggest conflict was like in my last treatment center with my therapist. He would say he was not by the book, he was very real, and he worked for the court system, in the prison release system for like 20 years. He was very in your face and very real. He basically told me what was going to happen. I was court
ordered, so I didn't want to be there. So, he pretty much told me that he knows I didn't want to be there, but I had to be there, and I had to deal with it. I had huge issues with that, and he kind of held it over my head. I knew I was looking at prison time, and I didn't want to be reminded of that every time I sat in his office. He would like give me assignments; and I was like, I'm not doing that assignment. I got really angry, left his office, and proceeded to chain-smoke cigarettes. (Ben, age 29, DOC heroin)

Carl (age 28, DOC heroin) shared how he eventually realized that the interpersonal conflicts he was having with the staff were a result of his own intrapersonal issues:

Conflicts were what I saw at the time were issues with myself that I had to learn that I was putting on to other people. Like with staff telling me I had to clean my room. And I would get upset and I would get mad. I can see now that that had nothing to do with them. I got mad because of me. But at the time I would blame them.

Two of the participants shared how being told “no” at the facility created intrapersonal conflict that affected their interpersonal relationships with the treatment staff:

Not getting what I want when I wanted it (laughing). I'm spoiled. My whole life I'm the only girl in the family. I wanted the phone when I wanted the phone, or just any kind of no it's not what I wanted to hear. (Emily, age 27, DOC opiates and heroin)

I got along with staff when I got my way. I wasn't like attacking them or anything, but I feel like I, I almost became very entitled in treatment. You know, I acted like
that towards them. Like if I didn't get my cigarettes, I would lash out at them.

(Amy, age 25, DOC heroin and crack cocaine)

Both participants shared that at the time, they believed they were entitled to whatever incidentals they wanted. After learning that their arguments were not going to change the rules, their conflict styles shifted.

Sub-theme 3: Collaborator. To transform from active addict to addict in recovery, participants expressed that they needed to think differently not only about themselves but about past experiences and personal potentials for the future. Taking suggestions from people who are in recovery is a form of collaboration. Taking responsibility for one’s life and giving back to society are just a few ways the participants evolved from being an avoider during their active addiction to becoming a collaborator in their recovery.

My responsibility was to do or give to society what I had taken for so long. So, I was just talking about this the other night. Being in recovery, I don't have the luxury of being lazy or being a bad breaker upper in relationships. Now that I am a woman in recovery, it is my burden to bear to be the bigger person. (Mary, age 26, DOC heroin)

Bob (age 28, DOC heroin and cocaine) shared the following:

The same way that I was finally a successful client at the treatment center, I take suggestions and I follow God. I didn't know what it meant to follow a higher power. I didn't even know what it meant to be a man. So, for the past two years I continue to do what I faithfully started to do when I committed to my recovery, which is take suggestions, follow the steps, [and] turn to my God. There's been a
lot of changes in my thinking and my reactions to things. Following directions and just showing up.

Sue (age 30, DOC heroin) explained her mental transformation:

Well I take the suggestions that were given to me. I got a sponsor. I take her suggestions. I never intended on staying sober. My intentions were to get sober, get court off my back, and then I was going to go back to the old lifestyle I was living because I felt comfortable there. Once, after nine months into treatment, I was also on my ninth step. I really believe the obsession had been lifted, and I just kept doing what everybody else was doing. Today, I'm still active in AA. I work with Addicts and alcoholics. I continue to maintain my sobriety because working the 12 steps work for me.

The theme conflict styles are significant in explaining how the participants transitioned from avoider, to competitor, and finally collaborator. The conflict style used was indicative of where each participant was within their transformational process from active addict to addict in recovery.

All of the participants in this study discussed the intrapersonal and interpersonal conflicts experienced during their treatment process. All participants must have had a minimum of one year sober, creating a significant time gap between the actual treatment experiences and the interviews. All participants were proud of their accomplishments and focused primarily on the person they had become as a result of their transformation from active addict to addict in recovery.
Conclusion

The overall essence of the treatment experience is the journey of identity transformation from active addict to addict in recovery through conflict management. The five distinct areas of conflict that needed to be managed which were disclosed by the participants were: 1) identity formation; 2) power of stigma; 3) interpersonal relationships; 4) group structure; 5) conflict styles. In the next chapter, four theoretical frameworks will be presented to further discuss the data analysis findings. The theoretical frameworks that suggest intrapersonal and interpersonal conflicts includes theory of human motivation, social identity theory, coordinated management of meaning theory, and theory of relative deprivation. The theories presented merge the fields of psychology, sociology, and conflict analysis and resolution. They will assist readers in understanding the importance of conflict resolution in terms of transforming from active addict to addict in recovery. In addition, the last chapter will discuss limitations, contributions, and implications for further research.
Chapter 5: Discussion, Conclusion, Recommendations

Chapter four disclosed the findings of the participants’ responses to the interview questions designed to answer the central research question regarding the intrapersonal and interpersonal conflicts an opioid addict faces while in treatment. This chapter will further discuss and analyze the results using Chapter two’s academic literature review as well as the theoretical analysis. The theories analyzed include: theory of human motivation, social identity theory, coordinated management of meaning theory, and theory of relative deprivation. These theoretical frameworks were chosen to integrate the fields of conflict resolution, psychology, and sociology and when combined, support the idea of the connected co-existence of internal and external factors that have the potential to influence opioid addiction while also providing the path for recovery from opioid addiction.

The study uncovered the overall essence of the treatment experience to be the journey of identity transformation from active addict to addict in recovery through conflict management. There were five distinct areas of conflict which integrated both intrapersonal and interpersonal conflicts where conflict management was needed for transformation to occur. These areas include identity formation, stigma, interpersonal relationships, group structure, and conflict styles, each unveiling corresponding sub-categories. Each theme and sub-theme will be discussed in great detail while integrating Chapter two’s literature review as well as the four theoretical frameworks.

Analysis Based on Theoretical Perspectives

All participants experienced conflict when attempting to establish a new identity and while attempting to release negative stigmas about the self. Intrapersonal beliefs
regarding who they believed themselves to be in their addiction had to shift, which meant that the groups they aligned with had to shift. By aligning with people in recovery, the participants began taking on the characteristics of their new group. This in turn helped them feel better about who they were as a person and no longer believe the negative stigmas about the self they once used to. Once transformation of the self was initiated, the participants disclosed how their interpersonal relationships changed as well as their temperament and conflict style. Below is the discussion reporting on the collaboration of Chapter two’s literature review, four theoretical analyses, and the findings of the participants’ responses to the interview questions which answer the question: What are the intrapersonal and interpersonal conflicts opioid addicts are presented with during residential treatment?

**Theory of Human Motivation**

In regards to theory of human motivation, all of the participants reached self-actualization, the highest hierarchy of need explained by Maslow (1943). The participants indicated reaching this level once the transformation to addict in recovery occurred because they felt as though they were living a moral, creative, self-fulfilling life, opposite of how they were living during their active addiction.
Figure 13. Active Addict Depiction of Maslow’s Hierarchy of Needs (1943)

Figure 13 represents the depiction of the participants’ reports of when they were in active addiction. According to Maslow (1943), if one of the basic needs are not met, it will be impossible for the individual to advance to the next within the hierarchy. Many of the participants mentioned during their active addiction, they were homeless, had not eaten for days, and were not maintaining their activities of daily living skills (ADL) that includes taking care of one’s self and body. All participants mentioned that during their active addiction they were not employable or could not hold a job due to their addiction. Many mentioned extreme family discord and a loss of connection to old peers prior to when their addiction started. All participants mentioned that during their active addiction they did not respect themselves and lived with feelings of guilt and shame. Finally, all participants mentioned that they felt as though they did not have a purpose, were avoiding their issues, and were in denial for many years.
Figure 14. Addict in Recovery Depiction of Maslow’s Hierarchy of Needs (1943)

Figure 14 represents the depiction of the participants’ reports of how their needs were met when they believed themselves to be in recovery from their addiction. All of the participants in this study during the time of the interview believed that their purpose was to help the next sick and suffering addict. All participants reported working full time jobs with all but two working in the field of addiction. All fifteen participants established a positive support network and maintained strong bonds with their network. All participants re-established family relationships and worked extensively on interpersonal family conflicts that resulted from their active addiction. However, the participants interviewed reported achieving self-actualization after successfully completing treatment, not while they were in treatment. Therefore, treatment has the potential to begin building a foundation for self-actualization while allowing for the lower needs to be met.

Social Identity Theory

Figure 15 illustrates how the participants perceived themselves when they first entered treatment. Many shared how they could relate more to the other clients than they
could to staff perceiving the staff as “them.” More than half shared how they struggled with the staff due to believing they were authority figures, creating interpersonal conflicts as the staff attempted to work with them. Participants struggled during their initial treatment experiences when aligning with peers who continued to identify as active addicts. Unfortunately this influenced the participant’s treatment process, which resulted in being discharged and resuming their addictive lifestyle, creating high relapse rates. More than half of the participants had multiple treatment attempts and failures due to their continued alliances with non-motivated peers which in turn kept them believing that they were a part of the addict group. Anderson (1994) believed that self-image guides individuals’ behaviors on what to do and what to expect when socializing with others.

![Figure 15. Active Addict Social Identity Theory](image-url)
On the opposite side, when participants began viewing themselves as more than just an addict, they began socializing with peers who were in recovery, allowing for a new identity to emerge as Figure 16 illustrates.

![Figure 16. Recovering Addict Social Learning Theory](image)

Biernacki (1986) stressed the importance of addicts changing their personal identities, perspectives, and social involvements. All of the participants reported the identity shift started when they began taking suggestions by the staff and therapists, no longer viewing them as a threat. In addition, involving themselves in a fellowship with recovering addicts allowed them to see others whose issues appeared similar utilizing the social comparison to help transform their personal identities. The positive benefits of social sober support appears to be reliant on the level of those providing “support are perceived relevant, similar and connected to the self” (Best et al., 2016, p. 112).
Interconnected Themes

This study established five interconnected themes that illuminate the overall essence of the treatment experience. All fifteen participants identified with the five themes. These themes provide the explanations that serve as the foundation for this chapter. All of the themes surfaced due to the intrapersonal and interpersonal conflicts that manifested as a result of the treatment process. The five themes are identity formation, stigma, interpersonal relationships, group structure, and conflict style. With each theme emerged sub-themes that many of the participants experienced. Proceeding the analysis of the themes, this chapter will consider the limitations of this study as well as the anticipated contributions within the field of Conflict Analysis and Resolution.

Identity Formation

Participants involved in this study shared their lived experiences of changing their identity of the self as a result of the treatment process. The amount of treatment experiences did not matter as some participants had multiple treatment attempts and others had only one. All of the participants changed their identity when they began associating with others who no longer were active in their addiction. The incredible power of group association was a major part of the participants’ self-concept. When attempting to stop addictive behaviors it is imperative that the first identity-related responsibility is to begin nurturing a new self-concept that is in alignment with the new orientation (Buckingham et. al, 2013). The results of this research parallels Biernacki (1986) and Koski-Janes (2002) in that they both believe when an addict decides they want to stop the addictive lifestyle, there is an addict identity conflict.
**Addict.** During the initial treatment process, more than half of the participants shared how they connected with other clients who continued to identify themselves as an addict. Anderson (1994) believed that their self-image guided them of what to do and what to expect when socializing with others. The ability to manipulate staff, rationalize, justify and minimize while avoiding healthy interpersonal relationships kept them identifying as an addict.

Maintaining addictive belief systems that were justified in conflicting situations initiated polarization placing themselves in the in-group and everyone else in the out-group. These intergroup ideologies were created with the purpose of pointing out differences between groups perceiving their group as favorable and the other as not (Folger et al., 2001). The participants stressed how they felt as though they were prisoners in their own mind believing that they needed the drug, powerless over its effects and unable to stop. The general human predisposition is to alleviate painful physiological and psychological symptoms as much as possible by avoiding uncomfortable situation (Mitchell, 1981). Connecting with other clients who were in the same mindset inhibited identity transformation while alleviating intrapersonal conflicts. Creating justifications and specific perspectives about the self and others allowed them to continue identifying as an addict.

