The cycle of relapse and recovery of substance misusing offenders on a community based rehabilitation programme: The impact of childhoods, family, relationships, significant life events and psychological wellbeing

An Interpretative Phenomenological Analysis and Approach

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ABSTRACT

Background and aims

There is a paucity of research into the relapse and recovery of Class A drug misusing offenders who are part of the Drug Interventions Programme (DIP). The key aims of the DIP, a UK Government criminal justice strategy, are to reduce Class A drug misuse and the [perceived] associated offending behaviour. This group have entrenched and long lasting addictions, with many ‘failed’ attempts at recovery. There is no published research about DIP clients, using a qualitative methodology, which explores childhoods, relationships, psychological health and significant life events and how these might impact on drug use, relapse and recovery from their perspective. The aim of the research was to ask community based DIP clients what they considered to be important factors in their relapse and recovery and to explore how they understand and make sense of these. Theories within the developmental psychology field, some of which have not been extensively applied within the addiction field, have helped to inform the research.

Method and participants

To address a gap in the field, an Interpretative Phenomenological Analysis (IPA) was adapted for use with a focus group design (four Focus Groups, total N= 10), to explore the value and merit of the research question. These findings helped to inform semi-structured interviews (N= 17) using IPA. Participants were adult men and women who were either current or past DIP clients recruited through the DIP teams in England.

Findings

The following themes were developed from the semi-structured interview study: 1) Experiences of abusive childhoods – links to emotions that were experienced as damaging/harmful and problem behaviours; 2) The divergent and damaged selves – links to substance misuse; and 3) Drug use to cope and survive dangerous events and trauma/responses. Recovery was about managing these in a healthier way. A fourth theme showed how participants’ experiences changed during transitions into and out of recovery, for example the presence or absence of supportive networks.
Conclusion

The research has implications for theory, policy, practice and future research. This includes the provision of trauma based therapy and supporting clients to manage their emotions as well as their wider mental health problems. The importance of an integrated framework of theories from a developmental attachment, trauma and family systems approach to inform training and practice are highlighted from the findings.
DECLARATION OF ORIGINALITY

This thesis and the work to which it refers are the results of my own efforts. Any ideas, data, images or text resulting from the work of others (whether published or unpublished) are fully identified as such within the work and attributed to their originator in the text, bibliography or in footnotes. This thesis has not been submitted in whole or in part for any other academic degree or professional qualification. I agree that the University has the right to submit my work to the plagiarism detection service Turnitin UK for originality checks. Whether or not drafts have been so assessed, the University reserves the right to require an electronic version of the final document (as submitted) for assessment as above.

Beverly Love
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I am grateful to Professor Jan Keene for starting me on this journey at the University of Reading and to the University of Reading for providing me with a bursary to continue my PhD at the University of Surrey.

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I would like to thank the Home Office for permitting me to conduct this research. I will always be grateful for the support from my colleagues at the Home Office during my research endeavours. I fully appreciate that it was new territory through which both parties had to navigate their way. My intention with this research is to help to improve policy and practice and to therefore improve peoples’ lives – aims and values which I held during my time as a civil servant for the UK Government. I hope that the findings in this research go some way to achieving those shared aims and values.

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In loving memory of

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and

Edmund Faris, the best father-in-law I could have ever wished for.
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CHAPTER 1: ORIENTATION TO THE THESIS

1.1 Political influences and terminology

This research represents a synergy of both my own personal political opinions, which have been influenced by my career working in UK Central Government Departments for over 12 years and my training in Psychology over several years. It should therefore be acknowledged that any such political opinions contained within this thesis and not specifically referenced or accredited to others are my own and do not necessarily reflect UK Government policy or opinion.

The term ‘drug misuser’ and ‘drug misusing offender’ were the terminologies favoured by the Home Office when referring to offenders who had severe and entrenched Class A drug addictions, primarily with crack and heroin. These terminologies will be used throughout this thesis to refer to the participant group who were part of the UK Government’s Drug Interventions Programme (DIP). As will become evident throughout this thesis this group have substance misuse problems also known as polysubstance misuse. However, Class A drugs are this group’s primary drug of choice and it is the perceived link between their use of this Class of drugs and their acquisitive offending behaviour which brought them to the attention of the UK Government, Home Office’s Drug Interventions Programme.

1.2 Background to the research question - my role as a policy adviser on the Drug Interventions Programme

The specific background to my research stemmed from my time working as a policy adviser for the UK Government Home Office, on the Drug Intervention’s Programme (DIP). The key aims of the programme were to reduce the Class A drug misuse and the [perceived] associated offending behaviour. There was recognition among policy makers, politicians and practitioners that this group had severe, entrenched and long lasting Class A drug addictions, with many ‘failed’ attempts at recovery. However, from my observations of working in the policy for over eight years (2002 – 2010), I thought that the emphasis of the rehabilitative interventions had been about the practical elements of support, such as providing housing, employment and educational
opportunities and that this was not adequately addressing the underlying reasons for the drug misuse.

There was some acknowledgement in the DIP policy that the role of family members had some relevance but this was in relation to rebuilding those relationships in recovery. My findings will highlight that family has a significant and important impact, not only on this group’s Class A drug use, but also on their wider substance misuse during relapse as well as recovery. Furthermore, that rebuilding those relationships in recovery might not always be appropriate.

I also believed that the mental health of this group was never properly understood nor that there was a concerted effort from the top down to address this among DIP clients at the time. My research will also highlight the impact of the participants’ mental health and their wider psychological well-being in relation to their substance misuse problems.

During my time at the Home Office I was permitted to conduct research for my MSc in Forensic Psychology. The findings from that further supported the need for a deeper understanding of this group. Most notably that they appeared to be replacing one addictive substance (Class A drugs) for others, in particular alcohol and cannabis, also known as cross addiction (Flores, 2012). This issue encapsulated a controversial debate in the DIP policy at the time – the political agenda was resistant to address this group’s polysubstance misuse and opted to focus on the Class A drug addiction problem only. I would go further and suggest that this debate highlighted the need to understand and then to address the underlying reasons for this group’s addiction per se and that focusing on the Class A drug addiction only was detrimental to the support on offer. In addition to this, most of the participants in the MSc study had mental health problems but were not accessing the necessary support. The indications from the wider literature at the time suggested that the DIP clients were at an increased risk of mental health problems (Strathdee et al., 2002, Social Exclusion Unit Report, 2002; Department of Health, 2002; and Banerjee, Clancy, & Crome, 2002).

Cross addiction was not addressed in the DIP for political reasons. On reflection, I now believe that cross addiction as well as mental health were also not addressed because there was very little understood about this group due to a paucity of research.
Furthermore there was no research using a psychological theoretical perspective which might have provided a more informed approach. This is something, which I hope this PhD has gone some way to addressing.

1.3 Developing the rationale for the theoretical and qualitative approaches used in this research

There is a paucity of research with the DIP clients because the participant group represent a hard to reach group (Rhodes, 2000) due to their drug taking and offending backgrounds. I would also argue that because the group is part of a Government criminal justice intervention it makes them a particularly hidden population, which adds a further layer of complexity when trying to access them. This is perhaps best evidenced when a review of the published research on the DIP, (see Chapter 2 and 3) generally, has either been commissioned by the Home Office or has been conducted by those with close contact/s with the organisations operating the DIP teams – myself included.

This group is a highly politicised and marginalised group, partly due to the criminalisation of their drug misuse by successive Governments since the late 1990s, because of the priority given to crime reduction and the involvement of criminal justice agencies in drug treatment (Hucklesby & Wincup, 2010). The published research has also been overwhelmingly quantitative because the Government favoured this approach (Hucklesby & Wincup, 2010). This group’s voice has gone unheard within policy and within the published literature. I was therefore interested to know more about this group’s lives from their own perspectives, in particular, before their substance use and Class A drug use took such a hold over their lives. I was further interested to explore and understand what was happening in their lives during relapses and periods of recovery. Therefore, a qualitative approach was considered to be the more appropriate methodology to meet these requirements and to address a gap in the literature.

Due to my unique political position in relation to the participant group from my time working in the DIP policy, it was important to use a methodological approach that heavily featured a reflexive process to mitigate any political bias and preconceptions that I might hold. An Interpretative Phenomenological Analysis and ‘Approach’ was
therefore used. The reflexive process showed that at the beginning of the research I had indeed viewed this group through a political lens of offender and drug misuser. However, this changed through my training during the PhD to a position of being able to connect with the participant group on a more humanistic level so that the labels of offender and drug misuser did not dominate my interpretations and findings. I was therefore able to see the participants as the vulnerable children they once were and the continued impact this had on their journey of relapse and recovery from drug and substance misuse. I found listening to participants’ adverse childhood experiences to be both distressing and shocking. Whilst I had anticipated such experiences I was less prepared than I had thought to hear, in face-to-face situations, participants’ stories about the violence and abuse they had suffered as children often at the hands of their parents.

The psychological theories chosen were based on evidence from the literature reviewed and the collective knowledge and expertise of the researcher and her supervisors. This knowledge base suggested that the participant group might have experienced some level of abusive or adverse childhood experiences involving family members/parents; suffered from mental health problems; experienced chaotic lives (including during childhood and adolescence); and that there might be issues relating to identity. The psychological theories chosen therefore both reflect this collective knowledge base and it will be argued, offer a compelling understanding of the participant groups’ lives and their concurrent journey of addiction, relapse and recovery. Furthermore, an appreciation of these theories offers a deeper understanding of the addiction and recovery field among Class A drug misusers. The framework of theories I am using are broadly, but not exclusively, rooted within the following perspectives; modern attachment theory, childhood developmental psychology and modern family systems theory. The influence of modern psychodynamic theories is also present. The aim of this thesis is not to prove or disprove any one of these theories. However, these theories have helped to inform the scope and direction of the PhD and have helped to develop the research questions. All of the theories discussed, when applied to an understanding of addiction, take a psychological developmental perspective of addiction and therefore do not view the development of addiction to be primarily the result of the chemically addictive nature of the substance itself.
1.4 Overarching research question and structure of the PhD

The overarching research question is: How do Class A drug misusing (ex)/offenders (who are/have been part of the DIP) experience and make sense of their journey of relapse and recovery in relation to their significant life events and relationships?

Firstly, this overarching question was developed and formulated into a card sort task and semi-structured questions in the pilot study using a series of focus groups, to explore its value and merit with the participant group. This helped to further inform questions for the second study, a series of semi-structured interviews that was more in depth, with the participant group. Therefore, the thesis is formed of two parts - Part One comprises of a series of focus groups and Part Two - a series of more in depth semi-structured interviews. Figure 1, illustrates this further.

This research will hopefully go some way to addressing a gap in the literature and empirical work by providing a more informed perspective about the DIP clients from the participant’s viewpoint and using a developmental psychological approach. It is also hoped that this research will help to further inform policy and practice and to stimulate further research with this group - a Class A drug misusing offender population based in the community in the UK - to help them in their journey of sustained recovery.

1.5 Chapter structure and summary

Chapter 2 - provides an introduction and brief overview of the research. The historical political context and background is covered alongside the author’s critical appraisal from her time working within the UK drugs policy. The political influence of definitions of addiction and recovery are provided as well as wider definitions from academia and health bodies. The reader is introduced to the methodological and theoretical approaches used and the aims and purpose of the research are also presented.

Chapter 3 – a critical first stage review of the quantitative and qualitative relapse and recovery literature concerning drug and substance misuse is provided, this includes offender populations. The theoretical approaches informing the scope and direction of
the research are introduced. Gaps in the empirical work, literature base and theoretical approaches within the addiction relapse and recovery field are highlighted. The aim of the chapter is to provide the rationale and justification for conducting the research.

Chapter 4 - covers the rationale for the qualitative methodological approach used in both Part One and Part Two studies, this includes an overview of the epistemological underpinnings and the particular phenomenological methodology used – Interpretative Phenomenological Analysis (IPA). A critical review of the use of IPA in a focus group design is introduced but covered in more detail in Chapter 5.1. The research questions are presented in more detail here and the ethical approval and permissions required to undertake the research are provided.

Chapter 5 – contains Part One of the research which is a series of focus group studies (total N=10 over four focus groups). This is delineated into three sections:

5.1 The methodology and method for the focus groups is provided including how an IPA approach was used and how IPA was adapted for use with a focus group design. Background information about the participant group features including information about demographics, criminal and drug use behaviour.

5.2 The findings section includes the supporting literature, a second stage review, to provide some context to the findings. A more in depth second stage review of the literature and extant theories is however, reserved for Chapter 6.3.

5.3 The discussion section provides a summary of the findings. How the findings from the focus group study were used to inform Part Two, a series of semi-structured interviews is introduced and then covered in more detail in Chapter 6.1. A critical appraisal of adapting IPA for a focus group design features. An overview of how the credibility checks were undertaken in the focus groups is also provided along with some reflective thoughts.

Chapter 6 – Part Two of the research, which is a series of semi-structured interviews (N=17), is detailed, again this chapter is in three sections:

6.1 The methodology and method for the semi-structured interviews is provided, including how the interview schedule was developed from the Focus Group findings. Background information on the participant group including information
about demographics, criminal and drug use behaviour is covered. An overview of the credibility checks also features.

6.2 The findings section provides detail on the superordinate themes and themes that were developed along with participants’ quotes. Reflective thinking also features throughout this chapter.

6.3 The discussion section positions the findings within the theoretical approaches and supporting literature to provide a context from which to understand the participants’ findings further. It also provides a critical second stage review of the wider literature and extant theories in relation to the findings.

Chapter 7 – the ethical, legal and safeguarding challenges that required consideration and management throughout the research are covered with some suggestions of key learnings for future research. This includes a critical discussion of the use of a focus group design with this participant group (drug misusing offenders).

Chapter 8 – presents the Summary and Conclusion sections. A brief overview of the findings are presented, which includes Figure 5, The Wheel of Relapse and Recovery. The implications and contributions for theory, policy, practice and further research are considered. This includes the development of a mapping tool, The Addiction Lifeline (Love, 2016). Methodological considerations, including, the scope and limitations along with key learnings, are summarised.
Figure 1: Flow Diagram of Methodology and Methods for Focus Group Study (Part One) and the Semi-structured Interview Study (Part Two)

Part One: Focus Group Study
Piloting of questions (N=10 across 4 focus groups)

Interpretative Phenomenological Analytical Approach (adapted IPA for focus group design)

Focus Group 1
- Alan
- Bobby

Focus Group 2
- Samuel
- Clare

Focus Group 3
- David
- Kevin

Focus Group 4
- Tina
- Zoe

Credibility checks:
- IPA researchers
- Supervision
- DIP drug workers
- DIP clients in recovery.

Reflective note taking:
- Focus group dynamics
- Participants

Findings from Focus Group Study informed Part Two: Semi Structured Interviews

Part Two: Semi-structured Interviews (N=17)

Interpretative Phenomenological Analysis (IPA)

Relapse & recovery status from Class A drugs at time of interview and participant name

- Over 2yrs recovered (N=6):
  - Freddy
  - Harry
  - Luke
  - Veronica

- 1-12 months recovered (N=4):
  - Gary
  - Jay
  - Luke
  - Rebecca

- Lapsed/relapsed (N=5):
  - Adam
  - Bruce
  - Mark
  - Olivia
  - Walter

Credibility checks:
- Independent IPA specialist
- London IPA network group
- DIP drug workers
- DIP clients in recovery.

Reflective note taking

Findings => implications for theory, policy, practice & further research
CHAPTER 2: INTRODUCTION

“I would like to stress that suffering is at the heart of addictive disorders and that this consideration should remain central in considering the treatment needs of individuals with addictive disorders. To understand and to be understood is a powerful antidote to the confusion, chaos and suffering associated with addictions” (Khantzian, 2012, p. 274).

2.1 Chapter overview

An overview of the historical UK political context of the ‘drug misusing offender’, which includes the UK Government’s strategic response, is provided to situate the research within the relevant background. A critical appraisal from the author’s perspective of the political context, from her time working within UK drugs policy, is provided. An introduction to the gaps in the knowledge and literature base on the participant group, which form the rationale for the research, is covered. A brief overview of definitions including ‘addiction’ and recovery is provided to situate the research within the broader addiction, relapse and recovery field. The qualitative methodological approach taken and the psychological theories informing the research are briefly introduced.

2.2 Introduction

This research is concerned with a particular group of drug misusers whose offending behaviour brought them to the attention of the UK Government (England and Wales), prompting the development of a multimillion pound, centrally led Government strategy involving rehabilitation initiatives in 2003. This research seeks to understand more about this group – their lives before their substance and drug use began and what this group consider to be important factors in their drug use, relapse and recovery. Theories from developmental psychology, modern attachment theory and modern family systems theory have helped to inform the scope and direction of the research. The hope is that the research will help to provide an informed approach to policy and practice for this group, from the perspectives of the participant group themselves and from a developmental psychological perspective.
2.3 The historical political context and background to the DIP

The historical supporting evidence and literature which informed the Home Office’s Drug Interventions Programme is presented in this section alongside the author’s critical appraisal from her time working on the policy (2002-2010), which led to the development of the PhD research.

2.3.1 What are Class A drugs and what is the extent of the ‘problem’ in the UK?

The UK operates a classification system for controlling the use of certain drugs, which includes a range of suggested legal consequences for possession and dealing. This is primarily based on the perceived risk of harm to self and to society but is not necessarily based on the actual number of deaths (Reuter & Stevens, 2007). Class A drugs are perceived to cause the most harm and include crack, heroin and cocaine.

In 2000, it was estimated that around 4 million people had used drugs, however, at the time the UK Government’s concern was primarily around what they considered to be the ‘problematic drug misuser’, of which there were estimated to be around 250,000 (Home Office, 2002). The Government favoured terminology at the time to differentiate recreational use from ‘problematic drug misuse’. The latter involved “dependency, regular excessive use, risky behaviour towards self and others, including offending behaviour” (Advisory Council on the Misuse of Drugs, 1988, adapted by Edmunds, Hough, Turnbull, & May, 1999).

At the beginning of 2000, the financial cost of drug misuse to society was estimated to be £10-17 billion each year, with the majority of these costs (99%) being attributed to problem drug users, furthermore, drug related crime accounted for 88% of these costs (Godfrey et al., 2002). More recent statistics suggest that drug related crime costs over £13 billion annually (Home Office, 2013). The UK Government’s main impetus for addressing drug misusing offenders at the time focused on this financial cost to society, although there was some recognition of other considerations that were not financial. These included the harms that drug related crime inflicted on the victims of crime, the
families of drug misusers, the drug misusers themselves and on the communities where drug misuse and dealing was prevalent (see Reuter & Stevens, 2007 for an overview).

2.3.2 The politicisation and criminalisation of the ‘Problematic Drug Misuser’

The ‘problematic’ Class A drug misusing offender

It was this problematic use of Class A drugs that the UK Government considered to cause the most harm to the individual and to society, although, ‘harm’ was not defined solely in terms of fatalities. For example, in 2011 The Office for National Statistics, which provides annual reports on the number of deaths due to drug related poisoning, found that 207 deaths were caused by paracetamol overdose, 393 deaths were from anti-depressants, 112 were from cocaine and 596 deaths where heroin/morphine were involved (Office for National Statistics, 2011). Whilst these statistics are not absolute figures (due to double counting if more than one drug was noted on the death certificate by the coroner), they do highlight that over the counter medicines and prescribed medicines can also cause fatalities. However, statistics for 2015 showed the highest rates of deaths from heroin/morphine (1,201) and cocaine (320) since records began (Office for National Statistics, 2015). Annual deaths related to cigarette smoking and alcohol are much higher than for any other controlled drug within the UK classification system (Reuter & Stevens, 2007). Therefore, defining the drug misusing offender (the DIP client) as the ‘problematic user’ was not just based on the number of fatalities caused by the Class and type of drug.

Why did the UK Government target Class A drugs?

Successive Governments since the 1990s have tackled this Class of drugs because of the perceived link between the problematic Class A drug misuse and certain types of criminal offending behaviour, with millions of pounds of taxpayers’ money being invested (Hucklesby & Wincup, 2010). Some such as Hunt & Stevens (2004) have suggested that this policy shift from health to a criminal justice focus has led to the increasing criminalisation of the UK drugs policy. This shift was perhaps most notable when in 2003 the UK Government in England and Wales set up a rehabilitation strategy called the Drug Interventions Programme (DIP) to focus on those Class A
drug misusers who were perceived to commit crime to fund their drug misuse. The term ‘drug misusing offender’ was introduced and the Class A drug user who committed crime was now firmly on the political agenda and was to become a highly politicised group.

2.3.3 The UK Government’s response to Class A drug misusing offenders - the Drug Interventions Programme

The Drug Interventions Programme (DIP) was a UK England and Wales, Government, Home Office led strategy with two key aims; to reduce Class A drug misuse and the [perceived] associated offending behaviour, primarily acquisitive crime. This was based on the belief that the Class A drug misuse was the motivating factor driving the acquisitive offending behaviour. Some support has been found for this economic necessity model of drug related crime (Bennett, 2000). Acquisitive offending behaviour included crimes such as burglary, theft and shoplifting. The DIP offered a package of services and access to support in the community for ex and current offenders being released from prison, on probation or who had been arrested for acquisitive offences and had an identified Class A drug misuse. The programme was based within the community and the support on offer included help with employment and education opportunities, finding and securing housing, debt and financial management, help with families and access to mental and psychological support. Help was also offered to address the drug misuse, which included methadone maintenance, harm reduction initiatives and access to residential rehabilitation. This part of the DIP was referred to as ‘Aftercare’ with the original intention being to provide (unspecified) long term support, in recognition of this group’s entrenched and long lasting Class A addictions which featured many ‘failed’ attempts at recovery. (See LeBoutillier & Love, 2010 and Hucklesby & Wincup 2010, for an overview of the DIP).

The drugs and crime link – the political impact and influence on treatment provision

I thought that focusing the DIP on a deterministic economic model of drug related crime was counterintuitive and misplaced for several reasons. Whilst some studies have found support for the economic model (see Hough, 1996 and Bennett & Holloway, 2009a for an overview) the wider debate considers that the link between
drug misuse and crime is more complex and multifaceted (Hough, 1996; Menard, Mihalic & Huizinga, 2001; and Bennett & Holloway, 2009a). Furthermore, the presence of drug misuse does not necessarily mean that acquisitive offending behaviour will always follow (Hough, 1996).

The raison d’être for the DIP was primarily about reducing the offending behaviour by addressing the Class A drug addiction [only], it was for this reason that the Home Office led the strategy rather than the Department of Health. This was evident in the key documents that were used to develop the DIP Aftercare programme, such as the Social Exclusion Unit report (2002). The focus of this report was concerned with the rehabilitation of offenders. It suggested a range of support and services around help with housing, debt/finances, families, education and employment opportunities and help managing drug misuse. However, during my time working on the DIP policy I thought that the emphasis was on the practical elements of support such as finding housing and help with job and educational opportunities. There was less policy development and understanding around mental health, family and relationships and providing access to the corresponding support. This was also apparent in many of the DIP teams across England and Wales at the time. Furthermore, the issue of multiple addictions among the DIP clients, of which practitioners and policymakers were aware and to which my MSc thesis had lent support, was never properly acknowledged or addressed.

I thought that the economic drugs: crime model and the politicisation and criminalisation of this group determined the direction, development and the scope of the DIP interventions. Furthermore, I considered that these political (and policy) viewpoints were detrimental to the support on offer for this group. The programme’s first concern should have been about addressing the addictive behaviours per se and more importantly the reasons underlying those addiction issues. Hucklesby (2010) and Turnbull and Skinns (2010) have also been critical of criminal justice interventions being able to properly address the reasons for people’s addictions.

These personal viewpoints from my time working within the DIP policy and from my MSc findings raised a number of important questions for me, which I believed, if
answered could help to further improve the Programme and the support on offer for this group. I thought that a deeper understanding of the group was needed.

2.4 Published research about the DIP clients – gaps in the literature and knowledge base

During my time working on the DIP there was a paucity of published research about the DIP. Home Office controlled statistical data provided information for policy makers to inform politicians about various aspects of the Programme. This was mostly concerned with arrest referral rates and treatment retention numbers. Furthermore, the published research on the DIP provided information about treatment retention and outcomes (Best et al., 2008 and Turnbull & Skinns, 2010) and reductions in drug related crime (Skodbo et al., 2007). However, there was and still remains no published research specifically about the DIP clients which could provide an insight and understanding of their lives before drug use, what life experiences, (including significant relationships) they had encountered, what their psychological health was and what might have been important influencing factors in their drug misuse, relapses and periods of recovery.

2.5 What else was known about substance misusing offenders - psychological health and co-morbidity?

At the time of the DIP’s inception there was a growing concern among practitioners and health professionals about the mental health of drug misusers, often referred to as co-morbidity or dual diagnosis (Abdulrahim, 2001). There was no specific research that had investigated co-morbidity among the DIP clients but as outlined here research with drug misusers and with offending populations suggested that the DIP clients had psychological health issues alongside their Class A drug misuse.

The Department of Health recognised that dealing with co-morbidity or dual diagnosis was a major challenge for front line workers (Department of Health, 2002). Historically, there had been a long standing debate between drug treatment services and mental health services about how an individual with a dual diagnosis should be treated, often resulting in the client falling through the gap of care (Department of
Health, 2002). The prevalence rates of dual diagnosis vary depending on the mental health issue or substance misuse problem of the individual. What is irrefutable is that rates for mental ill health are much higher for those with a substance misuse problem than for the general population. Furthermore, prisoners were at an increased risk of mental ill health than the general population (Social Exclusion Unit, 2002). Individuals with a dual diagnosis were at an increased risk of relapse, suicide, (Department of Health, 2002), worsening mental health problems and were more likely to come into contact with the criminal justice system (Banerjee et al., 2002).

The full extent of the mental ill health of UK Class A drug misusers with offending backgrounds is not fully understood. Indeed, there is no published research which explores the mental health and psychological wellbeing among the DIP clients and the impact this might have on their drug misuse. This research will therefore also explore the psychological health of the DIP clients, from their own perspectives.

2.6 Situating the ‘drug misusing offender’ within the wider addiction and recovery field

Drug misusing offenders represent a highly politicised and criminalised group (Hunt & Stevens, 2004 and Hucklesby & Wincup, 2010). The following discussion outlines how addiction and recovery among this group have been defined by successive UK Governments since the DIP began and considers the broader academic and health definitions of addiction and recovery.

2.6.1 The changing political landscape – political definitions of ‘addiction’ and recovery

Since the DIP began there have been several changes in Government. The movement from Labour to a Conservative and Liberal Democrat Coalition Government, heralded a shift in drugs policy, which was primarily outlined in the Drugs Strategy 2010 (Home Office, 2010). The greatest change in policy was the emphasis on recovery and abstinence rather than harm minimisation (although this emphasis has been partially reduced in the most recent Drugs Strategy, Home Office, 2017). The second change was that funding was no longer ring fenced. From 2013 Police Crime Commissioners were given the power to decide where the funding should go, providing a set of best
practice focused outcomes were achieved. These included; “freedom from dependence on drugs or alcohol, a reduction in crime and re-offending, improvement in mental and physical health and well-being and improved relationships with family members, partners and friends” (Home Office, 2010, p.20).

Some protagonists such as the former head of the now disbanded National Treatment Agency, Paul Hayes speaking at the Drugscope conference in November 2011 viewed this policy shift as essentially a move away from either a disease or offending led drive to tackling Class A drug misuse and a move towards a health led drive. Others, such as Tim Hollis who was the Chief Constable of Humberside Police, speaking at the same conference, were in no doubt that the drive to tackling ‘Problematic Class A drug misusers’ in the UK was still very much driven from the associated offending behaviour due to the continued substantial Government investment to support the DIP and the involvement of Police Crime Commissioners. Duke, Herring, Thickett, & Thom (2013) have recognised the policy shift to a recovery based approach. Senker and Green (2016) go further and note the influence that policy has in deciding and defining what recovery means.

West and Brown (2013) acknowledged how definitions of addiction can have implications for policy, commerce and society. This chapter however, illustrates how politically derived definitions have profound implications for who receives substantial state funded help for their addiction problems, when someone is considered to be recovered and the additional labels that can be attributed to those suffering with addiction. There were two approaches that were prominent in tackling Class A ‘addiction’ with the DIP policy; a disease or health approach of addiction, advocated by policymakers and practitioners from the health sectors; and a more politically derived offender led approach, favoured by the Home Office and those in the criminal justice system. However, there were concerns from the health sector that the politically led criminalisation of addiction with the DIP would encourage Class A drug users to commit crime in order to qualify for support with their addictions, Hucklesby and Wincup (2010) also raised this concern.
The DIP still continues to operate at the time of writing. This is under a third change in Government since DIP’s inception from a Coalition to a Conservative led Government, however, it is no longer a centrally lead strategy. More recent policy updates and the implications of this research for policy are covered in the Summary and Conclusion Chapter 8. Wider definitions of addiction and recovery will now be considered to help situate the participant group within the broader field of addiction and recovery.

2.6.2 Academic and health definitions of addiction

Definitions of addiction

Addiction has been defined by many academics, health bodies and clinicians. Some definitions of addiction tend to focus on substances such as drugs and alcohol and other definitions such as that proposed by West and Brown (2013) are more comprehensive and include gambling and sex addiction. The World Health Organisation incorporates a substance based definition which includes drugs or alcohol or a combination of the two and involves “Repeated use of a psychoactive substance or substances, to the extent that the user (referred to as an addict) is periodically or chronically intoxicated, shows a compulsion to take the preferred substance (or substances), has great difficulty in voluntarily ceasing or modifying substance use, and exhibits determination to obtain psychoactive substances by almost any means....” (World Health Organisation, 1994).

The WHO definition acknowledges the use of several substances (sometimes referred to as polysubstance, see next section on ‘substances taken by problematic drug misusers’), the harm caused to society as well as to the individual and recognition that the behaviour is “longstanding” and involves “variable usage”. The definition does not go into detail about which drugs or combination of drugs/substances is involved or whether these might be illegal drugs or the illicit use of prescribed and over the counter medication (World Health Organisation, 1994).

The American Psychiatric Association Diagnostic and Statistical Manual (DSM-V) also considers a definition of addiction to involve drugs or alcohol and acknowledges the harm to the user (West & Brown, 2013). Other definitions have included the
physiological reactions, including withdrawal and the neurobiological effects of addiction (West & Brown, 2013).

**Substances taken by problematic drug misusers (such as the DIP clients)**

Problematic drug misusers primarily take a combination of Class A drugs although many are polydrug and polysubstance misusers. Polydrug misuse involves taking a combination of other Classes of drugs such as Class C drugs (e.g. cannabis) and Class B drugs, (e.g. amphetamines). The user may also take prescribed medication, such as the benzodiazepine, Temazepam, illicitly to aid either a come down or a high. Polysubstance misuse is where a combination of illegal drugs and illicit drugs or substances (that might be prescribed or over the counter medicines) are used in combination with other substances that might not be illegal but are controlled, for example alcohol. The DIP clients were recognised by practitioners and policy makers as polysubstance misusers however their primary drugs of choice were Class A drugs, in particular heroin and crack.

**Wider definitions of recovery**

The term ‘recovery’ is less well defined in the addiction field than in the mental health field (see Salde, 2009 for definitions of recovery in the mental health field). Furthermore, when applied to a drug misusing offender population there is a paucity of research, especially including from the perspective of the drug misuser (Senker & Green, 2016). The wider addiction field suggests that recovery may include abstinence from all substances, abstinence from the primary problem substance only and substitute prescribing (Senker & Green, 2016). Recovery may also include social functioning such as maintaining employment and housing. Some consider recovery to have a definitive end point whilst others consider it to be a much longer term endeavour (Senker & Green, 2016).

This chapter has gone some way to demonstrating the political influences of definitions of addiction and recovery, which will be considered alongside the wider academic and health sector definitions, in this research. This research will focus on recovery from the perspective of the drug misusing offender to address a gap in the empirical work
and in the knowledge base. Addiction will be considered within the research as part of
the questions around first use, entrenched use, lapses and relapses. The importance of
understanding these two concepts from the perspective of a highly politicised and
criminalised group of ‘addicts’ is covered next.

2.7 Interpretative Phenomenological Approach

2.7.1 Showcasing the participant’s voice and lived experiences

The DIP clients represent a population who are difficult to both access and engage
within research. This is primarily due to both their offending behaviour and their
entrenched and often chaotic drug misuse. They are a highly politicised and
criminalised group (Hucklesby & Wincup, 2010) which increases their
marginalisation from society and increases the difficulty of accessing them within a
research setting. Their voices have therefore, remained unheard both within a political
domain and within the published research field (Neale et al., 2013). I therefore, thought
that the most effective and appropriate methodology to investigate my questions and
to address a gap in the literature base would be to use an approach that would showcase
the DIP client’s voice and allow their stories to be told from their own perspectives.
Therefore, an interpretative phenomenological approach has been adopted throughout
this research, more specifically Interpretative Phenomenological Analysis (IPA)
(Smith, Flowers & Larkin, 2012). This methodological approach is concerned with
people’s lived experiences of a particular phenomenon of significance in their life,
including relationships. From my reading of the literature, it can provide a platform
for a group whose voice has gone unheard both within the published research field and
within a political domain.

2.7.2 The researcher’s unique political position and the value of reflexivity

I worked within the DIP policy from its inception for nearly nine years and I have also
conducted previous research with the DIP clients during my time at the Home Office.
It was therefore necessary and important to employ a methodological approach which
recognised and acknowledged my preconceptions and areas of potential bias, in
particular my political viewpoints in relation to the participant group. An IPA
approach recognises that the researcher is part of the ‘meaning making’ process in
participants’ narratives and therefore strongly features the process of reflexivity. The reflexive process, which can be conducted through reflective note taking, helps to mitigate the researcher’s preconceptions and bias unduly affecting the research process including in the analysis and interpretation of the data (i.e. participants’ narratives).