**Separation.** As mentioned in chapter four, all participants separated from the environments where they were actively using opioids when they made the decision to enter treatment. All participants expressed that separation was absolutely necessary because they needed to be pulled out of the social group they were using with. Entering treatment placed the participants in an environment that would not allow them to numb
their minds with mind altering opioids while forcing them to self-reflect. In addition it decreased resources designed to maintain an addict identity while increasing resources to create a new identity. The identities acquired by people suffering with addiction in which their addictive behaviors are a major part of their self-concept present core identity issues that they need to solve (Koski-Jannes, 2002).

Many researchers have argued that the first step in the transformational process from active addict to addict in recovery begins with the management of a “spoiled self” (Waldorf and Biernacki, 1981; Waldorf, 1983; Biernacki, 1986). The separation from the old environment allowed the participants to see others who had lived similar lifestyles now living a recovery lifestyle. Robbins (1993) in his research discovered that relocation and a change of social structures, in which drug use was highly discouraged created a significant reduction in illegal drug use. Witnessing other addicts motivated for recovery placed the participants in a new position that gave them the power of choice. Separation gave the participants an opportunity to change their social group; thereby, changing their identity.

**Recovery.** All of the participants identified themselves as in recovery during the time of the interview and shared qualities that they had to attain and maintain in order to identify themselves as in recovery. The transformational process began in treatment but the participants stressed how treatment enabled them to create the foundation for identity transformation, but this process continued well after treatment. To change one’s identity from active addict to one that is in recovery requires access to a new social world. Biernacki (1986) explained in his article that individuals who identify as an addict must
be exposed to new social groups and perspectives wherein the addict identity is shut out or dramatically excluded.

All of the participants reported attending AA or NA meetings throughout their treatment stays. This provided an opportunity for the clients to see other individuals struggling with similar issues but not partaking in the active addictive lifestyle. Hearing other addicts’ testimonials during AA/NA meetings provided opportunities for the participants to connect with other addicts, but addicts in recovery. Buckingham, Fringe, & Albery (2013) reported in their article that social identity theory explains how addicted individuals use group membership as a means to create new identities.

All of the participants shared the same notion that they had to surrender to their addiction and admit that they were powerless over their addiction (12step.com, nd). They reported how following the 12 step principles changed them. Making a commitment, being honest and willing while accepting help from others was required to change their identity from active addict to addict in recovery. Once the participants joined the fellowship, continuing the life of an active addict was not as easy because they began seeing themselves as more than just an addict. Buckingham et al. (2013) stressed the idea of how an individual internalizes the qualities of their group members and often identifies themselves by their social groups’ characteristics. By changing one’s group, one can change their identity.

**Stigma**

All of the participants talked about the disappointments they felt within themselves as they continued their addictive lifestyle. Many participants expressed negative self-talk that included “I hated myself”, “I was the problem child”, and “I’m a
piece of garbage” when they first entered treatment. Goffman (1963) defines stigma as attributes that are meant to discredit and reduce individuals “from a whole and usual person to a tainted and discounted one” (p. 3). These negative thought patterns created barriers that were extremely hard to break interfering with most of the participants’ motivation to endure. Luoma et al. (2008) believes that individuals who identify with a stigmatized group may serve as a barrier to the recovery process due to the negative ideologies that the self and society holds on the idea of addiction.

**Self.** The participants in this study shared how one of the biggest conflicts they had to address while in treatment were the conflicts they had within themselves. Making the decision to enter treatment meant that they had to take into account they may be an addict relinquishing the power of denial. By identifying with the active addict group, the participants felt negatively about themselves due to group association. Luoma et al. (2008) reported in their research that those who are stigmatized may be affected through the process of self stigmatization.

All participants but two had multiple treatment attempts. More than half had over ten treatment attempts. By continuously stigmatizing the self, the participants continued the pathological addictive patterns, perpetuated by negative self-talk. This made it difficult to connect with new groups as they continued to embrace the negative stigmas. Labeling, stereotyping, separation, status loss, and self-discrimination provided fuel to resist identity transformation (Link and Phalem, 2001). Luoma et al. (2008) explains how the implementation of an acceptance based treatment for self-stigma may decrease negative thoughts about the self and describes the harm that can be caused when a
substance abusing individual stigmatizes him/herself as a result of their addictive lifestyle.

**Society.** Society has its own viewpoint on what it means to be an addict. Not only is it imperative to accept the self, but accepting society’s ideas of what it means to be an addict is another issue that must be resolved. Room (2005) explains how drug and alcohol use is heavily moralized by society and how this results in stigma and marginalization. Some of the participants shared how they felt stigmatized by the treatment staff and felt as if their opinion did not matter. In addition, almost all of the participants felt that loved ones were almost always looking for them to relapse, whether they were working a program or not. Many stated that they continued their addictive lifestyle because they felt as though society as well as their loved ones had no hope in them. These cultural and community stigmas associated with addiction perpetuated the participants’ negative thoughts of the self which interfered with their sense of belonging to those who did not struggle with active addiction. In addition, cultural and community stigma may not recognize individual autonomy in regards to the decision making process with treatment and recovery (Broyles et al., 2014).

**Interpersonal Relationships**

The purpose of treatment is not only about the cessation of drugs, it also involves unlearning what the addict has learned while living an addictive lifestyle. Acquiring new skills to implement with interpersonal relationships was something all of the participants agreed must occur. Figure 1 illustrates the differing intrapersonal ideologies that an active addict versus an addict in recovery believes. These polarizing ideas include: “It’s all about me” versus “how I can be of help to others?”; “I can take care of myself” versus
“there is something bigger than me.”; “hide and deny my fears so as not to feel weak” versus “acknowledging my fears and limitations while asking for help.”
(Chiverichards.wordpress.com, 2016)

**Staff.** All of the participants had interactions with staff while in treatment. Many shared that the staff played a major role in their transformational process. Most of the participants struggled with connecting to staff, so the leadership and guidance style of the therapists, case managers, and behavioral health technicians was a primary source of inspiration or discouragement. Relationships with staff had already been predetermined before verbal communication took place because of the differentiation of power between staff and client that previously occurred with other individuals who held similar roles. According to Folger et al. (2010), past relationships affect current relationships.

Most participants in this study had multiple treatment attempts. The facilities in which they felt safe and cared for were the ones in which the foundation for their recovery grew. Maslow (1943) believed that an individual has an intense need to feel safe and secure from harm. If an individual does not feel safe, this need will not be fulfilled. Living a drug addicted lifestyle involves violence, neglect, and abuse (Hawkins et al., 1992). These factors have the potential to create fears that follow the addict into treatment. Participants all agreed that the clinical work with their therapists did not begin until they felt safe around them, and they trusted them.

In addition, many of the participants had been paid to enter multiple treatment centers throughout their treatment journey and were sold drugs by marketers numerous times so they would qualify for insurance to pay for treatment. Most of the participants shared that it took a few days for them to assess the staff so they could interpret for
themselves if staff were *legit*. This negative perspective of staff had to be altered for the transformational process to occur. Once trust was established, healing began. As participant Jake stated, “I think a treatment center’s success is going to rely on the staff that are employed there” (age 26, DOC opiates and heroin).

**Peers.** Not only does treatment involve interactions with staff, but it also involves interactions with peers or other clients. The mere fact that the participants were grouped together with other addicts made it difficult to alter their identity unless they were ready to resolve the intrapersonal and interpersonal conflicts that had manifested as a result of their addictive lifestyle. Tajfel and Turner (1979) believed that individuals obtain their identity from those they interact with and define themselves by the roles they play within the group(s). Many of the participants shared that the relationships formed with their peers were surface level. They shared that the only thing they could talk about was the one thing they had in common which was their drug use. They described recognizing who was in treatment to truly find recovery and who was there because they had nowhere else to go. They shared that a big part of their recovery process depended on the clients with whom they spent the most of their time. Best et al. (2016) found in their research that when we interact with other groups and individuals we do so in the context of how we perceive ourselves and those that we are communicating with. They argued that we interpret meaning through interactions from the norms and values of the group as well as through our own intrapersonal systems (Best et al., 2016). Treatment is a process that must address conflict between the addicts and those around them (Griffiths, 2009).

**Family.** More than half of the participants mentioned how family impacted the transformational process from active addict to addict in recovery. The resolution of
family conflicts was a powerful influence in their recovery progress. All of the participants entered treatment with extreme family discord. All of the participants confessed to lying, cheating, stealing, and creating high levels of stress and discomfort to family members due to their addictive lifestyles. Most of the participants believed that there was no hope for the resolution of family conflicts until they began family sessions with their therapists.

The preconceived ideas of how the family would respond during family sessions terrified most of the participants. These preconceived fears developed as a result of learned rules obtained within a specific social situation that guided their understanding of what would happen if family was contacted during their treatment stay. Folger et al. (2001) describes this through the theoretical lens of coordinated management of meaning theory (CMM). CMM theory provides a framework when explaining how the participants brought meaning to messages, conversations, and family relationships, and how these meanings were established through past conversations. The idea is that humans within a social situation attempt to understand what is happening and apply learned rules to figure it out. These assumptions transpired as a result of interpretations based on conversations and messages between the participants and family members in the past, which ultimately shaped how the participant viewed themselves and how they viewed their family members.

Many of the participants were shocked to learn that family members continued to be supportive regardless of past behaviors. Many therapists would encourage the families to write the participants letters as well as the participants to write the families letters. Through this form of communication, many participants gained the courage to call their
families and begin new relationships, resolving old negative belief systems while creating new meanings through these conversations.

**Fellowship.** All of the participants shared that during treatment they attended AA and/or NA meetings and were introduced to the fellowship. These new interpersonal connections allowed the participants to witness others who had similar experiences, creating strong bonds through social identification. The ability to connect with addicts in recovery guided the participants in making sense of their addictive behaviors while reinforcing a new social identity (Best et al., 2016). The development of this new social identity provided the opportunity to strengthen the individual’s sense of belonging thereby creating new values, norms, and beliefs about the self (Best et al., 2016). Many of the participants shared how they felt accepted by the fellowship and felt involved in the recovery community, further reinforcing the social connections.

A big proponent of the fellowship is guiding active addicts to a life of recovery that involves living the spiritual principles. These spiritual principles, if lived to their potential, provide the pathway for self-actualization to occur. When describing the fellowship, participants used words like being accountable, having connections to good people, being of service, having a higher power that restored me to sanity, living honestly, and having a purpose. The positive benefits of sober social support appears to be reliant on the level of which those providing the support are similar to the self (Best et al., 2016). When new members of the fellowship enter the group, they are taught the belief systems of the group. All participants in this study eventually began acting as the group when they internally believed they were part of it.
Group Structure

The main treatment modality in treatment programs is group work. The clients spend the majority of their treatment process listening to group facilitators’ lecture and initiate dialogue on many different topics. Group structure and the interactions with staff and peers was an important component reported by all participants. Interpersonal relationships with staff and peers flowed into the group setting which affected many of the participants treatment focus. The combination of our intrapersonal and interpersonal systems creates a perspective that allows us to manage our reality (Pearce, 1976). This reality has the power to either create a successful recovery process or tempt an individual to relapse.

Gender. The decision to transform one’s soul from active addict to an addict in recovery is not the intention of all who enter treatment. For many, distractions are a welcomed deterrent when it comes to facing oneself. Mitchell (1981) reported in his work that the general human predisposition is to alleviate any psychological discomfort as much as possible by avoiding uncomfortable situations. Many participants shared that having groups with the opposite sex was any easy method of distraction. Many reported that they were “broken” when they entered treatment and seeking validation from a peer of the opposite sex was an unconscious need for some, obstructing the focus required to work on the self.

All participants mentioned having histories of either physical, verbal, and/ or emotionally abusive relationships with a significant other during their active addiction. Having to disclose and communicate feelings and thoughts in a co-ed group created an uncomfortable venue for many of the participants. Established meanings about the
opposite sex created barriers in the communication process. CMM theory provides a framework when explaining how individuals bring meaning to messages, conversations, and how groups establish their meanings through conversations (Folger et al., 2001). Folger et al. (2001) believed that meanings of a situation are detrimental when making decisions about what to do or what not to do. Integrating both male and female clients in the group affected how the participants participated in the groups due to the meanings they gave their male or female counterpart.