2.8 Psychological theories informing the research

Several psychological theories from modern attachment theory, developmental psychology and modern family systems theory have helped to inform the scope and direction of this research. The main theories which will be discussed further in Chapter 3, are Modern Attachment Theory, Self-Psychology, Affect Regulation Theory, Modern Family Systems Theory and Developmental Trauma Theory. The application of these theories within substance misuse suggests that the development of addiction lies within the individual and their relationships and not necessarily within the addictive nature of the substance itself. Furthermore, the theories recognise the influence of early harmful childhood experiences and family psycho-social environments in the development of addiction. Some of the theories have been applied within a therapeutic setting to treat those with addiction issues. The theories are of particular importance in this research because they imply that the DIP clients will have experienced adverse childhoods, including neglect, bereavement/loss and abuse. They further suggest that the DIP clients will have experienced and continue to experience difficulties with relationships, dealing with stressful or traumatic events and will suffer from mental health and other psychological and emotional issues. These are all areas involving significant life experiences which not only overlap with my key research questions but it is anticipated will be able to provide further guidance in the formulation of those questions and throughout the thesis.

These theories offer an understanding and explanation of addiction from a particular psychological perspective. However, they do not provide the entire picture, which many of these theorists also acknowledge. For example, Khantzian (2012) a proponent of affect regulation theory, acknowledges the value and contribution of genetics and neurobiology but suggests that these approaches alone are unable to offer a comprehensive understanding of addiction. The psychological theories chosen for this research were thought to be the most appropriate in helping to inform the research
questions and to achieve some of the overall aims and purpose of the research. They were also considered to be able to address a gap in the theoretical literature base with regards to the participant group and their Class A addictions.

2.9 Aims and purpose of the research

To address the gap in the knowledge base, published literature and empirical work, the purpose of this research is to investigate the DIP client’s journey of drug misuse, relapse and recovery in relation to their significant life experiences, relationships and psychological health, both past and present. The overall aim of the research is to help to further improve policy development and service provision for this group of Class A substance misusing offenders in their journey of sustained recovery.
CHAPTER 3: LITERATURE REVIEW AND THEORETICAL FRAMEWORK

3.1 Chapter overview

This chapter provides a first stage review of the quantitative and qualitative literature on relapse and recovery of drug misusers which includes drug misusing offenders, relevant to the research question. The search strategy used to identify that literature is included. An introduction to the theoretical approaches which have helped to inform the scope and direction of the research questions is also provided. A summary of the gaps in the field including those relating to the theoretical framework are discussed to support the rationale and justification for conducting the research and for the chosen methodological approach taken.

3.2 Introduction

Class A drug misusing offenders represent a group who have particularly entrenched and long lasting addictions (Hser, 2001) in particular to crack and heroin, and who present particularly chaotic and problematic drug use behaviours (Edmunds et al., 1999; Bennett & Holloway, 2009a; Seddon 2006; and Moyle & Coomber, 2015). This group have many attempts at recovery and seem to struggle with sustaining long term recovery. Furthermore, some research suggests links between the Class A drug misuse and acquisitive offending behaviour (Bennett, 2000; Hough, 1996; Young, Wells, & Gudjonsson, 2011). It is therefore important to consider the relapse and recovery literature which specifically explores Class A drug misusers with offending backgrounds before moving on to the wider relapse and recovery literature on Class A drug misusers.

3.2.1 Search strategy and terms

There are differing opinions about the extent of literature that should be reviewed at the start of a qualitative research process. Dallos and Vetere (2005) and Willig (2013) suggest that some literature review is required in order to provide some direction and scope from which to work and to ensure that gaps in the field are identified and the research question is justified. This approach was therefore adopted.
The literature search was carried out over the course of the 6-7 years of the PhD process (October 2010 up to May 2017). The first stage literature review was carried out at the start of the research process to support the development of the research questions. The second stage review was to help inform the findings for Part One and Two studies. Boolean Logic searches were used. The databases and search terms used are listed in Table 1. In addition the following approaches were also used; Government websites to locate relevant documents; references from relevant articles, book chapters and published online PhD theses; suggested references and readings from the author’s supervisors; references from attending conferences; searches of relevant journals and authors.

3.3 Review of the empirical literature on the relapse and recovery of substance misusing offenders and substance misusers

3.3.1 Literature review on the relapse and recovery of substance misusing offenders - the DIP clients

A review of the literature on the DIP clients was conducted and revealed a scarcity of published studies. Ten studies were found on the DIP clients however, these were concerned with treatment outcomes, retention (Best et al., 2008, Kouimtsidis, Edwards, Wallis, & Drabble, 2008) cost benefit analysis, the DIP service provision (Turnbull & Skinns, 2010; and Best et al., 2009) client demographics and the effectiveness of the DIP to reduce crime (Skodbo et al., 2007; Love, 2008; and Home Office, 2008). These studies were mainly quantitative, most likely a result of the Government favouring this methodological approach (Hucklesby & Wincup, 2010). Indeed many of these studies were commissioned to inform the Home Office or local Drug Action Teams overseeing the DIPs.
Table 1: Search Strategy and Terms for the Literature and Empirical Review

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<th>Databases and search engines used</th>
<th>Search term topics</th>
<th>Search terms used in various combinations with each other</th>
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<td>MEDLINE</td>
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<td>Web of Science</td>
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<td>Google Scholar, University of Surrey library catalogue and search system.</td>
<td>Relapse and recovery from Class A drugs</td>
<td>Substance use Relapse and recovery Drug use Offenders Heroin Crack Cocaine Drug interventions Rehabilitation Addiction Dual diagnosis Mental health</td>
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<td>Self psychology theory and substance use</td>
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<td>Trauma, drug use and offenders</td>
<td>Offenders, prisoners, inmates Trauma, childhood abuse, neglect, complex trauma Drug, substance use, abuse, misuse</td>
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The qualitative studies tended to focus on the DIP client’s views about service provision and their perceived links between their drug use and crime (Fox et al., 2005; and Keene, Stenner, Connor, & Fenley, 2007). The focus of many of the studies were on participant’s offending behaviour rather than participant’s drug use behaviour most likely a result of the Home Office’s emphasis on the crime reduction element of the DIP. Theoretical frameworks in the studies, when provided, evolved around the drugs: crime link debate.

No studies were found which explored the cycle of relapse and recovery of the DIP clients using a qualitative approach exploring the DIP client’s perspective. The search criteria were therefore widened to include the relapse and recovery of substance misusing offenders who were both community and prison based.
3.3.2 Literature review on the relapse and recovery of Class A drug misusing offenders – summary and gaps

The literature included for review focused on Class A drug misuse among either prison or community based offender populations in both the UK and non-UK settings. In the UK Class A drug misusing offenders can access treatment through the criminal justice system in prisons or in the community (Hucklesby & Wincup, 2010). An overview of the quantitative literature on the relapse and recovery of UK Class A drug misusing offenders overwhelmingly reports on the effectiveness of treatments and interventions to reduce or desist the drug misuse and the criminal behaviour, often with the study focus on the desistance of the criminal behaviour (Holloway, Bennett & Farrington, 2005). Recovery is both assumed and concealed within this largely politically driven rhetoric. Terms such as recovery are scant in this literature and instead treatment outcomes are the favoured terminology. Studies generally show improvements in drug taking behaviours. For example, Marsden et al. (2009) found psycho-social interventions reduced drug use in a sample that included a cohort of UK criminal justice referrals. Non-UK studies have shown treatment programmes help to reduce drug use and relapsing behaviours among offender populations (Fox, 2000). Law and Guo (2012) found increasing cognitive skills such as coping strategies, positive outlook, goal directed behaviour, motivation, emotion regulation and self-esteem among female drug using offenders in a Taiwan prison helped prevent relapse. However, generally these studies were unable to provide much detail about what recovery means to individuals and what might help or hinder an individual’s recovery. Smith and Ferguson (2005) further suggested that the quantitative literature has been unable to provide detail about the social and psychological processes that might be involved in relapse and recovery of drug misusing offenders.

Determining successful treatment outcomes (i.e. recovery) is also fraught with difficulties in such studies. For example, determining timescales, (Orford, 2008) how to accurately measure drug consumption and following up a ‘hidden’ population (Hucklesby & Wincup, 2010). Successful treatment outcomes in these studies do not consider if other drugs or substances are being substituted for the target drug. Furthermore, how a successful treatment outcome is determined in these studies might
depart heavily from what might constitute recovery in a therapeutic setting where more sustained recovery over a longer period of time is the goal and where cross addiction is also addressed (Flores, 2012). Some have criticised the UK’s criminal justice system’s ability to fully address the reasons for the drug misuse problems (Hucklesby & Wincup, 2010; and Turnbull & Skinns, 2010).

A review of the qualitative literature provided more relevant information about the relapse and recovery of drug misusing offenders in relation to the PhD thesis. However, as Senker and Green (2016) argued there is a scarcity of research exploring recovery among substance misusing offenders.

Patel (2010) suggested that supportive relationships and networks including Twelve Step groups, peer mentoring groups and drug worker interventions were important in recovery for UK drug misusing prison and community based offenders. Mental health problems and addictions to other substances were viewed as barriers to recovery. Furthermore, participants struggled to receive the support they needed to address these concerns. Participants considered that transforming their life provided meaning to them, which helped in their recovery; this included educational, employment and housing opportunities.

Smith and Ferguson (2005) found among drug misusing offenders in a UK prison that reasons for initial drug use included lack of family support, spending time in institutions (homes or prison), and being around drug and criminal lifestyles. Dealing with difficult emotions such as anger, depression and low self-esteem could threaten recovery and lead to relapses. Supportive family and staff were helpful in recovery. Will power, determination, honesty, awareness and reflection of drug use harms were considered to be helpful in maintaining recovery; this also included avoidance techniques. Having a meaningful life such as employment opportunities was also important. Smith and Ferguson (2005) situated their findings within a theory of change framework and stages of recovery (De Leon, 1996). They further draw on cognitive behavioural approaches such as Kearney (1998) and sociological perspectives. Their overview of the process of recovery is descriptive and therefore does not provide supportive literature or theoretical frameworks which might expand on the underlying reasons for the addiction, relapse and recovery process.
This search also produced a limited number of studies that were of relevance to the thesis so the search topic was widened further to include the relapse and recovery of substance misusers, which might not necessarily include offenders.

3.3.3 Literature on the relapse and recovery of substance misusers

Papers reviewed in this section included Class A drugs, although some of these studies also included reports on alcohol. Literature which included reports on tobacco, alcohol and Class B and C drugs only were excluded unless thought relevant to the theoretical frameworks informing the research. Use of these substances was considered to be much less chaotic and therefore less relevant to the thesis. Studies involving teenage cohorts only were also excluded primarily because these concerned less chaotic substances such as tobacco and because recovery was not the focus. A review of both the quantitative scientific and qualitative literature is now provided.

Quantitative literature review - summary and gaps in the knowledge base

The quantitative studies generally focus around clinical treatment outcomes such as reductions in drug use or desisting drug use, which is one measure of recovery. Ghodse et al. (2000) using quantitative methods found that opiate users who had aftercare treatment had better treatment outcomes than those who did not receive aftercare treatment. The study suggests that longer duration time in treatment accounted for the results. However, no theoretical frameworks were provided to situate the results within. Maffina, Deane, Lyons, Crowe, & Kelly (2013) using quantitative methods found that substance users and staff in a faith based rehabilitation in Australia considered supportive networks, abstinence from all substances and taking responsibility for recovery were regarded as important factors in recovery. However, this was based on staffs’ and clients’ perceptions of what they considered constituted recovery rather than what worked in clients’ own recovery journeys. Strang et al. (2012) in a review of worldwide studies, which investigated the evidence base for the effectiveness of drug interventions found some support for psycho-social treatments. Effectiveness included reducing drug use, abstinence from the target drug and harm minimisation. Psycho-social treatments included therapeutic communities, contingency management and brief interventions. Some support was also found for
peer led groups and family and couple based treatments. There was strong evidence for the effectiveness of substitute prescribing for opioids to reduce drug use. However, the review only included studies using specific scientific approaches such as randomised control design trials or quasi-experimental designs, which were unable to provide information about individual psycho-social processes. The review also provided no theoretical frameworks to help further understand the effectiveness of the programmes.

Generally the quantitative and scientific based studies were unable to report on personal recovery goals identified and defined by participants such as building social networks, rebuilding self-esteem or learning cognitive skills and how these were achieved. In these studies ‘recovery’ is defined quantitatively in terms of treatment outcomes such as the effectiveness of methadone prescribing to desist heroin use, which sometimes appears divorced from an individual’s own perspective of what has worked (and why it has) in their recovery journey.

**Qualitative literature review – summary and gaps in the theory and knowledge base**

Neale et al. (2013) and Rhodes et al. (2010) argue that there is a lack of published qualitative literature within the addiction field. A discussion on the reasons for this is covered in the Methodological Approach, Rationale and Criticisms Chapter 4, Section 4.3.2. In this first stage literature review ten studies were found which were of some relevance to the research topic. A critical appraisal of both the UK and non-UK based studies is provided.

**UK based qualitative literature**

Several UK studies have used IPA to explore addiction and recovery. Larkin and Griffiths (2002) explored meanings of addiction and recovery among Twelve-Step attendees, including those with drug and alcohol problems. Findings included an addict identity co-existing with a recovering identity, where participants sought normality and to rebuild their self-esteem. Participants implicated difficult childhood experiences such as abuse, loss, isolation and other difficulties with parental relationships in their addiction and recovery. Being able to cope with negative emotions including fear, loneliness, self-loathing and low self-esteem were considered
important in recovery. Being able to trust others was also considered important. Larkin and Griffiths (2002) situate their findings within self-identity theories which focus on the social as well as psychological aspects, these are however, heavily influenced from sociological perspectives.

Shinebourne and Smith (2009) in their case study of a woman with alcohol addiction found similar constructs around struggles with multiple identities including conceptualising a solid sense of self and the use of alcohol to affect emotions. They situate their findings within identity theories from psychology such as dissociative identity disorders and James’ (1902, as cited in Shinebourne and Smith, 2009) theory of the divided self. They also draw heavily on identity transformation theories within the addiction literature such as Biernacki (1986), Kellogg (1993) McIntosh and McKeganey (2000a, 2000b, and 2001) which are from sociological perspectives.

Rodriguez and Smith (2014) explored self-identity transformations among recovering substance misusers (which included Class A drugs), in relation to the values and frameworks of change required in Narcotics Anonymous (NA). Identity change was viewed as a necessary part of recovery in NA, and which was facilitated through its values and framework. This included self-care, building trust and relationships among group members, belonging to a group and experiencing shared meanings and discourses. The struggles of an addict identity existing alongside the development of a new ‘recovery’ identity were present among the participant group. Rodriguez and Smith (2014) highlighted the importance of social networks and situated some of their findings within social identity theory including identity transformation theories. Recovery was very much framed within NA’s values.

Watson and Parke (2011) explored recovery among female heroin users. Difficult childhood experiences featured heavily among participants’ including loss, (bereavement), rejection, abuse (physical and psychological) and other difficult parent-child relationships. Difficult mother-daughter childhood relationships were viewed to have an impact on participants’ self-esteem and on their negative feelings later in life. Links between childhood loss and later drug use to cope were postulated. Recovery involved a search for a normal life but participants’ struggled with what that might entail. For some housing, employment and relationships were considered to represent a normal life. They situate their findings within Flax’s (1978) feminist
theoretical perspective of child development within a patriarchal family. However, the theory is from the 1970s and was based on post war family units, which might not necessarily translate to family units in the present day.

Healey, Peters, Kinderman, McCracken, & Morriss (2009) used a grounded theory approach to explore reasons for substance use (including opiates and alcohol) in UK participants with a diagnosis of co-occurring bipolar disorder and substance misuse. They found links between substance misuse and mental health including substance use to alter emotions and cope with mental health problems. Substances were also used to feel normal such as in social situations or with family members. Drug use was a means to deal with stressful events for example bereavement or difficult childhood experiences. Healey et al. (2009) situated their findings within a self medication hypothesis but suggested the theory was unable to fully account for their findings. They further proposed a social conformity model (an attitudinal construct in Sociology).

McIntosh and McKeganey (2000a) examined identity transformations from a sociological perspective among drug users (including heroin) who had been in recovery for over 6 months. Participants underwent conflicted addict identities with their new emerging identities during recovery. This included participants being aware of the harms of their drug use and recognising that relationships during drug use did not constitute real friendships. Participants therefore distanced themselves from their addict identities as they formulated new identities around their non-drug using lives such as employment, voluntary work, managing a home and supportive (non-drug using) relationships. Participants actively avoided their old drug using lives to avoid relapse (McIntosh & Mckeganey 2000b).

Mullen and Hammersley (2006) taking a sociological perspective and using a grounded theory approach explored reasons for relapse and recovery among male heroin users. Drug use blocked problems such as difficult emotions, relationships and trauma and was a means to control participants’ lives. Reasons for stopping drug use involved gaining employment, maturing out of drug use, deteriorating physical health and pressures from family or the criminal justice system. Relapses occurred when participants were not engaged in wanting to stop their drug use, were unwilling to accept their problems (including emotional problems), returned to their previous drug
using lifestyle, expressed boredom, experienced traumatic or stressful events, and were using other substances such as alcohol. Recovery included being able to cope with negative emotions and events and avoidance techniques (e.g. old drug using networks). Identity changes were also noted. Mullen and Hammersely (2006) suggest that relapse and recovery were centred around “push and pull” factors in relation to participants’ drug using subcultures. They further situate their findings within the Relapse Prevention Therapy models (Parks & Marlatt 2000). However, their findings are largely descriptive of the process of relapse and recovery.

Non-UK based qualitative literature

Daniulaityte, Carlson, & Siegal, (2007) described patterns of crack cocaine use including first use, among a female cohort in the USA using a grounded theory approach from an ethnographic perspective. Many participants used substances in adolescence and cited substance use as part of their family or peer lives growing up. First drug use was linked to coping with traumatic events and emotional problems. Those who had abstained from crack use had avoided their old drug using networks although they continued to use other substances such as alcohol. Non-drug using networks and family helped to prevent more chaotic and heavy use and for some this helped during periods of recovery. Drug using partners were a barrier to recovery. The researchers considered that heavy users were polysubstance users and participants’ use was linked to traumatic childhood experiences such as abuse, loss or substance use involving parents. Self-medication theories were postulated as well as the importance of social networks in relapse and recovery behaviours.

Harris, Fallot, & Berley (2005) explored recovery among female trauma survivors in the USA who had dual diagnoses of substance use and mental health problems. Feeling connected to others with similar problems was helpful in recovery. The following were also considered helpful in recovery; being aware of and having insight in to their problems, cognitive skills such as problem solving skills, leading a meaningful life such as job or volunteer work and building self-worth. Dealing with depression was a trigger for relapse which some linked to their traumatic and abusive childhoods. Some were fearful of entering into new relationships because of past abusive relationships. Harris et al. (2005) do not situate their findings within a particular theoretical
framework but do acknowledge links between trauma, mental health and substance misuse among the participants.

Davidson et al. (2008) explored narratives among a group recovering from addiction and among a group recovering from mental health problems and found the following helped; engaging in relationships, helping others (in the services, community, jobs), managing day to day living and redefining a (positive) sense of self which involved building self-worth, self-esteem and having an understanding and acceptance of themselves.

Generally there were a limited number of studies within the qualitative literature on relapse and recovery which focus primarily on Class A drug misuse. In summary the studies suggested that the following were important in recovery; building a positive self or a new identity, having healthier non-drug using relationships and networks, building a life with meaning away from a drug using lifestyle and acquiring cognitive skills. Barriers to recovery or triggers for relapse included mental health problems, dealing with emotions and returning to old drug using networks and lifestyles. In some of the qualitative literature it was suggested that participants’ reasons for addiction, first use and relapse may be linked to their difficult childhoods and traumatic events. This will therefore be an area that is also pursued in this thesis. Using less chaotic substances was viewed as both helpful and unhelpful in recovery furthermore, some considered recovery to include the use of other substances. Therefore, participants’ own definitions of recovery in relation to substances will be explored in this thesis.

3.3.4 Summary of the empirical literature

In conclusion there were a limited number of studies on relapse and recovery using a qualitative approach which seek to explore the participants own perspective and which focus primarily on Class A drug misuse. Orford (2008) has noted a paucity of addiction research which focuses on understanding the processes of change in recovery, from participants’ own perspectives, using qualitative epistemologies and methods. The studies generally focused on either male or female populations in drug treatment settings rather than in criminal justice settings. There were no studies which explored the cycle of relapse and recovery of the DIP clients from their own perspectives.
Drake (2013) has been critical of the addiction field for not using theoretical frameworks more in understanding addiction. When the studies reviewed provided theoretical contexts these were dominated by theories on identity, which were mainly from sociological perspectives such as identity transitions and transformations during and after recovery (Rhodes, 2000, 2010 and Nettleton, Neale, & Pickering, 2011). There was a limited use of psychological theories in the literature in particular from a developmental psychological perspective. Furthermore, little attention was given to defining recovery within the extant recovery literature (Best, 2014) presumably because within the drug addiction field this is limited (Senker and Green 2016).

A review of the developmental psychological theories considered to be of relevance to the thesis is now provided along with a further review of the relapse and recovery literature in relation to these theories. The review of the theoretical framework (from a developmental psychological perspective) will also provide further scope and direction to the research questions.

3.4 Theories informing the research scope, direction and questions

3.4.1 Introduction

A review of the empirical relapse and recovery literature in addiction and offending behaviour (i.e. substance misusing offenders) has demonstrated that there is limited use of psychological theories. Larkin and Griffiths (2002) acknowledged the importance of understanding the psycho-social processes involved in addictive behaviour. This is because unlike biological and genetic factors, which provide little predictive value, psycho-social processes present variations which might illuminate addictive behaviours and how people recover more fully. Furthermore, proponents such as Khantzian (2012) whilst acknowledging the influence of the biological and genetic theories to explain addiction suggests these theories alone cannot account for the development of addiction. Many of the theories presented here are integrative of developmental biological and neurological processes however they also recognise the influence of early psycho-social environments on development across the lifespan (e.g. Schore & Schore, 2008; Flores, 2012; and Khantzian, 2014).
Developmental Psychology is interested in the reasons for change over a lifespan with a focus on childhood. Childhood is regarded as a period that has a great influence on a person’s subsequent later life (e.g. Michael Rutter – see Sonuga-Barke et al., 2017 and Bowlby, 1973). In particular, research supports the detrimental impact that extreme insecure childhood attachment relationships can have on a person in adulthood (Schore, 2001; and Schore & Schore, 2008). Developmental Psychology explores emotions, cognitions, relationships, self and identity, areas which have been highlighted in the empirical literature review as having some relevance in relapse and recovery. The review, thus far, has further alluded to difficult childhoods and the continued struggles in adulthood among substance misusers; therefore theories developed within the field of Developmental Psychology might hold some relevance in furthering our understanding of addiction and the participant group.

The theories presented here represent those that were anticipated to have relevance and significance to the research and which were drawn on to help support the development of the research questions. They will be introduced in this section to understand how the questions, scope and direction of the thesis were developed and how it was envisaged that these theories would be of some importance during the research process.

3.4.2 Overview of the Developmental Psychological theories

Attachment theory, developed originally by Bowlby (1973) has been used by some, for example, Flores (2012) and Khantzian (2012, 2014) to provide a developmental perspective of addiction and will be the core theory that forms the scope and initial direction of this thesis and the development of the research question/s. However, to investigate an area as complex as addiction and recovery with the participant group (an offending population with multiple complex issues and needs), required drawing on several other core theories/ists. Some of the theories/ists incorporate aspects of an attachment perspective and/or expand on some of its common components further and some of the theories help to provide a fuller understanding of addiction in conjunction with attachment theory. The main framework of theories I am using include, modern attachment theory, affect regulation theory, self psychology theory, developmental trauma theory and family systems theory.
It should be recognised that each of these theories/ists also sits within a wider substantial body of work and they each occupy multiple theoretical frameworks. However, it is not the intention of this thesis to provide a comprehensive overview of these wider bodies of work/theoretical frameworks. The thesis will focus on those aspects of the theories and those theorists, which are pertinent and relevant in furthering a fuller understanding of addiction, relapse and recovery primarily from a psychological developmental attachment perspective.

3.4.3 Attachment theory and addiction – introduction and overview

Attachment theory has been applied in substance misuse studies to investigate attachment styles (Schindler, Thomasius, Petersen, & Sack 2009), attachment cognitions (Miljkovitch, Pierrehumbert, Karmaniola, Bader, & Halfon, 2005) and affect regulation (Robinson, Sareen, Cox, & Bolton, 2011). Bowlby’s original concept of attachment theory is discussed before moving on to the work of Khantzian (2012, 2014) and Flores (2012), and others who have developed and applied attachment theory to offer an understanding of addiction from such a perspective.

Bowlby (1973) considered that the early attachment bond between the mother and her baby would have a lasting impact, throughout the child’s life span, on their ability to regulate their emotions (affective states), a template for interactions with others and for forming relationships, including with themselves (a coherent self) (Bowlby, 1973). Bowlby termed these templates ‘internal working models’. Cassidy (2008) considers that Bowlby’s internal working models are formed of cognitive components and represent an internalised view of the world that is formed from the earliest attachment bond, which is then used to navigate and predict the external world. Bowlby (1973) further viewed the quality of these early attachment bonds to have a lasting impact throughout the life cycle in relation to mental health and wellbeing.

An appropriate sensitive attunement by the mother in response to her baby/infant’s needs and expressions would develop a secure attachment and provide healthy appropriate internal working models. However, further attachment styles such as the anxious-resistant (Ainsworth, Blehar, Waters, & Wall, 1978), (insecure) disorganised/disorientated (Main & Solomon, 1986) and fearful-avoidant from adult attachment studies (Bartholomew & Horowitz, 1991) are considered to provide less
adaptive internal working models which can have a detrimental impact on a person’s ability to navigate emotions and relationships (Mikulincer & Shaver, 2008) and on their cognitive processing abilities (Schore, 1994; and Schore & Schore, 2008). Furthermore, such attachment styles have been implicated in the development of mental health problems (Nelson & Bennett, 2008). The application of attachment theory within emotion regulation, navigating relationships (including with the self), and mental and psychological wellbeing has relevance to how the theory can be applied to an understanding of those with addictions and their concurrent complex lives and presenting issues. This is discussed in subsequent theories in this theoretical framework section.

3.4.3.1 Evaluation, criticisms and advancements

Attachment theory was integrative and drew on ethological theory, family systems theory, biology and cognitive neuroscience (Bowlby, 1973). Modern attachment theorists (e.g. Schore, 2001; and Schore & Schore, 2008) have capitalised on this holistic approach to advance the theory further. This is discussed in Section 3.4.7 and in the second stage literature reviews in Chapters 5.2 and 6.3.

Modern adult attachment theorists tend to favour the ‘primary caregiver’ terminology rather than exclusively the mother when describing the attachment figure. This is also a reflection of further research which more fully acknowledged that the attachment figure might not necessarily be the mother but might be a father or non-biological caregiver and that a hierarchy of attachment figures exists (for an overview see Cassidy, 2008). Furthermore, some consider that the multiple relationships and therefore attachment strategies that exit within a family unit are also influential (Dallos & Vetere, 2012). Feminist psychologists have also been critical of the focus on the mother-child bond which they considered unduly blamed the mother for problem behaviour and mental health in their children.
3.4.3.2 Application of attachment theory in addiction – overview and gaps in the field

Reading (2002) considered that there was a limited use of attachment theory within the addictions field. However, since his comments there is now a growing body of empirical work within substance misuse from an attachment perspective. The body of work includes all classes of drugs such as cannabis, ecstasy and opioids (e.g. Schindler et al., 2009) with varying frequency and degree of use. For example, cannabis use among college students (Kassel, Wardle & Roberts, 2007) to more severe addictive use involving clinical populations (Delvecchio, Di Riso, Lis & Salcuni 2016). The empirical research has examined links between substance use and various aspects of attachment theory. For example, the fearful-avoidant (Bartholomew 1990) dismissing (Rosenstein & Horowitz 1996) and insecure attachment styles (Thorberg & Lyvers 2006) among those with substance misuse problems. Schindler et al. (2009) found that heroin users exhibited mostly fearful-avoidant attachment styles, which they suggest supports a self medication hypothesis. Others have sought to examine a more complex interplay between substance use, attachment theory and for example, mental health, self-esteem and family characteristics. (For example Kassel et al., 2007; and Finzi-Dottan, Cohen, Iwaniec, Sapir, & Weizman, 2003).

Drawing a general consensus within the addiction-attachment field is problematic due to the heterogeneous nature of the studies which use different populations (e.g. clinical, college students), different scales and measures, (Schindler et al., 2009) and the diverse range of substances and addictions being examined (e.g. drugs, alcohol and gambling). Furthermore, these studies have been overwhelmingly quantitative in nature using measures and scales. There is a paucity of qualitative research within attachment theory on Class A drug addiction and among community based UK offending populations in particular.

3.4.4 Affect regulation theory and attachment theory - application to addiction

The affect regulation component of attachment theory has been applied to an understanding of addiction by theorists such as Flores (2001, 2012) and Khantzian
(2012, 2014) and is of particular relevance to this thesis. This is because Flores (2012) considers that addiction is a mechanism to help manage overwhelming and negative emotions (such as fear, shame and sadness) and relational problems by those who have experienced difficult childhoods due to poor attachments to parents/primary caregivers where there is abuse, neglect, trauma or bereavement/loss, usually involving the primary caregiver/parent. Flores (2012) suggests that a person’s ability to regulate their emotions, also known as affect regulation, is compromised during early childhood development where attachment bonds are insecure or avoidant. This is based on Bowlby’s internal working model of emotion regulation that is formed from the early attachment bond. Flores (2012) advocates that if early attachment bonds are secure then a person’s ability to regulate their affective states throughout their lifespan will be much more successful because they have experienced an emotionally attuned caregiver who teaches them how to regulate and soothe. Those who have experienced insecure or avoidant attachments will struggle with this, especially during times of stress or trauma. Substances are a means to manage emotional and relational distress, to numb and avoid intolerable feelings such as fear, sadness and shame (Flores, 2001, 2012). Flores (2012) therefore considers addiction to be an attachment disorder. Gill (2014) further suggests that “a person’s addiction can be understood as resulting initially from a place of broken attachment relationships” (p. xiii).

Flores further considers that “attachment theory holds the position that substance abuse is both a solution and a consequence of a person’s impaired ability in developing healthy attachments” (Flores, 2012, p. 35). He suggests that continued problematic substance use leads to further isolation and deterioration in the person’s ability to form attachments or relationships to others, which further compounds the problem. The person’s primary attachment becomes the addiction to the substance and until this is addressed, forming healthy meaningful attachments to others will be problematic. Flores highlights (from his clinical observations) how those with addictions have either difficult relationships (e.g. are unhealthy or lack meaning) or they are non-existent. Reading (2002) considered drug addiction to be a miss-attachment, Khantzian & Weegmann (2009) also suggests this. (See Chapter 6.3 for a more in depth discussion on this).
Flores (2012) acknowledges that those with addictions often suffer from what he terms cross addiction. For example, a person might stop drug addiction but become addicted to alcohol or eating instead. Flores contends that it is not the addictive nature of the substance but a problem that lies elsewhere within the individual that drives all of the person’s addictive disorders. Flores believes this can be explained and understood using attachment theory alongside self psychology theory. Flores (2012) further proposes that the theories can account for the co-existence of emotional and mental health problems found among those with addictions (research has found high prevalence rates of the co-occurrence of substance misuse and mental health problems e.g. Strathdee et al., 2002).

3.4.3.1 Evaluation and criticisms

Both Khantzian and Weegmann (2009) consider that Flores’ view of addiction as an attachment disorder is an over generalisation and they more specifically consider addiction to be an affect regulation disorder, which will be expanded on further in Section 3.4.6. Flores brings together attachment theory, affect regulation theory, self psychology theory and neuro-biological/physiology theories to offer a compelling and comprehensive understanding of addiction with attachment theory being central. His use of Kohut’s (1977) self psychology theory in relation to attachment and addiction is now considered.

3.4.5 The influence of self psychology theory in advancing attachment theory to understand addiction

3.4.5.1 Introduction

Flores (2001, 2012) acknowledged that attachment theory required ‘expanding’ further to offer a more comprehensive understanding of the development of the psychic structure of the self to elucidate a fuller explanation of addiction from such a perspective. Flores (2001) suggested that self psychology theory first proposed by Kohut (1977) can explain the deficits in self-structure that are often found in those with addiction problems. Furthermore, these deficits arise from insecure attachments to parents/primary caregivers, which Kohut and Wolf (1978) referred to as self-objects (Flores 2001). Kohut and Wolf (1978) recognised that addiction and delinquency were
prevalent among their clients with narcissistic personality disorders, the result of deficits in psychic structure. Narcissistic personality disorder included anger, tenuous self-esteem/self-worth and an inability to cope with disappointment (Kohut & Wolfe, 1978). Others such as Ulman and Paul (2006) and Van Schoor (1992) have highlighted the prevalence of the narcissistic personality (disorder) among those with addictions. Ulman and Paul (2006) consider self psychology theory to be able to offer a shared understanding of those with deficits in self-structure including pathological narcissism and their concurrent addiction problems and symptomology.

3.4.5.2 Self psychology theory – overview

Kohut (1977) formulated his theory of the self from his clinical observations of patients who displayed (pathological) narcissistic propensities. He noted that these individuals had particular vulnerabilities pertaining to the self, such as low self-esteem, self-worth and sensitivity to failure and disappointment (Kohut & Wolfe, 1978). Furthermore, Kohut and Wolf (1978) from their clinical observations thought that dangerous and frightening events in childhood alone could not account for the disorders of the self (e.g. mental health problems such as borderline personality disorder, narcissistic personality disorder and schizophrenia).

Kohut viewed the development of a healthy sense of self, its structures (such as self-esteem, a healthy narcissism and empathy) and functions, (e.g. self-soothing, affect regulation), to be formed in early childhood (see also Stern, 1998). Kohut and Wolfe (1978) considered the formulated self as the nuclear self, an essential part of personality. Flores (2001) agrees with Kohut’s suggestion that the integration of the developed self also organises affect into meaningful experiences resulting in affect regulation. Banai, Mikulincer and Shaver (2005) consider Kohut’s psychic structures of the self to comprise feelings, thoughts and attitudes about the self and the external world. Flores (2012) considered Kohut’s psychic structures of the self to be similar conceptually to Bowlby’s internal working models.

The nuclear self can be fragmented or cohesive depending on the responsiveness of the self-object (or attachment figures) in early childhood development. Self-objects or attachment figures provide the functions of the self until the self becomes a healthy, coherent and independent nuclear self. The self-object (along with genetic and
biological influences) also shapes the emerging self-structure according to Kohut and Wolf (1978). Attunement, empathy and age appropriate responsiveness by a self-object would lead to the development of a healthy self that is coherent and independent and able to tolerate life’s traumas, difficulties and successes appropriately. However, a self-object that is unable to provide this could lead to a fragmented self with deficits leading to mental health problems developing such as narcissistic personalities, borderline personalities, schizophrenia, bipolar and depression (Kohut & Wolfe, 1978). Kohut and Wolf (1978) considered that it is how the self-objects (i.e. appropriate attunement by the attachment figure/s) are with the child that is essential.

3.4.5.3 Evidence base and application of self psychology theory within the addiction field

Self psychology theory (Kohut, 1977; and Kohut & Wolfe, 1978) has specific relevance within the addictions field because it considers that addictions are attempts at self-repair and to regulate affect states. In Kohutian terminology substances are used in place of insufficient self-objects during childhood in an attempt to provide functions that the self cannot, due to the deficits in psychic structures during the developmental stage. Essentially this is because of harmful attachments to parents (Weegmann, 2002).

Kohut’s self psychology theory provides a developmental explanation for what is often found in those with addictions with regards to a fractured sense of self or deficient psychic structure and functioning. For example, their low self-esteem, low self-worth, inability to self-sooth and regulate affect, resulting from insecure or insufficient attachment figures or self-objects. This is why it has relevance to both attachment theory and its application to understanding addiction (Weegmann, 2002).

Kohut’s theory of the development of the self is widely accepted within the psychoanalytical domain (Banai et al., 2005) although aspects of it have been advanced and developed further (see Fosshage, 2009 for an overview). There is empirical support for the narcissistic personality and pathology and for other elements of Kohut's theory, it has not, however, yet experienced the same extensive investigation as attachment theory (Banai et al., 2005). Most of the literature on self psychology has focused on its utility within a therapeutic setting (e.g. Stone, 2009) and its application
to understanding the development of mental health further. It has not been applied extensively within the addiction field despite Kohut’s (1977) references to the applicability of his theory to understanding addiction. For example:

“It is the structural void in the self that the addict tries to fill – whether by sexual activity or by oral ingestion. And the structural void cannot be filled any better by oral ingestion than by other forms of addictive behaviour. It is the lack of self-esteem of the unmirrored self the uncertainty about the very existence of the self, the dreadful feeling of fragmentation of the self that the addict tries to counteract by his addictive behaviour.” (Kohut, 1977, p. 197 footnote 11).

Levin (1991) and Ulman and Paul (2006) have applied self psychology theory specifically to further an understanding of addiction. Ulman and Paul (2006) view addiction as a sub type of the narcissistic behaviour disorder proposed by Kohut and therefore consider addiction to be a symptom of a psychological disorder rather than stemming from a physical or biochemical disorder. They have based their theory on their observations during therapeutic practice with people with addictions displaying narcissistic disorder, which they consider to include pathological emotions, behaviours and fantasies - in particular the dissociative nature of them, which some such as Van Der Kolk (2014) might recognise as a trauma defence. They further embed their theory within a Freudian psychoanalytical framework with a focus on the internal fantasy construction being central. However, importantly, many (e.g. Flores, 2012) now recognise that such elements of Freudian thinking, which viewed ‘psychopathology’¹ and childhood trauma to be due to the internal fantasy world of the individual and not connected to any real experiences, did not have the advantages of modern scientific advancements to understand that external reality was the influencing factor. Ulman and Paul (2006) provide a helpful focus on the narcissistic personality disorder and therefore fragmented self-structures found among many of those with addictions and go some way to highlighting common addictive characteristics. Their theory provides only a partial picture of addiction. Furthermore, Levin (1991) recognises that there are

¹ Terminologies which are used to refer to ‘mental health’ vary throughout the literature. In some circumstances the referenced author/s terminology of ‘psychopathology’ has been used. In other circumstances terminology such as ‘diagnosis of’ or ‘mental health’ has been used.
strong links between pathological narcissism and addiction but more specifically views addiction to be a disorder of the self.

Flores (2012) views Khantzian’s Self Medication Hypothesis (SMH) as expanding on Kohut’s (1977) belief that substance abuse was an attempt at regulating affect and repairing a damaged self, due to a defective psychic structure and functioning. They argue that this is the result of insecure or avoidant attachments to parents or “primary self-objects” to use Kohut’s language. The influence of Kohut’s theory is evident in Khantzian’s later work. Schore (1994) also acknowledges the place of Kohut’s theory within his affect regulation and modern attachment theory, an overview of which is provided in Section 3.4.7. Khantzian’s Self Medication Hypothesis along with others’ view of affect regulation theory will now be discussed. The influence of Kohut’s theory in SMH is also mentioned.

3.4.6 Khantzian’s Self Medication Hypothesis - an affect regulation theory of addiction?

3.4.6.1 Introduction and overview

Khantzian proposed his Self Medication Hypothesis in 1985 but developed it over the coming decades. He postulated that people take drugs or substances because they are unable to regulate their own affective states in particular negative or painful emotions. His original theory assumed that it was to alleviate ‘psychopathological’ symptoms. Later he revised this and suggested that people misused substances to alleviate affective states that might or might not be embedded within ‘psychopathologies’ (Khantzian & Weegmann, 2009). He further postulated that certain substances were preferred by individuals to alleviate particular affective states, for example alcohol to alleviate isolation, feelings of emptiness and anxiety, opiates to calm aggression and violent states and stimulants (e.g. cocaine) to manage depression and boredom or to calm high energy levels found in those with for example manic disorders (Khantzian, 1997).
3.4.6.2 Evidence base and criticisms of the Self Medication Hypothesis

Khantzian’s Self Medication Hypothesis was revolutionary at the time because it highlighted that drug addiction was not about pleasure seeking, moral positioning or an illness but was about alleviating psychological distress and pain (Khantzian, 2014). There was widespread acceptance of the theory during its early conceptualisation (Lembke, 2012). Since then there has been less widespread acceptance for the second part of the theory pertaining to the specificity of drugs to alleviate particular affective states. The evidence is contradictory. For example Suh Ruffins, Robins, Albanese, & Khantzian, (2008) found supporting evidence that heroin is used to calm aggression and manage negativity towards the self and others. Hall and Quenner (2007) and others have not found supporting evidence for the drug–affect specificity part of the theory. Researching this area is fraught with problems. For example using self-report measures about affective states with drug addicted populations is problematic because this group have difficulty identifying, describing and reflecting on their emotions (Tronnier, 2015). Active substance use would also act as a confounding variable making it difficult to ascertain if affective states are actually due to the effects of the substance or not (Suh et al., 2008). Tronnier (2015) argues that affective states change within an individual [for example during the course of a day] and capturing a moving state at the time when drug use is being utilised to affect those states is a more complex endeavour. Suh et al., (2008) suggest that more effective measures or means to gather such data are required.

There is considerably more support for the first part of the theory which suggests that individuals learn to use substances (including, drugs, alcohol) to regulate affective states, such as to feel alive when a person’s main state is dissociative or numb and to self-protect from overwhelming experiences. This is one possible explanation for addictive behaviour. For example, Robinson et al. (2011) in their longitudinal large scale quantitative (USA) based study found support for the Self Medication Hypothesis for those people using alcohol and drugs. Wilkinson, Halpern and Herring (2016) in their quantitative (USA) research involving teenagers using cannabis, alcohol and tobacco found corroborating evidence for the Self Medication Hypothesis. Henwood and Padgett (2007), in their qualitative study found support for the Self
Medication Hypothesis but also concluded that other factors were involved in drug use among their homeless (USA) population.

Some consider that the Self Medication Hypothesis is not a comprehensive enough theory to account for the complex interaction of psychological, social, environmental and biological components involved in addiction (Lembke, 2012). Lembke (2012) further argues that Khantzian’s theory ignores the harm that the substance use disorder itself inflicts and suggests that the central premise of the theory is misleading because self-medicating painful affective states does not relieve the symptoms. However, Lembke (2012) may well have misunderstood these aspects of the theory. Khantzian recognises the damage that the substances cause throughout his writings and further acknowledges that addiction is an ‘attempt’ to repair disorders in self-regulation but in the long term it is unsuccessful. Continued addiction to substances further weakens a person’s already deficient self-regulatory capacities (Khantzian, 2012).

3.4.6.3 Advancements and developments

Khantzian (2014) has acknowledged and addressed some of the criticisms over the years which has led him to advancing his theory further. Khantzian (2014), acknowledged in later developments the role of attachment theory, affect regulation theory, self psychology theory (Kohut, 1977) and trauma – including developmental (Khantzian & Albenese, 2008) in understanding addiction. Furthermore, the Self Medication Hypothesis was embedded within these theories (Khantzian & Albanese, 2008). Whilst Khantzian acknowledged the influence of the biological and genetic theories he considered that these on their own cannot account for the development of addiction (Khantzian, 2012).

Khantzian (2014) recognised the impact that insecure attachment bonds and relational trauma has on those with addictions. Khantzian (2012, 2014) now considers addiction to be a disorder of self-regulation which not only includes struggles with emotions, but also includes difficulty with behaviour, self-care (“wellbeing, safety and survivability” Khantzian, 2012, p. 276) and relationships including with the ‘self’ (the influence of Khout’s theory is most evident here). For example, based on his therapeutic work with over 1,000 clients Khantzian (2012) considers the following areas to be central risk factors in addiction:
• “an inability to recognize and regulate feelings;
• an inability to establish and maintain a coherent, comfortable sense of self and self-esteem;
• an inability to establish and maintain adequate, comforting, and comfortable relationships;
• an inability to establish and maintain adequate control/regulation of behaviour, especially self-care.” Khantzian (2012, p. 275)

In summary Khantzian’s first part of his theory where individuals self-medicate to alleviate affective states (in particular painful or distressing states) offers only part of the picture and its strength lies alongside a collection of theories (which are presented in this thesis) to provide a more comprehensive picture of addiction from a psychological developmental attachment perspective. Tronnier (2015) argues that the Self Medication Hypothesis is more comprehensively understood alongside affect regulation theory. However, Khantizan’s Self Medication Hypothesis could reasonably be considered an incarnation of affect regulation theory. A short overview of modern affect regulation theory proposed by Schore (2001), Schore and Schore (2008), which is relevant to the development of the research question, is now provided.

3.4.7 Modern affect regulation theory – a theory of self-regulation

3.4.7.1 A theory of self-regulation

Schore (1994), Schore and Schore (2008) bring together a range of theories from diverse disciplines including psychoanalysis, developmental psychology, neurobiology, socio-biology and genetics to offer perhaps the most comprehensive and widely recognised advancement of affect regulation theory. Modern attachment theory is considered by some to be an affect regulation theory (Vetere & Dallos, 2009; Mikulincer, Shaver, & Pereg, 2003; Padykula & Conklin, 2010; and Schore, 1994). Schore (1994), Schore and Schore (2008) further encapsulate this into a theory of self-regulation and therefore a modernised version of attachment theory.
Schore (1994) unlike others highlighted the evidence base that affect regulation was not just about regulating negative affect but was also primarily involved in regulating positive affective states too. For example, up-regulating positive affective states or emotions when a mother engages her baby in play using different tonal and facial expression. Schore (1994) offers a volume of research, theory and clinical observations to provide a compelling overview to account for the development of ‘psychopathologies’, affect deregulatory problems, relationship difficulties and ‘pathologies’ pertaining to the self.

Schore (2001) considered that some insecure attachment bonds are relational trauma. Relational trauma referred to abusive and neglectful parenting (the psycho-social environment) which Schore suggested had a detrimental impact on the developing brain in particular the right hemisphere responsible for attachment functions and emotional states. He highlighted the research evidence involving infants who had experienced abuse and who had deficits in their neuroanatomical brain development. He further postulates that relational trauma can be a predisposition to Post Traumatic Stress Disorder (PTSD). Van Der Kolk (2008, 2014) has gone further and examined what he views as early developmental trauma, which is distinct from PTSD. There are similarities between Schore’s relational trauma and Van Der Kolk’s developmental trauma and its impact on the development of mental health and behavioural problems. An overview of developmental trauma theory is provided next in Section 3.4.8.

3.4.7.2 Criticisms

Schore’s (1994), earlier work, like Bowlby’s also overly emphasises the mother as the sole person responsible for the development (normal or ‘pathological’) of her child and is therefore open to the same criticisms outlined earlier.

3.4.8 Developmental trauma theory

3.4.8.1 Definitions, prevalence and severity

Research within the field of childhood trauma is now being applied to the study of addiction. Childhood trauma has been referred to as complex trauma (Van Der Kolk, 2008), and developmental trauma (Van Der Kolk, 2008). Neglect, physical, sexual
and emotional abuse in childhood are considered to form part of childhood trauma. Van Der Kolk (2008) considered the most damaging form of developmental trauma to occur in early life, usually involving the parents/primary caregiver and is chronic and sustained over lengthy periods of time. Furthermore, attachment theorists such as Schore (2001) refer to insecure attachments to primary caregivers/parents due to abuse or neglect in childhood as relational trauma – which could reasonably be considered a constituent of childhood developmental trauma.

The prevalence of childhood trauma can be gauged from studies of childhood abuse and neglect. In the UK 5% of children under 11 years of age suffered abuse in the family and over 13% of 11-17 year olds suffered abuse by a parent or guardian. Snap shot figures over a year showed that 2.5% of under 11 years olds and 6% of 11-17 year olds suffered at least one episode of emotional, sexual, physical abuse or neglect by a parent or guardian (National Society for the Prevention of Cruelty to Children, NSPCC, 2011). In the UK 12% of under 11 year olds and nearly 18% of 11-17 year olds had witnessed domestic violence in the home (NSPCC, 2011). The UK study found that those children who had experienced abuse and neglect had poorer mental health and higher rates of delinquent behaviour (NSPCC, 2011). The World Health Organisation (2002) has recognised the detrimental impact that abuse and neglect in childhood has on victims, for example, substance abuse problems, damage to cognitive development, engaging in delinquent, violent and risky behaviours and mental and physical health problems.

A study in the USA (Felitti et al., 1998) has specifically focused on the prevalence of childhood trauma responses and found similarly high rates. For example, over 30% of a general population cohort had experienced physical and sexual abuse, which included violent abuse (10%) and sexual abuse (22%). Over 11% had experienced psychological abuse. Furthermore, over 25% had experienced problems in the family with substances including drugs and alcohol and 18% had family members with mental health problems. Almost 13% had witnessed their mothers being violently abused. The study also highlighted that those who had experienced such adverse childhoods were significantly more likely to suffer with drug and alcohol misuse problems and mental
and physical health problems (Felitti et al., 1998). Others have found that offenders have experienced historical childhood abuse, trauma and neglect (Fox et al., 2005).

**3.4.8.2 Developmental trauma theory – overview**

Van Der Kolk’s (2014) theory of developmental trauma is an attempt to account for ‘psychopathologies’ and other mental health symptomatology which he observed in his clients who had a history of childhood abuse, neglect and other early life trauma. He considered a diagnosis of Post Traumatic Stress Disorder (PTSD), was unable to adequately capture this type of early trauma, which he suggested has a more profound impact on early development (Van Der Kolk, Roth, Pelcovitz, Sunday, & Spinazzola, 2005), for example, cognitive functioning, language skills, motor skills, socialisation abilities, affect regulation, insecure attachments and problems relating to the self, such as self-care (Van Der Kolk, 2008). Van Der Kolk (2014) utilises a multiple framework of theories including, attachment theory, affect regulation theory and neurophysiology/chemistry/biology of the developing brain to elucidate the specifics of his developmental trauma theory. He further considers the effects that developmental trauma has on the physiology of the body (including sleep disturbances, eating/digestive disorders and headaches) as well as the psychological impact on the individual. He also suggested that adults with histories of childhood trauma such as physical and sexual abuse are more likely to have substance abuse problems, diagnosis of borderline personality, antisocial personality, dissociative and affective disorders (Van Der Kolk, 2003).

More specifically his theory postulates that a person’s inability to regulate internal states such as cognitive and emotional capacities affects their ability to process and therefore cope effectively with the trauma which he considered to be a central component of traumatic stress. He further implicates relational trauma, due to insecure attachments by primary caregivers/parents, as exacerbating the trauma response, as well as being a traumatising experience in itself. Furthermore, those who have experienced childhood trauma and damaging attachments are prone to repeat traumatising experiences throughout their lives because they have not learnt to process and resolve past trauma and therefore lack a template (or internal working model) to
deal with future trauma effectively (Van Der Kolk, 2008). However, secure attachments to primary caregivers/parents promote resilient responding which can help children to manage and cope with trauma and minimise the negative response and any long term ill effects (Van Der Kolk, 2008; and Van Der Kolk, 2005).

Despite a growing evidence base and compelling arguments developmental trauma remains excluded from the Diagnostic and Statistical Manual of Mental Disorders handbook (Van Der Kolk et al., 2005; Van Der Kolk, 2008; and Rahim, 2014). Some consider this to have a profound impact on clients and patients in obtaining a correct diagnosis and treatment (Van Der Kolk et al., 2005; Van Der Kolk, 2008; and Rahim, 2014).

3.4.8.3 Application of developmental trauma theory to addiction and gaps in the literature/field

Research which has attempted to investigate childhood trauma in those with addictions has used measures for PTSD but many argue this does not adequately measure or capture childhood developmental trauma (Van Der Kolk et al., 2005; and Rahim, 2014). There are few studies to date that have examined childhood developmental trauma or complex trauma among addicted populations. Although it can be reasonably argued that studies, which have examined the prevalence of childhood abuse, neglect or maltreatment among such populations, are a good enough proxy given that these constitute the definition of developmental or complex (childhood) trauma. Quantitative research has demonstrated that those with alcohol and drug addictions have a high prevalence of historical childhood abuse and neglect (Huang, Schwandt, Ramchandani, George, & Heilig, 2012; Cohen & Densen-Gerber, 1982; Rohsenow, Corbett, & Devine, 1988).

Ruggiero, Bernstein and Handelsman (1999) found in their sample that those with drug and alcohol abuse problems and who had experienced severe childhood trauma including sexual abuse, neglect, emotional and physical abuse had the highest scores of poor mental health. In particular those who experienced sexual abuse by a family member suffered from the most severe forms of ‘psychopathology’. Bernstein (2000)
highlighted that childhood trauma needs to be more specifically differentiated from other trauma types such as PTSD, which can refer to a single event only, to understand its impact on adulthood and in those with addictions. Bernstein (2000) suggested that the following factors affect the severity of the outcome on the individual: duration of the trauma, if family members were the perpetrators, the developmental stage the trauma occurred and how the trauma was dealt with at the time by the family, school and the community.

There is a lack of extensive qualitative research on childhood abuse, neglect and trauma among addicted populations, more specifically Class A drug addiction. Watson and Parke (2011) and Larkin and Griffiths (2002) found childhood abuse, neglect and trauma among their participant groups. These studies have not however placed their research and findings within a psychological developmental trauma-attachment perspective (see Section 3.3.3 for an overview of the studies).

There is no qualitative research about childhood abuse, neglect and trauma in a UK community based offending population with Class A drug misuse. Qualitative studies can highlight the impact and meaning of childhood abuse, neglect and trauma from the victim’s perspective. This can illuminate individual’s meanings they ascribe to the trauma and pinpoint differences with regards to the type, degree and severity of those experiences. Furthermore, they can uncover and explore nuances that quantitative research might not be sensitive enough to capture.

3.4.9 Family systems theory

3.4.9.1 Family systems theory – overview

Family systems theory considers the family unit to be of central importance in the field of psychology in helping to understand the individual development of a person (Vetere & Dallos, 2003). Family systems theory postulates that the pathology of a person’s difficulties with mental health, wellbeing and relationships are rooted within interpersonal relationships in particular within the family unit and are not only intrapsychic, residing within the individual (Dallos & Draper, 2015). Attachment theory also holds this premise. However, attachment theory has centred around the
dyadic interpersonal relationship, predominantly that between the mother and her infant (or caregiver-infant). Family systems theory considers a more complex interpersonal set of relationships within a family to be involved, (Dallos & Vetere, 2012). Essentially a family is a system, which is made up of several components (family members) who interact and influence each other’s relationships, which in turn feeds back into the system (circular processes) thus influencing and reinforcing for example behaviour patterns, beliefs and rhetoric over time. These can be patterns and behaviours that are helpful or unhelpful, depending on the context. Family systems theory also considers that the family system interacts and is influenced by wider social systems such as the community, schools and friends.

The most relevant incarnation of family systems theory to this thesis are those that are attachment orientated, such as Vetere (2014), Dallos and Vetere (2009) and Byng-Hall (1999). Vetere (2014), Dallos and Vetere (2009) in particular bring together attachment theory and family systems theory (as well as psychodynamic and narrative approaches) to offer an understanding of relationships, emotional expression, communication and cognitive functioning within a family system. This can help to understand the impact of emotional, psychological wellbeing and relationship functioning on family members throughout the lifespan. Dallos and Vetere (2009) have formulated their theoretical approach from their clinical practice, which Vetere (2014) has applied in clinical interventions with families experiencing problems including substance misuse, violence and abuse (Vetere, 2014). An overview of those attachment orientated family systems theorists such as Vetere (2014) Dallos and Vetere (2009) and Byng-Hall (2002) is now provided.

3.4.9.2 Attachment theory and family systems theory

Dallos and Vetere (2014) suggest that a family systems theory can offer an understanding of how problem behaviour and discourses are maintained within families. However, they consider the addition of an attachment theory perspective to offer an understanding of the development of those problematic behaviours and discourses, which includes emotional regulation/expressions within the system of the family. They consider family systems theory has lacked this fundamental aspect in the past (Dallos & Vetere, 2014). They also suggest that it is not just the dyadic mother-
infant relationship that affects the infant’s attachment bonds and therefore the infant’s development but that triadic relationships or attachment strategies between the infant’s parents, for example, are also involved. Therefore, what happens in a relationship in a family (between parents) can have a profound impact on a third person (the child), (Dallos & Vetere, 2012). More specifically children are aware of their parents’ relationship and this affects their relationship with them and with others in their family. When there is a problem, such as violence or conflict, within the parents’ relationship it can have a detrimental impact on child development (Minuchin, Rosman & Baker, 1978; and Dallos & Vetere, 2012).

Essentially children are influenced by multiple attachment strategies occurring in the family including those between their parents. Furthermore, Vetere and Dallos (2008) suggest that attachment styles offer different forms of communication styles within families which govern what can be discussed, how and with whom. This is heavily laden with how emotions are communicated and/or expressed and cognitive functioning, such as reflection. For example, in anxious attachment styles over-arousing affective states can block cognitive functioning and the ability to communicate and articulate problems, resulting in for example, over simplified explanations of difficulties and expression of aroused states, such as anger. Anger often fronts fear, sadness and shame and is self–protective (Dallos & Vetere, 2014). This is especially during times of trauma or stress, for example during critical transitions in a family life cycle such as the birth of a baby (Vetere & Dallos, 2003). This set of functions are referred to as meta-communication, meta-cognition and reflective self-functioning within the psychotherapeutic field (Dallos & Vetere, 2014).

Some parent-child patterns that can arise from parental conflict and abuse (or insecure attachment styles) within families can be harmful to the developing child (Byng-Hall, 2002). Family behaviour patterns can also become repetitive generational patterns of behaviour so that past generations can influence and impact on future generations. If these are dysfunctional or damaging they can continue to have detrimental impacts on successive generations (Byng-Hall, 1995).
Family Systems Theory highlights the importance of family relationships, furthermore the reparative benefits on members when unhelpful attachment styles, patterns of behaviour and narrative are resolved and such relationships can be strengthened (Dallos & Vetere, 2014). Attachment theory, like Family Systems Theory considers relationship dependency (with a healthy balance of autonomy) as a necessity throughout the lifecycle and not an unhealthy undesirable endeavour (Dallos & Vetere, 2014). Indeed the reparative benefits of supportive relationships within addiction treatment have been noted in peer support groups such as NA and AA (Flores, 2012).

3.4.9.3 Research base, application within addiction and gaps in the field of family systems theory

The evidence base for family systems theory has mostly emerged through studies that have applied family theory in therapeutic practice, for example the effectiveness of family therapy. Carr (2000) and Stratton (2011) in a review of studies found that family based therapy had been effective in the treatment of mental health, abuse, emotional problems and drug misuse. However, Vetere and Dallos (2003) raise a number of methodological problems of researching an area which involves multiple family members with differing views of ‘reality’ and urge researchers to be mindful and sensitive to such complexities.

The wider research field outside of therapy has also examined aspects of family systems theory, such as insecure parent-child relationship structures and characteristics including parentification and enmeshment. Preli and Protinsky (1988) found high rates of insecure parent child structures among those with alcohol misuse problems compared to control groups. Madanes, Dukes and Harben (1980) found cross generational and other ‘hierarchical role reversal’ in families of heroin addicts. The research has tended to focus on adolescents and less severe substance misuse problems. Generally speaking there is much less research which has applied the theory outside of therapeutic interventions. Furthermore, there is no research applying the theory specifically with a UK community based Class A drug misusing offender population from a qualitative methodological perspective.
3.4.9.4 Further application and relevance of family systems theory to the thesis

The theory has further relevance to the thesis because it considers how people ascribe meaning and understand multiple relationships within their family system. For example, it considers not just a person’s dyadic relationship between the self and a parent but also the meanings that a person ascribes to the relationship between their parents and other family members and the impact this has on them throughout life. It further focuses a spotlight on the communication and dominant narrative meanings ascribed in the family by individual family members. The theory also recognises that those meanings are subjective and that there are many forms of reality that exist among family members, there is no one objective truth of social reality.

Participants in this thesis will therefore be asked about their family relationships throughout their life including up to the present. The analytical method employed will focus on how participants ascribe meaning to those relationships and the impact it has had on them and on their journey of relapse and recovery and during significant family and other life transitions and events.

3.5 Summary of the theoretical framework and gaps in the field:

The theoretical framework review has mapped out how the theories and theorists relate and link to one another, their relevance within the thesis and in helping to develop the research questions, scope and direction. The theories collectively offer a guide to what might be found among the participant group in terms of adverse relationships, difficult childhood experiences, mental health, psychological wellbeing and difficulties pertaining to the self and identity. Some of the theories have been specifically applied within the addiction field and others less so. However, there is a clear gap in the field in applying this collective framework of theories to the specific participant group, a Class A drug misusing community based offending UK population, using a qualitative approach.
3.6 Research questions:

1. How do Class A drug misusing (ex)/offenders experience and make sense of their journey of relapse and recovery in relation to their significant life events and relationships?

2. More specifically, how do they make sense and experience this within the ‘context’ of their family upbringing, family and other relationships, significant life events such as trauma, bereavement, loss and their psychological health?

3. How has this ‘context’ impacted on their experiences and meaning making of their first substance/drug use, their continued use including lapses, relapses and during periods of recovery including sustained recovery?
CHAPTER 4: METHODOLOGICAL APPROACH, RATIONALE AND CRITICISMS

4.1 Chapter overview

An overview of the qualitative methodological approach used in both the Focus Group Study (Part One) and the Semi-structured Interview Study (Part Two) is covered. This includes the rationale for a qualitative approach, the epistemological underpinnings, the value of self-reflexivity and the particular phenomenological methodology used, Interpretative Phenomenological Analysis (IPA). A discussion on the use of IPA in a focus group design and a critique of IPA is provided. The research questions are presented and an overview of the ethical approvals and permissions required for the research. There is also a brief overview of how quality and standards were achieved throughout the thesis.

4.2 Introduction

4.2.1 Rationale for using a qualitative methodology – epistemology and the research question/s

The type of research question and phenomenon to explore can dictate which methodology to choose. The aim of this research was to understand who this group are as people, their experiences and lived worlds, using extant psychological theories to help to inform the scope and direction of the thesis (covered in Chapter 3). The research questions and aims are not concerned with empirical generalisability but are concerned with understanding in depth and detail the experiential ideographic accounts and meaning making of a small group of drug misusers who are part of a specific rehabilitation management programme. Qualitative approaches epistemologically consider that knowledge is subjective and selective (Willig, 2008) and there are many possible ways of viewing social reality that hold equal merit. Accessing knowledge therefore requires focusing on people’s lived worlds using more naturalistic techniques such as interview methods (Smith, Harré & Langenhove, 1996) and using inductive approaches where interpretations, concepts and theories ‘emerge’ from the data. This approach privileges the participants’ accounts or lived worlds and can lead to new understandings of a phenomenon, such as drug taking (Rhodes, 2000).
Some qualitative methods consider that understanding participants lived worlds is an interpretative process which involves the researcher making sense of participants meaning making which can be achieved through reflexivity. This process involves the researcher acknowledging their biases and preconceptions and how these might influence the interpretative process (Smith, et al., 2012).

Therefore, a qualitative approach with an emphasis on psychological processes, relationships and significant life events - Interpretative Phenomenological Analysis (IPA), was considered more able to capture those experiences relevant to the research questions and aims. By understanding this group in depth and detail the hope is to help to improve policy and practice and to help this group in their journey of sustained recovery.

4.3 Further reasons for using a qualitative approach in the research

4.3.1 Understanding the drug misusers’ world from their perspective - uncovering novel areas of importance

It is important to hear the narratives of participants from a hard to reach population to understand more fully what drug use, relapse and recovery means to the Class A drug misusing offender. A researcher or ‘outsider’ might interpret and view drug addiction and recovery differently to how the drug user understands and describes their world. For example, drug users often describe positive aspects of drug taking (McIntosh & McKeganey, 2000a), a concept that might be difficult for an ‘outsider’ to comprehend. During my time working in the Home Office, from my perspective, heroin and crack users were viewed politically as desperate criminals whose prolific acquisitive offending behaviour supported their Class A drug addiction. These politically held negative preconceptions might lead to important questions or lines of enquiry to be omitted or obscured. Rhodes (2000) suggested that qualitative methodologies (most notably within sociology) within the substance misuse field have provided new understandings about the substance misuse subculture, which had previously been considered deviant (Rhodes, 2000). A sea change in understanding substance misuse evolved (Rhodes, 2000). Neale, Allen and Coombes (2005, p.1586), suggested that “stereotypes and myths” were replaced by realistic and compassionate accounts that
humanised the ‘deviant’ drug user and which led to new understandings that helped to develop policy, theory and practice.

Rhodes (2000) considered that the drug user is the expert on their lived experiences of drug use; and furthermore, that qualitative methods provide the flexibility and conditions for the participant to offer explanations and accounts that a researcher might not have considered. It was therefore hoped that using a qualitative approach in this research would provide the opportunity to uncover novel areas of interest and importance from the user’s perspective.

4.3.2 Addressing a gap in qualitative drug misuse research and its application in policy development

There is a scarcity of published qualitative research within the addiction field despite its contribution to developing addiction policy and practice (Neale et al., 2005 and Neale et al., 2013, Berridge 2000, Rhodes 2000). Rhodes (2010) considers that the addiction field is dominated by quantitative research (the literature review in Chapter 3, supports this contention). Rhodes et al. (2010) found that in a snap shot year of 2009 the top eight ranked addiction journals contained on average only 7% qualitative studies. Some journals published more than others, the range being <1%-57%. Rhodes (2010) and Neale et al. (2013) suggest that publishers and researchers can do more to address this gap. For example, researchers can ensure high quality where standards are embedded and articulated in their research. Quality and standards will be embedded throughout the thesis (see Chapter 4, Section 4.12; Chapter 8, Section 8.6.1; and Appendix 21).

The influence of historical qualitative addiction research was evident in the DP policy. In the 1990s qualitative research furthered an understanding of the complex injecting behaviours among those with Class A drug addictions to curb the spread of HIV and other blood born infectious diseases, which were on the rise among this group. This paved the way for the development of harm reduction policies, strategies and practices within the drug misuse field (Neale et al., 2005). Harm reduction strategies were apparent in the Government’s Drug Interventions Programme.
However, the impact and influence of research (whether it be quantitative or qualitative) to help inform Government policy and strategy is politically driven and is dependent upon the policies and political views of the Government in office. From my perspective and time working in a politically driven environment this is not always conducive to developing policy, strategy and practice which are in the best interest of the client group. Unfortunately, it is outside the scope of this thesis to debate the impact of political agendas on the interpretation and the use of drugs research within policy, (for an example see, McKeganey, 2011 and Berridge, 2000). However, it is important to use a qualitative approach, which has been highlighted, can help inform drugs policy and also address a gap in the literature. (Recommendations and implications developed from the research findings for policy will be covered in Chapter 8).

4.3.3 Accessing and engaging hard to reach and vulnerable groups – the drug misusing offender

Qualitative methodologies can be more conducive when engaging with hard to reach and vulnerable populations. The research cohort, drug misusing offenders, are a “hidden” population because of their criminality and their deeply entrenched drug taking behaviour (Rhodes, 2000, p.23). Furthermore, they occupy a particularly marginalised position within society partly due to the politicisation of their drug use behaviour by Government (as outlined in Chapter 2). This means they are difficult to access, engage and retain within research (Rhodes, 2000). However, qualitative methodologies provide an opportunity for the researcher to build rapport and trust so that “hidden” populations such as these are more willing to engage in research and to disclose personal information about sensitive topics (Neale, Allen and Coombes, 2005). Furthermore, the group are considered to be vulnerable due to their often co-occurring health problems which raises a number of ethical challenges when discussing sensitive topics (Sammut-Scerri, Abela, & Vetere, 2012). Choosing a qualitative approach which puts the participant’s voice and experience at the centre of the data collection and analysis will provide an environment more conducive to managing ethical considerations pertinent to the group (these are discussed in more detail in Chapter 7). Engaging large numbers of the research cohort would have proved difficult within the confines of a single researcher led PhD project with limited funding. Previous experience of using quantitative approaches with this participant
group by the researcher, including commissioning research, bears testimony to this. A qualitative approach requiring a smaller sample size and which would be more amenable for the research cohort and questions was therefore considered more feasible and appropriate.

4.4 Subjectivity, generalisability and small sample sizes – value, merit and scope of qualitative methodologies

Qualitative approaches are subjective, do not offer empirical generalisation of findings and use small sample sizes which are acceptable because of the different epistemological and ontological position that qualitative methodologies occupy. Qualitative research does not seek to determine cause and effect relations, it explores different types of questions in different ways (Neale et al., 2005). Small sample sizes are preferred so that detailed and in depth analysis is possible. The volume lies in the amount of data produced rather than the number of participants (Neale et al., 2005). The value and merit of such data therefore resides in generating rich and textured accounts of people’s experiences and lived worlds that can therefore address the types of research questions specific to qualitative approaches and to this research. Whilst qualitative approaches do not aim to achieve empirical generalisability they can offer theoretical generalisability (Neale et al., 2013). (See Chapters 5.2, 6.3 and 8 for how the findings in this thesis have implications for theory).