Most of the participants shared in their interviews that having gender specific groups was beneficial to their recovery process. Both males and females in the study shared this belief. Participants used strong words that clearly stated that they struggled with honesty and self-disclosure in groups that had both male and female clients. Two of the participants admitted that they could not get sober in a co-ed treatment center; so they had to go to an all-female facility believing that this was the only way they could get sober, and they did.

**Size.** The size of the groups was a significant factor that more than half the participants reported effected their treatment process. The idea of quality versus quantity was expressed as many of the participants had multiple treatment experiences where they were exposed to different sized groups. Participants shared that when they entered treatment communicating was difficult but having the larger groups made it more uncomfortable. Managing meanings of a situation that involves changing identity requires the ability to interpret social cues (Folger et al., 2001). Interpreting social cues was difficult for the participants because the social cues of an active addict are much different than the social cues of addicts in recovery. CMM theory builds off of social
learning theory by recognizing that meanings are determined by interactions between those communicating and by the members of the group the communicators belong (Folger et al., 2001).

Speaking openly and honestly in the larger groups was difficult for the participants because the idea of being vulnerable in front of strangers was frightening. Half of the participants shared that the ideal group size did not exceed ten clients. Unfortunately, many of the participants had to sit in groups ranging from 30 to 40 clients throughout many of their treatment experiences, co-existing with peers whom they related to as addicts. West and Turner (2000) summarized that human beings live in communication and co-create reality depending on intrapersonal and interpersonal meanings. Many of the participants had used drugs with the very clients they were interacting with in groups. This made it difficult for the participants to take some of the groups seriously. Participants involved in groups had perceptions manifested by the content that was discussed in groups, but these perceptions depended on subjective perceptions that were based on past and present interpersonal relationships (West & Turner, 2000). The more clients in a group, the harder it was for the participants to be open and honest about what it is that they were going through because they feared being judged.

**Topics.** This sub-theme refers to the topics that the group facilitators discussed during groups. Unfortunately, we are living during a time when many young adults under the age of 26 have had extensive treatment experience. It was not surprising to hear the participants mention that the “cookie cutter” material that includes relapse prevention, triggers for use, and symptoms of PAWS had no effect on them because they had gone
over these topics multiple times. In fact, one participant mentioned that these groups made the time pass, but he believed it was non-beneficial (Ben, age 29, DOC heroin).

Maslow (1943) believed that an individual will feel discontent and restless unless they are doing something that brings meaning into an individuals’ life. Not to discredit group content or report that groups are not meaningful, but many of the participants stressed it was during the creative groups, the experiential groups, and the inter-active groups when the participants accomplished the most.

One of the most profound philosophies of the 12 steps of AA and NA is the idea that “wisdom is knowing the right thing to do, virtue is doing it” (12stepphilosophy.wordpress.com, 2018). It is therefore a dual responsibility of the group facilitator to teach wisdom and the client to live it. The group facilitator is responsible to educate and facilitate in a way that hopes to inspire and motivate clients. The clients’ responsibility is to learn that there is always something to learn. Unfortunately, the speech act between staff and client becomes difficult at times due to cognitive processes that take place when living the life of an active addict (Mitchell, 1981). Most of the participants reported that it did not matter how inspiring or creative the group facilitator was when they were not ready to get sober, and it was during these times that cognitive consistency or selective perception occurred.

Conflict Styles

All the participants shared about the different conflict styles that were present during their transformational process from active addict to addict in recovery. Opioids are a class of drugs that reduce the intensity of both physical and emotional pain by attaching to opioid receptors found in the brain (NIDA, 2015). Since opioids have the ability to
reduce emotional pain, it was no surprise to hear that the participants had the ability to avoid conflict during their active addiction. Unfortunately, this tactic to avoid conflict was synthetic, so other conflict styles emerged throughout their treatment experience as a result of not having the drug to numb the mind.

**Avoider.** Avoiding interpersonal and intrapersonal conflicts when they were actively using opioids was something all the participants reported they did for years. The habitual pattern of numbing the guilt and shame they felt as a result of their addictive behaviors is what they trained themselves to do. Interpersonal conflicts experienced with family members, significant others, and peers was too overwhelming, so using the drugs allowed them to ignore the conflicts while increasing their desire to continue their addiction. Intrapersonal conflicts of not having their needs met combined with the reports of self-loathing gave them the fuel they needed to increase their drug use. Maslow (1943) believed that when needs are not met, maladjustments and severe pathologies will erupt creating a lifestyle that perpetuates internal strife and conflict.

Participants used words that expressed how they could not deal with life on life’s terms. The emotional weight of conflicts that had been avoided began surfacing immediately following the cessation of the opioids as physiological withdrawal occurred. Many of the participants expressed how the physiological withdrawal was the easy part of treatment. The main struggle was the psychological and social conflicts that needed to be addressed once the physiological withdrawals were stabilized.

**Competitor.** The participants had been training themselves for years to avoid conflicts, making it difficult for all of the participants when they entered treatment. The ability to take a pill or intravenously use heroin whenever mental discord arose created
habitual unhealthy coping mechanisms that needed to be challenged by staff. Anger was an emotion that many participants talked about upon admission. They shared they were angry with themselves which made them angry with the world. More than half shared that during their initial treatment experience, they did not know how to live without the mind-numbing substance. This intensified the intrapersonal conflicts while increasing interpersonal conflicts with the treatment staff.

Treatment center rules are strict in an attempt to create a safe environment for those admitted (drugaddictiontreatment.com, nd). Unfortunately, many of the participants expressed how they became angry with staff for implementing rules that involved no personal phone use and no access to personal funds. Participants used words like “not getting what I wanted when I wanted it.” This mindset forced many of the client to leave treatment against medical advice, relapsing within hours of discharge.

Taking personal responsibility for one’s life and well-being is very difficult when one believes that life without the drug is a form of deprivation. In addition, the “us” (the client) versus “them” (the staff) attitude created by group identification has a high propensity to generate an initial foundation of the treatment process that is riddled with frustration and resentments associated with the resistance of incompatible interests. Treatment may seem like a prison term as they may feel as if they are being deprived from the one thing that they believe will make them feel better. Pruitt and Kim (2004) believe that “deprivation per se is not the cause of conflict. Rather it is deprivation in comparison to what Party expects or feels it should get” (p. 20). When addicted individuals enter a treatment center that focuses on recovery and not on monetary gains,
they may struggle with what they believe they are entitled to due to previous experiences they have had when enticed by monetary focused facilities.

**Collaborator.** As mentioned previously the abstinence of drugs does not mean transformation of active addict to addict in recovery. All of the participants shared that the removal of the drug actually made things emotionally worse. The clichéd saying of being sick and tired of being sick and tired is what propelled the participants to surrender to the transformational process. The most profound experience occurred for them when they decided to take suggestions, listening to those that have either lived through the transformational process or had the skills necessary to help them resolve conflicts.

Collaboration is a conflict style that involves listening to the other side while discussing different viewpoints with the purpose of finding the best solutions. This involves both parties cooperating with each other while understanding each parties concerns so satisfactory solutions can be met for all involved (Conflict Management Strategies and Styles, 2018). The first step in the Principles of AA is to surrender, or admit that one is powerless on his/ her own (12Step.com, nd). This mental shift allowed the participants to open their minds to the possibility that they needed help.

The third Principle in the Principles of AA is commitment. Commitment in this context is translated to mean accepting and receiving help from others (12Step.com, nd). The need to surrender and the willingness to commit and take suggestions is what the participants believed began their transformational process. This process involved the participants connecting with a new social group taking on this new group’s values and beliefs, eventually taking on the characteristics of the new group. This allowed the
participants to create a new identity of the self-based groups’ characteristics allowing for their transformation from active addict to addict in recovery to materialize.

Limitations

Presenting the limitations of this study is critical. Providing treatment to individuals struggling with substance abuse is something I have done for over a decade. In addition, having people in my personal life who struggled with this disease makes this research personal. Understanding why people behave the way they do while active in their addiction was something I have always wanted to understand due to the pain that I felt watching people deteriorate in front of my eyes. Witnessing many clients die as a result of their addiction has sent me on a quest to figure out new and innovative ways to treat this issue of epidemic proportions.

That being said, I knew starting this research would be difficult due to the amount of time I would need to spend mentally involved in the addictive world. Phenomenology was chosen so my personal and subjective ideas of what it means to be an addict would be disclosed. Chapter one illustrates my bracketing as openly and as honestly as I could report, including a divorce that transpired as a result of opioid addiction. Even so, the possibility that my personal experiences influenced my data analysis must be considered.

Another important limitation to consider in this study was the sample population. Understanding the intrapersonal and interpersonal conflicts and opioid addict faces while in treatment was difficult to interpret at times due to the participants having completed a treatment program one or more years ago prior to when the interviews took place. Perceptions of the experience may have been altered due to the time lapse. In addition, all of the participants had been working some kind of program post treatment and continued
to evolve since their successful discharge. Alcoholics Anonymous teaches individuals to have a solution focused mind, so many of the participants were happy to disclose the good works they had done when identifying as an addict in recovery. The conflicts experienced while actually in treatment may be different for those who are actually in treatment versus those that have one year out of treatment. Perspectives shifted, and as a result, the participants’ reality of their experiences may have shifted.

Another limitation of this research study was the recruitment process. All participants were obtained through word of mouth or recruited through referrals from recovering addicts working in the field of addiction. This may have limited the diversity of the population because many of the participants were involved in the same fellowship and attending the same AA or NA meetings. All participants disclosed that they were actively involved in a 12-step fellowship while in treatment. Again, this may have influenced the data analysis and therefore must be considered.

Other areas of research that might be considered would be to combine participants who may have worked alternate programs in treatment like SMART Recovery or even those that utilized agonist medications like methadone as their primary treatment modality. These treatment methods are very different from the 12-step way and may have altered the data had individuals been recruited who utilized these alternate systems within their treatment process.

Finally, the participants recruited for this study had low levels of comorbidity and many people who are diagnosed with a substance abuse disorder are also diagnosed with mental disorders (Drugabuse.gov, nd). Drugabuse.gov (nd) reports that many people addicted to drugs are estimated to be twice as likely to suffer with mental disorders like
depression and anxiety disorders. Unfortunately, research is still trying to determine if mental health disorders proceed addiction or is it the reverse? None of the participants disclosed these comorbid issues, and I did not ask these questions in the interviews. Consequently, this may have altered the data analysis and must be considered.

**Implications/ Practice Related Contributions/ Conclusion**

The purpose of this study was to gain a better understanding of the current treatment environment and determine what internal and external conflicts in the environment are influencing the recovery process. In order to gain a better understanding of the intrapersonal and interpersonal conflicts an opioid addict faces while in treatment, this study established five interconnected themes that uncovered the overall essence of this phenomena. The overall essence of the treatment experience is the journey of identity transformation from active addict to addict in recovery through conflict management. This theme was further illuminated by the participants in five distinct ways: 1) identity formation; 2) power of stigma; 3) interpersonal relationships; 4) group structure; 5) conflict styles. Identifying these distinct themes solidifies the importance of addressing biological, psychological, and social needs, but it also paves the way in recognizing that there may be a distinct need for conflict analysis and resolution practices regarding the solution of deeply rooted intrapersonal and interpersonal conflicts surrounding opioid addiction.

The expected contributions to the field of conflict analysis and resolution includes: (1) incorporating practice-related conflict resolution techniques that could be implemented during cravings, on-set of negative thought patterns, and family relations; (2) resolving interpersonal conflict through appropriate communication techniques in an
effort to decrease interpersonal conflicts; (3) bringing unconscious awareness to the conscious mind with the purpose of increasing overall awareness while decreasing impulsive responses; (4) negotiating boundaries, increasing problem solving techniques, and altering thinking patterns that have the potential to resolve intrapersonal conflicts, which will ultimately lead to resolving interpersonal conflicts. This in turn may decrease stigma, alter ideas of the self, and finally increase recovery potentials.

More research is needed to determine the intrapersonal and interpersonal factors within treatment centers in order to gain a better understanding of how individual and group identification and stigma influences the recovery process. Because treatment centers treat individuals who are part of the addict group, what stops the outside external factors from entering the treatment center thereby creating an environment that only increases addict group identification? AA and NA require active and non-active addicts to state their names followed by “I am an addict” or “I am an alcoholic.” Does this slow down the recovery process because addicts still identify themselves as addicts and not recovering addicts? Lastly, not much research has been done analyzing how addiction therapists view their clients. Do they attach stigmas? What kind of clinical work do they do? How high is the burn out rate for professionals in the addiction field, and why does burnout occur?

There is no known cure for opioid addiction. Including conflict analysis and resolution curriculum that addresses intrapersonal and interpersonal conflicts may provide additional resources to transform active addicts to addicts living a recovery lifestyle. A very helpful extension of this understanding may be to implement conflict resolution training techniques as a continuum of the 12 Step model of recovery which
may help individuals suffering with the disease of addiction learn healthy, tangible coping mechanisms to implement within their new lifestyle, thereby altering their sense of self through newly developed group identification. Some of the conflict resolution training topics could include Bradberry and Greaves’ (2016) Emotional Intelligence 2.0 that lists tenets that focus on self-awareness, self-management, social awareness, and/or relationship management. By sharing academic and experiential knowledge of this phenomena, more resources may become available for the professionals in the addiction field to utilize to aid in the transformation from active addict to addict in recovery. In the end, is this not what we all want!
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Appendix A- Interview Questions

The interview questions follow Creswell’s (2207) recommendation to reduce the “entire study to a single overarching question and several subquestions” (p. 108). The primary interview lasted about 60 minutes. The sixteen interview questions used are:

1. Please tell me about yourself and when your addiction started?
2. What were your drug or drugs of choice?
3. What does it mean to be an addict?
4. What does it mean to be an addict in recovery?
5. Please explain the relationships you had with your peers while in treatment?
6. Please explain the relationships you had with the staff while in treatment?
7. What contexts or situations typically influenced or affected your experience while in treatment?
8. What conflicts did you have to face during your treatment experience?
9. How did you manage these conflicts?
10. What have you found to be your best treatment experience(s)?
11. What have you found to be your worst treatment experience(s)?
12. What exercises or practices helped you or was the most effective with your transformational process of active addict to being in recovery?
13. What exercises or practices were the least effective with your transformational process of active addict to being in recovery?
14. Have you noticed any change in your own personality as a result of treatment?
15. How have you stayed sober after your treatment experience?
16. Is there anything else you would like to add with reference to your experience?
Appendix B- ASAM’s Six Dimensions of Multidimensional Assessment

AT A GLANCE: THE SIX DIMENSIONS OF MULTIDIMENSIONAL ASSESSMENT

ASAM's criteria uses six dimensions to create a holistic, biopsychosocial assessment of an individual to be used for service planning and treatment across all services and levels of care. The six dimensions are:

1. DIMENSION 1
   Acute Intoxication and/or Withdrawal Potential
   Exploring an individual's past and current experiences of substance use and withdrawal

2. DIMENSION 2
   Biomedical Conditions and Complications
   Exploring an individual's health history and current physical condition

3. DIMENSION 3
   Emotional, Behavioral, or Cognitive Conditions and Complications
   Exploring an individual's thoughts, emotions, and mental health issues

4. DIMENSION 4
   Readiness to Change
   Exploring an individual's readiness and interest in changing

5. DIMENSION 5
   Relapse, Continued Use, or Continued Problem Potential
   Exploring an individual's unique relationship with relapse or continued use or problems

6. DIMENSION 6
   Recovery/Living Environment
   Exploring an individual's recovery or living situation, and the surrounding people, places, and things

Retrieved from: https://www.asam.org/resources/the-asam-criteria/about
Appendix C- Research Study Flyer

Research Study

A Phenomenological Research Study on the Treatment Experience of Opioid Addicts: Exploring the Intrapersonal and Interpersonal Conflicts that Opioid Addicts Face During the Treatment Process

Principal Investigator: Nicole Ouzounian
Doctoral Candidate

Supervisory Professor/Co-Investigator: Claire Michèle Rice, Ph.D.
Chair & Associate Professor of Conflict Resolution
Department of Conflict Analysis and Resolution
Graduate School of Humanities and Social Sciences
Nova Southeastern University
Fort Lauderdale, FL 33314
NO112@nova.edu
(973)885-3032

This study is a research project authorized by Nova Southeastern University, entailing the collection and analysis of data. The purpose of this phenomenological study will be to describe the experience of opioid addicts’ treatment process, exploring the intrapersonal and interpersonal conflicts faced while in treatment. The ultimate goal will be to determine the strengths and weaknesses of the opioid addicts’ treatment experiences in an effort to improve the treatment environment with the hope of increasing recovery rates.

The initial phase of the study will be about a 60 minute interview process

Fifteen (15) participants, ranging in age between 21 and 30-years-old, will be selected who have been in active recovery for at least 12 months following a minimum 30 day drug and alcohol treatment program. Participants must report that their drug of choice is an opiate, opioid, or combination of the two. All participants will be asked to voluntarily participate in the study.

The Principal Investigator will take appropriate steps to protect any information collected from the participants.

If the results of this research are published or presented at social scientist meetings or a social scientist journal, all participant identities will not be disclosed.

The risks associated with this study are low. Some participants may feel uncomfortable describing their past drug history. The Principal Investigator will be prepared to address any discomfort you may experience and will be able to provide you with appropriate referrals as needed.

The results of this study may help us develop better treatment programs and curriculum that increases recovery rates.

In general, presenting research results helps the career of a social scientist and the field of conflict analysis and resolution. Therefore, the Principal Investigator is interested in increasing knowledge about the overall treatment experience and reporting the findings to professionals in the treatment field about the importance of including conflict analysis and resolution within their evidenced based curriculum.
Nova Southeastern University
3301 College Avenue
Fort Lauderdale, FL 33314-7796

Subject: Site Approval Letter

To whom it may concern:

This letter acknowledges that I have received and reviewed a request by Nicole Ouzounian to conduct a research project entitled “A Phenomenological Research Study on the Treatment Experience of Opioid Addicts: Exploring the Intrapersonal and Interpersonal Conflicts that Opioid Addicts Face During the Treatment Process” at All in Solutions Counseling Center and I approve of this research to be conducted at our facility.

When the researcher receives approval for his research project from the Nova Southeastern University’s Institutional Review Board/NSU IRB, I agree to provide access for the approved research project. If we have any concerns or need additional information, we will contact the Nova Southeastern University’s IRB at (954) 262-5369 or irb@nova.edu.

Sincerely,

Wendi Rabucha, LCSW
Chief Clinical Officer/ Corporate Compliance Officer
All In Solutions
1710 Corporate Drive
Boynton Beach, FL 33426
561-345-1086
Appendix E: Individual and Textual Description

Henry Individual Textual Description

Participant Henry is a 29-year-old man whose drug of choice was heroin. He began his addictive behaviors as young child when he would steal his best friend’s toys and sell them. The use of mind altering substances began around the age of 13 when he started smoking cigarettes, progressing to marijuana and alcohol. At 16, Henry tried both cocaine and heroin when introduced to these substances by a girlfriend. This is when his life changed paths and the drugs became a priority.

The behaviors that manifested quickly included truancy, stealing from his parents, and lying to his family. He met other teenagers who were using the same substances and began hanging out with what he called “the wrong people”. When the school started calling his parents reporting excessive absences and failing grades, he could no longer hide the fact that he was an active drug user. His parents searched his room and found drugs and drug paraphernalia and decided to send him to his first treatment center his junior year of high school. Ironically, this was where Henry learned more about the drug scene and his addiction became worse. This was the beginning of many more treatment attempts to come.

During his late teens and twenties, Henry had about 15 treatment attempts. The treatment centers varied in their structures, programs, and staff. Through these experiences, he learned what was effective for his recovery and what was not. Therapists’ and staff attitudes and communication styles had a huge influence on his treatment progress. Working with many doctors and therapists, who he felt treated him like a number not like a person, made him shut down and be closed minded to positive possibilities.

Henry spoke of therapists who appeared to be working for a pay check versus therapists who really cared and were available. The creativity of the group facilitators he
rated as very important. He used words like “cookie cutter treatment didn’t work”, explaining how some group facilitators would just read from books or “drill us with statistics”. Henry described how not feeling judged by staff and feeling respected were very significant factors that influenced his transformation. In addition, He explained that he could tell when a therapist was “lazy” and did not really care about the work they were doing.

Not all clients in treatment actually want treatment. In the beginning Henry gravitated towards the patients who did not want to be there and created an atmosphere of chaos to deflect the truth of their horrible circumstances. Aligning with the non-motivated clients decreased motivation for Henry to want recovery. This increased a victim’s mentality of not taking personal responsibility for the existing situation. Henry shared that he blamed his parents for his drug use and was angry at everyone. Connecting with peers who felt the same way fueled his addiction. This usually resulted in him leaving the facility against clinical advice and relapsing on heroin. During this cycle of treatment and relapse, conflicts resulted out of justifications and rationalizations to continue to get high. Interpersonal conflicts with his family and friends who were not using drugs increased in order to “keep them away from me”. When confronted by staff or family, being disruptive and avoidance were the tactics used. Henry talked about refusing to go to AA or NA meetings, refusing to get a sponsor, and refusing to open up to therapists. Unfortunately, this way of life can only last for so long before you eventually die, like so many of his friends did.

Due to an extensive legal history, loss of family, loss of many close friends who died of overdoses, homelessness and near death experiences, Henry finally came to a decision that he did not want to die. As a result of this new perspective, he decided to attempt treatment one more time. He explained that it was this internal decision that created a mind-set of willingness and surrender. The conflicting decision about wanting to get sober was resolved.
During his last treatment experience, Henry decided that he would do everything he could to get clean and sober. One of the things that he remembers having to let go of was how other people treated him, mainly staff. He explains one doctor he saw that was rude and did not want to hear anything he had to say. He shared that he prescribed medications that gave him uncomfortable side-effects, and “he wouldn’t listen to me”. Learning how to accept other people and the way they are without taking things personally was a huge lesson Henry learned when he was ready.

A second significant factor that needed to be addressed was his family. He remembers behaving badly towards them and the fear of confronting this issue always deterred him from family therapy. Slowly mending the broken relationships with his family and making the required amends was a big motivator for continued sobriety.

During this time, Henry decided to attend NA meetings. He shared how he immediately felt like the fellowship was a family. He was inspired by seeing other recovering addicts helping active addicts that were struggling. He shared how he began to recognize that he was more attracted to people in recovery and began establishing a sober, positive social support network.

Henry has been sober for 5-years now. He is married and has a 2-year-old son who he adores. He is working in Orlando, Florida at a high end hotel and continues to attend meetings while helping other addicts searching for recovery.

Mary Individual Textual Description

Participant Mary is a 26-year-old female originally from Washington D.C. Her drug of choice was heroin, which she began using around 16, but she started experimenting and using recreationally at 12-years-old. Mary talked about always feeling awkward and believing that the people in this world were “scary”, using drugs to feel more comfortable in an uncomfortable world. She talked about having a low self-image and used words to
describe herself at one time as “garbage” and “a piece of shit”. She shared that she use to tell herself that she got high because she “hated” herself and what is the point of getting sober if “I don’t like who I am”. She spoke of how she was able to be a functioning addict for a few years until her boyfriend passed away from an overdose and this is when her use increased.

The emotions that had been repressed for years came out in a rage and her heroin use escalated to a point where she had to partake in illegal behaviors to feed her habit. In addition, family relations ceased and “I was going to die”. She explained her first treatment experience as confusing. Meeting young people like herself but unable to connect with her peers. She spoke of not having traumatic experiences like the other clients and had a difficult time relating to them. Mary shared how she would deliberately isolate, not wanting to make friends because she knew that many of them were going to die. She spoke about throwing chairs and being confrontational whenever staff or even clients tried to speak with her or redirect her.

In and out of treatment multiple times planted some seeds of recovery but Mary was not ready to get sober. She talked about one treatment attempt that took place in the mountains, away from everything. The ability to not be distracted and living with nature helped her feel like she was removed from society. She explained this feeling as “freeing” but it was short lived as she relapsed on heroin when she returned home.