Epistemologically qualitative approaches also accept that research is subjective. The approach used in this research, IPA, acknowledges that the researcher is part of that subjectivity because the researcher is a co-creator of participants’ meaning making. However, IPA has guidelines to deal with the researcher’s subjectivity (or researcher bias), from unduly influencing participants’ accounts and the analytical process but also ensuring that participants’ voices are raised. For example, self-reflexivity and validation checking are used to ensure findings are ‘grounded’ within participants’ accounts. This also forms part of following high quality and standards in qualitative research (see, Smith, Flowers, & Larkin, 2012; Yardley 2000, 2008; Neale et al., 2005; and Neale et al., 2013). An overview and the reasons for using the specific methodological approach (IPA), including an understanding of its epistemological underpinnings is now provided in the following sections.
4.5 Interpretative Phenomenological Analysis

4.5.1 Introduction

IPA was developed over 20 years ago by Jonathan Smith and colleagues. It is a qualitative thematic based approach developed within the field of health psychology, which has epistemological routes within the philosophies of phenomenology, hermeneutics and ideography. IPA allows a focus on the psychological aspects of the individual in particular, emotions and “cognitions” (Larkin, Eatough & Osborn 2011, Smith, et al., 2012, p.191). It is a case study type approach which requires an in depth and detailed introspection of a particular individual’s account as told by them. Qualitative analyses such as IPA is recognised for being able to acknowledge that despite individuals sharing similarities they also have individual experiences which may not be captured easily by quantification and categorisation on scales or psychometric measures. This point can be illustrated by Perron’s (2006) illumination of the disadvantages of quantifying depression:

“At best, what one can do is to arrange people according to a gradient ranging from the least depressed to the most depressed. One does not ‘measure’ depression as one weighs potatoes. If one thinks one can, it is an illusion of measure which entails a second illusion, namely, of believing one has defined a homogeneous sample because one has only selected subjects whose ‘note’ (the notation of depression, in the chosen example), is higher than a predefined level. This boils down to creating a class of objects, depressive patients, all considered identical in relation to a characteristic named ‘depression’. Only a so-called quantitative variation is recognised, while any form of qualitative variation disappears” (Perron, 2006, p. 928)

IPA is able to illustrate and explore the nuances and details of an individual’s lived experience whilst allowing for commonalities across a homogenous participant group. Some of the key philosophical concepts underpinning IPA are now discussed.
4.5.2 Phenomenological psychology and IPA

Phenomenological psychology is broadly concerned with how people experience and perceive the world they live in. More specifically the meanings they ascribe to that lived world and how they relate to it (Langdridge, 2007). Phenomenological philosophy has influenced psychology since the 1970s, when a paradigm shift away from positivism began to emerge in psychology (Langdridge, 2007). Smith and colleagues (2012) when developing IPA drew from the phenomenological philosophers, Husserl, Heidegger, Merleau-Ponty and Gadamer.

One of the key concepts in phenomenology pertinent to IPA is epoché (Husserl 1931/1967 as cited in Langdridge, 2007) which is the belief that we can bracket off our own preconceptions about a phenomenon to be able to attend to the experience with a certain level of doubt or scepticism. Husserl thought that it was possible to achieve this. However, Heidegger (1962/1927, as cited in Smith et al., 2012) argued that we could never completely achieve this and that our own influences and bias had to be acknowledged when attending to a phenomenon (or a person’s lived experience of the world). IPA is largely influenced by Heidegger’s understanding of epoché. The means by which this is achieved in IPA is through the reflexive process (such as a research diary, supervision and self-reflexive interviewing), which the researcher undertakes throughout the research project (Smith et al., 2012).

4.5.3 Hermeneutics and IPA

Hermeneutics is another important philosophy situated within existential phenomenology that is central to IPA. Smith drew on the hermeneutic concepts of Heidegger (1962/1927 as cited in Smith et al., 2012) and Gadamer (1990/1960 as cited in Smith et al., 2012). Hermeneutics is primarily concerned with the theory of interpretation of phenomenon/experience which can be accessed from language or text (Smith et al., 2012). To understand a phenomenon or experience requires considering a part of that experience in relation to the whole and vice versa – the hermeneutic circle. (Smith et al., 2012). IPA involves a “double hermeneutic” whereby the researcher is trying to understand the participants’ meaning making, whilst the participant is trying to make sense of that particular experience for
themselves (Smith et al., 2012, p.35). The researcher is required to question or to be sceptical of their understanding of participant’s meaning making and also the participant’s own understandings of their experiences. It is the balance of connecting with the participant’s experiences and meaning making whilst retaining this questioning position where IPA’s interpretative co-creation of meaning making resides (Smith, 2004). The researcher is viewed as part of that co-creation of meaning-making and this is where the importance of epoché and reflexive thought is central to IPA. The reflexive thought process helps to manage the preconceptions, assumptions or bias held by the researcher from overly influencing and eclipsing the meaning making of the participant. (See Chapter 5.1 Sections 5.1.8.3, Step 2; Chapter 6.1, Section 6.1.5.3, Step 2; and Appendix 10, for further information on how this was achieved in the research).

4.5.4 Ideography and IPA

IPA is an idiographic approach, a detailed focus and analysis on an individual’s particular lived experience within a particular context or topic. This departs from a nomothetic approach in psychology which aims to make generalisations about large population sizes (Smith et al., 2012). The ideographic nature of IPA therefore requires a homogenous group who share a similar experience. An individual’s case is analysed before moving on to the next which allows a greater focus on the ideographic nature of a person’s experience before considering commonalities across a group (Smith et al., 2012). IPA considers that people’s experiences are “uniquely embodied, situated and perspectival” (Smith et al., 2012, p. 29) but that there are also similarities among people undergoing similar experiences.

In summary, these key philosophical concepts in IPA were considered conducive to addressing the research questions and aims.

4.6 IPA and the addiction/substance misuse field

IPA studies offer a good example of how qualitative approaches within psychology have been applied within the addiction field. Smith (2004) argues that IPA has a wide application to a range of fields within psychology and it is therefore more important to consider a research question’s suitability to IPA’s epistemology. He notes that
many IPA studies deal with “significant existential issues of considerable moment to
the participants and the researchers. Thus many are about significant life transforming
or life threatening events, conditions or decisions” (Smith, 2004, p. 49). Substance
misuse encompasses such experiences and IPA has therefore been used within the
addiction and substance misuse field. Smith et al., (2012) recognise the significance
of the experience of emotions within the lived worlds of those with addictions in a
number of IPA studies concerning addiction. Examples of IPA studies involving
addiction include, alcohol misuse (Shinebourne & Smith, 2009; and DeVisser &
Smith 2007) and drug misuse (Watson & Parke, 2011; and Boserman, 2009). For
papers on experiences of addiction and recovery see Larkin and Griffiths (2002);
Rodriquez and Smith (2014); and Watson and Parke (2011). (See Chapters 3, 5.3 and
6.3 for a more in depth review of the most relevant IPA and substance misuse papers).
IPA was therefore considered appropriate for the types of questions raised with the
drug misusing participant group.

4.7.1 Epistemological position in this research and rationale for
using IPA rather than other phenomenological methodologies.

It is important to recognise the political and “hidden” (Rhodes, 2006, p. 23) status of
the participant group further to understand why an IPA approach was the more
appropriate methodology to use. The research participants are a highly politicised and
marginalised group in society. They are subject to Government interventions (e.g.
DIP), institutions (rehabilitations, NHS, prisons) and authority figures (police,
probation and prison officers). This group are hard to reach and difficult to engage
within research. Combined together these issues mean that their voices are largely
unheard within published research and elsewhere. During my time working in the DIP
policy (2002-2008) I often heard claims from clients that they felt they were not
listened to and that rehabilitative approaches (including DIP) were not tailored enough
towards their own individual needs and concerns. Mckegany (2011) provides an
overview of how politically held agendas have eclipsed drug users’ voices and
concerns. In my opinion an understanding of this group as ‘people’ was lacking. Their
offending labels were dominant within the corridors of the Home Office, closely
followed by their chaotic drug user labels. These labels eclipsed the person, their
experiences, their lives and what drug use and recovery meant to them. For example,
many within the health professions (myself included) would suggest that there are no benefits to crack and heroin misuse however as mentioned earlier, substance misusers might disagree (McIntosh & McKeganey, 2000a). Therefore (e.g. politically held) preconceptions might lead to important lines of exploration being missed, omitted or obscured.

A phenomenological approach provides an opportunity for the voice of those who are largely unheard to be heard but the idiographic nature of IPA permits “distinctive voices” to be heard and “does justice to the complexity of human psychology itself”. (Smith et al., 2012, p.38). This would allow a participant group, who felt ignored, to have an opportunity to speak individually and to be heard individually. Essentially, IPA provides a fuller picture of a person’s lived experience because it captures their meanings through their words about their lived worlds. I believe that by allowing participants’ voices to be heard and ‘accepting’ their meanings and understandings of their lived world will also provide the opportunity to be able to uncover some novel and important areas of interest and further investigation for this much maligned group. However, acceptance should not be taken to mean that a participant’s version of what they consider to be a truth should go unquestioned by the researcher. This is another important aspect of IPA methodology which will be discussed next in relation to what ‘truth’ means in the methodological approach.

The phenomenological position of IPA considers that there are many possible ways of viewing social reality or a person’s experience, departing from the assumption of an absolute singular ‘truth’. Furthermore, it is possible to access the varied meanings that people attribute to their experiences and what they believe to be a ‘true’ account of their lived experiences (Smith et al., 2012). Whether this is a truth that I as the researcher would agree with is not what IPA aims to achieve. IPA crucially advocates that meaning is co-created, it is a dynamic process and the researcher is part of that process of interpretation and meaning making or hermeneutics (Smith et al., 2012). It recognises that the researcher might bring biased interpretations to the methodological process however, “bracketing” these biases, i.e. acknowledging and recognising them, can help to minimise unduly influencing participants meaning making (Smith et al., 2012, p.25). Smith et al. (2012) acknowledge (as do I) that it is not possible to achieve
completely biased free IPA research. They suggest self-reflexive note taking to help with the “bracketing” process (Smith et al., 2012, p.25).

Using a methodological approach, which includes self-reflexive note taking was essential to help identify my political bias, views and preconceptions about a group who were politicised by the very organisation that I had worked in for many years. My reflexive note taking in the research illustrates how I grew from viewing the group through a political lens as a policy adviser working in Government, to viewing them in a humanistic manner and to eventually understanding them as people first – ‘the vulnerable child once within’, without the labels of offender and chaotic drug misuser dominating (Chapter 5.3, Section 5.3.4.4.). This was a surprise to me because I had considered myself to have a healthy critical awareness of politics, Government agendas (hidden or otherwise) and the social political processes behind policy creation. This metamorphosis very powerfully highlights the important role that the reflexive and the hermeneutic process had in this research. The reflexive process was essential in helping me as the researcher to connect with the participants’ experiences and meaning making whilst retaining a sceptical questioning position.

In summary, IPA’s epistemological position and psychological interpretative focus were important in relation to the participant group (e.g. their political position and social power imbalance), my political position and in addressing the research questions and aims.

4.7.2 Why not a discourse analysis or grounded theory approach?

A discourse analysis approach would not have been a suitable approach to use with the research questions. The power imbalance created around this group and the researcher’s unique political position in relation to that group constitute the cultural position within which this group are situated. Smith et al. (2012) suggest that the cultural position of participants’ needs be recognised and understood to help in the analysis and in the interpretation process. This does not therefore mean that a Foucauldian Discourse Analysis was an appropriate methodology to pursue. The “unit of analysis” (Smith et al, 2012, p.195) in this research was not the power imbalance per se but how the participants make sense of their worlds in relation to their cultural
context and how the researcher makes sense and interprets that, (within the reflexive process), in relation to her own political biases. Both IPA and a Foucauldian Discourse Analysis can be described as social constructivist approaches; however, Smith et al. (2012, p.196) argue that IPA is less so, recognising that the individual is also shaped by “symbolic or cognitive activity”. IPA also focuses on the psychological construction of experience (Smith et al., 2012). Furthermore, discourse analytical methodologies are less concerned with phenomenology and the meaning of participants’ experiences and some tend to favour a more descriptive approach (Langdridge 2007), therefore, a discourse analysis approach, (including a Foucauldian) would not have been a suitable methodology to use for the questions raised here.

A grounded theory approach, which explores social process not personal meaning per se, would have been less suitable because grounded theory looks across the findings to produce more generalizable “mid-level” theories about a particular group, so eclipsing the ideographic experiential claims of individuals (Smith et al., 2012, p.202). IPA’s ideographic approach favours a detailed focus and analysis on an individual’s particular lived experience before moving onto the next participant, so that not only similarities but essentially differences or divergences can be captured. This is not to suggest that IPA cannot produce claims at a more macro level; it merely implies that the focus of analysis must be at the micro level first and foremost. (Smith et al., 2012).

When considering the specific research questions and the aims of the PhD it was considered important to use an approach such as IPA, which considered psychological aspects such as emotions and cognitions (Smith, et al., 2012). Grounded theory however, does not necessarily focus on psychological “mentation” (Smith et al., 2012, p. 191). It was important to consider such “mentation” because a further aim of the PhD was to include how the findings might help to further develop practice (treatment and rehabilitation) for the participant group. It was thought that understanding an individual’s experience from a psychological perspective would be able to explore how to then help them in a therapeutic and rehabilitative setting. Levitt (2015) has recognised the value of using qualitative approaches to achieve both an understanding of a client group and to help develop treatment and therapy for those clients. IPA has
been used in studies concerning clients in therapy and treatment interventions (Smith, 2004). It was considered that IPA would therefore also be able to achieve these wider research aims. Grounded theory would also have been less suitable because it might require a larger sample size to achieve saturation of themes. It was unlikely a larger sample size would be achievable with this group.

IPA is especially suited to research using extant theories. There is a paucity of research involving this participant group, (as mentioned previously) therefore existing psychological theories were used to guide the scope and direction of this research and to offer explanations, where possible, to the emerging themes and findings. Smith et al. (2012) and Smith (2004) suggest that IPA findings can be used successfully to either challenge or provide further information about extant psychological theories. However, this is not to suggest that theories cannot be postulated from IPA findings. Smith et al. (2012, p. 38) acknowledge that theoretical concepts may emerge from the findings, “And the reader can in turn continue this process of theoretical transferability as they examine the case from the perspective of their own experiential knowledge base and they begin to think about the implications for their own work”. Grounded Theory, which tries to develop mid-range theories and largely eclipses the ideographic nature of participants’ accounts would not therefore have been appropriate. Furthermore, it was particularly pertinent to use an IPA approach for the focus group study where the main criteria was to help to inform a second study to add to the limited published literature on the specific participant group.

In summary taken together IPA’s epistemological positioning - its ideographic, hermeneutic and psychological interpretative focus made it the most appropriate phenomenological methodology to use to investigate the research question with the participant group and to be able to take into consideration the researcher’s unique political position in relation to these.
4.8 IPA ‘approach’ in Focus Groups – adaptations, applications and theoretical considerations

4.8.1 Introduction

This section provides a discussion on how and why IPA was adapted for use with the focus groups (Part One study) and will address some of the theoretical considerations underpinning those adaptations.

Wilkinson (1998) argues that focus groups are not bound by a particular epistemological positioning and can therefore be used with a diverse range of epistemological approaches. However, epistemological positions which consider that individuals hold their own ideas, thoughts and understandings might pose a challenge to a researcher who has to elicit these in a focus group setting. Smith (2004) suggests that IPA can be used with focus groups if participants are able to discuss their own personal experiences despite the group presence. He further advises that transcripts should be analysed for group dynamics and patterns and then analysed again for idiographic accounts. He cautions about dominating views and a group collective voice overshadowing and eclipsing individual accounts. However, he acknowledges that focus groups can foster disclosure of personal experience that might not have emerged in a one to one interview. Flowers, Knussen & Duncan (2001) note that focus groups can add extra depth and richness to personal accounts. The benefit of this unique peer to peer interaction to produce rich data in this research will be discussed further in Chapter 5.1 Section 5.1.2.

IPA has been used with focus groups by several proponents such as Dunne and Quayle (2001) and Flowers et al. (2001). Others have chosen to adapt IPA for use with focus groups for example Tomkins and Eatough (2010) and Palmer, Larkin, DeVisser, and Fadden (2010). Tomkins and Eatough (2010) have been critical of studies which have not articulated how they have applied IPA with their focus group data, for example, Blake, Ruel, Seamark, & Seamark (2007) and Flowers et al. (2001). They suggest that IPA cannot be used with focus group data without adaptations if it is to stay close to its ideographic and phenomenological roots.
4.8.2 Ideographic phenomenological accounts vs the group experience – striking the balance and staying close to IPA’s epistemology

When using IPA with focus groups establishing how the ideographic and phenomenological experience of an individual is not eclipsed by the group experience has to be considered. This should be during the data collection stage and during the analytical stage. This is to stay close to IPA’s epistemological positioning within ideography and phenomenology (Tomkins & Eatough 2010, Palmer et al., 2010). Tomkins and Eatough (2010) have been critical of studies which they consider have not achieved this, such as that by Dunne and Quayle (2001). They are equally critical of studies which only include individual quotes, thereby ignoring the group interaction. This, they suggest, questions the rationale for using a focus group study over the use of interviews although it should be recognised that there are many different reasons for using focus groups. The rationale for using a focus group in this research was firstly to capitalise on the homogenous peer to peer shared experience in the hope that it would reveal novel areas of inquiry; secondly, it would also help to build rapport quickly and therefore foster rich discussion; and finally, it would help establish a research topic and group worthy of further research. These points will be discussed in more detail in the focus group methodology Chapter 5.1.

4.8.3 The complexity of the hermeneutic and iterative process in focus groups

The hermeneutic and iterative process is more complex in a focus group setting which needs to be managed. IPA holds that meaning making is co-created and that the researcher is part of that process. As is the case with interviews, focus groups involve social interactions and the co-creation of meanings, albeit there are more opportunities for them to occur. It is this that Palmer et al. (2010) suggests can complicate the issue of retaining the individual experience during the research process. Palmer et al. (2010) provide suggestions of how to keep participant’s individual experiences at the centre of the analysis whilst also acknowledging the group dynamic in which those experiences occur. For example, having small numbers in the focus groups, allowing all participants to talk about a given topic from their own experiences and making
careful reflexive observational notes about the group dynamics and interactions (Palmer et al., 2010).

Tomkins and Eatough (2010) offer suggestions of how to deal with the individual experiences in a group setting in relation to the iterative and hermeneutic process, which they suggest is more complex in a focus group setting. IPA involves a double hermeneutic process whereby the researcher is attempting to make sense of the participant trying to make sense of their experiences. However, it could be argued that in a focus group setting a triple hermeneutic or multiple hermeneutics are occurring. This can happen because the researcher is trying to make sense of the participants making sense of their own experience whilst also trying to make sense of each other’s experiences (Tomkins & Eatough, 2010). This adds a further layer of complexity to the analytical hermeneutic and iterative process and it is therefore essential that the researcher’s contextualised notes are catalogued. (The reflexive note taking process will also be used to achieve this in the Focus Group Study - Part One).

Tomkins and Eatough’s (2010, p.250) use of the “additional iterative loop” to showcase the ideographic experiential accounts of participants was used as a guide in Part One of this research, outlined in Chapter 5.1. Various other steps were taken in this research to ensure that the ideographic focus of participant’s individual experiences and accounts were captured and analysed whilst also recognising the influence, including the benefits of the group dynamic, on those experiential accounts. These are outlined in the Part One Focus Group Study: Methodology and Method Chapter 5.1, Section 5.1.8.3 and in the Discussion Chapter 5.3, Section 5.3.5.1.

4.8.4 An ‘IPA approach’ – bridging epistemological gaps

Proponents such as Palmer et al. (2010) and Eatough and Tomkins (2010) who have adapted IPA for use with focus groups offer compelling arguments, solutions and guidelines. Therefore, the adaptations for an IPA approach with focus groups in this research are based on papers by Palmer et al. (2010) and Tomkins and Eatough (2010). Palmer et al. (2010) favours terminology which describes an IPA approach in recognition of incorporating narrative discursive and critical psychologies to take into account the interactive and socially situated elements of the focus group
dynamic. Palmer et al. (2010) argue that epistemologically this is acceptable because “hermeneutic phenomenology can accommodate such work because the defining quality of being in the world, its central concept, is relatedness” (Palmer et al., 2010, p. 102). Tomkins and Eatough’s (2010) conclusions are supportive of adapting IPA for focus groups in order to “bridge [such epistemological] gaps” (p. 260). In recognition of those incorporations and adaptations an ‘IPA approach’ terminology will be used when referring to the Focus Group Study.

4.9 Criticisms and limitations of IPA

IPA has been criticised for its close alignment with a scientific cognitive psychological paradigm, which is not compatible with IPA’s underlying hermeneutic phenomenological epistemology (Langdridge, 2007; and Willig, 2001). However, others such as Larkin, Eatough and Osborn (2011) consider Smith’s interpretation of ‘cognition’ has been misunderstood. Within IPA cognition refers to the original concept proposed by Bruner (1990, as cited in Smith et al., 2012), which is concerned with the complexities of sense and meaning making, for example in relation to emotions. IPA holds that these can be accessed through people’s experiential accounts and narratives and how they make sense of their lived worlds. It is the process of layered reflective thought that participants engage in during their meaning making that represent the ‘cognition’ in IPA. This is a departure from the direction that mainstream cognitive psychology followed. This was primarily concerned with the process of cognition through experimental or questionnaire methodological approaches and viewed emotion and cognition to be separate domains (Smith et al., 2012).

Giorgi (2010) has criticised IPA for not being prescriptive enough and therefore questions its scientific methodological grounding and rigour. However, Smith (2010) suggests that Giorgi’s assumption is based on a different understanding of scientific rigour, (such as replicability) which Smith (2010) feels is at odds with a qualitative epistemology. Smith (2010) and Smith et al. (2012) contend that IPA is prescriptive (i.e. systematic in the guidelines it offers) and therefore has ‘scientific’ rigour. Smith (2010) further notes that providing a set of guidelines is no guarantee of the quality (or rigour) of an IPA study, which also depends on the skills and experience of the
researcher. Ensuring ‘scientific’ rigour is as much about this as it is about following a set of ‘how to do’ guidelines. Smith is therefore claiming that he cannot prescribe how to do a quality piece of IPA research because this involves more than a set of ‘how to do’ guidelines. Smith (2010) therefore implies that Giorgi’s (2010) criticisms are contradictory and that Giorgi has misunderstood what he and his colleagues meant by IPA methodology not being prescriptive. However, a criticism of this debate might consider that Giorgi’s (2010) observation that IPA is both prescriptive and flexible has some merit. Smith, et al. (2012) do offer prescriptive ‘step by step how to do IPA’ guidelines but they also encourage a more flexible approach (Smith, 2004). This might be reflective of Smith and colleagues acknowledging and accepting that when developing a ‘new’ method and methodology the process inevitably involves advancements, developments and additions by subsequent researchers and academics. This might therefore be where some of Giorgi’s “misunderstandings” arise.

Smith (2004) notes that qualitative methods of data collection, such as IPA, have been criticised for favouring more educated and articulate participants. However, he refutes this notion based on his own studies. He suggests that the quality of data is linked to how important the experience is to the individual and how involved they feel in the research process. The research reported here would support Smith’s argument. He does suggest that a more dominant guiding role by the researcher might be necessary for participants such as children and those with learning disabilities. This research, which involves a vulnerable group with complex issues, would support Smith’s more guided approach by the researcher. Neale et al. (2005) provide specific suggestions of how a researcher might provide guidance to participants with addictions. How this was achieved in this research is discussed further in the focus group and interview methodology Chapters Part One, 5.1 and Part Two, 6.1.

4.10 Research questions

In formulating the research questions a number of resources were influential; these have been discussed in detail elsewhere but in summary they were: The Home Office DIP policy, literature from the relapse and recovery field, extant psychological theories (see Chapter 3) and practitioners working within the drug misuse field. This also included the researcher’s own experience of working on the DIP policy within
the UK Government Home Office for over 8 years. The participant group who took part in the Focus Group Study (Part One) also informed Part Two of the research questions for the Semi-structured Interview Study (Part Two).

1. How do Class A drug misusing (ex)/offenders experience and make sense of their journey of relapse and recovery in relation to their significant life events and relationships?

2. More specifically, how do they make sense and experience this within the ‘context’ of their family upbringing, family and other relationships, their significant life events such as trauma, bereavement, loss and their psychological health?

3. How has this ‘context’ impacted on their experiences and meaning making of their first substance/drug use, their continued use including lapses, relapses and during periods of recovery including sustained recovery?

4.11 Ethical approval and permissions

4.11.1 Gaining access to participants and ethical approvals

Several ethical approvals and permissions from a range of organisations and bodies were required for the research to commence. The participants, due to their drug taking and offending backgrounds and their status as a vulnerable group, could pose risks to themselves and to the researcher. This therefore complicated the ethical approval process and the necessary permissions required to access the participant group. Whilst these ethical and safeguarding considerations were necessary to safeguard those involved they added several months on to the research timescale.

4.11.2 Home Office “blessing”

Permission to conduct the research was initially sought from the Home Office Drugs and Alcohol Directorate. This was a requirement because of the researcher’s employment as a civil servant with the UK Government at the time the research began. The Director at the time gave her blessing for the research, however since the research
began in earnest the researcher ceased working for the UK Government and no further permission was required or sought thereafter. Indeed the DIP programme since 2012 was no longer centrally governed by the Home Office and at the time of writing remains devolved to local police crime commissioners.

4.11.3 Rehabilitation organisation’s approval

Various permissions were sought from the rehabilitation organisation. A drugs and alcohol rehabilitation charity was approached through the researcher’s contacts during her time working in the Home Office. This involved an initial meeting with the charity’s Deputy Director where the researcher presented an overview of the proposed research. This included the anticipated involvement of the charity in the research and the potential benefits to them. The aim was to secure agreement to conduct the research with the charity’s clients and to be given a research placement at an England based DIP team. The Deputy Director at the charity stipulated that agreement from their Service User Forum Council was required before the research could proceed. The researcher therefore presented her proposal to the forum and permission was granted. (See Appendix 1 for an example of one of the research proposals presented to staff at the rehabilitation organisation). An initial placement at an England DIP team was then secured but fell through due to the service being re-tendered and operated by another charity. Therefore, another DIP team was approached and secured, with consent from the Deputy Director. The DIP team further required the researcher to obtain a Criminal Records Bureau (CRB) check by the appropriate authorising police body. This was obtained before client contact was approved.

4.11.4 NHS ethical approval

Approval from the Local Primary Care Trust (PCT) to gain NHS ethical approval, was required before the research placement with clients could commence. This ethical approval was sought and granted after the NHS ethical board meeting requested several minor amendments to the research proposal. These amendments included providing a set of terms and conditions about client confidentiality and the potential disclosure of criminal offences not known to the police (see Appendix 7). The board also considered the inclusion of psychometric measures in the second study too
onerous for participants to cope with alongside a semi-structured interview. The Board’s suggestion of a follow up meeting for participants to complete the psychometrics at a later date was not considered by the researcher and her supervisors to be a feasible option, given the difficulty of engaging this population in research. The psychometrics were therefore dropped from the study. As requested by the Board, annual progress reports for the study were provided to the NHS ethics board. (See Appendix 8 for the NHS ethical approval documents).

4.11.5 University ethical approval

The research also received a favourable ethical approval from the University of Surrey. As part of the approval the researcher was advised to undergo a series of vaccinations by the University’s Occupational Health and Safety Department (and in consultation with the researcher’s GP). This was in recognition of the potential for the participant group to have weakened immune systems and therefore having greater potential to carry a number of infectious diseases. This risk was perceived to be compounded because of the violent criminal backgrounds of some of the participant group and therefore the increased personal safety this might pose to the researcher. The researcher therefore had the recommended vaccinations. (See Appendix 9 for the University of Surrey ethical approval documents).

4.11.6 Further ethical approvals and permissions for Part Two - The Semi-structured Interview Study

Ethical approval from the University of Surrey and from the NHS was sought and granted for Part Two. This involved a ‘substantial amendment’ to the NHS ethical board, which included a detailed interview schedule for Part Two along with the consent and information sheets. (See Appendix 13 and 14 for a copy of the consent form, information sheet and interview schedule and Appendix 8 for the NHS ethical approval documents for the substantial amendments).

Some early findings from the Focus Group Study (Part One) were presented to the Deputy Director of the rehabilitation organisation. His consent was then gained for the second study (Part Two). This included an extension of 4 months to the research placement to allow extra time for recruitment. A further month extension was later
granted to include a participant who was unavailable to take part within the original timescales but who wished to take part.

A trained counsellor from the rehabilitation organisation consented to provide a half hour, over the phone debrief session with participants after their interviews. A further trained counsellor agreed to cover annual leave periods during the summer. The debrief with the counsellor was voluntary and required the participant to give their consent. The debrief session did not form part of the research and was confidential between the counsellor and the participant. Drug workers were initially asked to conduct the debrief sessions but they felt that a trained counsellor was best placed to offer this support. The purpose of the debrief was in recognition of the vulnerable nature of some of the participants and that some of the questions might elicit responses about sensitive topics. For some, painful memories and emotions might surface and they might need help negotiating them afterwards with a counsellor. A debrief plan was devised by the researcher, her supervisors, the trained counsellor and the Deputy Director of the organisation. (See Appendix 11 for a copy of the communication on the counsellor’s debrief with participants).

A debrief by the researcher conducting the interviews was also agreed by the above parties. This was to ensure that participants had access to further support in the community if they chose not to take up the debrief with the trained counsellor afterwards. One out of the 18 participants chose a debrief session with the counsellor afterwards.

4.12 Ensuring quality and standards in qualitative research

Quality and standards were embedded throughout the thesis. This included the researcher undertaking training on IPA, attending regular IPA groups for continued support and undertaking independent validation checks of the findings. Guidelines set out by Yardley (2000, 2008), Neale et al. (2013) and Smith (2011) were followed. For further information see Appendix 21, which provides a summary of how quality and standards were achieved and embedded throughout the research.
CHAPTER 5.1 - PART ONE FOCUS GROUP STUDY: METHODOLOGY AND METHOD

5.1.1 Chapter overview

This chapter begins with the rationale for using a focus group method and an overview of the card sort design task used. Details about how the card sort items and focus group schedule were developed are then provided. Background information about the research cohort and the selection and exclusion criteria are included with specific information about focus group participants’ criminal justice and drug use histories. The procedure for recruitment, conducting the focus group tasks and how IPA was adapted for use with focus groups is covered. Ethical approval for both studies has been covered in the Methodological Approach, Rationale and Criticisms Chapter 4.

5.1.2 Rationale for using Focus Groups

The use of focus groups originated within market research. However, its application spread to the social sciences where it was developed and adapted to suit the needs of the field. Morgan (1997) recognises the wide application and versatility of focus groups and their continued application and development within the social sciences. Focus groups are often used by researchers who want to explore views and opinions about a predetermined topic or set of questions by a group of individuals who share similar experiences. The questions or topics of interest can be explored in an unstructured manner, which makes it suitable for use with qualitative methodologies and analyses (Bryman, 2001). Focus groups have been used extensively to help develop survey questions and are therefore a suitable method to help develop research questions (Morgan, 1997), although, the application of focus groups for the development of questionnaire design within a psychological research setting is less well documented. Furthermore, there is a paucity of literature on the use of focus groups involving Class A drug misusing (community based) offenders. This might be due to the practical difficulties involved in engaging with participants who are members of a ‘hidden’ population in a group setting. There are also ethical, safeguarding and legal considerations that need to be managed with this particular
participant group, for example, ensuring rival criminals are not part of the same focus group. These considerations are discussed in more detail in Part One Focus Group Study: Discussion Chapter 5.3 and in Chapter 7.

Utilising focus groups can provide a varied and novel interrogation of the research topics and questions. This is because of the interaction between group members who share a similar experience within a peer group. In particular how they construe views and opinions in discussion among themselves which cannot be achieved in a one to one interview with a researcher who does not share those experiences. The interaction of group members involves qualifying or challenging members’ reasons for a particular issue or viewpoint raised. Therefore, issues that are of particular importance surface. Bryman (2001) suggests that focus groups unearth more realistic and ‘honest’ responses and reflections due to the challenges from group members, which elicit a deeper thinking process that might not occur in a one to one interview with a researcher. This is in part due to the homogeneity of the group members who share a particular lived experience outside the researcher’s personal experience. Members may raise questions and topics of discussion that the researcher may not have thought of asking (or indeed felt comfortable asking) in a manner (peer to peer) which may evoke a more realistic answer from the group members. Furthermore, focus group participants who are part of the same peer group, may feel more comfortable addressing sensitive lines of enquiry from their peers than from an unknown outsider such as a psychology researcher.

Focus groups offer the opportunity to involve several participants in one session as opposed to the individual interview method and are therefore considered less time consuming yet yield a large amount of data. However, when conducting focus groups involving substance misusing offenders extra time may be required to consider and plan for ethical, legal and safeguarding issues. For example, checking that group members are not from rival gangs or conducting risk assessments relating to violent or sexual offences among focus group members (see Chapter 7).

Focus groups can generate questions and topics of interest and qualify key areas of interest. They can further help to verify if the research questions convey the
researcher’s intended meaning to the participant cohort (Morgan, 1997). One of the purposes of the focus group study in this research will be to help to develop a semi-structured interview schedule for Part Two to provide direction for the main study.

5.1.3 Criticisms of focus groups – overcoming challenges

Focus groups are not without their criticisms. The group dynamic itself can be a source of conflict and create bias which could question the underlying face validity of the data being produced. This needs to be a key consideration during the analytical stage. For example, dominant individuals within a group setting might overshadow the opinions of quieter members so their views and opinions do not surface. Another consequence of this is that a group opinion is then formed and not challenged (Morgan, 1997). However, a skilled focus group facilitator could help to mitigate against this occurring and encourage all members to take part in the discussion. This can be achieved by creating a room dynamic where people feel on an equal status with one another, for example, seating is set in a circle and all seats are of equal height including the facilitator’s and an ice breaker introductory discussion is included. The facilitator can also interject during the discussion and encourage quieter members to take part. However, it must also be recognised that there is no guarantee that the quiet individual in a group setting would be any more talkative in a one to one interview setting.

Research has also found that individuals can give different opinions depending if they are in a group setting or in an individual one to one interview (Wight, 1994). It is therefore important to consider the influence of the group dynamics during the analytical stage to ensure that the meaning attributed to any analysis is set within the wider context of the group dynamics. For example, what role participants might occupy within the group setting, the influence of their gender, sex, age and their relationship to one another and how this might influence what is said and the manner in which something is said, in order to provide a more comprehensive understanding of the analysis.
5.1.4 Focus group size and the number of focus groups

Practical, ethical, methodological and analytical considerations need to be taken into account when considering the number of participants to use in each focus group and the number of focus groups required. The overall aim and purpose of the focus groups will also be a key consideration. Bryman (2001) cites studies ranging from 9 up to 52 focus groups with a range of 3 to 9 participants in each group.

For this research, the aim was to have four focus groups with a maximum of five participants in each. This was for several reasons. Morgan (1997) suggests that groups which are more homogeneous and less diverse will require a fewer number of focus groups because they are less likely to generate greater diversity within the topic. However, this is usually related to satisfying methodological requirements where saturation of themes might be the goal, which IPA does not seek. Morgan (1997) suggests that smaller numbers of participants in groups are adequate if they are particularly emotionally involved in the research topic. This aligns closely with IPA’s ethos of homogeneity among a participant group. A smaller number of participants can also provide the opportunity to capture individual responses better, which would further complement the methodological approach in this research. It was also important with a vulnerable group to be able to establish individual reactions to sensitive topics to help determine if any further ethical and safeguarding considerations were required for Part Two, where participants would be asked more in-depth questions.

There were several pragmatic reasons for not using larger numbers of participants. It was anticipated that recruiting larger numbers from a ‘hidden’ population would present particular recruitment difficulties. Managing safeguarding, legal and ethical considerations with a larger number of participants was also considered unworkable within the timescales and resources of the PhD. For example, checking for rival gang member status among participants to satisfy legal and safeguarding considerations. Other considerations included the impact that the participant group’s drug-taking and health (e.g. mental health) can have on their processing capabilities such as
concentration abilities. It was thought that larger participant numbers might exacerbate these problems for some participants.

In conclusion, a maximum of five participants per group was felt to be both a feasible and adequate number to satisfy safeguarding, ethical, legal and methodological considerations. Furthermore, this number was felt to be adequate to generate a reasonable amount of discussion but small enough to encourage group members to feel comfortable discussing potentially sensitive topics.

5.1.5 The card sort task in a qualitative phenomenological approach and in a focus group design

5.1.5.1 Definitions of the card sort technique

A card sort task can be defined as “A general term for any task in which the [participant] is required to sort cards according to some principle or rule. Some are simple sensory/motor tasks in which sorting is carried out according to a specific instruction (‘triangles in one pile, circles in the other’), others are more complex, including tasks in which the [participant] must figure out the rules that determine the correct sorting” (Reber, 1985, p.107). Within psychology the term ‘card sort task’ usually involves a test of a person’s problem solving abilities, brain functioning, memory, attention and speed for example. The card sorting task in this research was loosely developed on a particular type of card sort called the Q sort technique which has been used by phenomenologists such as Shinebourne (2009) and Shinebourne and Adams (2007a, 2007b). However, in this research it departs heavily from any quantification of the ranked items. Principally the card sorting technique in this research was used as a tool to engage participants, create camaraderie and foster rich discussion. There were no right or wrong answers and participants were encouraged to disagree if they wished. The focus of the analysis was very much on the participants’ narrations. The term card sort will be used to avoid confusion with the card sort technique associated with a ‘Q’ methodological approach (Stainton-Rogers, 1996), unless discussing specific studies which used the Q card sort technique (e.g. Shinebourne, 2009; and Shinebourne & Adams, 2007a, 2007b).
5.1.5.2 Showcasing or eclipsing the participants voice and researcher bias

The use of a card sort task in a phenomenological methodology could be considered to undermine the epistemology. This therefore warrants further discussion. Phenomenological qualitative research is interested in the lived experiences of participants in relation to a given phenomenon. Complementary analytical approaches such as IPA (Smith et al., 2012) explore these experiences by analysing what participants have said about a particular experience or phenomenon (as discussed in the Methodological Approach, Rationale and Criticisms Chapter 4). The card sort task involves predefined statements selected by the researcher on cards. Some might consider that this restricts what the participants choose to talk about. Is it the participant’s voice being heard or the researcher’s? This might lead to researcher bias as well as eclipsing the participant’s experiences and meaning making. However, many qualitative methodologies such as IPA acknowledge that qualitative research and analysis is not free from researcher bias (Langdridge, 2007). Furthermore, IPA addresses how to manage such bias (Smith et al., 2012). As discussed in Chapter 4, IPA has guidelines on how to recognise, acknowledge and deal with such bias.

Some suggest a card sort can be constructed in a manner that allows participants to have more interpretation and to therefore lessen its perceived ‘restrictiveness’. For example, card sorts can involve participants deciding on the importance or relevance of card sort items or choosing whether to agree or disagree with card sort items. Similar to interview questions, card sort items which are more open ended or are viewed to hold multiple meanings can allow for a greater scope of interpretation by participants: follow up questions by the researcher can help to understand such interpretations (Shinebourne and Adams, 2007a). Shinebourne and Adams (2007a, 2007b) suggest that card sort statements that are derived from a mix of sources including participants themselves, can help to address researcher bias. Shinebourne and Adams (2007a) used interviews alongside a card sort method in their research with therapists working within the addictions field.

A focus group setting whereby participants might challenge each other’s decisions can help to interrogate the decision making processes further and can therefore present
another opportunity for the participant’s voice to be heard. Focus group participants in the PhD research will be encouraged to disagree with each other if they wish and to actively discuss their decision making process with each other. This will provide an opportunity for participants’ voices to be heard.

5.1.5.3 The application of the card sort task in the focus groups

The card sort task can be a useful research tool in focus groups to help foster co-operation, interaction and build trust among group members. Shinebourne (2009, p. 96) states that ‘for both researchers and participants the Q sort [a type of card sort] method provides an opportunity to engage with the research topic in a novel and creative manner’. Shinebourne and Adams (2007a, 2007b) consider it to have a valuable application in pilot studies where researchers can explore initial ideas in a collaborative and engaging manner with participants. The card sorting task was therefore viewed as a potentially complementary tool that could be used with some adaptations with the focus groups in this research. These are discussed below.

Application and development of the card sort task in the focus groups

In recognition of the potential researcher bias and in consideration of the theoretical (phenomenological) approach in this research, participants were asked open question(s) prior to the card sort tasks. This was to provide participants an opportunity to think freely about the subject matter and to reduce potential researcher bias. It is important to note that in this research the ‘card sort items’ and ‘card sorting’ process were used as a tool to foster interaction, co-operation and camaraderie among participants in the hope of stimulating rich discussion. The rich discussion that ensued from the card sorting process was the focal point for (qualitative) analysis and not the ranks in themselves. The data from the use of the card sort tasks was never intended to be subjected to a quantification factor analysis as is the case with a traditional Q card sort.

In this research, the card sort items were developed from a range of sources, such as the literature review (including the psychological theories reviewed), drug offender rehabilitation policy, practitioners and specialists within the addiction field, including
drug misusers. Shinebourne (2009), Shinebourne and Adams (2007a, 2007b), suggest that this can further help to minimise researcher bias. The items on the card sorts can be thought of as sub-questions or prompts to help respond to broader questions, very much like a semi-structured interview style format. Many of the card sort items in the focus group studies were open ended, to further allow participants to interpret them more widely and encourage discussions, for example, ‘parent’, ‘family’ and ‘friends’. Further information on the development of the card sort topics is discussed in the design and materials Section 5.1.6.1 and 5.1.6.2 in this chapter.

**How many card sort items are adequate?**

It is essential to consider who the participant group are and what the purpose of the card sort is when determining the number of card sort items to use. Shinebourne (2009) suggests using between 40 – 80 card sort items but suggests that pilot studies can include less. Watts and Stenner (2012) acknowledge the demands that too many Q card sort items can exert on participants and that consideration needs to be given to certain groups of participants such as children or adults with learning disabilities. It was anticipated that the participant group, due to their drug taking behaviours and other vulnerabilities, might have reduced attention spans, so sorting through a large number of cards might be too onerous. Watts and Stenner (2012) further suggest that if more than one Q card sort task is administered then fewer Q sort cards would suffice. The card sort items in the focus groups were tools to act as prompts for discussion among group members. Therefore, a higher number of card sort items for consideration in a statistical Q method analysis was not required. Fewer card sorts may also be adequate where a group of individuals comprise an homogenous group (Class A substance misusing offenders in relapse and recovery), where the research has a specific purpose (developing an interview schedule for a semi-structured interview) and focal point (the PhD questions and aims). Therefore, in this study 34 card sort items across two card sort tasks were considered to represent an adequate amount.

**Number of ranks and type of analysis – qualitative thematic based analysis**

In a card sort participants are required to sort or rank the card sort items based on a set of instructions or questions. Participants might be asked to select the top 10 cards of
relevance to them or to sort the cards into ascending order of importance/relevance. The ranking of Q sort cards traditionally takes the form similar to that in a Likert scale (Shinebourne & Adams, 2007a). The number of rankings required varies between 9-13 (Watts & Stenner, 2012). This arises out of satisfying the statistical requirements of the Q method of factor analysis. However, in the focus groups the aim was to provide as few ranks as possible to simplify the process for speed and understanding. Three ranks were used and given meaningful labels (‘Most important’, ‘Quite important’ and ‘Not important’), in relation to the research questions in each task. Ranks were not assigned values because there was no statistical necessity. The ‘unit of analysis’ was participants’ narrations, therefore a thematic qualitative approach described in the Methodological Approach, Rationale and Criticisms Chapter 4, was used.

5.1.6 Design and materials

The Focus Group Study design included N=10 participants across four focus groups. Participants included men and women who were past or current DIP clients at various stages of relapse or recovery. Participants were asked several open ended questions first about what might help or hinder their relapse and recovery and then they were given two card sort tasks on the same subject matter. An Interpretative Phenomenological Analysis was adapted for use with a focus group design. Credibility checks and reflective note taking were also used as part of the hermeneutic and iterative process and to ensure quality and standards were embedded within the focus group study. The findings were used to help to inform a semi-structured interview schedule for Part Two. See figure 2 for a flow diagram of the Focus Group Study.
Figure 2: Flow Diagram for the Focus Group Study (Part Two)

Part One: Focus Group Study
Piloting of questions
(N=10 across 4 focus groups)

Interpretative Phenomenological Analytical Approach (adapted IPA for focus group design)

Focus Group 1
Alan
Bobby

Focus Group 2
Samuel
Clare
Moses

Focus Group 3
David
Kevin
Ellen

Focus Group 4
Tina
Zoe

- Open-ended questions
- Card sort tasks (x2)

Credibility checks:
- IPA researchers
- Supervision
- DIP drug workers
- DIP clients in recovery.

Reflective notetaking:
- Focus group dynamics
- Participants

Findings from focus group study (Part One) informed semi-structured interviews (Part Two).
5.1.6.1 Formulating the focus group schedule and developing the card sort items

The researcher and her supervisors drew on their own knowledge within the substance misuse field, the DIP Home Office policy and wider fields of attachment theory, family systems theory and childhood and lifetime trauma literature to identify areas of potential importance and relevance to the research. This included the researcher attending relevant conferences which involved listening to recovering Class A drug misusing ex/offenders talking about their relapse and recovery. This revealed several areas of interest including, childhood upbringing, family, coping mechanisms, affective disorders such as depression, anxiety and stress and childhood and lifetime trauma. A literature review on these theories and areas of interest and a review of the substance misuse relapse and recovery literature, helped to identify areas that were anticipated to be of relevance and importance to the participant group. The focus group schedule and card sort topics were developed from these sources of knowledge. Further advice about the card sort items and task was sought from the DIP drugs workers. (See Chapter 3 for an overview of the theoretical approaches and the relapse and recovery literature which has helped to inform the scope and direction of the research questions).

The draft schedule for the focus groups therefore included the following general headings:

- Life experiences surrounding first use of Class A drugs and entrenched Class A drug use
- Life experiences surrounding periods of relapse and recovery
- Childhood experiences
- Negative/traumatic experiences
- Relationships (e.g. family, partners)
- Support networks
- Psychological health and well being
- Offending behaviour.
This draft schedule was then adapted into two card sort tasks and four main questions were asked to invite discussion among group members (see Appendix 2, 3 and 4).

**Aim of the Focus Groups**

The first aim of the focus group was to determine if the identified topics were relevant to the participant group and therefore determine the relevance of the actual research questions. The second key aim was to discover any further areas of importance to participants, that should be included in Part Two (a series of semi-structured interviews). The final aim was to ensure that the topics and questions would not be unduly distressing for the participants in Part Two, where topic areas would be explored in more depth.

**Focus group design – maximise rich discussion**

The aim of the focus group design was to encourage participants to talk from their own perspectives in an informal setting about relapse and recovery capitalising on the peer to peer interaction to build trust and camaraderie and therefore to encourage rich discussion. The card sort task was designed to focus participants on particular topics and areas anticipated to be of interest and importance within a specified allotted time. The card sort was further designed to provide a striking visual interactive aid to engage participants and encourage rich discussion. The task also placed the control and direction of the focus group in the hands of the group members rather than the facilitators. For example, the group task required members to engage with each other and to take part because they had to discuss each topic and to qualify their reasons for agreeing or disagreeing where to place each card sort item on the answer sheet.

One of the facilitators was a DIP drugs worker who knew some of the participants. To minimise this being a confounding variable every effort was taken to reassure participants that the DIP drug worker’s role during the focus group was that of a research assistant. However, there was evidence in some of the focus groups that this may have encouraged some participants to emphasise the importance of their drugs
worker in their recovery. This is discussed in the Part One Focus Group Study: Findings, Chapter 5.2, section 5.2.8.1.

_Piloting the card sort topic and focus group questions – further developments_

The card sort items along with the question and answer sheet were piloted with DIP drug workers and a recovered drug misuser. Generally there was strong support for the approach. In particular, it was felt that the participant group would respond well to an interactive aid and to the colourful nature of the design. There were several minor amendments required. For example, the word ‘sustaining’ was included in the card sort task question about recovery. ‘Help from (name of rehabilitation organisation)’ was amended to ‘help from a drug worker’. These terms were considered to be more familiar to the participant group. Further amendments included changing some of the items to be more open ended. For example, ‘Not able to cope with being a parent’ was amended to ‘Having responsibility for looking after children/dependents’ and ‘Being a parent’. ‘Not able to cope with feelings of boredom’ was amended to ‘feeling bored’. ‘Not able to cope with feeling down or depressed’ was changed to ‘feeling depressed’. This provided participants with the opportunity to have wider interpretations and it was thought would encourage rich discussion among group members.

5.1.6.2 The card sort items, tasks and schedule used in the focus groups

Ethical considerations raised by the NHS ethics board meant that questions to the focus group had to provide participants with the option of talking more generally about the research topics, if they wished. Therefore, the questions were formulated in a manner to allow for this. However, all participants chose to speak about their own experiences.

Participants were asked to complete two card sort design tasks answering two main questions about relapse and recovery. The first card sort task had 16 topics, such as ‘friends’, ‘feeling depressed’, and ‘unable to deal with painful emotions from childhood’. Participants were asked to sort the topics into three categories, ‘The most important’, ‘Quite important’ and ‘Not important’ in relation to the question ‘What do you think might cause someone to relapse from Class A drugs?’ Participants were
encouraged to discuss each topic in relation to the question when deciding in which category to place each topic.

The second card sort task asked participants ‘What do you think is helpful in sustaining a person’s recovery from Class A drugs?’ The 18 topics, included ‘family’, ‘being a parent’, and ‘somewhere to live’. Participants were asked to discuss and then sort the topics into the three categories of importance. See Appendix 2, for details of the card sort task and Appendix 3 for pictorial examples of the card sort task.

A copy of the remaining focus group schedule can be seen at Appendix 4, which included a further two questions about Class A drug use and misuse, which the researcher asked focus group members directly. These questions were, ‘What might be the reasons for some people to first use Class A drugs?’ and ‘What might be the reasons for some people to become addicted to Class A drugs?’

Participants were also asked to complete a short demographic questionnaire, which included questions about their drug misuse history and their DIP and Prolific and other Priority Offender (PPO) status. For example, if they were a current or past DIP or PPO client, what their main drug of choice was and when they had last used drugs. A copy of the demographic questionnaire can be found at Appendix 5.
Table 2: Topics for the Card Sort Task in Relation to the Question: ‘What Do You Think Might Cause Someone to Relapse From Class A Drugs?’

<table>
<thead>
<tr>
<th>Topic number and order</th>
<th>Topics for ‘What do you think might cause someone to relapse from Class A Drugs?’</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Feeling bored</td>
</tr>
<tr>
<td>2.</td>
<td>Being a parent</td>
</tr>
<tr>
<td>3.</td>
<td>Feeling upset about something</td>
</tr>
<tr>
<td>4.</td>
<td>Unable to deal with painful memories from childhood</td>
</tr>
<tr>
<td>5.</td>
<td>Family when growing up</td>
</tr>
<tr>
<td>6.</td>
<td>Feeling anxious</td>
</tr>
<tr>
<td>7.</td>
<td>Not having friends</td>
</tr>
<tr>
<td>8.</td>
<td>Friends</td>
</tr>
<tr>
<td>9.</td>
<td>Feeling stressed about something that has happened</td>
</tr>
<tr>
<td>10.</td>
<td>Feeling lonely</td>
</tr>
<tr>
<td>11.</td>
<td>Unable to deal with painful memories from the past</td>
</tr>
<tr>
<td>12.</td>
<td>Unable to deal with painful emotions from childhood</td>
</tr>
<tr>
<td>13.</td>
<td>Feeling depressed</td>
</tr>
<tr>
<td>14.</td>
<td>Not having a partner</td>
</tr>
<tr>
<td>15.</td>
<td>A partner</td>
</tr>
<tr>
<td>16.</td>
<td>Unable to deal with current relationships</td>
</tr>
</tbody>
</table>

Table 3: Topics for the Card Sort Task in Relation to the Question: ‘What Do You Think is Helpful in Sustaining a Person’s Recovery From Class A drugs?’

<table>
<thead>
<tr>
<th>Topic number and order</th>
<th>Topics for ‘What do you think is helpful in sustaining a person’s recovery from Class A drugs?’</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Having responsibility for looking after children/dependants</td>
</tr>
<tr>
<td>2.</td>
<td>Help from a drug worker</td>
</tr>
<tr>
<td>3.</td>
<td>Partner</td>
</tr>
<tr>
<td>4.</td>
<td>Supportive partner</td>
</tr>
<tr>
<td>5.</td>
<td>Being a parent</td>
</tr>
<tr>
<td>6.</td>
<td>A volunteer job</td>
</tr>
<tr>
<td>7.</td>
<td>Family</td>
</tr>
<tr>
<td>8.</td>
<td>A drugs worker</td>
</tr>
<tr>
<td>9.</td>
<td>Being able to cope when upset, without having to use drugs</td>
</tr>
<tr>
<td>10.</td>
<td>Supportive family</td>
</tr>
<tr>
<td>11.</td>
<td>Not committing crime</td>
</tr>
<tr>
<td>12.</td>
<td>Friends</td>
</tr>
<tr>
<td>13.</td>
<td>Something to do such as a hobby</td>
</tr>
<tr>
<td>14.</td>
<td>Not hanging out with friends who take drugs</td>
</tr>
<tr>
<td>15.</td>
<td>Not hanging out with friends who commit crime.</td>
</tr>
<tr>
<td>16.</td>
<td>Feeling able to cope with stress without the need to use drugs</td>
</tr>
<tr>
<td>17.</td>
<td>Somewhere to live</td>
</tr>
<tr>
<td>18.</td>
<td>A job that is paid</td>
</tr>
</tbody>
</table>
5.1.7 Participants

5.1.7.1 The research cohort

Substances

Participants were primarily ‘problematic’ Class A drug misusers with offending backgrounds who were based within the community (see Chapter 2 for a definition of ‘problematic’ drug misuser). Participants were part of a drug rehabilitation programme called the Drug Interventions Programme (DIP). The DIP was part of a range of UK Government (England and Wales) led initiatives to break the cycle of drug misuse and offending behaviour by intervening and engaging with drug misusers at every stage of the criminal justice system, including those who had been in residential treatment or were recently released from prison. (For more information on the DIP and the Government’s Drug Strategy see Introduction Chapter 2). It was recognised by both policy staff at the Home Office and by the DIP drugs workers that many DIP clients were also polysubstance misusers, however Class A drugs were their primary drug of choice (See Introduction Chapter 2 for a definition of polysubstance use).

Offence type and criminal behaviour

The types of offences for which clients (and therefore the research participants) were referred to the DIP were acquisitive crimes, such as burglary, robbery and theft. This was due to the Home Office’s perceived link between their Class A drug use driving this type of criminal behaviour. (See Introduction Chapter 2 for an overview of the drugs: crime link debate). It must however, be recognised that this group may well be involved in other types of crime too.

Some participants were also part of the Prolific and other Priority Offender programme (PPO). A PPO is an offender who has been identified by the local police to be committing a large number of offences within a locally defined geographical area. These offences include acquisitive crimes but also more serious offences considered to present a significant risk to the community (Best, Walker, Aston, Pegram, & O’Donnell, 2010). PPOs receive more intensified monitoring and support by the authorities to reduce their criminal behaviour. Many PPOs have Class A drug misuse
problems and are therefore referred to their local DIP programme. The PPO programme on which the researcher worked was also a centrally led Home Office strategy aimed at reducing crime.

The rehabilitation organisation taking part in the research

The rehabilitation organisation taking part in this research is a third sector provider that operates some of the DIP programmes in England. Most of the participants were either receiving help from the rehabilitation organisation at the time the research was conducted or had received help from them in the past as part of the Drug Interventions Programme. Some of the participants also had a Prolific and Other Priority Offender status. Participants, who were longer term recovered, had been accessed through the rehabilitation organisation’s links with its ‘sister’ organisations with which it worked closely.

The rehabilitation organisation in this research is a charitable organisation that operates rehabilitation services for people with substance misuse issues. It is run by practitioners, some of whom are ex-substance misusers themselves. Current substance misusers are also involved in the work of the organisation in the form of the Service User Forum Council. Clients in receipt of support from the DIP are all adults, aged 18 years and over.

5.1.7.2 Selection and exclusion criteria of participants for the focus groups

The researcher liaised closely with DIP drug workers and members of the Service User Forum Council to help to define the inclusion and exclusion criteria to ensure safeguarding and ethical considerations were fully met.

Selection and inclusion criteria

The primary selection criteria were that participants’ main drug of choice was Class A drugs, such as crack, heroin or cocaine and they were either currently accessing support from the DIP through the rehabilitation organisation at the time of the research or in the past. (Some participants were also part of the PPO programme). Due to the nature of the DIP, clients were assumed to have an offending background given that
this was one of two key reasons for them being referred to the DIP (the other key reason being their Class A drug misuse). Those with polysubstance misuse issues were also included providing that Class A drug use was their primary drug of misuse.

Men and women over 18 years of age and from all ethnic and religious backgrounds and denominations including ‘no religious’ affiliation were eligible. Participants were required to have a good grasp of spoken English, largely due to the practicalities of a focus group setting and because there was no funding available to provide translators.

_Exclusion criteria_

Given the vulnerable nature and complex needs of this cohort exclusion criteria were deemed necessary. This was to safeguard clients who were perceived by the DIP workers and the researcher to be particularly vulnerable and where taking part in the research might have posed particular barriers to their recovery. ‘Particularly vulnerable’ was defined in several ways. Those who were exhibiting obvious signs of being intoxicated at the time of the focus group were excluded. This would have been both impractical and would have confounded the data. Extra NHS ethical considerations are required to include pregnant women, therefore participants, who were known to be pregnant at the time of the interviews, were excluded. Clients with a sexual offending Multi-Agency Public Protection Arrangement status (MAPPA) were also excluded to safeguard any participants discussing their own sexual abuse within the group setting. Those MAPPA status clients who were deemed to present a low risk to the researcher’s personal safety were included in the Semi-structured Interview Study (Part Two). Those clients who suffered from social anxiety phobias, where taking part in a group setting might have caused undue stress, were also excluded from the focus groups. These clients were given the opportunity to take part in the semi-structured interviews (Part Two). Participants who were deemed to exhibit severe psychological distress during the focus group, (following discussion with the participant), would be excluded from participating further. Whilst this might be considered a confounding variable given that the research was also investigating psychological health it was thought necessary to safeguard the group’s vulnerable ‘status’. However, no participants were excluded on this basis during the focus groups. Clients, who were especially difficult to engage in the DIP and where it was felt that
being involved in the research would pose another barrier to engagement, were also excluded from participation.

Whilst the exclusion criteria might be considered to confound the findings, the welfare of a vulnerable group with severe drug misuse issues was considered a priority. Research should always be mindful that participants are people and can be adversely affected by taking part in research. This should be especially apparent in research involving vulnerable groups. The welfare of participants should always be the researcher’s primary priority. Furthermore, it is unlikely that researchers will gain access to vulnerable participant groups if they are unable to demonstrate and follow through safeguarding measures to those (practitioners) who are both the gatekeepers and have responsibility for the participant group’s welfare.

**Determining the suitability of participants- applying the selection and exclusion criteria**

A three stage process was undertaken to determine each participant’s suitability for taking part in the focus groups. 1). The researcher liaised with the DIP drugs workers (who have access to the DIP clients) to discuss the suitability of potential participants in line with the exclusion and inclusion criteria. One participant self-referred therefore the DIP drugs workers undertook the relevant background checks in line with the selection and exclusion criteria. 2). Potential participants were then asked a series of questions over the phone by the researcher before the focus groups met to further establish a participant’s suitability in line with the selection criteria. 3). Suitability was further checked at the focus groups where participants were asked to complete a form about their DIP status and their drug misuse.

**5.1.7.3 Focus group study participants: Criminal justice programme management status and other demographic information**

There were 10 participants in total across four focus groups. Focus Group One and Four comprised of two same sex participants and Focus Group Two and Three comprised of three participants - two men and one woman. In total there were 6 men and 4 women. The age range was 32 to 48, the mean average age was 41 years. Most of the participants were White British (N=3), White Other (N=2) or British Irish
Two participants were (Afro) Black Caribbean, one participant was Mixed Race ($N=1$) and one described themselves as Other ($N=1$). Five of the participants were single and 3 considered themselves to be in a relationship. A further participant was unsure of his current relationship status and ticked both the single and in a relationship box, which he elaborated on during the focus group discussion. A further participant described his relationship status as separated.

All 10 participants were either current or past DIP clients, seven of whom were current DIP clients. Two participants had current PPO status and eight had no previous PPO status. (See Table 4).
### Summary Table 4: Participant’s Criminal Justice Programme Management Status, Focus Group Number and Other Demographics

<table>
<thead>
<tr>
<th>Focus group</th>
<th>N</th>
<th>Male or Female</th>
<th>Age</th>
<th>Ethnicity</th>
<th>Relationship status</th>
<th>Current DIP client (CD)</th>
<th>Past DIP client (PD)</th>
<th>Current PPO client (CP)</th>
<th>Past PPO client (PP)</th>
<th>Other criminal justice status</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1</td>
<td>M</td>
<td>34</td>
<td>White British</td>
<td>Single</td>
<td>PD</td>
<td>No</td>
<td>Not known</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>2</td>
<td>M</td>
<td>48</td>
<td>White Other</td>
<td>Separated</td>
<td>CD</td>
<td>CP</td>
<td>Not known</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>3</td>
<td>M</td>
<td>43</td>
<td>Other</td>
<td>He is unsure if single or in a relationship</td>
<td>PD</td>
<td>No</td>
<td>Not known</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>4</td>
<td>F</td>
<td>32</td>
<td>Black Caribbean</td>
<td>In a relationship</td>
<td>CD</td>
<td>No</td>
<td>Not known</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>5</td>
<td>M</td>
<td>36</td>
<td>White</td>
<td>In a relationship</td>
<td>CD</td>
<td>No</td>
<td>Not known</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>6</td>
<td>M</td>
<td>46</td>
<td>Mixed</td>
<td>Single</td>
<td>CD</td>
<td>No</td>
<td>Not Known</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>7</td>
<td>M</td>
<td>48</td>
<td>White British</td>
<td>Single</td>
<td>CD</td>
<td>CP</td>
<td>Not known (might be MAPPA - violence)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>8</td>
<td>F</td>
<td>47</td>
<td>White British</td>
<td>Single</td>
<td>CD</td>
<td>No</td>
<td>Not Known</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>9</td>
<td>F</td>
<td>34</td>
<td>British Irish</td>
<td>In a relationship</td>
<td>CD</td>
<td>No</td>
<td>Not known</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>10</td>
<td>F</td>
<td>46</td>
<td>Afro Caribbean</td>
<td>Single</td>
<td>PD</td>
<td>No</td>
<td>Not Known</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Table 5: Participants’ Substance Use for the Focus Group Study (Part One)

<table>
<thead>
<tr>
<th>Focus group and participant number and pseudonym</th>
<th>Clean time from Class A drugs at time of the focus group and length of use</th>
<th>Main drug of choice and length of use</th>
<th>Using Class A drugs at time of interview</th>
<th>Under 6 months</th>
<th>6-12 months</th>
<th>13 months to 2 years</th>
<th>Over 2 years</th>
<th>1. Using Methadone or Subutex 2. Other substances. (at time of interview)</th>
<th>Currently using alcohol?</th>
<th>Currently using alcohol?</th>
<th>Quantity?</th>
</tr>
</thead>
<tbody>
<tr>
<td>FG1: 1: Alan</td>
<td>2 months abstinent. Used heroin for 7 years.</td>
<td>Heroin</td>
<td>N</td>
<td>N</td>
<td>Y</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td></td>
</tr>
<tr>
<td>FG1: 2: Bobby</td>
<td>1 month abstinent. Used for 25-30 yrs for several months at a time.</td>
<td>Opiates</td>
<td>N</td>
<td>N</td>
<td>Y</td>
<td>N</td>
<td>N</td>
<td>O</td>
<td>N</td>
<td>O</td>
<td></td>
</tr>
<tr>
<td>FG2:3: Samuel</td>
<td>4 months abstinent. Used crack for 20 years on and off and heroin for 8 years.</td>
<td>Crack and heroin</td>
<td>N</td>
<td>Y</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td></td>
</tr>
<tr>
<td>FG2:4: Clare</td>
<td>Is still using cocaine. Used for 10 years.</td>
<td>Cocaine</td>
<td>Y</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>N</td>
<td>N</td>
<td>Y</td>
<td>3 days a week, 3 pints Guinness, ¼ bottle of vodka a day.</td>
</tr>
<tr>
<td>FG2:5: Moses</td>
<td>12 months abstinent. Used Class A drugs for 4 years.</td>
<td>Crack and heroin</td>
<td>N</td>
<td>Y</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>O. Twice a month, two cans of beer or Jägermeister.</td>
<td>N</td>
<td>O</td>
<td></td>
</tr>
<tr>
<td>Focus group and participant number and pseudonym</td>
<td>Clean time from Class A drugs at time of the focus group and length of use</td>
<td>Main drug of choice and length of use</td>
<td>Using Class A drugs at time of interview</td>
<td>Under 6 months</td>
<td>6-12 months</td>
<td>13 months to 2 years</td>
<td>Over 2 years</td>
<td>1. Using Methadone or Subutex 2. Other substances. (at time of interview)</td>
<td>Currently using alcohol?</td>
<td>Currently using alcohol?</td>
<td></td>
</tr>
<tr>
<td>-------------------------------------------------</td>
<td>-------------------------------------------------</td>
<td>-------------------------------------</td>
<td>--------------------------------------</td>
<td>----------------</td>
<td>--------------</td>
<td>-------------------</td>
<td>-------------</td>
<td>--------------------------------------------------------------------------------</td>
<td>-----------------</td>
<td>-----------------</td>
<td></td>
</tr>
<tr>
<td>FG3:6: David</td>
<td>14 months abstinent. Used for over 20 years.</td>
<td>Heroin and Benzodiazepines</td>
<td>N</td>
<td></td>
<td>Y</td>
<td></td>
<td>Y</td>
<td>Y</td>
<td>O. Glass of wine, 1 can of larger one day a week.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>FG3:7: Kevin</td>
<td>3 years abstinent. Used for 17 years.</td>
<td>Heroin and crack</td>
<td>N</td>
<td></td>
<td></td>
<td>Y</td>
<td>Y</td>
<td>N</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>FG3:8: Ellen</td>
<td>12 months abstinent. Used on and off for 20 years.</td>
<td>Heroin and crack</td>
<td>N</td>
<td></td>
<td>Y</td>
<td></td>
<td>Y</td>
<td>O. 1 glass of wine one day a week</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>FG4:10: Zoe</td>
<td>Still using heroin. Been using heroin for 5 years and using marijuana for 29 years.</td>
<td>Crack</td>
<td>Y</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>N</td>
<td>N</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
5.1.7.4 Participants substance misuse for the focus group study (Part One)

The selection criteria required participants to be past or current DIP clients, which meant their primary drugs of choice were Class A drugs. The aim was to recruit participants at different stages in the relapse or recovery journey to help inform an interview schedule for the Part Two Study, a series of semi-structured interviews.