Distractions was something that Mary focused on throughout the interview. She shared that she could not get sober by doing the “co-ed thing”. Having groups with both males and females made her self-conscious and she could not open up the way she wanted for fear of being judged. Family was another big factor in terms of obtaining sobriety. Being Asian, Mary shared how her family was never affectionate or even that close. The treatment centers that provided family therapy allowed her to see a side of her parents that she had never seen before. She explained that seeing her family genuinely concerned about her eased
her anger because she believed they hated her. The family component helped her ease the internal conflicts she had with her family which helped the interpersonal conflicts that she had with them for many years.

When Mary realized that it wasn’t physically or emotionally possible for her to feel any worse than she did, and she recognized that she had no more fight left in her, she made the decision that she wanted to get sober. She chose a long term all female treatment center that was a minimum of six months. She talked about living with the same girls for six months and it feeling like a “real community” and “it felt nice”. She spoke of how she felt accepted and she felt safe. Many of the groups focused on cognitive restructuring and altering perceptions that no longer serve you. Incorporating family in the treatment process as well as daily AA meetings allowed her to learn how to reconnect with family and connect with new sober women. She mentioned how AA increased her self-esteem and gave her courage, connecting to women that she could relate to.

Mary was very adamant about explaining how treatment did not change her but it did open her mind to believing that she could change herself. Mary has been sober for two years. She works in a treatment center in Florida and is a powerful sponsor in AA helping many struggling addicted women.

Sue Individual Textural Description

Participant Sue is a 30-year-old woman from Boynton Beach, Florida whose drug of choice was heroin. Her addiction started around the age of 20, the same time she met her future husband who she quickly learned had stage four cancer. He was being prescribed opiates for pain and she would steal them occasionally to numb the pain of watching her husband slowly dying. He was given six to ten years and passed away on the sixth year. She shared that she became addicted to opiates because it numbed the pain of her reality. She explained that once her body became addicted to the drug, she became powerless over using
it. Unfortunately, the opiates became too expensive, so she turned to heroin to get a more intense high that was less expensive.

Sue had four treatment attempts, three of them in state run facilities. Structure was lacking in these facilities and it was not mandatory for clients to go to group. She explained that in these facilities it appeared that the staff did not care and they were just there for “a paycheck”. She admitted because of this, she was resistant to treatment for two years. She used words to explain herself as “angry”, “disrespectful”, “resistant”, and “a lost soul”. She shared that she isolated and had “zero” relationships with staff or her peers, taking her anger out on everyone she came in contact with. On her fourth treatment attempt, one therapist at a long term inpatient private facility would not give up on her and was determined to love Sue until she could love herself. She mentioned that feeling loved and safe is what opened her mind to the possibility of change.

When she initially entered treatment, she shared that she had no intentions of staying sober. She went to appease court. Returning to her old drug using ways was what she had intended to do after completing treatment, stating “I was comfortable there”. For years Sue had been avoiding grieving the loss of her husband. During a group session, a letter pretending to be written by Sue’s husband was written by Sue’s mother. She explained that she did not know her mother wrote the letter and the therapist had a male peer read the letter out loud to mimic the voice of her deceased husband. She shared that “I broke”. This was her core issue and she had repressed it for so long. She eventually came to believe that the avoidance of the issue wasn’t allowing her to heal. This is what Sue believed was the turning point for her to begin embracing recovery.

Intrapersonal conflicts regarding the family created intrapersonal conflicts with the family. The last treatment center Sue was admitted, had a large family component. There were weekly phone sessions and scheduled face to face sessions. Knowing that her family
was participating in her treatment process helped her believe that they still cared for her regardless of what she had done during her addiction. In addition, she explained that she had resentments towards her father that she was harboring. The family sessions allowed her to speak to him with a third party, while feeling safe and validated to express herself appropriately.

By her ninth month, she was on her ninth step of the 12 steps of AA. She believed that it was around this time that her obsession to use had been lifted. She explained that this is when she began taking suggestions and fully participating in her recovery process. Immersing herself in the fellowship with other women in recovery was a major component to motivate her to stay sober. She explained that she was just doing what everyone else in the fellowship was doing. Learning the principles of AA and living them fully is what allowed her to transform her soul. After completing treatment, she identified herself as a “woman of integrity”, trying to better herself daily.

Sue has been sober for two years. She has a beautiful one in a half-year-old daughter and is getting married to the father of her child in May 2018. She works in the treatment field and is a very active member of AA, mentoring struggling women who suffer with drugs and/or alcohol addiction.

Jan Individual Textural Experience

Participant Jan is a 28-year-old female whose drug of choice was heroin. She shared that she does not have many memories of her childhood but believed her addiction began when her brother passed away. She was in college at that time and went straight to heroin, admitting that there was no progression of less intrusive drugs. Jan spoke of how her body quickly became dependent on the substance and she used it as a way to cope with the depression and anxiety she was feeling at the time. She shared that she did not want to feel and the only thing she could do was numb herself.
Jan shared that she grew up in a home where her mother and step-father were addicted to drugs and alcohol. She shared that her she and her father never really had a relationship and he was not a significant part of her life. In addition, three out of her four siblings struggled with addiction. As a result, she did not have anyone to talk to when her brother died. She reported that she “hated” herself but could not stop using, unable to imagine her life without drugs. She shared that it was a constant battle with herself and with her family.

Having over 15 treatment attempts, Jan learned how to manipulate the system to get what she wanted. She explained herself as a “master manipulator” with her peers as well as staff when in treatment. She shared that she used to view herself as a victim and believed that the world owed her something because of what she went through. While in treatment she would befriend staff so she could get what she wanted and she usually did. Unfortunately, this created a perpetual cycle of relapse after completing treatment. She explained that she had a big “ego” and this wouldn’t allow her to take the suggestions needed to sustain sobriety. It had been suggested by multiple therapists for Jan to stop speaking to her family due to the toxic relationships that had been created because of her families’ addictions and the loss of her brother. She explained that it took her a while to sever ties with her mother because she knew once she did, her financial resource would stop. After years of refusing to do this, she eventually took the suggestion believing that this was the first step in becoming serious about her recovery.

Distractions were a very powerful deterrent when it came to Jan’s recovery process. Her physical appearance was top priority, so going to the gym and wearing high end clothes was her focus. When she decided to stop speaking to her family, she didn’t have the financial resources to support these interests, forcing her to attend groups and work a program. She explained that by this time, she had been to numerous treatment centers and heard the same
groups over and over. She shared that it was not the groups that helped her get sober; rather, it was the separation from the drugs and the alcohol.

Another distraction included co-ed groups. Having groups with male peers made it difficult for her to speak her truth for fear of being judged by men. She shared that gender specific groups was where she could really get work done because she didn’t care how she looked or what she said. She shared that she needed to cry and needed to process her life and where she wanted to go with her life. She shared that she could not do this with men in the room because they were part of her problem. “I did very well in the gender specific groups. That’s another thing, when I really wanted to get stuff out and I’m just around women, it’s perfect because I didn’t care how I looked”.

Jan spoke of the ineffectiveness of doing groups that focused on drugs because it was more about the trauma of losing her brother and growing up in an addicted home. She expressed that she knew what to do, she just didn’t know how to do it. Obtaining a sponsor and beginning the 12 steps is where “the magic happened”. Speaking to people who understand “you” and have the ability to relate to where you are emotionally is what continued to help her grow in her recovery.

She shared that the transformation shifted when the perspective about herself shifted. She shared that treatment was a “stepping stone” for her and her recovery would not have been possible without it. She believed that her pain and suffering was needed to help transform her and break family patterns.

Jan described herself during the interview as a more positive person involved in the community and a strong member of the AA fellowship. She explained that she feels as though she has a purpose now by helping other suffering addicts and instead of “picking up a drug, I’ll pick up a girl and help her”. She shared that she no longer “hates” herself and is
proud of the woman she has become. Jan has been sober for five years and works in the treatment field in Florida with the specific task of placing addicted individuals in treatment.

Jake Individual Textual Description

Participant Jake is a 26-year-old male whose drug of choice was opiates. He shared that his addiction started when he was 15 after being prescribed Vicodin for a concussion. He admitted to immediately liking the way Vicodin made him feel and quickly began abusing it. Once his body became addicted to the substance, he believed he had no control over its use and the power of choice was removed. He confessed that everything addiction related became a priority, whether it was the lifestyle or the using of the substance itself. A boy who grew up in a suburban, middle class Connecticut home, with loving parents, began stealing, lying, and manipulating for selfish gains to feed his addiction.

Jake has been to two treatment facilities, the first was a state run facility and the second a private treatment program. He confessed that his first experience was a “nightmare”. “Just like the whole experience was like not good”. He shared that he had a difficult time relating to the clients in the state run facility because most of them were homeless intravenous heroin drug users and this was not him. The only way he was able to bare the experience was aligning with two other clients who he felt the most comfortable with and had similar demographics to him. He shared that he had to “adapt” by isolating and staying quiet, avoiding confrontation at all costs. He struggled with being scared throughout his time there and never knew if staff and/ or a client would instigate an argument or even a physical fight. He shared that there were people getting “high” in the facility and the clients could do whatever they wanted, reporting no structure. “It was a shit show”. The average group size contained 25 people making it impossible to have a productive group. He continued by stating that the clients did not respect the staff and the staff did not respect the clients. He remembers people arguing and yelling for six hours every day while he attended
groups, creating more chaos in his mind than before he was admitted. He went on to explain that they were housed in a neighborhood where drugs were being sold outside their front door. He shared that he couldn’t relate to the housing staff and was guarded throughout this experience getting no clinical work accomplished. He was unable to put his guard down so there was no actual treatment occurring. In addition, client admitted that he did not go to treatment to get sober, he went to “appease” his family. He shared that he could not relate to anyone and when discharged, quickly relapsed.

Jake’s second treatment experience was quite different. He shared that he went to a private facility where the clients were from good communities and had decent families. He believed he could relate to his peers more due to the background and demographic similarities. Although, the relationships formed at the treatment center were “very surface level”, and unfortunately the only thing they could talk about was the drugs they had been using while glamorizing the lifestyle. Jake explained that he always had a difficult time forming relationships and this is why he took the opiates to begin with, “they relaxed me”. “I didn’t know what else to talk about and I don’t think they did either”. He did share that he felt safe at this facility and this helped him open up more to the staff. He believed that the staff were more available and actually “cared”. Jake explained that treatment got him off the streets and cleared his mind so he could make better decisions regarding his future.

According to Jake, what truly transformed his soul from active addict to someone in recovery included 1) being involved in the 12 step program, 2) being involved in the recovery community, 3) having a relationship with a spiritual entity, and 4) being of service to other addicts seeking recovery which gives him purpose. He shared the changes that have occurred within himself and outside himself. He shared that he reacts differently to people and is not as impulsive with his behaviors. He shared that he is able to be present in his friendships and relationships. He shared that he is no longer withdrawn from his family and is employable.
He explained how he has been able to regain all of the things he lost as a result of his addiction.

Being ready and actually wanting treatment is a huge factor in gaining recovery according to Jake. He believes that one has to commit and actually commit daily to their recovery. He explained, “it takes a commitment a daily commitment to do whatever it is that is required to mature your sobriety”. In addition he stated that “a treatment centers success is going to rely on the staff that is employed there”.

Jake has been sober for three years and is working in the field of addiction in Florida helping struggling addicts find the help they need. In addition, he continues to attend fellowship meetings and sponsors many men who have begun their 12 step journey. He positive relationships with his family and believes he is now a productive member of society.

**Albert Individual Textural Description**

Participant Albert started his addiction somewhere between 13 and 14 when he stole Tramadol from his father. He shared that he liked the way they made him feel but had no idea that they were a synthetic opioid and was not aware of the short or long term effects that would soon take place. He shared “I went into his office and just took a handful, I was bored. I had no idea what they were and I liked the way they made me feel”. He eventually progressed to Oxycontin which became his drug of choice.

Albert spoke of the time when he realized something was wrong when he would wake up in the morning and say he was not going to use and before he knew it, he would be high. He shared “I couldn’t help but use it”. He shared that he felt like he had no control. He was in denial for a long time trying to stop on his own. He was admitted to 45 detoxes and has had four treatment attempts. During his first treatment attempt, he did not know what to expect, so fear made him polite while aligning with staff. “So the first time around I pretty much stuck as close as I could to the staff. Made sure that I was extra polite. I think I tried to
play the innocent kid who never been in treatment before”. He shared that he played the victim and manipulated himself and others in believing he was ignorant and innocent in a place where everyone else appeared as “veterans”. Unfortunately, Albert was unable to get sober because he was not being honest with himself or with those who were trying to help him.

He shared that after he had been to a couple treatment centers he became more comfortable and began joking around and glorifying his drug use. It was difficult for him to connect with the therapists because he did not feel they had anything in common. It was the small conversations he had with the behavioral health technicians that began to open his mind to recovery. “It was easy to pick out a small amount of individual staff members to kinda open up to or kinda relate to and those are the ones you feel more comfortable with”. Albert related better to the technicians because they were usually younger than the therapists and usually new in sobriety, “so they are easier to connect with right away before the therapists or medical staff”.

Albert struggled with trying to conform to whoever he was around. When he was with therapists, he was serious, when he was with peers, he participated in exaggerated stories, glamorizing his addictive lifestyle. He explained it as an internal conflict. “It was almost an internal conflict of how I had to act in front of each person I came across in treatment. It was like the truth I was trying to portray versus the actual truth”. He shared that he didn’t like himself and was trying to hide the fact that he was ashamed at what he had become. But this is what came natural explaining that manipulation is what addicts do. It provided him an opportunity to create a new mask for each situation. While this was happening, Albert admitted that he did care about his recovery and his future and this created turmoil in his mind. He was upset with himself because “my feet weren’t matching my footprints in the sand”.
He goes on to explain that the environment in treatment almost creates this due to treatment being like an “overnight camp”. Having 40 up to 80 people who never knew each other, with many coming off the streets having long term active addiction and some new to the addictive lifestyle, relating the only way they know how, “through drugs”. The turning point for Albert was when he realized the truth about the negative stigmas attached to people who struggle with drug addiction. He shared a story when he was cleaning up and was pricked by an exposed needle. He immediately went to staff and they did nothing, acting as if it was no big deal quoting a staff member’s reaction, “look what you were doing when you were on the streets”. He reported that this made him feel unsafe and judged badly and he transferred to another facility. “This is when I got sober”.

He talked about meeting two counselors in this new facility who had a big impact on his life. What he remembered about them was their level of professionalism and genuine compassion for the clients they served. This helped him feel less judged and cared for not having felt this in the previous program. He talked about aligning himself with peers who were more motivated for recovery and attending AA meetings. He shared that when he was actively using the people he surrounded himself with were “loud”, “tough”, and “obnoxious”. It finally came to a point when he became aware that he wanted “peace of mind and financial stability. I needed different relationships and I just started hanging out with a different group of guys”. He stressed this point often throughout the interview.

Albert admitted that he does not know if he could say his sobriety is a direct result of treatment and believes working the 12 steps with a sponsor and going to meetings is what transformed him. In addition he shared “I definitely credit most of my transformation with the people I surround myself with”. He expressed his belief that positive change comes from being uncomfortable and moving through conflicts instead of staying stuck in them.
Albert is a grateful recovering addict who has two years of sobriety. He continues to attend AA meetings, has sponsees, and speaks regularly at treatment centers telling his story to addicts all over Florida.

Emily Individual Textual Description

Participant Emily is a 27-year-old female who began her addiction at 15. Her drug of choice was opiates, mainly “Oxycontin”. She shared that she always struggled with anxiety and the drugs helped her cope throughout high school. “I always had a lot of fears and anxiety and I was a lot more outgoing when I was on drugs”. Prior to her addiction, Emily reported that she was a cheerleader and a dancer but always felt like there was something missing. She shared that she just “fell into drugs” using them recreationally at first. “I liked the way they calmed me down”. As a result of the numbing feeling, she began taking more of the substance until she was unable to control her use. She shared that she was unable to stop “and just kept going and going”.

By about 16, Emily dropped out of cheerleading and dance and began using daily. Her use escalated quickly until eventually nothing else mattered but getting high. She explained that she stopped speaking to her friends who were sober, avoided her family, and began hanging out with peers who were also using drugs and drinking alcohol, able to identify with this group due to similar lifestyles. She went on by stating that “this went on for years” until “I got arrested”.

She shared that she never wanted to go to treatment but at that point believed she did not have a choice. “I went to treatment because I went to jail and that was my only choice to stay out of jail”. During this time Emily continued to struggle with believing she had a drug problem and minimized the consequences of what had occurred due to her drug use.

Prior to jail, there was no conflict as she rationalized and justified her behaviors creating a perception that she could stop anytime and it wasn’t as bad as it truly was. She
shared that “the first conflict I had was definitely with myself and opening myself up to believing that I really had a problem, realizing that I can’t do certain things. I can’t go out and drink with my friends anymore”. The second conflict that Emily shared was with her family and how “they went out of my life”.

Emily reports one treatment attempt believing that leaving New Jersey to come to Florida would not have happened had she not been arrested. She shared that when she was admitted to the facility she immediately struggled with entitlement. “I’m spoiled. My whole life. I’m the only girl in the family. I wanted the phone, or just any kind of NO, it’s not what I wanted to hear”. She expressed that she had been living a certain way since 15 and was numb to her own emotions. “Anger was just normal”. She shared that the staff at the treatment center were patient with her but it took time to connect with her therapist. “I actually really got along with the staff when I went to treatment. My counselor not so much at first because I had no emotion and I believe that crying was a weak emotion. I’m not supposed to cry in front of people”. The idea of crying is weak is an agreement with the self that was learned and needed to be unlearned.

According to Emily, the size of the groups mattered. She expressed feeling less anxious in the smaller groups. She continued by reporting groups that focused on self-awareness were what helped her become honest with herself and her feelings that she had repressed for years. “My therapist made me do like a body dysmorphic activity and I had to outline my body and kind of fill in things that I thought represented me. That kind of made me think about a lot of things with me and everything about my addiction”.

In addition, conflicts with her family were addressed by her therapist. Emily believed that the relationship with her brother was over and this created added conflict in her mind, having resentments towards herself. “The letter from my brother was amazing because I read
the letter and I was able to have an emotion and I actually read that he still loved me, and that I was able to get my friendship back with him”.

Through the process of treatment, Emily began noticing that people she thought were her friends were not. The connections she had with people when she was partying were gone. In addition, she re-established connections with friends she stopped talking to when she began her addiction. “The people that I thought were my friends weren’t my friends and the people that I really had no connection with anymore. People knew I was in treatment, and they kind of reached out to me when I was down there, these are friends who I had before I started partying”.

Emily took the suggestion of not returning to New Jersey for one year. This was a struggle for her because she wanted to go back “home” since arriving to Florida. She explained, “my biggest struggle the whole time when I was there that I’m going home as soon as I get out of here and a lot of people like my mom said NO, you couldn’t come home”. “It was suggested to me to not go home but my mom also didn’t want me home”. She shared that she believes if she had went home earlier than she did “I definitely think I would’ve used again”.

During Emily’s first year of recovery she attended AA meetings, obtained a sponsor, and worked the 12 steps. She is one of the two participants out of the 15 that is no longer working a program. She presently lives in New Jersey and is working in the treatment field as a computer technician. She shared that she has a lot of interaction with the clients and this reminds her of a place she does not want to be. She has been sober for two years and shared “it’s really cool to not have to worry if I’m going to be arrested or someone’s coming after me”. She did share that continues to feel anxiety but continuing her drug lifestyle is not an option, “I just deal with it”.

Angie Individual Textual Description

Participant Angie is a 24-year-old female whose drug of choice was heroin. She shared that her addiction started around 13, when she had her first sip of alcohol and started hanging out with the wrong people. The characteristics of this crowd included “people who weren’t really caring about school, people who wanted to smoke and do all these things”. She shared that she always felt “awkward” and “stupid” and she felt comfortable around this new group, identifying with them. “I felt comfortable with people who wanted to do bad things because I thought your stupid, what’s the point anyway”.

Intrapersonal and interpersonal conflicts started with Angie around her pre-teen years. She shared that her mother would make comments about her weight and tell her frequently that she was getting big. She shared that her mother would ask her almost daily “when are you going to lose weight, when are you going to lose weight”? She shared that “that sent me over the edge”. In addition, she was in special education classes for a speech impediment that added to her insecurities. She shared that she was bullied in school and this completely put her in an emotionally dark place. Angie admits to sniffing her first bag of heroin at 14, going from recreational alcohol use to heroin use quickly. She shared that she didn’t care. She was struggling with body issues, resentments towards her mother and would party every weekend. “I felt that’s what life was about and I would tell myself why try to be something better”. She shared that she wanted to numb her feelings and did not “want to be alert, I wanted to be just nothing, just knocked out”. She shared that there were times when she wanted to stop “but I just couldn’t”. This victim mentality created a perception that sent Angie on a journey of over 15 treatment attempts.

Being in so many treatment centers taught Angie how to hide her feelings and her truth. “I would be the one who would come to treatment and always be smiling and loving others and always be smiling. But I never let people know how I was really feeling and that’s
what kept me sick”. Her inability to be her authentic self only exacerbated the problem. She shared that when she did not feel comfortable with staff she would just say what she had to say “to get by”. “When I didn’t feel comfortable with the therapist, I just shut down”.

Conflict avoidance was a tactic Angie continued to use throughout her treatment attempts.

Family therapy was not a good experience due to the deep seated resentments Angie had with her mother. She explained that when the therapists would get her mother involved she would again, “shut down”. She went on by reporting that there were many issues she and her mother had throughout her childhood and she was not ready to address them. This was one of her core issues that Angie was avoiding and unfortunately kept her sick.

Trusting your therapist and building a positive interpersonal relationship is what allowed Angie to open up more than she ever had during past treatment experiences. She believed that “if you don’t trust your therapist and you don’t feel that connection it makes it a lot harder because you won’t ever open up”. In addition, doing activities about body image and increasing self-esteem is what began altering perspectives to change existing identity beliefs. “When you get sober and you ever wanted to deal with body images I think doing activities on them is what’s important”.

Treatment was difficult for Angie because she shared that for the most part she did it to appease her family. She adamantly stressed the point that “you have to want it”. She shared that she did not want it for years because she had a very low self-image and did not believe she could be anything better than an active addict. The idea of what she thought she should be was not matching with the idea of what she thought she was. Her mother’s voice would continuously resonate in her head and this would remind Angie that “I’m not good enough”.

Through building a therapeutic alliance, clearing her head by staying sober, learning how to establish actual and emotional boundaries with her mother, Angie began feeling better
about herself motivating her to keep moving forward with her recovery. Her last treatment center took weekly field trips to outside activities that attempted to integrate their clients to the rest of the world. Activities like “ice-skating, bowling, certain things like that to get you out there” is what helped her feel less institutionalized and more like an actual member of society.

Angie shared that after her first three weeks of staying sober at her last treatment center, “I got a sponsor”. She shared that she began working the 12 steps and talked openly to her sponsor. “I let her know everything about me because I couldn’t do this anymore”. After she completed her 12 steps, Angie shared that she began to sponsor young women and this helped give her a purpose and provided meaning in her life. She shared that she began working as a Behavioral health Technician at a treatment center in Florida and “I love what I do”. She shared that people respect her and this feels good.

At the time of this interview, Angie had been sober for one in a half years. She has since relapsed and is living in Connecticut, homeless and actively using heroin.

Carl Individual Textual Description

Participant Carl is a 28-year-old male whose drug of choice was heroin. He grew up in Connecticut in a predominately white neighborhood and is of Puerto Rican descent. He shared that his mother passed away when he was young and his father remarried when he was 10. He reported that his step-mother also passed away. He explains that he began smoking marijuana and drinking alcohol at the age of 11, never really liking the feeling, “I just did it”. He shared that he sniffed his first bag of heroin at 18 and was using this substance intravenously by 21.