Therefore, two participants were using Class A drugs at the time of the focus group study (\(N=2\)), four participants had been recovered for under 6 months (\(N=4\)), two had been recovered for 12 months (\(N=2\)), one participant had over 12 months recovery (\(N=1\)) and a further participant had over 2 years recovery (\(N=1\)). Another participant (Kevin) had achieved some of his recovery time in prison. The majority of participants could be described as under 2 years recovered (\(N=7\)). One participant could be described as longer term recovered with over three years of recovery time. However, one participant, Ellen, who had 12 months recovery at the time of the focus group had also experienced over 11 years in recovery in the recent past, which she talked about extensively. The main Class A drug of choice was heroin for two participants (\(N=2\)), crack for two participants (\(N=2\)) and cocaine for one participant (\(N=1\)). Five participants cited poly Class A drug misuse, four participants main poly Class A drug use combination was Heroin and Crack (\(N=4\)) and one participant described their main combination of Class A drugs as opiates (\(N=1\)). Three participants were on a Methadone or Subutex script at the time of the Focus Group Study. Four participants did not drink alcohol, four drank occasionally and two participants drank more frequently with indications that they were consuming more than the recommended weekly allowance of 14 units.
Table 6: Focus Group Demographics and Reflective Comments Including Group Dynamics

<table>
<thead>
<tr>
<th>Focus group number</th>
<th>Focus group members</th>
<th>Focus Group Gender/s</th>
<th>Focus Group Recovery Range</th>
<th>Focus Group scripts (Subutex/Methadone)</th>
<th>Stand out group dynamics and reflections</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Alan Bobby</td>
<td>Men</td>
<td>1-2 months</td>
<td>None</td>
<td>Both members worked well together in the group and were very cooperative, polite and friendly towards each other. Bobby spoke about how he used drugs later on in life for physical pain (he was in a wheel chair). This was different to other members of the focus groups who cited emotional pain as one of the reasons for drug use. They both appeared to enjoy the focus group experience. Bobby asked if he could take part in the semi-structured interviews. However, this was not part of the selection criteria for Part Two study). Standout themes were: difficult and traumatic childhoods.</td>
</tr>
<tr>
<td>2</td>
<td>Samuel Clare Moses</td>
<td>Men and women</td>
<td>Still using-12 months</td>
<td>None</td>
<td>Moses was a quieter member of the group, he had a diagnosis of schizophrenia. He heard voices in his head which competed with those in the group. Samuel and Clare appeared to have a good rapport and there even appeared to be some flirtatious behaviour from Samuel. Whilst Clare appeared to get on with Samuel her body language was more defensive at times, (e.g. when Samuel appeared to ‘invade’ her space). However, there was a lot of rich discussion, including Clare disclosing that she had been the victim of sexual abuse during her childhood. Samuel and Clare appeared to enjoy the focus group experience. Standout themes: Difficult and traumatic childhoods and struggles with complex and tense relationships.</td>
</tr>
</tbody>
</table>
Table 6: Focus Group Demographics and Reflective Comments Including Group Dynamics

<table>
<thead>
<tr>
<th>Focus group number</th>
<th>Focus group members</th>
<th>Focus Group Gender/s</th>
<th>Focus Group Recovery Range</th>
<th>Focus Group scripts (Subtext/Methadone)</th>
<th>Stand out group dynamics and reflections</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>David Kevin Ellen</td>
<td>Men and women</td>
<td>12 months – 3 years</td>
<td>Yes</td>
<td>Kevin disclosed that he had murdered someone when he was a young teenager and David disclosed that he had been the victim of an attempted murder, which had been his reason for starting to take Class A drugs. There was tension between David and Kevin, mainly from David. Ellen and David were friends and this may have helped to soften the atmosphere between David and Kevin, although David did warm towards Kevin towards the end of the group. Kevin was very talkative and at times tried to dominate the group but he was interrupted by David. All members of the group were engaged in the focus group process. They enjoyed the focus group experience, Kevin in particular. Standout themes - recovery, mental and psychological well-being and criminality.</td>
</tr>
<tr>
<td>4</td>
<td>Tina Zoe</td>
<td>Women</td>
<td>Still using – 7 weeks clean</td>
<td>None</td>
<td>Tina was very talkative. Zoe was a little more withdrawn at times. Zoe was still using drugs and had mental health problems. Zoe’s narrative was incoherent at times. Zoe did open up more about her mental health concerns when Tina spoke openly about her mental health concerns. Tina also tried to offer Zoe help by suggesting support groups for mental health problems during the break. This may have encouraged Zoe to talk more openly. Standout theme – struggles with mental health.</td>
</tr>
</tbody>
</table>
5.1.8 Procedure

5.1.8.1 Recruiting the participants for the focus groups:

*Approaching potential participants*

Several methods were employed to recruit participants. Leaflets and posters were created to advertise participation in the research (see Appendix 6, Figure 1). A free lunch was offered in the advertising material as an incentive to encourage participation. These were made available in one English borough in the premises of the rehabilitation organisation where clients frequented. Leaflets were sent to the organisation’s volunteer network and were handed to the DIP drug workers to pass on to their clients. A presentation about the selection criteria and suitability of participants was given to one DIP team and its satellite substance misuse services. Staff who had client contact were asked to contact suitable past and current DIP clients. The researcher attended the DIP team meetings on a regular basis to further promote the research and the recruiting process with the DIP staff and the DIP drug workers.

The most successful recruitment method involved the DIP staff and drug workers approaching past or current DIP clients from their caseloads to discuss the research first. Clients’ details (with their permission) were then forwarded on to the researcher who contacted interested clients by phone to provide more information about the expectations and scope of the research. The DIP clients were also informed that a research assistant, who was also a drugs worker, would be present in the focus group. All of the clients agreed to this arrangement. Participants who initially agreed to take part but were not willing to provide their phone number to the researcher were sent a letter with details of the time and date of the focus group. This means of recruitment was however unsuccessful.

*Retaining participants – dealing with a high dropout rate*

To help retain participants, the researcher made reminder phone calls and sent text messages two weeks, one week and the day before the focus group. This also allowed time for further recruiting if participants dropped out at these stages. The most successful means of retaining participants at this stage was to speak to the participants at least two days before the focus group with a reminder text the day before the group.
Leaving voice mail messages or texting only, did not always yield a reply due to the cost this would incur for the participant.

The dropout rate was high and further recruiting was required with all of the focus groups. To ensure at least two participants attended each focus group a backup list of 10-12 participants for each focus group was required. Participants on the backup list had given their permission and had been pre-vetted for their suitability including the necessary legal and safeguarding checks. A successful means to recruit participants from the backup list on the day of the focus group was to contact participants who lived close by. In one of the focus groups three participants cancelled due to ill health an hour before it was due to begin. Therefore, a participant was recruited from the waiting area of the rehabilitation drop in service. The research assistant, who was also a drugs worker, was able to verify her suitability.

Further considerations to maximise recruitment and retention

All dates for focus groups were pre agreed with the DIP staff and the counsellor to ensure there were no other conflicting events and to help maximise participation. For example, focus groups were held on days and times that did not clash with benefit payments and when educational courses were held. Recruiting during the winter months meant that a number of participants did not attend because they were unwell with seasonal colds.

5.1.8.2 Procedure during the focus groups

Participants were asked to read an information sheet which included a section about confidentiality. The confidentiality clause was necessary to ensure that participants were aware of the limitations of confidentiality. This was due to the offending background of the participant group and the potential of some of the questions to prompt discussions about their own offending behaviours. The clause included the rehabilitation organisation’s own confidentiality policy which was also in line with the National Treatment Agency’s recommendations. Participants were then given a consent form to initial and asked to complete a demographic questionnaire. Two participants were unable to read or write therefore the researcher offered to help. The
consent form included a section asking for permission to tape record the session, this request was reiterated at the beginning of the focus group. All participants gave their consent to audio recording. (See Appendix 7 for a copy of the information sheet, the confidentiality clause and consent form).

The researcher then provided an introduction to the research which included an overview of the purpose of the research and the focus group. The role of the research assistant was reiterated to ensure that participants understood that he was not working as a drug worker in the focus groups and that the information they provided was for the purpose of the research only. Participants were informed that they would be completing two small tasks and they were given instructions about the tasks. They were told that there were no right or wrong answers and they were encouraged to engage in discussion with group members throughout the focus group. Participants were informed that the focus group had been designed so that they could discuss the questions in a general manner if they wished. However, all group members spoke about their own personal experiences in relation to the main questions and during the card sort tasks. Participants were provided with refreshments during the focus groups and a coffee/tea break was offered half way through the focus group. Lunch and reimbursement for travel was provided at the end of each focus group. Participants were advised at the start and at the end of the focus group that a trained counsellor was available for a one to one session if they felt the focus group discussion had raised any issues for them, that they wanted to discuss further. This was in recognition that some of the questions could provoke discussions about sensitive topics and because the participants were considered to be vulnerable due to their drug taking problems and complex needs. The counsellor de-brief session did not form part of the research data and participants were informed of this. One participant chose to have a de-brief with the counsellor after the focus group.

In the first focus group only, participants were given the card sort tasks first and then asked to add anything in the ‘most important category’, which they felt had not been included in the topics. However, for the remaining three focus groups participants were asked the two main questions independently of the card sort task first and then asked
to complete the card sort task. This was to encourage participants to provide their own ideas before introducing the card sort topics for a more focused discussion.

At the end of the focus group participants were informed that they had been helping to develop a set of interview questions for research about relapse and recovery. They were asked if they felt that questions about childhood, upbringing, family, trauma and offending behaviour were OK to ask service users like themselves. They were then thanked for their time and provided with travel reimbursement and lunch. Where appropriate some participants were also given leaflets about the research to help recruitment for subsequent focus groups and interviews. It was unclear if this recruiting method produced any further participants.

5.1.8.3 Procedure for IPA analysis – developing and adapting IPA for use with focus groups

A detailed description is now provided of how IPA was adapted for use in the focus group study. It was developed from the steps set out by Smith et al. (2012) and also incorporates some of the suggestions proposed by Tomkins and Eatough (2010) and Palmer et al. (2010) as well as some of the researcher’s own adaptations. The steps set out below and in the Table 7 ‘Protocol for IPA analysis for the Focus Group Study’, were not necessarily conducted in isolation from one another because of the need to adapt IPA for use with focus groups. Examples of the analysis on participants’ raw data from the Focus Group Study can be found in Appendix 19.

IPA is an in-depth analysis which, when applied to focus group data, increases the complexity of the analysis and therefore the time to conduct the analysis. Furthermore, adapting IPA for use with focus groups in this study was also time consuming. This therefore meant that the analysis of the focus group data took twice as long as anticipated (over 7 months).
Table 7: Summary of the Protocol for IPA Analysis for the Focus Group Study, Which Incorporates Suggestions by Smith et al. (2012) and Adaptations by Palmer et al. (2010), Tomkins and Eatough (2010), the Researcher and Her Supervisors'.

<table>
<thead>
<tr>
<th>Step number</th>
<th>Process</th>
<th>Description</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Step 1. Immersion in the data – transcribing the data.</strong></td>
<td>Researcher manually transcribed all data using Word.</td>
<td>Full transcription of all spoken words, including descriptions of participants’ tone, pitch, emotion, gesticulations and group dynamics where relevant.</td>
<td>Smith et al. (2012) and Palmer et al. (2010)</td>
</tr>
<tr>
<td><strong>Step 2. Identifying the researcher’s orientation and potential bias.</strong></td>
<td>a. Self-reflexive interview with the researcher before the focus groups.</td>
<td>Questions to the researcher were to identify her bias, perceptions and views of the research topics and client group and her reasons for undertaking the research.</td>
<td>Researcher and her Supervisors</td>
</tr>
<tr>
<td></td>
<td>b. Making notes about the experience of facilitating the focus group and reflections afterwards.</td>
<td>Extensive field notes after each focus group, including reflective thoughts.</td>
<td>Smith et al. (2012) and Palmer et al. (2010)</td>
</tr>
<tr>
<td><strong>Step 3a. Familiarisation with the data and identifying life experiences and relationships.</strong></td>
<td>Descriptive</td>
<td>Significant relationships and events, which can be identified by “assumptions, acronyms, idiosyncratic figures of speech and emotional responses”.</td>
<td>Smith et al. (2012, p. 84)</td>
</tr>
<tr>
<td></td>
<td>Linguistic</td>
<td>The use of language e.g. pauses, humour, laughter, repetition, tone, metaphors, imagery, coherence and degree of articulation.</td>
<td>Smith et al. (2012, p. 88)</td>
</tr>
<tr>
<td></td>
<td>Conceptual comments</td>
<td>Interpretation and questioning what the participant means – therefore departing from “the explicit claims of the participant”.</td>
<td>Smith et al. (2012, p. 88)</td>
</tr>
<tr>
<td></td>
<td>Positionality</td>
<td>a. Consider how the researcher and research assistant’s role influences the focus group (e.g. interactions with participants). Consider how the researcher’s preconceptions and bias influence the research process including during the analysis stage.</td>
<td>Palmer et al. (2010, p. 104)</td>
</tr>
<tr>
<td></td>
<td>b. “Explore the function of statements made by respondents (what is their perspective, stance?)”</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Stories</td>
<td>“How do participants support or impede each other to share their experiences?”</td>
<td>Palmer et al. (2010, p. 104)</td>
</tr>
<tr>
<td></td>
<td>Language</td>
<td>a. “Patterns: repetition, jargon, stand out words and phrases, turn-taking, prompting” – at the individual or group level? b. “Function: How/why is language being used? (e.g. to emphasise back up a point, to shock, to provoke disagreement, to amuse/lighten the tone?) in the group setting”.</td>
<td>Palmer et al. (2010, p. 104)</td>
</tr>
</tbody>
</table>
Table 7: Summary of the Protocol for IPA Analysis for the Focus Group Study, Which Incorporates Suggestions by Smith et al. (2012) and Adaptations by Palmer et al. (2010), Tomkins and Eatough (2010), the Researcher and Her Supervisors

<table>
<thead>
<tr>
<th>Step number</th>
<th>Process</th>
<th>Description</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>4a.</td>
<td>Identifying emerging themes.</td>
<td>“Themes are usually expressed as phrases which speak to the psychological essence of the piece and contain enough particularity to be grounded and enough abstraction to be conceptual”. The focus is at the micro level but also considering this in relation to meanings across the whole text.</td>
<td>Smith et al. (2012, p. 92)</td>
</tr>
<tr>
<td>4b.</td>
<td>Adaptations to IPA for how to identify emergent themes in focus groups.</td>
<td>“Adaptation of emergent themes” use Palmer et al’s (2010) questions to guide the process.</td>
<td>Palmer et al. (2010, p. 104)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>b. Clustering themes and identifying emerging superordinate themes for each focus group.</td>
<td>Smith et al. (2012)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Abstraction</td>
<td>Clustering similar themes together.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Contextualisation and function.</td>
<td>Consider the wider context (e.g. cultural) and the function of themes (e.g. in relation to the participant).</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Subsumption</td>
<td>A theme in a cluster becomes a superordinate theme because it is able to explain or pull together the other ‘like’ themes.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Polarisation</td>
<td>Identifying opposite or conflicting themes, which are somehow interlinked.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Numeration</td>
<td>The frequency with which a theme is mentioned but this should not be the only means of identifying the importance of a theme too.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>c. IPA adaptation – the “additional iterative loop” and the part-whole relationship.</td>
<td>(Also Tomkins and Eatough 2010)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Use the “additional iterative loop”: Assess the emerging group level superordinate themes (taxonomy) for each individual and assess the individual in relation to the overall emerging superordinate themes (taxonomy). How well do the group level superordinate themes (taxonomy) represent each individual in the focus group?</td>
<td>Tomkins and Eatough (2010, p.250)</td>
</tr>
</tbody>
</table>
Table 7: Summary of the Protocol for IPA Analysis for the Focus Group Study, Which Incorporates Suggestions by Smith et al. (2012) and Adaptations by Palmer et al. (2010), Tomkins and Eatough (2010), the Researcher and Her Supervisors’

<table>
<thead>
<tr>
<th>Step number</th>
<th>Process</th>
<th>Description</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Step 6. Adapting IPA - amalgamating the data across all focus groups to produce a master taxonomy of superordinate themes and themes.</td>
<td>“Data should be checked to ensure sufficient homogeneity between focus groups to allow for successful integration”.</td>
<td>1. Pick out commonalities and stand out differences between groups drawing out superordinate themes. 2. Frequent revisits of the transcripts to check themes in relation to original claims made to help ensure accuracy. 3. Consider the analysis in the wider context of existing relevant theories, models and explanations”. 4. Consider them in relation to the research. Use the “additional iterative loop” in Step 5 when amalgamating themes across all the focus groups.</td>
<td>Palmer et al. (2010, p.105) Smith et al. (2012) Tomkins and Eatough (2010)</td>
</tr>
<tr>
<td>Step 7. Checking the recurrence of themes, and superordinate themes.</td>
<td>Incorporating the individual and the collective voice.</td>
<td>The recurrence of superordinate themes (Smith et al., 2012) and themes (Tomkins &amp; Eatough 2010) were checked at the individual participant level (Smith et al., 2012) and at the focus group level (Tomkins &amp; Eatough 2010). This was to ensure the individual’s voice as well as the group collective voice were included to stay close to IPA’s ideographic underpinnings, whilst also acknowledging the value and merit of the focus group design. Including stand-alone themes in line with Tomkins &amp; Eatough (2010) suggestions were also followed. (Appendix 12 and 18).</td>
<td>Smith (2012) Tomkins and Eatough (2010) and Palmer et al. (2010)</td>
</tr>
<tr>
<td>Step 8. Order the superordinate themes.</td>
<td>Create a taxonomy of themes. Create a ‘flow’ diagram.</td>
<td>Themes were ordered into a “logical sequence” see Table 8. Figure 3, shows hypothetical links with themes in relation to the research questions.</td>
<td>Smith (2012, p.109) Researcher</td>
</tr>
<tr>
<td>Step 9. Credibility checks.</td>
<td>Discussion of an extract of data with IPA qualitative researchers and the focus group assistant, presentation and discussion of the findings with drug workers. Discussion of extracts of data and analysis with the researcher’s supervisors.</td>
<td>Researcher Researcher and her Supervisors.</td>
<td></td>
</tr>
</tbody>
</table>
Step 1: Immersion in the data - transcribing the data

I transcribed the focus group data in full to help immerse myself in participants’ accounts. This included my descriptions of participants’ voice tone and pitch, and my observations of their emotions, gesticulations and the group dynamics.

Step 2: Identifying the researcher’s orientation and potential bias:

a. Before the focus groups:

I undertook a self-reflexive interview to establish my orientation and reflections about the topics pertinent to the research and about the participant group to help identify any thought processes that might influence the focus group process and later interpretations as suggested by Dallos and Vetere (2005). (Some of which have been mentioned in Chapter One). My supervisors and I developed the interview schedule, which was designed to help identify my beliefs and thoughts about the participant group and the research topic at the beginning of the research. A close family member posed the questions from the schedule, which can be found in Appendix 10.

b. During and after the focus groups:

The methodological approach taken views the researcher as part of the participant’s meaning making process. I therefore noted my own experience of facilitating and conducting the focus groups. This included my thought processes and emotions about group members and dynamics during and after the focus group. These reflections feature throughout the Part One Focus Group: Findings Chapter 5.2. and some are outlined in the Part One Focus Group: Discussion Chapter 5.3.

Step 3a: Familiarisation with the data and identifying significant life experiences and relationships

The first step of the transcript analysis included re-reading the transcripts and making initial notes “which have a clear phenomenological focus and stay close to the participant’s explicit meaning” (Smith et al., 2012, p. 83), for example relationships and significant events. This was achieved by noting “descriptive, linguistic and conceptual comments” (Smith et al., 2012, p.84 & 88). “Similarities, differences,
“echoes, amplifications and contradictions” were also noted (Smith et al., 2012, p. 83). This included times where group members disagreed or agreed with each other, as suggested by Palmer et al. (2010), which will be discussed in more detail in Step 3b. (See Step 3 in Table 7).

Examples of how Step 3a was achieved in the analysis:

There were many significant life experiences mentioned during the discussions, for example, bereavement, sexual abuse in childhood, managing mental health problems, becoming heavily addicted to drugs, criminal behaviour and relationships. These were often very emotional for the participants to talk about. Emotions were punctuated by an animated voice, fluctuations in voice tone, stuttering, repetition, long pauses in a participant’s voice or talking excessively quickly. Key life events and areas of interest were also identifiable by some participants repeating key phrases and returning to talk about the event throughout the focus group discussion. Gesticulations were a strong feature for illuminating discussion and identifying key areas of interest. For example, one participant, Ellen spoke about her experience of becoming heavily addicted to crack. She described how heroin brought her to her knees but crack cut off her knees. Ellen physically demonstrated this by her whole body flopping over at her waist in the chair, producing a striking visual display of how debilitating her addiction had been. Shinebourne and Smith (2010) suggests metaphors are a useful means by which to identify significant topics. Some participants used rich metaphors to articulate some of their discussion, for example Samuel used religious metaphors, (see Quote 33, Appendix 16).

Step 3b: Adaptations to IPA for identifying significant life experiences and relationships

Palmer et al. (2010) suggests exploring positionality, stories and language as outlined in Table 7 ‘Summary of Protocol of IPA analysis used for the Focus Groups’. Step 3a and 3b were not necessarily mutually exclusive and where appropriate were conducted in parallel.
Examples of how Step 3b was achieved in the analysis:

How participants discussed a topic was a key indicator of a significant experience for group members. For example, noting where group members engaged in a lengthy and heated debate, which involved contradictions, disagreements, animated voices, emotions and gesticulations. Important events were identified by agreements, interruptions, topic changes, digressing from the topic and returning to a topic. Another key identifier of significant experiences included when a participant spoke about a sensitive topic and prompted others to also talk about their similar experiences. For example their complicated and tense relationships with partners and their mental health (See Quotes 18a Chapter 5.2 section 5.2.4.4 and 18b Appendix 16 and Quote 24 Chapter 5.2 section 5.2.5.3).

Step 4a: Identifying emerging themes:

This step represents a move away from the transcript to the initial notes. The data are summarised and interpreted in a manner where patterns, connections and relationships emerge from the data across the focus group. It is important at this stage to consider the hermeneutic process whereby the micro level data (the initial notes which remain close to the transcript) are interlinked with the macro level data (the meaning and context across the interview or focus group discussion). As part of the hermeneutic process here the researcher’s own thoughts, bias and emotions about the data and the participant(s) are evident in the interpretative stage and need to be acknowledged and managed. An example of this is provided in Chapter 5.3.

Step 4b: Adaptations to IPA for identifying emergent themes in focus groups:

Palmer et al. (2010) suggest reviewing emerging themes whilst considering the following: shared group experiences, areas of agreement/disagreement, how these are managed within the group and how meaning making is made evident to other group members. A list of guidance questions suggested by Palmer et al. (2010) were followed and are outlined in Table 7 ‘Summary of Protocol of IPA analysis used for the Focus Groups’.
Examples of how Step 4b was achieved in the analysis:

Participants spoke about the role of friendships. However, clear differences emerged about these relationships when participants challenged each other. Some participants viewed drug related associates as friends who were part of their current network but others regarded these as past criminal and/or drug taking associates who were no longer friends and some further recognised that these associates had never really been friends. I wondered why these differences existed among participants. Two participants Ellen and Kevin, who challenged the concept that drug taking associates were friends, had both experienced longer term recovery. These interpretations helped to develop several themes around support networks and the role of friendships in recovery, which is detailed in Chapter 5.2 Sections 5.2.4.5 and 5.2.9.1.

Step 5: Clustering themes together and identifying emerging superordinate themes

a. Organising the data: PowerPoint and Word files:

PowerPoint was used to display and organise themes and superordinate themes. This also provided an audit trail during the different theme and superordinate theme developmental steps. Colours and codes helped to keep track of a participant’s quote. These codes could be cross referenced with a Word table containing participant(s) transcript extracts (i.e. participant’s supporting quotes). The Word file also included the researcher’s supporting comments and reflective notes, which were catalogued against each theme. For example the researcher’s rationale for why a participant was represented in a particular theme. This helped with the iterative and hermeneutic process and also with Step 7, the checking of recurrent themes.

b. Clustering themes and identifying emerging superordinate themes for each focus group

Smith et al. (2012) suggest that ‘like’ themes should be clustered together, which can be achieved by using abstraction, subsumption, polarisation, contextualisation, numeration and function. These processes can be applied to focus group data without the need for adaptation and they are explained further in Table 7: ‘Summary of Protocol of IPA analysis used for the Focus Groups’. Some of the themes became sub themes or aspects of a theme where a theme was able to pull together other themes. In
some cases a newly created theme was developed to pull together other themes. A ‘miscellaneous’ slide was also created where themes did not initially group with others. The miscellaneous themes were checked at a later stage to see if they ‘fitted’ into emerging themes from other focus groups during the amalgamation process described in Step 6. This process was completed for each focus group first before moving onto the amalgamation process.

c. Adaptation to IPA – the “additional iterative loop”

Tomkins and Eatough (2010, p.250) suggest that there are multiple meaning making processes occurring in a focus group setting. The researcher is attempting to understand the participant’s meaning making whilst the participant is also trying to understand their own experiences. In a focus group setting this hermeneutic process is more complicated because participants are trying to make sense of each other’s experiences too. To deal with this multiple hermeneutic Tomkins and Eatough (2010) suggest an ‘additional iterative loop’, which was used.

Step 6: IPA adaptations - amalgamating the data across all focus groups to produce a taxonomy of superordinate themes and themes

Adapting IPA for use with focus groups – ‘Integration of multiple focus groups’

These adaptations were based on Palmer et al. (2010) and included looking across the focus groups for similarities and differences whilst revisiting the hermeneutic and iterative loop. See Table 7 Step 6 for further detail.

Examples of how Step 6 was achieved in the analysis:

The first attempt to amalgamate the superordinate themes and themes was conducted using a hard copy of the colour co-ordinated theme diagrams from PowerPoint. Superordinate, themes or themes were then cut up by hand and grouped together where there were similarities or duplications thereby repeating the processes outlined above in Step 5 to produce a master taxonomy of superordinate themes and themes across all focus groups.
Each transcript was then rechecked using basic word searches to identify further possible supporting quotes for any newly formed themes and superordinate themes. The word searches were based on words used in existing supporting quotes and generic words that would capture the essence of the quotes. For example, ‘death’, ‘bereavement’, ‘dying’, ‘grief’ to identify areas where participants spoke about this topic. Any new narratives identified were analysed alongside contextualised notes to decide whether to include them and if the participant should be represented in the theme. The miscellaneous themes mentioned in Step 5 were re-checked and where appropriate included.

_How themes were discarded, developed and included_

Themes were discarded for several reasons. This was mostly due to duplication across focus groups or renaming of themes to capture and represent the meaning of the amalgamated focus group data better. Other reasons included a lack of prevalence or strong evidence for the importance of including a theme. Examples of this process can be found in Appendix 17.

**Step 7: Checking the recurrence of superordinate themes and themes**

a. _Superordinate theme or theme level checking and the ‘stand-alone’ theme_

The final stage was to check the recurrence of superordinate themes and themes. Smith et al. (2012) suggest recurrent checking at the superordinate level and Tomkins and Eatough (2010) suggest checking at the theme level. Smith et al. (2012) suggests at least a third of individuals should be represented by the theme for it to merit further inclusion and recognises that not all participants will be present in all themes. However, Tomkins and Eatough (2010) suggest that there is merit in including a ‘standalone’ theme which is represented by one participant. They further suggest that this remains close to the idiographic ethos of IPA. In a focus group setting a stand-alone theme may be embedded within focus group discussions which therefore requires particular attention in the interpretative process to illuminate the full significance of a ‘stand-alone’ theme. Furthermore, it was worth considering the purpose of the focus group – to help develop an interview schedule for Part Two. Therefore including a ‘stand-alone’ theme in the focus group analysis may provide
some important topics to pursue further in Part Two. A less stringent approach, more in line with Tomkins and Eatough’s (2010), suggestion was taken. An example of why a theme, which was represented by 3 participants only, is provided in Appendix 18.

b. **Ensuring the ideographic individual account is privileged whilst acknowledging the group dynamics**

In recognition of criticisms outlined in the Methodology Approach, Rationale and Criticisms Chapter 4, Section 4.8.2, to ensure the ideographic focus is not eclipsed by the group, recurrent theme checking was conducted at the individual participant level as suggested by Tomkins and Eatough (2010) and also at the focus group level, as suggested by Palmer et al. (2010). The individual theme checking was achieved by re-visiting the transcripts and checking if individuals were represented in each theme and superordinate theme, this included individual dialogue or where they were involved in conversations with others. Contextualised notes further aided re-visiting of the ‘analytical loop’. This was time consuming and further prolonged the analytical process.

In the focus groups there were four identifiable dialogue typologies occurring in relation to this debate and support for themes came from all four of these dialogue typologies. The collective group voice ‘type 4’ might be considered the more traditional use of the focus group method. However, the purpose of the focus groups in this study was to encourage participants to talk about their own experiences. Therefore, all four dialogue typologies were considered to hold important data and the supporting quotes in the Part One Focus Group: Findings Chapter 5.2, are reflective of this.

**The four identifiable dialogue typologies:**

1. The individual dialogue where no obvious group interactions or influences were present.
2. The individual dialogue which had been influenced by other group members, for example, by prompts, encouragement and re-visiting or referring back to topics. (This includes where the influence of the group was less obvious).
3. Dialogue which was part of a conversation amongst group members, where different group members agreed, disagreed or had differing interpretations on a topic.

4. The group collective voice where all group members agreed or disagreed about a topic.

**Step 8: Ordering the superordinate themes and themes**

Smith et al. (2012, p.109) suggest ordering the themes into a “logical sequence”. I therefore, ordered the superordinate themes around participant’s chronological life experiences and their journeys around relapse to recovery. This made logical sense in relation to the developmental theories used to shape the scope and direction of the research and in relation to the research question. This is illustrated in further detail in the Part One Focus Group Study: Findings Chapter 5.2, Section 5.2.2.1, Table 8. A flow diagram was created to illustrate hypothetical links between themes in relation to the research questions (see Figure 3 in the Part One Focus Group Study: Discussion Chapter 5.3, Section 5.3.2).

**Step 9: Credibility checks**

Credibility checks were undertaken to ensure high quality and standards were embedded throughout the application of the methodology and during the analytical and interpretative stages. These included checks with my supervisors, an IPA network group, the focus group research assistant and a DIP drugs worker. An overview of these credibility checks is provided in the Part One Focus Group Study: Discussion Chapter 5.3, Section 5.3.4.
CHAPTER 5.2 – PART ONE FOCUS GROUP STUDY: FINDINGS

5.2.1 Chapter overview

An overview of the superordinate themes alongside participants’ quotes is covered, some of which can be found in Appendix 16. My reflective observational thoughts about participants’ interactions and the group dynamics are included to provide context and further understanding of my interpretations. The supporting literature is discussed alongside the findings. However, a more in depth and comprehensive appraisal of the extant literature is reserved for Part Two, Chapter 6.3. How the findings were developed further and integrated into an interview schedule for Part Two is covered in Chapter 5.3. Section 5.3.3 and Chapter 6.1, Section 6.1.3.1, Table 9. A transcription key can be found in Appendix 15.

5.2.2 Introduction and overview of the findings

This section explores the following questions posed in the focus groups. These were then followed up in two card sort tasks with open ended topics (a list of the topics can be found in Chapter 5.1, Section 5.1.6.2, Tables 2 and 3).

1. What do you think might cause someone to relapse from Class A drugs?
2. What do you think is helpful in sustaining a person’s recovery from Class A drugs?

Smith et al. (2012) and Smith (2004) suggest that IPA can be used to analyse focus group data providing participant’s own experiences are present in the discussions. The focus group design and the card sort tasks were used as tools to help engage participants in dialogue and to encourage rich discussion in a focused manner around the research questions and topics. Participants in the focus groups did not always agree on the importance of a given card sort topic. Furthermore, they were given permission

Transcripts are verbatim and include participants’ stutters, slang terminology and words they pronounced incorrectly or created themselves.
to disagree with each other if they wished. This approach encouraged rich discussion and all participants spoke from their own experiences.

For the purpose of the research, themes were developed to a stage thought adequate to determine the relevance of the research question and to inform Part Two. Seven superordinate themes were developed from the focus group data. Smith et al. (2012), suggest that a third of participants should be represented at the superordinate theme level although a less stringent approach in line with Tomkins and Eatough (2010) was adopted. Between 8-10 participants were represented in each superordinate theme. In summary all participants were represented in 6 of the superordinate themes and 8 participants were represented in one superordinate theme. This is detailed in Table 1 ‘Recurrent theme check for all seven superordinate themes and their corresponding themes for the focus group study (Part One)’, in Appendix 12.

Smith et al. (2012, p. 109) suggest ordering the themes into a “logical sequence”. I therefore, ordered the superordinate themes around participants’ chronological life experiences and their journeys around relapse and recovery. This made ‘logical sense’ in relation to the developmental theories used to shape the scope and direction of the research and in relation to the research question. The first superordinate theme was participants’ difficult and/or traumatic childhood experiences which represented participants’ past, the next three superordinate themes represented their struggles in their adult lives such as with mental and psychological health, criminal behaviour and with relationships. Participants’ reasons for their drug use, which had links to the previous superordinate themes was placed next in order and the last two superordinate themes concerned how participants coped with their lives and what they found helpful in their recovery.

5.2.2.1 Overview of the findings

The superordinate themes, which are outlined in Table 8, illustrate the traumatic and complex lives (both past and present) of the participants. They experienced difficult and traumatic childhoods which included substance misuse, criminality and abusive relationships. These difficult and traumatic childhood experiences continued to exert a damaging impact on them in their adulthood. Difficult and traumatic experiences
also dominated participants’ adult lives, these included struggles with relationships, mental and psychological health and criminal and drug using lifestyles.

The reasons for participants’ drug use, lapses and relapses were heavily intertwined with what had happened to them in their childhoods and with their traumatic and difficult life experiences in adulthood. Drug use, lapses and relapses were viewed as a coping mechanism to deal with their life traumas, dramas and difficulties both past and present. However, drug taking was also viewed as a means to cope with everyday life including the more mundane aspects such as living independently after residential rehabilitation. It was clear that participants struggled (past and present) to cope with life per se.

When participants talked about recovery they were able to demonstrate healthier ways to cope and manage their lives free from drugs. This included supportive relationships, networks and help from professionals. Participants spoke about their attempts to learn to live a “normal” non-drug misusing life, which had some sort of structure and routine away from their drug misusing lifestyle.

To help maintain and manage recovery participants also demonstrated insight, understanding and rational thinking about their drug use and recovery behaviour. Learning and applying life skills was essential in helping them to maintain and manage a non-drug using life. However, participants also illustrated that lapses and relapses were part of their journey of recovery. Coping mechanisms, such as avoidance, were viewed as a “double edged sword” by some participants. For example avoiding old drug using acquaintances was a means to avoid lapses and relapses however, avoiding dealing with their problems could lead participants back in to using drugs and substances as a coping mechanism.