Carl could not recall the amount of times he went treatment estimating about 10 attempts. He shared that the experiences and relationships he had with staff and peers changed “drastically” between his first treatment attempts to his last. Carl explained himself
as being emotionally awkward, finding it difficult to connect with people. “People didn’t understand me. It’s hard for me to connect still”. He admitted that the staff had a major impact on his recovery during his last treatment attempt. “The staff, they played a major role the last time I went to treatment”. He remembers how the staff made him feel accepted and at ease with who he was. He shared “they made me feel accepted and normal. They made me feel more at ease and able to open up more my mind a little bit more and feel accepted”. He shared that “the level of genuine compassion and empathy was major. Someone just listening, someone just being there, you know what I mean?” The power of interpersonal relationships between staff and client is what enabled Carl to continue with his sobriety.

Initially Carl had a victim mentality and a problem with authority. He shared that conflicts were “what I saw at the time, were issues with myself that I had to learn that I was putting on to other people”. Like with staff telling me I had to clean my room. And I would get upset and get mad. I can see now that that had nothing to do with them, I got mad because of me. But at the time I would blame them”. In addition Carl would defy treatment rules. He shared that it was a rule not to engage with females but “I didn’t listen”. This allowed him to distract from himself. He shared that he continued to break the rules until he realized he was “repeating the same mistakes over and over again and was having bad results”. Once this awareness surfaced, Carl began “conscious decisions” to abide by the guidelines of the program. He explains “it was definitely internal change”.

Some of the distractions that interfered with his progress included co-ed groups and large groups with over 20 people. He shared that he could not focus when there were females in the groups and would focus more on the females than on is recovery. He shared that females had been an issue when he was actively using. He continued by reporting that large groups did not provide the attention and guidance that he felt he needed stating “it was just a sea of tons of people”. He continued reporting “the best is when it was small groups and I
was able to be guided and receive attention”. The bigger facilities, with nonprofessional staff were major issues for Carl. Witnessing clients not wanting recovery or even using drugs while in treatment was a big challenge. He shared that having to work with staff who were “in it for the pay check” influenced him to continue to blame external circumstances for internal pain.

During Carl’s last treatment attempt, he shared that he kept to himself and was very mindful with who he allowed into his personal space. He shared that through his treatment journey how he identified himself shifted “I am not the same person that came to or from Connecticut. The kid that was hanging out on the streets with homeless people and carrying myself a certain way. I slowly reverted back to the person I was raised to be. The way I spoke, the way I walked, the way I carry myself changed”. He shared that his ability to remain sober depends on who he surrounds himself, reporting on the power of group identification.

Carl expressed strong feelings against the stigma that has been placed on addicts when talking about how addicted individuals get treated by society and how this enables struggling addicts to stay sick. He shared “I think something that can be lost in treatment centers is the level of humanity. I think this needs to be understood, that they are dealing with actual people”.

Carl has been sober for three years. He lives in Florida and is working full time at a treatment center. He does not attend AA but follows the principles of each step. He shared that he knows his worth “now”, is “self-aware”, and “I recognize healthy versus unhealthy decisions”.

Randy Individual Textual Description

Participant Randy is a 24-year-old male whose drug of choice was heroin. He reports growing up in a loving home receiving everything he needed and shared he had a great
relationship with his family. He shared that he started with alcohol and marijuana as an early teen but realized he was an addict around the age of 21. He shared that he recognized he could not stop using heroin and was unable to “deal with my emotions”. He reported “It could be a bright sunny day and I would still get high or drunk”. He went on to state that “my girlfriend could break up with me and I would get really depressed and would have self-pity”, justifying his continued use by creating a victims mentality. For him, the circumstances did not matter, “I wanted to use and I wanted to keep using”. He shared that once he started using drugs, he began avoiding life, “I ran away from all my problems”.

Randy reported having about 5 treatment attempts. He shared that by the last attempt, treatment was really about getting him off the streets so he could clear his head. He shared that not everyone in treatment wanted treatment and a big part of his motivation relied on the peers he aligned with. He explained that his first four treatment attempts he did not take seriously and would relapse quickly after being discharged. By this time, he no longer had good relationships with his family and was partaking in criminal behaviors to pay for his addiction.

During his last treatment attempt, he stated that he wanted to leave against clinical advice. He reported that a behavioral health technician spoke to him. He shared that “I needed someone to talk to. I needed someone to listen to me”. The advice that was given was to pray for others and “others will seek you out”. He continued and shared “I started doing that and some guy, another client, came up to me and asked if he could talk to me and needed help”. He reported that helping another client actually helped him. This new perspective of being of service to another promotes a positive self-image of feeling needed in the world. This was the beginning of Randy doing service work that the 12 steps of recovery promotes. Randy ended up asking the Behavioral health Technician to be his sponsor.
Family was a big component for Randy. He shared that they lost trust in him and the loving relationships they had when he was younger no longer existed. He shared that when he called his father after being admitted to his fifth treatment center, “my father freaked out on me, my mother started crying, and my dad pretty much said you’re on your own.” The relationships with his family remained strained for a while; however, the boundaries that his family created, motivated Randy to move forward with his recovery process, “I really had to put in work to build [trust] back with my parents”.

Randy shared how attending groups was difficult when there were 30 to 40 clients involved. He shared that there were too many clients and many did not want to be there, distracting him from his sobriety. Disclosing personal issues was not going to happen in a room full of addicts, when most of them did not want to be there. He shared “the bigger type settings of groups did not do me well because I liked to do more of the personal, like individual sessions. Just, you know talking to people individually and kind of working through things”. In addition, he strongly believed what worked for him was going to outside meetings. He shared that he tried every other way to get sober but never worked an AA program, never doing the 12 steps. He admitted that “while I was in treatment they would take us to meetings and it didn’t push me away, it kind of threw me in because it talked about solution”.

Randy reported that working the 12 steps and being a part of a fellowship is what got him sober and what has kept him sober. He shared “I found my solution in Alcoholics Anonymous”. He credits the fellowship, his sponsor, and the people he surrounds himself with for transforming his soul promoting the power of group identification. He shared “I take very little credit for where I am today and ultimately, I give it to God”. He shared that he has transformed in multiple ways as a result of his treatment experiences. He reported that he is not as “explosive” as he used to be, he has genuine care for other individuals, and provides
service to other struggling addicts. He shared “there is absence of motive, I don’t want anything from you”. Randy believes that treatment was necessary for him because it pulled him from the streets and away from society. “Being put in a facility where I could be safe, not use, and actually clear my mind a little bit”. He went on to state that treatment will not keep him sober and he needs to be involved in a fellowship to continue his evolution.

Randy has been sober for one in a half years. He is very involved in AA and is working with sponsees, guiding them with their recovery process. He has reconnected with his family and is happy to report that “we are closer than we were before”.

**Cole Individual Textual Description**

Participant Cole is a 26-year-old male whose drug of choice was Oxycodone 30. He reports feeling “different” throughout his childhood and never felt that he was accepted. He explained “all I ever wanted was to be accepted”. He shared that he began his addiction at 14-years-old. For him, it was no great mystery as to why he progressed quickly into his addiction, “I was very young and I hung out with the wrong people. I hung out with people that I never thought I would have”. Cole shared that he felt as accepted as he could, “running” with the wrong crowd due to the stigma addicts had in the southern state he grew up in. He explained “coming from my hometown you’re either an addict or you’re not and they really treat addicts bad”. He continued “it was the label you were going to get the rest of your life”. Cole explained how addicts are marginalized and judged, creating an identity of an outcast. He shared that he kept his use a secret for many years until he could no longer.

He talked about how his life became “unmanageable”. He shared that he became a “hellion” and was “disturbed”, aware that “I was going down the wrong path”. He shared that he was “bitter” and “angry” but did not know why. He shared “when I was young I loved conflict, if you do this to me I’ll show you”. He shared he found comfort in the opiates because they “numbed my feelings” and allowed him to continue with his addictive
behaviors. He shared “when I was high I didn’t care, it’s when I came down that I felt like shit about who I was”. The intrapersonal conflicts within the self, created feelings of guilt and shame for Cole that fueled his addiction as well as created interpersonal conflicts with his family and people in his community.

Cole explains that his body couldn’t handle the toxins he was ingesting and “I almost died”. He shared that he went to the emergency room after collapsing and had to go for immediate surgery. He shared that he did not know if he was going to live or die and for the first time his father was there for him. He explained that his father was “really tough love on me but at 22 he stayed in the hospital with me for five weeks and he prayed to the good man above, if you get my son healthy and alive, I’ll change”. He shared that after seeing his dad change his lifestyle, “I needed to change mine”. This is when he told his family the truth about his drug use and they sent him to Florida for treatment. Cole is just three out of the 15 participants who has had only one treatment attempt.

He shared that “I was ready”. He commented “when I got there it could’ve been one of the most nastiest, grimiest places and I would’ve completed”. The decision to change his life was made, as he resolved the intrapersonal conflict of deciding if he wanted to change. He shared “I came down here to better myself … I had to make myself happy”.

Some of the conflicts Cole faced included the reality that not all treatment centers focus on health and healing. There were many times he wanted to leave stating “it took a toll to see just how mean and greedy people can be”. The internal and external conflicts he endured had to be resolved or he would have left. Had it not been for the behavioral health technicians and their support, “I probably would’ve left”. Learning the truth about the addiction field was a hard reality that Cole had to face, for him “it was very sad”. Another hard lesson Cole talked about was the amount of clients he witnessed leave treatment and die
the next day. He shared “I didn’t want to be the guy who went to treatment and was dead the next day”.

He shared that when he entered treatment he surrounded himself with people that could help him think differently. He explained “when I went to treatment I immediately went to people who had what I wanted and I stuck with them because I wanted to be taught a new way”. He reported that he began going to AA meetings and immersed himself in the fellowship. He shared that he changed “people, places and things right off the bat”. He believed that it was through the fellowship, meetings, working the steps, and reconnecting with “God” is “what changed me”. Cole explained that the new people he surrounded himself with helped him change his thinking stating “now, I’m like, I care more about how I treat others”. For Cole changing his thinking is what changed him. He reported that he learned to “notice the potential I had which made me more confident that I didn’t have to pick up”.

Participant Cole has been sober for 2-years. He works as a behavioral health technician at a treatment center in Florida. He is very involved in the AA community and sponsors men who are struggling with addiction. He has a renewed relationship with his father and visits his family often.

Amy Individual Textual Description

Participant Amy is a 25-year-old female whose drug of choice was heroin. She shared that she never really felt like she fit in and began experimenting with marijuana and alcohol around the age of 13. She reported that she began taking opiates around 14 and progressed quickly to heroin. Amy made it clear that she never intended on becoming an addict, “I didn’t know what I was doing or what I was getting myself in to”. She expressed that once her body became addicted she couldn’t stop stating “it’s like not being able to stop something once I’ve started, like a complete extreme”.
Amy shared that during her first few treatment attempts she was judgmental with her peers and entitled with the staff. She shared that she would become confrontational with staff when “I didn’t get what I wanted”. She shared “I got along with staff when I got my way … like if I didn’t get my cigarettes I would lash out”. Believing that she had a problem was a conflict Amy struggled with for a year. In an attempt to resolve this conflict Amy would mentally convince herself that she was not like other addicts. She shared “I judged them because I didn’t want to be like them”. Creating separation internally and externally from her peers kept her sick by denying the severity of her circumstances.

Amy stressed the importance of connecting with her therapist. She reported that she worked with many who she felt were judging her and as a result, she did not trust. This lack of trust made her guarded which deterred her from being honest. She shared “If I connected with a therapist then I was able to be honest with them. Because I’ve had therapists where I felt judged like a cookie-cutter type of therapy, like it wasn’t personal. But like then I had one therapist that I connected with, I connected with her and I actually listened to her”. The ability to trust her therapist and feel safe enabled Amy to be honest and take the suggestions given.

Amy entered treatment with an extensive legal history due to her addictive lifestyle. She shared that she struggled with internal conflicts because she had to “let go” and allow the treatment centers staff to help her. She explained “I had conflicts within myself because I had a lot of court dates and so being able to not put my hands over that and having someone else take care of it for me was stressful”. At times Amy would become confrontational with the staff because she wanted certain things relating to her legal issues to be handled immediately, “according to my time”.