Each superordinate theme is discussed in more detail and in relation to the relevant literature and will follow the hierarchy set out in Table 8. Where appropriate and where space allows the corresponding themes are also discussed.
<table>
<thead>
<tr>
<th>Superordinate themes</th>
<th>Themes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Difficult and/or traumatic childhood experiences</td>
<td>• Difficult and or traumatic experiences in childhood</td>
</tr>
<tr>
<td></td>
<td>• Damaging relationships with parents</td>
</tr>
<tr>
<td></td>
<td>• Difficult or traumatic relationships in childhood</td>
</tr>
<tr>
<td></td>
<td>• Familiarity with substances or drug lifestyle</td>
</tr>
<tr>
<td></td>
<td>• Familiarity with crime/criminality</td>
</tr>
<tr>
<td>2. Struggles with complex and tense relationships</td>
<td>• Relating in a negative way to others</td>
</tr>
<tr>
<td></td>
<td>• Tensions with parents</td>
</tr>
<tr>
<td></td>
<td>• Negative and positive family relationships</td>
</tr>
<tr>
<td></td>
<td>• Complex and tense relationships with partners</td>
</tr>
<tr>
<td></td>
<td>• The role of friendships in drug using and non-drug using lifestyle</td>
</tr>
<tr>
<td></td>
<td>• Being a parent – the impact on relapse and recovery</td>
</tr>
<tr>
<td>3. Challenges and struggles with mental and psychological health</td>
<td>• Mental health diagnoses</td>
</tr>
<tr>
<td></td>
<td>• Impact of psychological or mental health</td>
</tr>
<tr>
<td></td>
<td>• Links between mental or psychological health and drug use</td>
</tr>
<tr>
<td></td>
<td>• Managing mental health in a healthier way</td>
</tr>
<tr>
<td></td>
<td>• Struggles with other addiction/addictive tendencies</td>
</tr>
<tr>
<td>4. Criminality – pathways, turning points and U-turns</td>
<td>• Criminal and problem behaviour in childhood</td>
</tr>
<tr>
<td></td>
<td>• Involvement in criminal lifestyle in adulthood</td>
</tr>
<tr>
<td></td>
<td>• Rejecting versus accepting aspects of the criminal lifestyle</td>
</tr>
<tr>
<td></td>
<td>• The links between crime and drugs</td>
</tr>
<tr>
<td>5. Reasons to use drugs, to lapse or relapse – a coping mechanism</td>
<td>• Drug use to feel better (to stop feeling bad)</td>
</tr>
<tr>
<td></td>
<td>• Block out painful and/or stressful thoughts</td>
</tr>
<tr>
<td></td>
<td>• To cope with mental health and/or difficult emotions</td>
</tr>
<tr>
<td></td>
<td>• To cope with stressful relationships with family or partners</td>
</tr>
<tr>
<td></td>
<td>• To cope with different types of stress – anything and everything can be a trigger to use</td>
</tr>
<tr>
<td></td>
<td>• To cope with trauma/responses</td>
</tr>
<tr>
<td>6. Ways of coping with life ‘the mundane to the extreme’.</td>
<td>• Healthy ways of coping ‘structure, routine and support’</td>
</tr>
<tr>
<td></td>
<td>• Healthier coping mechanisms: improving the self and problem solving skills</td>
</tr>
<tr>
<td></td>
<td>• Avoidance to cope “a double edged sword”</td>
</tr>
<tr>
<td></td>
<td>• Unhealthy ways of coping and surviving: crack, heroin and other substances.</td>
</tr>
<tr>
<td>7. What helps recovery and to prevent lapses/relapses</td>
<td>• Support from others /not being alone in recovery</td>
</tr>
<tr>
<td></td>
<td>• Insight/understanding into reasons for your drug use, lapse and relapse behaviour</td>
</tr>
<tr>
<td></td>
<td>• Developing, managing and maintaining life away from drug use/lifestyle</td>
</tr>
<tr>
<td></td>
<td>• Changes required (in thinking/ socially)</td>
</tr>
</tbody>
</table>
5.2.3 Superordinate theme 1: Difficult and/or traumatic childhood experiences

5.2.3.1 Difficult and traumatic experiences in childhood

Participants experienced a range of difficult and dangerous experiences in their childhoods, which they viewed as traumatic. This included, sexual abuse by a family member, physical violence by a parent and being heavily involved in a family criminal network. Van Der Kolk (2003) suggests that those with addiction problems may have experienced developmental trauma in childhood, including neglect and abuse by parents and close family members. It would appear from the focus group data that participants had experienced extreme trauma and abuse during their childhoods.

5.2.3.2 Difficult and traumatic relationships in childhood

Bobby from Focus Group One and Clare from Focus Group Two talked about abusive relationships during their childhoods, which included violence and sexual abuse by family members (see Quote 1, 2a, 2b and 3. Quote 2b can be found in Appendix 16).

---

**Quote 1, Focus Group One:**

**Bobby:** Unable to deal with painful memories from childhood?

**Alan:** Oh I don’t know, I don’t know about that… (whispers).

**Bobby:** My Dad used to beat the crap out of me but I never thought anything of it.

**Alan:** No

**Bobby:** It didn’t bother me.

**Alan:** is it..

**Bobby:** But may be in the sub…

**Both say together:** [may be in the subconscious]

**Bobby:** Who knows?

**Alan:** That’s what I’m thinking. I’m going, am going to put it there if you’re alright with that?

**Bobby:** I’m happy with that yeah.

**Bobby:** ‘Family when growing up’

**Alan:** Family when growing up.. it’s sort [of saying the same

**Bobby:** I guess that could be] parental influence, yeah why not. [Role models.

**Alan:** Yeah, yeah…]
Bobby was at first dismissive of the violent abuse he suffered by his father however, he realised during the focus group discussion that this may have had an impact on his drug use, which also began in his childhood.

Bobby’s dismissive attitude was prevalent throughout the focus group and I wondered why this might be. He considered that his mental health diagnosis of autism affected his ability to form relationships and that it caused him to struggle with his emotions. There was indeed a sense of isolation about Bobby’s life during his childhood and then later in his adult years. For example, he talked about his search to find other children at school who might also be into drugs - was this ‘search’ to belong to an alternative group because he did not feel as though he fitted in with the mainstream school children? Bobby was able to develop a good relationship with Alan during the focus group discussion. They completed each other’s sentences, laughed in appropriate places at each other’s humorous comments and co-operated with each other during the task. Bobby became less dismissive as the discussion progressed and he built a good rapport with Alan. Modern attachment theory (such as Crittenden, 1992) suggests that abuse, such as physical violence by a parent, during childhood can lead to emotional problems, attachment issues and difficulties with relationships throughout the lifecycle. This theory could also account for Bobby’s emotional and relationship problems that he mentioned. (See Quote 1, 2a and 2b. Quote 2b can be found in Appendix 16).

**Quote 2a, Focus Group One:**
Bobby: *(Interrupts Alan)* I’m autistic. I can’t form relationships so erm, I suppose a lot of other kids at school got a lot of fun and pleasure out of sports which I couldn’t do. And so perhaps some people get euphoria out of playing sports but I can’t because my you know fundamental brain make up or whatever.
Clare in Focus Group Two explained in Quote 3a (and 3b in Appendix 16), how the sexual abuse she suffered in her childhood by her Grandmother’s partner continued to exert an impact on her in her adulthood, which she felt had led her to Class A drug use. Clare disclosed the abuse to her family in her adulthood but they were dismissive of her claims, which she found extremely distressing and which caused tension in those relationships. Clare was not alone in citing drug use as a means to cope with difficulties and traumas experienced in her childhood. Flores (2012) and Khantzian, Mack, & Schatzberg (2007) view addiction as a coping mechanism to deal with trauma, relationships and other difficulties throughout life.

**Quote 3a, Focus Group Two:**

**Clare:** Eh (pauses) yeah, (pause) my it’s like a whole host of things like you know from back in the past. Things that you’d thought of, yeah things that I felt I had dealt with or situations I’d been through where you thought you know what I’m cool with it and erm, actually realising, actually realising that I hadn’t dealt with it was a stress in itself. It oh god so I’ve spent the last (whispers whilst calculating the years) like 11 years thinking (Samuel laughs)I’m alright, no one can’t tell me nothing, I’ve dealt with the situation, erm, I’m on top of things and it came to light and, and then just realising hold on a second (pause) I’ve actually I’m getting in to arguments with family members and I’m like arguing with you lot where’s, where’s this coming from like. (Pause) Why are we I arguing? (?). Actually it was one. It was leave it. Basically when I was erh, between like the ages of 4 and 8 I was molested (pause) by my Gran’s partner anyway to cut a long story short, years have gone down the line, like it had come out but been put back in, come out been put back in erh, but I never, it was never actually addressed by then any adult you know what I mean. It was like no way it could not possibly be happening. Anyway so to cut a long story short my Gran moved in to my mum’s old house (?) moved in with her partner, with her husband and erh they were actually living in my old bedroom (says slowly in disbelief).

**5.2.3.3 Damaging relationships with parents**

Difficulties experienced by participants in childhood also included broken relationships with family members in particular with parents, for example an absent father. Participants experienced these relationships with distrust and they also felt isolated from others. Difficulties with relationships continued into adulthood, (which is discussed in section 5.2.4). Flores (2012) suggests that those with substance use addictions have experienced attachment insecurity with parents or primary care givers.
Although the research cannot categorically determine the attachment strategies of the participants in this research it is clear that participants had suffered harmful and broken relationships with parents and close family members during their childhoods. Farrington (2015) also recognises that disruptive family environments, including absent fathers are risk factors, involved in the development of offending behaviour.

5.2.3.4 Familiarity with substance and drug use (in childhood)

Participants spoke about substance use during their childhoods and for some there was acceptance or encouragement by parents, another form of abuse and neglect. For example, Tina in Focus Group Four (Quote 4) talked about her first memory of getting drunk in her early childhood when her parents gave her alcohol. It is unclear if this was a regular occurrence although she implies it was part of her childhood “lifestyle”. Research suggests that substance use in early childhood can increase the likelihood of later substance use problems in adulthood although other factors, such as family environments which are abusive and where alcohol problems are present, are also influencing factors (Mitchell et al., 2011).

**Quote 4, Focus Group Four:**
Tina: I’m not talking for anyone else other than from myself but yeah me it was mainly peer pressure and erm, family. And, erm the, the childhood I was brought up in you know like the lifestyle so–
PI: Do you want to say a bit more about, about that?
Tina: Well like –
PI: Anything in particular –
Tina: I’ve always seen drugs and alcohol, drugs and alcohol have always been part of my life like, like as far as I can remember like I can’t I can remember from like my first drink you know what mean I was about 8 or 9.
PI: Ok. And was that going on in your family were their members of your family - ?
Tina: And that was from my family yeah it was actually my Mum and Dad that give me my first drink and you know I got so blot toed anyway but that’s not the point. Yeah it was my Mum and Dad that actually give me my first drink and that was from when I can remember like from when like the first time I got really ever drunk.
5.2.3.5 Familiarity with crime/criminality

In Quote 5a and 5b, Kevin talked about growing up in a family criminal network and that he had murdered someone in his childhood. He then spent the remainder of his childhood in secure institutions. Farrington (1995) and Farrington (2015) found that criminality among family members such as a father, mother or siblings were predicative of offending behaviour among boys. The risk factor increased for same sex relationships, for example, a father with convictions was a strong predictor that his son would be involved in criminality. Other longitudinal studies examining developmental protective and risk factors have found that large family size and inadequate parenting are also among predictors of offending behaviour in males (See Farrington, 2015, for an overview of developmental risk and protective factors in offending behaviour).

**Quote 5a, Focus Group Three:**
Kevin: …but when I was a kid I kept got in trouble a lot with the police, at age of 11 and in the end when I bunked off school a lot and they put me in to a community school and I, I got I was there for a year and I got kicked out of there then I got nicked for murder at the age of 14 right in a place called (names the place) a (names an institution) in (names a date) that was right then erh, erh I was in another community school at that time and then I got put into a secure unit. So where I’ve done a lot of time in like, like the community thing, prison…

**Quote 5b:**
Kevin: Class A I went straight, I went straight to Class A because what it was when I was younger I thought it was when I was younger I was always a little fucker sorry my language. I was always ducking and diving and nicking things and that yeah I was a little thief yeah and a bad little thief yeah (laughs) yeah alright. Yeah I thought it was normal coz my Dad I used to see my Dad cutting safes open (pause) because my Dad was a criminal an all. He’s not now he’s been out of trouble for 30 years and like he’s as straight as they come now but I thought it was all normal the circles I come up and when I was younger like alright I had confidence in thieving but when it was nick and grab I didn’t have that confidence so for me if I used a bit of gear it used to give me, I can’t explain it, it give me that sort of glow basically I thought I was invisible so I’d go in and mix that’s the reason I started using.
5.2.4 Superordinate theme 2: Struggles with complex and tense relationships

Participants continued to struggle later on in life with relationships, with their parents, family members, partners, friendships and with their children. In some cases these were linked to their childhood experiences of those relationships involving parents or childhood family members. Some participants linked these struggles to their drug use.

5.2.4.1 Relating in a negative way to others

Some participants talked about their difficulty relating to others, this included difficulty trusting others, feeling different to others or feeling they did not belong. Kevin in Quote 6 discussed his distrust of others, for example, he was apprehensive about accepting help from professionals for his problems and he felt uncomfortable in groups. The issue of trust was further evident during the course of this focus group in the interactions between Kevin and David, (which is detailed in Chapter 5.3 sections 5.3.4.4 and Chapter 7, Section 7.6.3).

Quote 6, Focus Group Three:
Kevin: You know what I mean? Basically I’ve been told yeah I’m anti authority sort of thing anyone who’s doing a figure of authority not meaning yourself, or psychiatrists, psychologists or any you know what I mean. I’ve had that all my life and I’ve put up the barrier up, I wouldn’t let go but I’ve come out and like I’ve said fuck it I ain’t like that I want to get all the help I can get. One, one I’m a PPO I thought yeah I’m a PPO they’re on my case but I’m taking advantage out of it, no disrespect to you, I’m milking it. If I can get something out of it, all this to me this is free, so I’ll come to these meeting and it helps me.

Both Bobby and Alan in Focus Group One discussed feeling isolated and different to their peers even among their drug taking associates. Their distrust of others was evident. These feelings were present in their childhood and in their adulthood. This is illustrated by Alan in Quote 7a (and 7b in Appendix 16). Alan also mentioned that his mother was a psychiatrist and that he had researched reasons for his drug use, this may be where his understanding of attachment theory had come from. He felt these feelings of distrust were present before he encountered drug use. However, it was unclear
whether Alan accepted that attachment theory could offer an explanation for his problems with addictions.

**Quote 7a, Focus Group One:**

**Alan:** But I’ve always been trying to cover up and looking at it from a sort of err, a psychologist point of view it’s got to do with something my Dad leaving the house between I was 0 and 5 and I grew up not trusting adults and it’s you know about attachment theory. These sorts of things, so erm, yeah so I’ve always been trying to fit in…

For both Zoe and Tina in Focus Group Four, there was evidence of them feeling different to others and of them feeling as though they would not fit in with others. When Tina talked about her mental health condition there was a sense that she felt very different to others including her family. She used derogatory labels for herself such as ‘mad’ and ‘crazy’ which is how she thought her family also viewed her (See Quote 17). Zoe (Quote 34a and b in Appendix 16) felt different to her family and to others in her culture because she felt she had not conformed to her traditional gender cultural expectations, which included having a partner and children. Participants felt uncomfortable about themselves and different to others. Khantzian (2012, 2014) and Flores (2012), suggest links between drug use and fragmented and damaged selves.

### 5.2.4.2 Tensions with parents in adulthood

When participants talked about their relationships with parents there were many contradictions, for example, some participants viewed these relationships as important but they also found them distressing. Attachment theory suggests that the strength of a bond does not predict the quality of it. Some participants used drugs to cope with these relationships (Flores, 2012 and Khantzian, 2014).

For example, both Tina and Zoe in Focus Group Four, felt their families were important to them but they exhibited emotional turmoil and tension when discussing these relationships. Tina talked about how important her parents were and mentioned occasions when they had been supportive but also spoke about rejecting their support. She created the word “smothercated” to describe her relationship with her parents and
cited them as being a source of her relapses (See Quote 8a and for Quote 8b see Appendix 16).

**Quote 8a, Focus Group Four:**
*Tina*: Yes. Well yeah in my personal experience I got clean *(pause)* like from getting away from someone and they took me in *(Tina’s parents)* and just they were running my brain ragged you know like and getting me to do like stuff that I should have been doing that I know I should be doing now. It was too much pressure you know –

*PI*: From a partner? –

*Tina*: No from my family from my parents and like they wanted me to do their routine and so I ended up going back to my partner and erm, thinking you know I’d rather go back than, than I don’t know do what they wanted me to do. *Cuz* I had more freedom I, you know like I was able to do what I wanted to do when I was with my partner but when I was at my parents it was like right you *gotta* be here you *gotta* do this you *gotta* do this and it all just that got to me and it all just sent me back so even though they had their best intentions at heart for me but it just at that time it just made it worse for me.

Zoe like Tina talked about the importance of her family but tension and emotional turmoil surrounded these relationships. Zoe struggled with her relationships with her parents. It appeared she felt a sense of loss with those relationships that she struggled to accept. She distanced herself from close relationships. She discussed emotional pain and trauma which she linked to ‘family problems’ and cited these problems as being the reason for her drug taking. Zoe struggled to provide a coherent explanation of what those family problems were, she spoke in a quiet voice and in a very disjointed manner. This might have been for several reasons; her mental health condition, her continued drug taking, her lack of engagement in the task, (she commented that she “could not be bothered” with the task), her physical demeanour appeared lethargic and her recent isolation from people (See Quote 12). However, there was further evidence that discussions about her family were emotional for her. In Quote 35 in Appendix 16, Zoe chose to talk about her strained relationship with her father, when this was not related to the card sort topic. Holmes (2006) suggest that those who have experienced trauma/responses can struggle to coherently narrate their stories, if they have not resolved/processed their trauma responses/memories. Smith, Flowers and Larkin (2012) note that when topics are emotional and of importance to participants this can lead to more incoherent speech. A combination of the factors outlined above may account for Zoe’s incoherent narrative.
5.2.4.3 Negative and positive family relationships

Contradictions were also evident among participants’ wider family members. Kevin in Focus Group Three, discussed the ongoing conflict in his family in relation to criminality. However, he also talked about support from one of his sisters. He appeared to value his family and talked about them frequently throughout the focus group. Kevin exhibited a strong attachment to his family. He was affectionate when he talked about them. For example, he considered himself to be “lucky” to have his family and regarded himself as coming from a “good” family. He also talked about his loyalty towards his family, which he felt had deterred him from stealing from them during his entrenched drug use (see Quote 36 in Appendix 16).

Some participants also demonstrated wanting to repair and rebuild relationships with family members that had been strained further during their drug use. Both Tina and Kevin’s strong attachments to their families were surprising considering, from an outsider’s perspective, the harmful elements present in both families (e.g. Kevin was involved in a criminal family network and Tina had been given alcohol by her parents in childhood). However, Attachment Theory suggests that insecure attachments can be stronger than secure attachments.

Not all participants felt their family members were important. For example, Ellen in Focus Group Three, referred to her mother as a “dog” and cited her relationship with her mother being a reason to relapse or use drugs. In Quote 9 Kevin, Ellen and David discussed their families. David clearly stated that he did not have any family and he interrupted Kevin who tried to talk about his family. David was dismissive of the subject matter on more than one occasion. Was this because David did not want to talk about his family? David cited using drugs as a means to cope when his mother died. Was it too painful for David to hear about Kevin’s large and supportive family when David did not have this? The topic of ‘family’ was clearly an emotive one for David although he provided little detail as to why this might be.
Quote 9, Focus Group Three:
David: ‘Being able to cope when upset without having to use drugs?’
Ellen: That’s very important. Mmm.
David: That’s very important. And so is a supportive family init?
Kevin: Yeah.
Ellen: Mmm.
Kevin: If you have it as Ellen’s said. A lot of people haven’t got… have you got, have you got supportive? (Asking David and Ellen).
David: No.
Ellen: Ish.
Kevin: But not all of us have got it. I’m lucky I’ve got a lot of support.

5.2.4.4 Complex and tense relationships with partners

Participants spoke at length about relationships with partners, which were volatile, violent, strained or evolved around substance misuse. Some participants acknowledged that these relationships were unhealthy and some further recognised that they were not helpful in their recovery. However, this was not the case for all participants. For example, Tina in Focus Group Four, discussed her relationship with her long term partner who still continued to use drugs. The relationship was volatile, however she did not consider that the relationship was a barrier in sustaining her recovery but rather considered it to be supportive in her rehabilitation (see Quote 8a and for Quote 8b see Appendix 16). Zoe from the same Focus Group, spoke about her partner as though he had died, she later explained that her partner had moved to another country. However, sometimes she spoke as though he was still present in her life but acknowledged on other occasions that she was not in a relationship. Like her relationship with her parents there was a sense of loss about this relationship that she struggled to accept.

Alan and Bobby in Focus Group One and Ellen and Kevin in Focus Group Three all acknowledged that some relationships were not healthy and could lead to relapses. Both Kevin and Ellen had opted to remain single during their current recovery because they considered being in a relationship posed a risk to their recovery. Ellen’s previous relationship had been violent and she cited this as one of the reasons for her relapse after being in recovery for 11 years.
Clare and Samuel discussed their relationships about their current partners in Focus Group Two (Quote 10a and for Quote 10b see Appendix 16). There was a shared understanding between Clare and Samuel about their frustrations with their partners. They both referred to those relationships as “double edged swords”, indicating the precarious nature of those relationships for them. Samuel was in the process of an ongoing dispute with his partner and he was unsure if he was still in the relationship. He talked about the risk he felt the relationship posed to his recovery. Was he using the group discussion as an opportunity to work through his emotions and thoughts to decide if he should remain in the relationship?

Samuel exhibited flirtatious behaviour towards Clare during the focus group. They often glanced at each other and laughed when topics about partners (and other topics) were presented. Samuel was very theatrical when he was describing his disputes with his partner. He used vivid imagery and metaphors, his voice was animated and he constantly gesticulated. He also directed his conversations towards Clare. Did Samuel emphasise his frustrations with his partner because he was flirting with Clare? He sat very close to Clare at times and I felt that he was over familiar with her. Clare appeared to reciprocate the humour and there was a vibrant rapport between them. However, on one occasion Samuel invaded Clare’s personal space by leaning over and putting his arm across the back of her chair, she recoiled immediately and appeared to be very uncomfortable.

*Quote 10a, Focus Group Two:*

**Samuel:** I’ve had it from driving, just driving. I’m driving past where I used to use. (?) I’m talking about the past. This time round I’ve devised a system to help me, which is a higher power but before I’ve had it where I’ve been clean for a long time and I’m driving and I’ve got money in my hand and I’m not thinking about it or maybe I was but I didn’t even realise *(Clare also says the word ‘realise’)*, I was thinking about it and I’ve driven past somewhere and it and it’s just, *(pause)* just like, the whole world’s gone dark you know. It just sort of comes from you just get that feeling and you know you’re going to use coz it just comes over you think, a tingling back you’re just thinking about that nice aspect of using. Yeah you’re not running through the whole picture because that thought process has been closed, locked off, by Satan or whoever is controlling these negative forces yeah. It’s been locked off. So all you’re thinking about is the *highs* of it. You know that’s all that exists. That’s happened a lot of times for me, *no, no* apparent reasons. You know that used to happen a lot.
5.2.4.5 The role of friendships in drug using and non-drug using lifestyles

Participants spoke at length and in depth about friendships. The role of drug using friends is discussed in this theme and the role of wider friendships supporting recovery will be discussed in the theme, ‘What helps in recovery and to prevent lapses/relapses’ in Section 5.2.9.

Some participants considered drug using friends posed a risk to their recovery and considered those friends were not part of their friendship or network groups. However, some participants disagreed with this. Research has found that drug using associates can pose risks to recovery (Brown, Tracy, Jun, Park, & Min, 2015; and Daniuilaityte et al., 2007).

For example in Focus Group Two Samuel, Clare and Moses discussed friendships and their role in recovery (see Quote 11a and for Quote 11b see Appendix 16). Samuel stated that he did not have friends, Clare was surprised by this admission and challenged him. Samuel went on to explain that he considered past friends as either criminal or drug taking associates whom he did not trust. He also considered these
associates posed a risk to his recovery. He considered that his support came from his family and his religious faith.

**Quote 11a, Focus Group Two:**
*Samuel:* Erh, ‘not having friends’. *(Contemplative tone)*
*Clare:* *(Laughs loudly when she looks at Samuel).*
*Samuel:* I would question that. You know why. I haven’t got friends. But then again all my friends are not friends they’re associates.
*Clare:* Associates.
*Moses:* *(Agrees).*
*Samuel:* So not having friends are right…(?) the true meaning of not having friends means…
*Clare:* Mean you don’t have…Yeah man.
*Moses:* Yeah.
*Clare:* Erh.’ Friends’. Argh, you see now again, when you say friends if I’ve got my friends and they are around I don’t even thinking about it coz I’m my, we’re just on a different vibe. True friends I’m talking about. So when I’m around my friends its…
*Samuel:* But the thing is I haven’t got any friends. *(Long pause)* I haven’t got any friends. That’s the honest truth. I’ve got acquaintances and, and a sort of my Mrs, you know and an ex. I haven’t got any friends. *(Long pause)* My lifestyle is derived from me just getting on courses that’s why my time is so hidden. Like if I go back to what I call friends they are either dealing in fraud, selling drugs, doing this or [doing that.
*Clare:* Yeah, yeah].

Ellen and Kevin in Focus Group Three, also discussed the role of past drug taking friends whom they considered to be associates and not helpful in their recovery. However, Kevin still considered his criminal associates, some of whom were his family members, to be his friends. He contradicted himself about whether these criminal relationships affected his recovery. Sometimes he considered they posed a risk to his recovery and on other occasions he rejected this notion. For example in Quote 37 Appendix 16, he recognised that getting involved with a family member who was involved in crime could pose a risk to his recovery, although it required another family member to support him in making the decision to avoid this involvement. The contradictions in Kevin’s narrative might reflect the conflict between his loyalty and strong attachments towards his family and his commitment to remaining in recovery, which for him included avoiding criminal activity. For Kevin, his drug use and criminality were linked (See Quote 5a and 5b). This lends support to a more
multifaceted link between Class A drug use and criminality than the economic model would suggest (Hough 1996, Hammersley, Forsyth, Morrison, & Davies, 1989; Menard et al., 2001; Bennett, 2007; and Bennett & Holloway, 2009b).

Tina in Focus Group Four however considered both her non drug taking friends (whom she had met in rehabilitation) and her drug taking friends to be part of her friendship networks and felt both were supportive in her recovery. Kevin and Ellen considered friendships from rehabilitation were supportive providing they continued to abstain from drug use. I wondered if the differences in these opinions reflected the length of recovery time among participants. That is, those in longer term recovery were able to recognise the risks for relapse that drug using friends could pose.

Some participants avoided friendships altogether. Zoe in Focus Group Four, talked about isolating herself from others and opted for ‘plutonic interactions’ only. A previous relationship had left her feeling depressed and she mentioned domestic violence, although it is unclear if she had experienced such violence. Zoe experienced consistent difficulties in her relationships, including with her parents and this might explain her reluctance (and inability) to form new relationships (see Sections 5.2.4.2 and 5.2.4.4 and Quote 12). As previously discussed Samuel talked about not trusting past drug taking criminal associates. Did Samuel not know how to form non-drug taking and non-criminal friendships? Flores (2012) suggests that those with substance use addictions struggle with relationships and that substance misuse can also lead to further isolation and problems forming and maintaining relationships.

**Quote 12, Focus Group Four:**

**Zoe:** Yeah ] Well I mean erm, you were saying earlier about erm, your family and then erm, your partner but that’s probably why I’m single because the minute you said your partner I thought Oh *(pause)* that’s why I’m not facing domestic violence but everyone I know in a relationships got domestic violence so that’s why I’m single but *coz* I don’t care I just can’t be bothered. Erm.

**Tina:** Yeah. With a relationship?

**Zoe:** No with anybody.
Quote 12, Focus Group Four continued from previous page:

**Tina:** [Or just getting involved with anyone.

**Zoe:** Apart from… No I can’t be bothered from my family my Mum-

**Tina:** What are they hassling you?]

**Zoe:** Well no she’s left me alone and she’ll let me do what I want but she watches me and she can tell what it’s like when I was on drugs, what I’m like on drugs and what I was like before so she’s constantly nagging me and watching me but erm I think because of that and constantly being under surveillance I just assume everybody’s watching me and I really can’t be bothered even just erm I can’t tell the last time I’ve talked to somebody. *(Tina’s tone changes to agreeing sounds of sympathy). No I can’t be bothered I’d just have normal plutonic interactions than anything personal. But then I think current relationships have made me realise that one of the things that I do miss is the person I used to confide in a lot doesn’t speak English, and we never used to speak in English together and I now speaking English so may be it is unable to deal with current relationships with a partner has left me feeling depressed because we don’t really speak anymore because *(Tina: Yeah) of you know a misunderstanding and you know if I’m in so much trouble here why didn’t I just go erm so it’s in there somewhere [it’s not family…

5.2.4.6 Being a parent - the impact on relapse and recovery

Participants, some of whom had regular contact or custody of their children despite their heavy drug use, found discussing their own children an emotional topic. They felt that managing the relationships with their children was stressful. For some this could be a trigger to relapse for others it was a motivation to remain abstinent. What is concerning from these findings is the impact of these relationships on participants’ children. This will be considered further in Part Two.

Samuel and Clare in Focus Group Two, found parenting stressful and exhibited a shared understanding of those stresses. They both looked at each other and laughed when questions about children were posed, followed by lots of verbal noises and exclamations of exasperation. When they were deciding where to place the topic about ‘being a parent’ they wanted to create a new category of importance on the card sort task (see Quote 40, Appendix 16). Samuel talked about having to learn from his therapist how to manage his relationship with his daughter so that he did not repeat negative patterns he had learnt from his father (See Quote 26). Family systems theorists such as Dallos and Vetere (2009) consider the impact that distorted and
confusing communication patterns can exert on future generations in a family unit. Clare considered that when her son’s behaviour was challenging it could be a trigger for her to use (see Quote 40 Appendix 16). Others felt that managing children regardless of their behaviour, could be stressful and cause relapses.

In Focus Group Four Tina, who no longer had custody of her children, talked about her struggles to communicate with her son, who had a diagnosis of ADHD. Ellen in Focus Group Three, discussed her difficulties being a mum to her new born. She had suffered postnatal depression which lead her into heavy Class A drug use and addiction (see Quote 38 in Appendix 16). Kevin felt that he would relapse if he was denied access to his son. Flores (2012) suggests that drug use is a coping mechanism to deal with relationships.

5.2.5 Superordinate theme 3: Challenges and struggles with mental and psychological health

5.2.5.1 Mental health diagnoses

Participants discussed a range of mental health diagnoses and the impact these had on them. They talked about struggles with depression, anxiety and stress. Having a mental health diagnosis was prevalent across focus group members and included diagnoses of bi-polar depression, schizophrenia, autism and personality disorders. This is supportive of the wider literature on substance misuse and mental health (Strathdee et al., 2002) and substance misusing offenders (Ruiz, Douglas, Edens, Nikolova, & Lilienfeld, 2012). Participants also talked about the impact that their mental health and well-being had on their drug use.

5.2.5.2 The impact of mental and psychological health

Bobby in Focus Group One, talked about how his diagnosis of autism impacted on his ability to form relationships and understand emotions throughout his life including during his childhood. Tina in Focus Group Four, spoke about the impact that her diagnosis of bi-polar depression had on her life, she struggled to communicate with others, to relate to others and to herself. She was aware of her mental health diagnosis and referred to herself as “crazy” and “mad”.

Zoe’s anti-social behaviour and her mental health problems had led social services and the police to intervene in her life. She further talked about her struggles with her mental health, for example, she felt she was being watched and was under surveillance (See Quote 12). This may be imagined feelings of paranoia or feelings stemming from, or exacerbated by the authorities, drug rehabilitation services and her mother intervening to help her. The paranoia may also be part of her continued drug use. It is possible that a combination of these factors contributed towards her feelings (see Quote 12 and for Quote 31 see Appendix 16).

5.2.5.3 Links between mental or psychological health and drug misuse

Tina from Focus Group Four, linked a previous relapse to her mental health problems. In Quote 13, she talked about being overwhelmed by the speed and ferocity with which she had embraced her previous recovery leading her to relapse. This speed and ferocity was also evident throughout the focus group, for example, she spoke very quickly, emotively and dominated the discussions.

**Quote 13, Focus Group Four:**

*Tina:* Them two times I’ve finished rehab I’ve completed I was in sobriety for like a year and two months and everything was going well. But I was overwhelmed by what I was doing it was doing like AA meetings and CA meetings and NA meetings and it was like *yeah I’m taking it all in in there (excited tone, animated)* and grabbing as much info as I could you know and I got caught up in it all and that, that, it set my mind –

Ellen in Focus Group Three, suffered (undiagnosed) post-natal depression after her son was born and felt unable to ask for help. Ellen considered that her Class A drug use was to cope with her mental health. Zoe in Focus Group Four, was also unable to ask for help for her mental health problems and therefore turned to drugs to cope. Participants in Focus Group Three and Four talked about using drugs to cope with depression (See Quote 14 and for Quote 38 and 39 see Appendix 16). Research has suggested several links between substance use and mental health (Centre for Substance Abuse Treatment 1994, as cited in Flores, 2012). This is discussed further in Chapter 6.3.
Quote 14, Focus Group Three:
David: ‘Feeling depressed’
Kevin and Ellen: Yeah. (Talking over each other).
David: That’s number one isn’t it?
Kevin: I’d normally have a fix on a depression.
David: Feeling depressed that’s me I want to use up.
Kevin: He done your “reddies” so …
Ellen: And then you ’re even more depressed, it’s a cycle. (Laughing).