Another conflict Amy experienced was with her family. She shared that they would not let her move back home to New Jersey and she felt “forced” to stay in Florida. She shared
that she would have phone sessions with them, arguing because she tried to manipulate them to allow her to move in with them. She said that she was “fearful of change at that time” and had to learn to “surrender and accept the situation”.

Amy admitted that she struggled with communication skills, “I didn’t know how to talk to people”. She shared that she benefited from groups that taught communication skills stating “The group on communication was good because I’m not really that good at that. I wasn’t like listening and digesting what other people were saying at the time and so I really didn’t know how to respond … I pretty much didn’t know how to listen.” A second group that Amy benefited from was the gender specific groups. She was adamant about the importance of separating males and females in treatment to avoid added distractions. She shared “I also think it’s better to keep genders separate throughout treatment … first of all when you come to treatment you’re already broken and shot … so you’re always going to want validation from whoever”. For Amy the gender groups allowed her to “focus more on bettering myself then worrying what they guys thought of me”.

The idea that treatment is a place where an addict gets off the streets and has an opportunity to “get your head straight” was also discussed. Amy believed that treatment was the first step that prepared her for the next when discharged back into society. She shared that attending AA, connecting with other women in recovery, and working the 12 steps is what has truly transformed her. She shared that she feels more spiritually connected, is more outgoing, and no longer isolates. She reported that “I’m happier, you know, my anxiety has gone down a lot”. She explained herself as being a woman of “integrity”, a woman who is “honest”, and is “selfless”. Implementing these principles created a lifestyle that has allowed for continued self-actualization. For Amy the principles of AA have allowed her the opportunity to have another chance at life. She explained “people don’t get to live by the
principles that I get to live by … it’s like some people don’t know that you’re in recovery and they don’t know that you used to be this crazy person”.

Amy has been sober for 2-years. She is an active member of AA and sponsors many women struggling with drug and/ or alcohol addiction. She speaks all over Florida sharing her testimony to other addicts. Amy works at a treatment center in Florida and visits her family in New Jersey often.

Bob Individual Textual Describing

Participant Bob is a 28-year-old male whose drug of choice was heroin. He began smoking cannabis and drinking alcohol at the age 14, progressing to heroin by the age of 20. He shared that he was initially in denial about the severity of his “disease” but quickly began to accept that he had a problem explaining “my disease progressed and like my behaviors changed”. He went on to report “I lost relationships, I lost jobs”. He explained his addiction as a “bondage of the mind, feeling like your mind is in prison”. The theme of powerlessness is mentioned yet again as Bob shared having an addiction means “to be powerless [and involves] bad thinking”.

Bob has had six treatment attempts. He shared that he always tended to gravitate towards the wrong people stating “I always seemed to go with the people who weren’t really serious about their recovery”. For him, it was “like a game”. He shared that he would break one rule whether it was fraternizing with the females or bringing food into the facility. He explained it as being his “form of manipulation”. Bob explained that the biggest conflict he had was with himself. He shared that “I would start thinking of things I’d done right before I would get in. I would focus on the damage that I had done throughout my addiction … and I would feel really bad about myself”. He shared how his own self stigmatization kept him spiraling out of control. He shared that he initially did not want to face himself and this kept him sick. The relationships that he formed with negative peers and relationships he had with
female peers distracted him from the work he needed to do so transformation could occur. These behaviors continued throughout his first five treatment attempts and as a result, he continued to relapse after being discharged.

Bob shared that the last treatment center was very strict and “they didn’t put up with my bullshit”. He shared that he attempted to manipulate the staff but he could not. He stated his life had become so unmanageable and this is when he finally came to the realization that he wanted to get sober. For Bob this was the change maker. He shared “I’m a true believer that you can get sober anywhere, whether it be a bougie facility or a state run facility, if you really want it, you will do what it takes”. Bob made a conscious decision to get sober, no longer conflicted with the idea of getting sober.

It was after this realization that Bob began taking suggestions. He shared “I just listened to people and did what they told me to do. Even something as simple as making my bed or doing the dishes getting to group on time or like not talking to females”. Taking the suggestions of writing his life story was something Bob shared helped him realize the truth of his situation. Putting his story on paper and reading it out loud forced him to recognize where his life had gone. Having awareness and admitting his wrongs guided Bob to move past some of his conflicts.

Bob’s last treatment facility had groups throughout the day that separated the males and females. He explained “another thing that was beneficial was that we would have these groups where it was basically just gender groups. So separating the males and the females helped me a lot too”. He shared that he learned how to have toxic relationships during his active addiction and reported “they always say that alcohol and drugs are a problem in treatment but I also had a problem with relationships”. These groups allowed Bob to share things in groups that he normally would not have shared had females been in the room.
Throughout Bob’s treatment experiences he shared that he learned quickly which facilities were about the business and which really “cared”. He explained “you can tell when a treatment center was more focused on the business and not client care”. He went on to share one treatment center “wanted so many clients that they just weren’t ready for it so the quality of it turned into quantity and it was just a really bad turn off”. Unfortunately this seems to be happening more frequently which is creating a negative stigma towards treatment. He acknowledged that “it’s like a trickledown effect when you have owners who are more about the money it trickles down to the staff and then eventually hits the clients, we see it”.

Bob shared that once he began learning about the 12 steps and living according to the principles things true evolution began. He reported that he learned to take suggestions and he follows a higher power. He reported “I didn’t know what it was like to be a man so for the past two years I continue to do what I faithfully started to do when I committed to my recovery, which is take suggestions, follow the steps, turn to God”. He explained that he needed more than the treatment experience and his “real work” began when he joined a fellowship and got a sponsor.

Bob lives in New Jersey. He is very active in AA and has been sober for one in a half years. He is very involved in the fellowship and sponsors males, guiding them through the 12 steps.

Cody Individual Textual Description

Participant Cody is a 27-year-old male whose drug of choice was heroin. He reported that his addiction started when he was 14-years-old after being prescribed opiates due to a dirt bike accident. He shared that five years later, he began injecting heroin. The decision to come to Florida for treatment was his decision. He reported internal and external conflicts starting when he got on the plane from Ohio because his parents did not want him to leave. He shared that they were worried about all of the “bad things they heard about treatment” and
did not think he would be safe in Florida. The stigma of treatment almost deterred Cody from entering treatment but his addiction had gotten so bad admitting that he was physically and mentally dependent on heroin and he was behaving in ways that “just weren’t me, I’m not a criminal”. He shared “I didn’t know who I was anymore… I had to go”. He shared he felt guilty about leaving his family and was fearful that treatment wouldn’t work. He explained “I had a lot of guilt a lot of shame and not knowing if I was going to do anything or if I was going to be coming back to Ohio or staying in Florida”.

Cody has had one treatment attempt. He went to treatment with the mindset of having no other choice, “I had to do it”. Cody believed that his first week of treatment was the hardest. Admitting the truth about where his addiction took him was overwhelming. He reported “it was really bad about learning all of the problems that I really did have and how bad the issues with drugs really was”. He admitted to not knowing how to have relationships and feeling sorry for himself, blaming doctors for his addiction. This victim mentality is what kept him sick during his active addiction. Awareness allowed his to take responsibility for his recovery. He believed that he was lucky because he was immediately assigned a therapist who he trusted and did not feel judged or stigmatized. This interpersonal relationship motivated Cody. He shared “you could tell he was passionate, you could tell that he wasn’t there for the paycheck and that he was a genuine good person and you could tell that he was doing this because he genuinely wanted to help others”.

Because Cody entered treatment with the mindset of “I have to do it”, he gravitated towards other clients who were serious about their recovery. He shared that it was not hard to distinguish between the clients who were there for the wrong reasons versus who was serious. He mentioned that the large groups were the most difficult because it forced him to be in the same room with people who did not want to get sober. He shared “I liked the small
groups … they were much better than like the groups with 30 to 50 people in it … they were a shit show”.

Cody shared that the biggest change he has seen within himself as a result of his treatment experience is “the way I think”. He shared that before treatment he was “ego driven” and “self-centered”. He shared that he now has “self-awareness” and has “self-worth”. For Cody one of the most profound changes that he has made in his life was to join AA. He reported that obtaining a sponsor and working the steps taught him a new way to “see life”. He shared that this has changed many of his perspectives. He admitted to surrounding himself with people in the fellowship who he aspires to be like and has learned how to make genuine connections. He shared “the people I connect with an AA, we all want to grow, and we’re like on the same path”.

Cody remained in Florida and never went back to Ohio. He is very involved with his family who are now grateful that their loved one went to treatment. He has been sober for four years and continues to attend AA meetings and sponsors men struggling with addiction. He presently works in the treatment field continuing to guide others towards their transformational process.

**Ben Individual Textual Description**

Participant Ben is a 29-year-old male whose drug of choice was heroin. His addiction began at 10-years-old when he started smoking marijuana progressing to cocaine and opiates at 12-years-old. By the time he was 14, he was injecting heroin. For Ben addiction is a “mental thing”. He shared that once he started he could not stop, stating “when I use I end up doing terrible things and I end up in really worse situations”. He admitted that when he first went to treatment he did not want to get sober and went because he was court mandated to go. Due to this mindset, Ben had a difficult time connecting with the staff and related more to the clients, listening to their suggestions while defying the staff. This “us” versus “them”
attitude kept Ben from a sober lifestyle feeding his addiction. He shared that it took him 10 treatment attempts before “I got it”.

Ben talked about being hypersensitive to staff. He shared that he would judge them by the amount of time they spent with him. He explained “if I saw a therapist in group settings and like individual sessions it was hard to relate”. He continued by explaining he believed that if a therapist truly cared they should go out of their way to talk to him. Ben later came to realize that staff did not want to be around him because he was aggressive and disrespectful to them. Continuing to blame staff’s lack of attention justified his negative views of them. This victim mentality deterred Ben from taking personal responsibility thus keeping him sick.

It was not until Ben was facing long term prison time that he decided to take some of the suggestions that was being asked of him. He shared that he had a therapist that was honest with him and told him that “I needed to stop acting like a child”. He shared “one day he sat me down and told me, he said that if you could write down 15 feelings on a piece of paper, I will let you go and I will sign your completion papers”. He reported that the only feelings he could write down was “happy”, “mad”, and “sad”. He shared “I couldn’t explain any other feeling that I had felt in my life”. Ben reported that he became very angry and walked out of the office. He shared that as he was chain smoking cigarettes, he came to the realization that he was not aware of anything going on inside of him. As his anger escalated he became more disruptive. He shared that not only the staff was confronting him about his behaviors but now his peers were as well. This was a change maker for Ben. He was in a position where he could not relate to the staff and now he could not relate to his peers. He shared “I was lost”.

Ben had been in denial for a long time about the damage he had caused his family. He shared that his last treatment center had a large family component. He explained that his therapist asked his family members to write letters explaining how Ben hurt them. He shared
“my youngest brother was what hit me the most. He was like seven and it was literally just like, he wrote I hope you get better and like scribbled it out and then wrote I just want to see you soon … It literally hit me that my youngest brother knows that I’m a mess”. New awareness of Ben’s situation provided the motivation to move forward.

During his last treatment attempt, Ben went from pre-contemplation stage of change to preparation stage of change. He shared that “working with my therapist and some of the community members they literally attempted to complete me but I actually begged them to keep me longer because I knew I wasn’t going to do well”. The treatment center scholarhiped him for another two weeks allowing him to remain in treatment for free. This once again, shifted Ben’s perspective that “maybe they don’t hate me”. As a result of trusting the staff and the process, he was able to put his guard down and “I started learning what really made me tick”.

After completing treatment, Ben reported that he became very active in the 12 step fellowship. He continued treatment for another four months and lived at a male sober living facility for a year. He shared that this is what kept him sober, “I just have to stay connected to other recovering addicts”. He shared that he lives by the principles of AA and strives to be a better person every day and “a contributing member of society”.

Ben has been sober for nine-years. He continues to attend AA meetings and is actively involved in the fellowship. He sponsors many men struggling with addiction and works in the field of addiction in Florida.