Drugs were also used to cope with a range of painful and difficult emotions, such as anger, stress, despair and loneliness as well as diagnosed mental health conditions. For example Ellen, David and Kevin discussed using drugs to deal with painful emotions (See Quote 19), and Zoe discussed using drugs to cope with emotional turmoil related to her family (See Quote 15a/b and for Quote 34a/b see Appendix 16).

Quote 15a, Focus Group Four:
Zoe: Some sort of emotional turmoil. Erm.

Quote 15b:
Zoe: Erm family, parents erm well I’m an older child, the eldest erm, erm, and it’s, it’s personal experience basically that you know that it must have being going on a long time, I’d notice on a day to day basis and weekly I just couldn’t erm, manage and emotionally I turned to drugs and then as a erm, secondary measure to, to medicine.

In Quote 40 in Appendix 16, Samuel and Clare discussed how stressful they found parenting. Clare was emotional during this and struggled to fully understand the question. She was dismissive about her anger towards her son’s behaviour but spoke about using drugs to cope. She mentioned anger being a trigger for using drugs on other occasions too. Clare also talked about ensuring her home life was “just right” in Quote 40, I wondered why this might be. Did her son’s behaviour threaten some sort of stability in her home life? She also talked about hiding herself away behind closed doors. These aspects might reflect her need to feel safe and secure in her own home because she did not feel this way growing up, due to being sexually abused by her Grandmother’s partner in her childhood bedroom. Vetere (2014) suggests that anger
can mask a person’s own feelings of shame and fear and substance use can be a means to self-protectively numb or diminish those feelings.

Khantzian et al. (2007) suggests that drug use is a means to cope with emotions (especially anger) and external realities, particularly stressful ‘realities’. For example, Clare struggled to deal with the sexual abuse she suffered as a child, David struggled to deal with his girlfriend’s death and her family’s attempts to murder him, Ellen struggled to cope with being a Mum and with post-natal depression and Samuel spoke about feeling distressed about a car accident. They all used drugs to cope with these stressful events and the emotions they felt in relation to these external ‘realities’.

What is also interesting to note is how participants experienced positive emotions and the links of these to their drug use. Some participants talked about taking drugs to seek pleasure because they struggled to feel positive emotions without the use of drugs. For example, Bobby talked about wanting to feel “euphoria” because he felt unable to do so like other children, because of his diagnosis of autism. Some participants who talked about chasing an initial “buzz” from their first Class A drug use went on to talk about continued drug use to block emotional pain. Samuel in Quote 16 and Zoe Quote 15b talked about maintaining some sort of emotional balance. David sometimes used drugs to reward himself (see Quote 20b in Appendix 16). Schore (1994) suggests that affect regulation also applies to regulating positive emotions. Therefore, drug use may be about regulating positive affective states as well as negative ones (Healey et al., 2009).

**Quote 16, Focus Group Two:**
**Samuel:** Looking for that, chasing the dragon man looking for that initial buzz that you got *(Moses: Yeah, yeah)* that ecstasy feeling that you had. *(Moses and Clare agreeing)* erm, yeah and, you with me and its actually unfortunate because I discovered through the use of crack and heroin I got you know there were times that I could use and put it down maintain a, a nice level but it probably after using so much I’d be maintaining a nice level without been paranoid coz I used the heroin to maintain a erm, a level thing.
5.2.5.4 Managing mental health in a healthier way

Some participants were able to talk about managing their mental and psychological well-being in a healthier way without using drugs. This involved an understanding of their behaviour, emotions and thought processes. Ellen in Focus Group Three, talked about needing to have a strong relationship with “yourself” and being a “friend to yourself” in her recovery. In Focus Group Four Tina and Zoe talked about monitoring their behaviour. Tina used encouraging positive self-talk to do this, kept a diary and attended dual diagnosis groups, which helped her to understand her condition (See Quote 17a and for Quote 17b see Appendix 16). Some participants had counselling to help with their mental health problems. Davidson et al. (2008) found similar management techniques among those recovering from mental illness and addictions.

Quote 17a, Focus Group Four:
Tina: Yeah and erm, trying erm, to stay sane. I know that’s sounds like mad but just knowing that when I do think of mad things in my head, because like erm, (pause) I’m bi polar and I’ve got like a personality disorder I didn’t know all this out do you know what I mean I’m only finding out stuff about myself and looking in to it so basically not only am I having a relationship with everyone else but I’m rebuilding a relationship with myself erm. And erm, I think that’s important as well getting to know yourself.

5.2.5.5 Struggles with other addiction/addictive tendencies

Participants spoke about other addictive tendencies in their lives including with other substances. Kevin felt he had an addiction to food, Samuel mentioned a gym addiction, Alan talked about sex and relationship addictions and other participants mentioned their struggles with alcohol and other substances. Some participants recognised that they had addictive tendencies, which could be transferred onto other aspects in their lives including the use of other substances. The main psychological theories mentioned in Chapter 3 suggest that the development of addiction lies within the individual and relationships and not within the addictive nature of the substance itself. Flores (2012) further outlines the problem of cross addiction where one addiction is merely replaced by another. It would appear that this was the case with participants in the focus groups.
5.2.6 Superordinate theme 4: Criminality – pathways, turning points and U-turns

Participants discussed many different types of links between their Class A drug use and criminality, which, also included violent crime. These were interesting findings given that the premise for the Drug Interventions Programme was based on a perceived link between Class A drug use and crime, primarily that drug misusers committed acquisitive crime to fund their addiction. Some participants suggested that criminality could drive them back in to drug use, others recognised that they were involved in crime before they were involved in Class A drug use and others suggested that there were some underlying causes driving both their drug use and criminality. Some participants rejected any link between drug use and crime, although this mostly came from one participant, Zoe. She did however talk about how her involvement in drug use had led her to become involved in anti-social behaviour, which involved the police and social services intervening in her life. Samuel in the Quote 11 talked about how criminality led him back into drug use. He went on to elaborate further in the group discussion where members suggested that drug use and crime somehow influenced each other (See Quote 18). These findings lend support to theories, which suggest multiple links between drug use and crime (Hough, 1996; Menard et al., 2001; Bennett, 2007; and Bennett and Holloway, 2009b). Studies by Farrington and colleagues have shown other links that predict or increase the risk of offending behaviour. The strongest developmental predictors of offending behaviours are concerned with family environments and parenting, in particular multiple changes in parenting figures, a parent leaving before the age of 10 and a lack of parental supervision, such as parents being unaware of where their children are (see Farrington 2015, for an overview). Many of the participants experienced these ‘risk’ factors.

Quote 18, Focus Group Two:

Clare: ‘Not committing crime’, definitely. Anyone else disagree? Like –
Moses: Yeah.
Clare: That committing crime its one road init? (?) Friends?
Samuel: No I totally agree with that. I’m just, just saying that it’s surprising that somebody else thinks the same. It’s brilliant.
5.2.7 Superordinate theme 5: Reasons to use drugs, to lapse or relapse – a coping mechanism

Drug use was a coping mechanism for participants to deal with a range of issues. These included, to feel better because they wanted to stop feeling bad, to stop emotional pain, difficult memories or painful thoughts, to deal with mental and psychological health issues, to cope with traumatic events, to cope with stressful relationships and to cope with everyday life. Some of these have been discussed elsewhere and are therefore not repeated here.

5.2.7.1 Block out painful or stressful thoughts

Ellen, David and Kevin in Focus Group Three, talked about using drugs to deal with painful memories and thoughts they felt unable to cope with (Quote 19a and for Quote 19b see Appendix 16).

5.2.7.2 Drug use to cope with mental health and/or difficult emotions

Drugs were used to deal with difficulties with emotions. In Focus Group Three participants talked about how drugs gave them comfort, warmth and love, for example, Ellen hugged herself when she described the feeling of warmth that drugs gave her and Kevin described how he “fell in love” with drugs and he thought the drugs loved him “but it didn’t, it loved money” (Quote 19b, Appendix 16). Kantzian and Weegmann (2009) and Flores (2012) suggest that those with addictions have strong attachments to their substance of choice. Reading (2002) considers addiction to be a miss-attachment of affectional bonds and Gill (2014, p. 105) suggests that giving up an addictive substance is like “saying goodbye to a loved one, a main carer or a partner”. Both Ellen and Kevin’s experiences reflected these sentiments.
Quote 19a, Focus Group Three:
Kevin: To block out feelings. People to… To me personally to block out feelings to how I felt basically—
P: Is that how you felt from—
Kevin: How I was before on drugs then from when I was using drugs I’ll be truthful like if it weren’t addictive we would most probably all be on it now I think the whole world would because It’s the best mind blocker going I don’t care what anyone says right—
P: So it blocks emotions and thoughts?
Kevin: It blocks everything out when you’re on it you don’t think you don’t care about nothing you aint got no care in the world the only thing you care about is getting your next fix. Because you don’t want that feeling to go away it gives you that warm glow
P: Right Mmm.
Ellen: The Ready Brek glow—

5.2.7.3 To cope with different types of stress – anything and everything can be a trigger to use

Some participants recognised that they needed intensive support just to cope with life, without using drugs. Khantzian (2012), Khantzian et al. (2007) and Flores (2012) suggest that those with severe addictions have difficulty dealing with mild setbacks in life such as failures in relationships or disappointments in employment. For this group it was not just disappointments or mild setbacks but dealing with everyday life, drug free that posed problems for them. Ellen talked about the fear she felt when the effects of her drugs subsided, (see Quote 19b in Appendix 16). Both Ellen and Kevin talked about the intensive support they felt they needed to achieve living a ‘normal life’ after leaving intensive support in residential rehabilitation. For example, Ellen struggled with paying bills and filling in forms. David considered that “everything and anything” could be a trigger to use drugs (see Quote 20a and for Quotes 20b, 20c and 20d see Appendix 16) and Clare and Samuel in Focus Group Two, talked about how the “shock of the weekend”, “making loads of money” and “driving past somewhere” could be triggers to use.
Quote 20a, Focus Group Three:

Kevin: Erm, bad news, erh bad news, erh getting back into old company, hanging out you know with old friends basically getting replaceant whatever you’re doing and that at the moment to stay clean if you sort of with me if I slack off that ain’t good for me you know what I mean so I’ve got to keep busy by coming to things like this, appointments and all that but for me to relapse it would be like thing like something like, they said I couldn’t see, if my ex partner said I couldn’t see my boy no more. Because I’m not good with bad news I don’t know how to deal with it so I don’t talk about it.

PI: Ok

Kevin: I bottle it up and just go through the worse.

Ellen: I would say just about anything frankly. I mean erm I agree with everything that Kevin said but erm my experience and certainly my experience of other peoples has been if I or other people don’t lose that obsession to use I could use or someone else could use just because is raining or its sunny or I’ve got money in my pocket or I see someone I use to use with like Kevin said. Erm I don’t know I’ve maybe I’m a bit cynical now but I just (sighs) it could be anything, it really could be anything, good news, bad news, erm indifferent news, erm but usually it’s around negative stuff.

5.2.7.4 To cope with trauma/responses

Participants spoke about using drugs to cope with a range of difficult and dangerous events that they viewed as traumatic, these could be past and present events. Samuel talked about a car accident, which he was accused of causing, leading him to relapse. Several participants spoke about using to cope with bereavement of family members, friends or partners: bereavement featured in many participants’ lives. Watson and Parke (2011) also found death and loss featured heavily among their women heroin users. As previously discussed Clare struggled to cope with the sexual abuse she suffered in her childhood (See Quote 3a) and Zoe talked about using drugs to cope with trauma responses. David began Class A drug use to deal with the emotional pain he felt when his girlfriend killed herself and her children and then her family tried to kill him. David made painful noises when recounting this difficult time. He also cited using drugs to cope with other difficult times which he experienced to be traumatic, for example, when his Mother died (see Quote 21). Ellen spoke about using drugs to cope with several events she experienced as traumatic, including being wrongly accused of murder, having a serious physical health problem and being in a violent relationship (See Quote 21). Khantzian (1997) and Flores (2012) suggest that
substance use during times of crisis is to cope with regulating negative affective states. Daniulaityte et al. (2007) also found Class A drug use was a means to cope with trauma responses.

**Quote 21, Focus Group Three:**

**David:** I used when I found out my mother had died.

**PI:** OK.

**David:** The minute. You know what I mean like, suddenly.

**PI:** Yeah, yeah.

**David:** And I used immediately.

**PI:** Yeah, Yeah erm.

**David:** As soon as I found out I used right there and then.

**PI:** Yeah?

**David:** I didn’t know how to deal with it so I used.

**Ellen:** But there are different kinds of erm relapse and using. There can be one offs for me and there can be a process of replace and I can of had some staunch really totally abstinent on the programme recovery and then it will be a process of relapse. Where a bit like Kevin said we’ll drop out erm, little commitments going to meetings, maybe start lying or start nicking something out the shop. You know old behaviours will come back in. And then the process of one of my relapses after nearly 11 years clean I was telling, telling Kevin earlier was I looked back and my process of relapse had been behaviourally two years I’d been heading for that relapse.

**PI:** What, what do you know what triggered that, that first kind of going down that road, when it was like 2 years…

**Ellen:** Bad health–

**PI:** Bad health?

**Ellen:** Yeah.

**PI:** Health is that physical health?

**Ellen:** Physical I was on interferon for Hep C. Got TB but I was in a dodgy relationship which became violent. Erm, I stopped working, started lying, erm avoiding people even nice people erm just went into kind of fear and errh *(vuck sound)* I don’t want to do life yeah. *(Ellen demonstrates her thoughts and feelings by physically mimicking a foetal position in her chair).*

**PI:** And David?

**David:** What, what happened to me was erh, my girlfriend left erh, well when I was in *(name of a city)* my girlfriend set my house on fire and that started me using. I didn’t use to use there I used to selling. And she set my house on fire.
Quote 21, Focus Group Three continued from previous page:

**PI:** And you started using after that?

**David:** She killed herself and two *wee* kids and that’s when I started me using. Argh…

**PI:** What she killed herself and her two kids?

**David:** Yeah.

**PI:** Were they your kids as well?

**David:** Erh No her kids.

**PI:** OK.

**David:** But erm, but then 6 weeks later her brother tried to kill me. Like he was for murder. And I just didn’t want to stay in *(name of place)* be looking over my shoulder for the rest of my life so I ended up in *(name of place)* using.

**PI:** OK.

**David:** So I ended up in *(name of place)* using and I’ve been here for over 20 year now.

5.2.8 Superordinate theme 6: Ways of coping with life ‘the mundane to the extreme’

Participants discussed a range of coping mechanisms, which included both healthy coping mechanisms and unhealthy coping mechanisms most notably using drugs and substances. This was to deal with a range of issues from the extreme such as difficult and/or dangerous events and trauma responses to the mundane in everyday life.

5.2.8.1 Healthy ways of coping - structure, routine and support

Participants talked about a range of support from professionals, selected family members, friends and peer support groups. Samuel in Focus Group Two, Kevin in Focus Group Three and Tina in Focus Group Four, talked about the help that they had received from their drugs worker. Tina had learnt to apply her drug worker’s words of encouragement to praise and support herself in her recovery (See Quote 42, Appendix 16). Participants considered the relationship that they had with their drugs workers needed to be supportive and honest (See Quote 27). Samuel in Focus Group Two spoke about how important his drugs worker was in his recovery. However, his drugs worker was the research assistant. Therefore, would Samuel have emphasised the importance of this had he not been present in the room? It is possible that his drugs worker’s presence may have served as a reminder to him to acknowledge the
importance of his drug worker in his recovery (see Quote 30, Appendix 16). Other support networks will be discussed further in Section 5.2.9.1

Participants talked about moving away from their old drug taking lifestyles and building a ‘normal’ life, which included structure and routine. Participants’ attempts to build a ‘normal’ structured routine life included a range of activities such as attending the gym, employment, attending church, visiting family members, childcare and domestic duties. Generally these structures and routines appeared to serve two purposes for participants, to keep them occupied so they did not think about their triggers and to keep them away from their old drug using lifestyle. However, some participants found that routine and structure could become overwhelming for them and lead to relapses. Tina in Focus Group Four, struggled to follow a structure and routine imposed on her by her parents during a period of recovery, which lead to her relapsing. In her current recovery, Tina appeared more comfortable with her own routine, which included jewellery making, attending support groups and visiting her partner. Clare in Focus Group Two and Ellen in Focus Group Three recognised that being too busy could become stressful and lead to a relapse or lapses. Struggles with managing a ‘normal’ life among recovering drug users is consistent with the literature (Harris et al., 2005).

Quote 22, Focus Group Three.

Ellen: And me erm everything that’s just been said so it’s like structure, routine, support and honesty with myself and others erm but still myself when I’m having dodgy thoughts erm, or –

PI: What are those dodgy thoughts about?

Ellen: Dodgy thoughts might be planning a use up erm, dodgy thoughts might even be that I’m raging with my mother or something –

PI: What having arguments –

Ellen: So being emotionally honest with my thinking, my feelings, my emotions erm, yeah it’s kind of honesty I think plays a massive part in sustaining recovery for me but on the other hand having realistic expectations of myself and others. If I get into having too higher expectations of myself and other people I’m in trouble personally.
5.2.8.2 Healthier coping mechanisms: improving the self and problem solving skills

For those participants who had experienced periods of recovery they were able to talk about healthier coping mechanisms that did not involve drug misuse or other substances. This included a healthier relationship with themselves, for example, encouragement, honesty and a positive attitude towards themselves. This healthier relationship with themselves may well have developed from support from counsellors, peer group support and other professionals (See Quote 41 and 42, Appendix 16). Some of the therapeutic rhetoric was evident in participants’ discussions. For example, Ellen talked about “being a friend to yourself”, “having a strong relationship with yourself” and “being honest with yourself”, (see Quote 23). Honesty and positive self-regard were key features for participants in building a healthier relationship with themselves (See Quote 23, and for Quotes 41 and 42 see Appendix 16). Davidson et al. (2008) found similar coping mechanisms among those recovering from addictions and mental health problems.

Participants’ endeavours to build healthier relationships with themselves may be because they held very negative views about themselves during their drug use and for some during their childhoods. For example, both Kevin and Ellen in Focus Group Three, alluded to their self-loathing (see Quote 23 and for Quote 20c see Appendix 16). Tina and Bobby were derogatory of their mental health diagnoses, Zoe talked about her academic setbacks and Alan was negative about his inability to fit in with others throughout his childhood and adulthood. Wolf (1988), Levin (1991), Khantzian (2012, 2014) and Flores (2012), suggest links between drug use and damaged selves including low-esteem and self-worth.

Participants in recovery were able to think through their problems by talking to others, this included asking for help and accepting it. Kevin talked to a sister about his problems and Samuel talked to a counsellor about his drug problems and how to manage his relationships. Tina felt she needed to learn how to communicate better with people, which she learnt in therapy groups and through counselling.
**Quote 23, Focus Group Three:**

**Ellen:** What do you think is helpful –

**David:** In sustaining a person’s recovery from Class?

**Ellen:** [Friends is really important

**Kevin:** Friends is of course it is], I think that’s the biggest one out of the lot (Ellen: mmm) friends and family.

**Ellen:** And being a friend to yourself.

**Kevin:** [Yeah

**Ellen:** And not your own enemy – mmm

**Kevin:** I don’t usually like myself -

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**5.2.8.3 Avoidance to cope “a double edged sword”**

Participants considered that avoidance as a coping mechanism was a “double edged sword”. Avoiding drug dealing locations could help avoid lapses and relapses however avoiding dealing with problems could lead participants back to drug use. Ellen thought that avoiding dealing with her problems had led her to relapse (See Quote 20c in Appendix 16). Ellen suggested “running away” to avoid situations as a means of coping however, Alan recognised that this did not solve his problems (See Quote 24).

David, Kevin and Ellen in Focus Group Three, all discussed using drugs as a means to avoid coping or dealing with difficult emotions, thoughts and feelings as previously discussed (See Quote 19). Participants’ reasons for drug use, lapses and relapses could be considered as avoidance tactics to cope with a range of problems, thoughts, emotions and mental health problems with which they felt unable to deal. McIntosh and Mckeganey (2000b) found avoiding old drug using lifestyles and building a new life was a means to avoid relapses among recovered Class A drug users. Research has found that those who have suffered childhood abuse and neglect use maladaptive coping strategies during times of stress such as avoidance because of a reduced ability to deal more effectively with stress (Hyman, Paliwal, & Sinha, 2007).

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**Quote 24, Focus Group One:**

**Bobby:** Yeah, just being able to get away from the location, where you know if you’re in location…
Alan: Geographical…yeah my only problem with that is that I’m someone who has lived in other countries for multiply years and err, the problem is, is that I always have to take Alan with me so…
Bobby: Take what?
Alan: Alan, as in myself with me, so where as it may work for 6 months, a year I’ve inclined that for me drug addiction is a behavioural problem, yeah it’s got fuck all, excuse my language to do with the actual substance. I was an addict before I ever used drugs is how I feel about myself and so whether I lived in America for 5 years and the same behaviour will sneak back in. So it has a good initial effect but unless you deal with what’s going on for you so what’s causing you. You’re going fall back… I find the same people wherever I go. You can drop me in any city in the world and I’ll find crack and heroin within an hour if that’s what I want to do and I know that from previous experience some. It can be a short term help but, but ultimately it’s, it’s like a, it’s like a behavioural problem.

5.2.8.4 Unhealthy ways of coping and surviving: crack, heroin and other substances

Participants used drugs as a means of coping with a range of issues, including pain and trauma responses, mental and psychological health problems, emotional issues, such as painful thoughts and feelings and relationships, some of which have been discussed elsewhere. Participants also talked about using drugs to cope with mundane everyday life. Whilst drug taking might have seemed like a means of coping and surviving in the beginning it was clear that participants’ lives either continued to be chaotic or became more chaotic during their drug using (Khantzian, 2012). Samuel in particular in Quote 25 talked about how desperate his life had become during his addiction. He was very emotional when talking about this, his tone was excited and dramatic and he gesticulated widely.

Samuel: It’s easier to be on drugs and you’re new responsibility is chasing the drug and making the money (?) I understand where she is coming from but when you’re in it yeah and the times that you’re, you’re low in it but low you look up and think where am I? I want to die. How many times did you think you want to die? (Clare agreeing and Moses, yeah). (?) Oh my God I’ve got this problem, IT’S THE CHALLENGE, I’VE GOT TO DO THE CHALLENGE, I’ve got to work on that challenge
5.2.9. Superordinate theme 7: What helps in recovery and to prevent lapses/relapses

Participants recognised that changes were required in their thinking, behaviour and social life to be able to manage the recovery process. This included support networks, building and managing a life away from their drug using lives and learning to understand the reasons for their drug use. This superordinate theme will be explored further in Part Two. A selection of the themes related to this superordinate theme are now discussed.

5.2.9.1 Support from others/not being alone

Participants spoke about a range of supportive networks which helped them in their recovery. The support included help to manage their relationships, communication skills with themselves and with others and monitoring their progress in recovery, such as recognising relapse behaviour. Samuel in Quote 26 talked about the support he had from a counsellor to help him manage his relationship with his daughter.

Quote 26, Focus Group Two:

**Samuel:** You have to have counselling coz it really, really helps. Erm, I’ve got counselling for drugs and counselling for family. You know, I mean –

**PI:** Is that family, current family or [family when you were growing up?

**Samuel:** Current family, current family]. Yeah coz I still take and pick my kids up from school. Erm, I mean the beauty of it, I’ll give you a real life example. I’ve been teaching my little girl home work. And she’s slow child, she’s a bit she’s just slow and a bit below average, well she’s not actually I went to a sch, school meeting and they said she’s average. But anyway, I’ve been teaching her but the way I’ve been teaching her, I been saying core are you stupid, or what this is look 3 plus it’s so easy and can’t things like that coz I get frustrated and I went to the counsellor and I was discussing that with her and as soon as I said that to the counsellor she said you know what you’re doing to your child? You know, she, she opened up and took me, made me realise that, that effect (pause) is something that my father’s passed on to me, and
The quality of the support was important and needed to include trust. Kevin talked about learning to trust his probation officer in Quote 27. For Kevin this was an achievement because he talked about his difficulties with trusting adults during his childhood, which continued into his adulthood with authority figures. Attachment and psychodynamic therapies recognise the importance of the therapeutic alliance for clients where they can feel safe and secure in their relationship with their therapist. From this they can then (re)build a healthier self, (Khantzian and Weegmann, 2009; and Wolfe, 1988). Dallos and Vetere (2009) consider that learning to trust others is an important step in being able to relinquish a person’s reliance on substances.

**Quote 27, Focus Group Three:**

*David:* So a good support network –

*Kevin:* Basic… and I got, got and what he said I’ve got a lot of support. I’ve got a lot of support what David said. I’ve got (name of drugs worker) here and I got (name of staff member) and my probation officer believe it or not. The first time I’ve ever had a probation officer it was blinding and that yeah coz it looked like. I thought I was going to get recalled a few weeks ago. I said what I’m going to get recalled and she went no. I went back in there with a couple of bags of clothes and a bag of toiletries and she went what you bring that for. You’re gonna, I’ve been told in the past I’m not being recalled and I’ve, I’ve come in and been recalled me. And she went, Kevin I will tell you, I’m on the level. So I’ve built up a little bit of trust. But I’ve got a lot of support, I’ve got my key worker, I’ve got about 5 key workers.

Kevin, Ellen and David talked about the risks to their recovery of being alone, which is highlighted in the group discussion in Quote 28. Peer support groups such as Twelve...
Step groups and in Tina’s case a dual diagnosis group were important for participants’ recovery. Khantzian (2012, 2014), Khantzian and Weegmann (2009), Mack (2007) and Flores (2001, 2012) discuss the merits of groups such as Twelve Steps to help sustain recovery. They emphasise the importance of such groups providing healthy attachments to people rather than to their addictions. The groups can also offer sources for regulating thoughts and emotions.

**Quote 28, Focus Group Three:**

**Ellen:** Not having friends god that’s really [an addict alone is in the worst possible company isn’t it.

**Kevin:** Yeah I’d say that’s a big one there. Yeah we isolate and all don’t we. I’m like that I used to get my drugs and isolate.]

**Quote 28, Focus Group Three: Conversation develops to talk about support…**

**David:** Yeah I think a good support network but to have a bit of structure here and a bit of structure there in your life to maintain you know to keep you clean.

**PI:** So the networks is that about family or friends…?

**David:** You know keeping appointments, keeping yourself busy because erm, it’s when you, you know, too much time on your own you start thinking and get bored and you know what I mean it leads to depression and if you get depressed you just think fuck I’m going to use, you say fuck I’m going to use, you know what I mean. You have got to keep yourself busy, to keep your mind off of using.

**PI:** Ellen what about you?

**Ellen:** And me erm, everything that’s just been said so it’s like structure, routine, support and honesty with myself and others erm, but still myself when I’m having dodgy thoughts erm, or –

**Conversation reverts back to the issue of needing support and not being alone…**

**Kevin:** I go because I can’t do it on my own. That’s one thing I’ve learnt. I’ve learnt that the hard way and all, plenty of needles (Kevin laughs and Ellen laughs too).

### 5.2.9.2 Insight and understanding into reasons for your drug use, lapse and relapse behaviour

Some participants, who had experienced long periods of past or current recovery, recognised that relapse behaviour was a process that occurred over a period of time and being self-aware of what was involved in this process was important in sustaining recovery. For example, understanding control issues around use, understanding the range of potential triggers and reasons for them, understanding the severity,
implications and consequences of lapse and relapse behaviour and being aware of the need to be honest about recovery and relapse behaviour, thoughts and feelings. (See Quote 21, 29 and for Quotes 43 and 44 see Appendix 16). McIntosh and McKeganey (2000b) found that recovered addicts contemplated the consequences of their previous drug using lives as motivations to sustain recovery. However, they consider this to be because it threatens a newly formed identity. Identity theory is discussed in more detail in Chapter 6.3.

**Quote 29, Focus Group One:**

*Alan: (interrupts Bobby)* Depends on what stage they’re at in their understanding of their addiction. Err, I know loads of people, erm, that would probably, well it’s not for me to diagnose anyone, they’re not ready to look at whether they’re addicted. So you can’t sort of diagnose that. It’s hard to erm, know, until you have an understanding, until you sort of hit a place where you can’t blame external things anymore and you have to look at yourself that’s really when you can start coming to terms with your behaviour you know what I mean. I know loads of people that could really do with some, some help you know but as long as they can just sort of blame it on this and blame it on that, it’s my work it’s, it’s this, it’s that and they never really actually confront it I suppose.

### 5.2.10 Summary and next steps

The findings highlight participants’ difficult lives past and present, their struggles with trauma responses and the links between these experiences and their drug use, relapse and recovery journeys. The findings have also demonstrated that the research question and topic areas were of value and importance to participants. Some areas emerged that were unexpected and these will be explored further in Part Two. How the findings were used to develop an interview schedule for Part Two is covered in the Discussion Chapter 5.3.
CHAPTER 5.3 - PART ONE FOCUS GROUP STUDY: DISCUSSION

5.3.1 Chapter overview

A summary of the Part One findings is provided in Diagram Two. An overview of how the findings were used to develop an interview schedule for Part Two is then provided. Further reflective observations along with credibility checks are covered. A discussion of key considerations, challenges and learnings from the methodological adaptations and the focus group design are presented. Ethical, legal and safeguarding considerations of the focus group method are covered in Chapter 7. The limitations, scope and further key learnings are covered in the Summary and Conclusion Chapter 8.

5.3.2 Summary of findings

The taxonomy of superordinate themes and themes was developed into a ‘flow’ diagram to provide a visual image to capture participants’ lives (both past and present) in relation to their journeys of drug use, relapse and recovery. Figure 3, shows the superordinate themes in blue along with some supporting themes in red, amber, green and purple. The blue arrows indicate hypothetical links between themes and across participants’ lives both past and present, in relation to their journeys of relapse and recovery from Class A drug use.
Figure 3: Flow Diagram of Superordinate Themes, (in Blue) and Themes (in Purple, Red, Amber, Green and White) From the Focus Group Study (Part One) - Showing Hypothetical Links Between Themes Across Participants’ Lives Past and Present, in Relation to Their Journey of Relapse and Recovery from Class A Drug Use.
5.3.3 Developing the findings from the Focus Group Study (Part One) into a semi-structured interview schedule for Part Two

The findings from the Focus Group Study demonstrated that the research question and the topic areas were of relevance and importance to the participant group. The semi-structured interview schedule for Part Two was developed by formulating questions from the superordinate themes and corresponding themes.

However, the superordinate theme ‘Criminality – pathways, turning points and U-turns’ was not included as a main area of discussion for Part Two for several reasons. The NHS ethical body required a stringent confidentiality clause with regards to criminal disclosure. Therefore, discussing criminality in depth with this client group could compromise the confidentiality clause. Participants would be permitted to speak in general terms about their criminality within the parameters of the confidentiality clause in the Semi-structured Interview Study: Part Two.

The questions for Part Two will therefore cover significant life events both past and present in participants’ lives in relation to their drug use (first use), more entrenched Class A addiction, lapses, relapses and periods of recovery, including more sustained recovery. To help participants to think about key life events, experiences and relationships which were identified as important from the Focus Group Study, questions will include the following topic areas: childhood family relationships, upbringing, family relationships in adulthood, relationships with partners and children. Questions about participants’ psychological health and how they manage day to day life will also be included. A list of the questions posed to participants and the semi-structured interview schedule is provided in the Part Two Semi-structured Interview Study: Methodology and Method Chapter 6.1, Section 6.1.3.1 and in Appendix 14.

5.3.4 Credibility checks

With IPA research Smith et al. (2012) suggest that credibility checks should be conducted to ensure that a transparent system of analysis and interpretation has taken place so that high level interpretations can be traced back to the initial note taking process and grounded in direct quotations. This can be undertaken by an independent
researcher. Smith et al. (2012) also suggest that supervisors can conduct checks to ensure the correct application of the method has been employed. It was also important to have the input of a DIP drugs worker who has knowledge of the participant group, to help situate the findings and to help further develop the interview schedule for Part Two. Therefore, credibility checks were undertaken with my supervisors, an IPA network group, the focus group research assistant and a DIP drugs worker.

5.3.4.1 Credibility checks with Supervisors and the IPA network group

The researcher’s supervisors provided credibility checks throughout the development of the method design, methodological adaptations and during the interpretative and analytical process. Feedback included adapting some of the superordinate theme and theme titles to include more descriptive detail.

A credibility check on the superordinate theme ‘Challenges and struggles with mental and psychological health’ along with supporting quotes were presented to an IPA network group. The group included PhD students, versed in the use of IPA methods and techniques. The group supported my interpretations, for example the theme concerning drug use to alleviate mental health symptoms.

5.3.4.2 Credibility checks with the focus group research assistant

The research assistant, who was versed in the use of IPA, was given an extract of the transcribed data and asked to provide a first stage (initial note taking) IPA analysis. This was to help to provide an informed discussion about my interpretations of the data extract. The chosen extract (Quote 31 and 32 in Appendix 16), was from Focus Group Four, where Zoe discussed her mental health. It was selected because comprehending Zoe’s narrative was difficult because of its lack of coherence.

Zoe had diagnosed mental health problems and the police, social services and the drug rehabilitation organisation had intervened in her life because of these problems as well as her anti-social and drug taking behaviours. She expressed emotional turmoil and conflict with her family growing up and in her adulthood which she linked to her drug use.
My interpretation of Zoe’s narrative was that she struggled to cope with her mental health problems and experienced paranoid feelings which were linked to her mental health. A debate between the research assistant and me about this however lead me to consider that these feelings might not just be imagined feelings of paranoia but feelings based on actual events in Zoe’s life. In Quote 31 and 32 in Appendix 16, Zoe talked about the police and social services becoming involved in her life due to her mental health and drug misuse problems although the specifics around this event were unclear from Zoe’s narrative. As a result of these interventions Zoe’s behaviour was indeed being monitored. However, she talked on other occasions about being “watched” by her family members and professionals. She went on to talk about her distrust of others, her isolation and desire to avoid relationships. She also appeared to resent the support. Zoe might view her mental health and her drug taking as a retreat and a ‘mental space’ where she felt comfortable and safe, which was now being threatened by ‘others’ (e.g. the mental health and drug workers). This is expressed in Quote 5 in Appendix 16, where Zoe talked about how drugs gave her a mental escape from others. As part of the interventions Zoe’s behaviour was being managed and there were expectations as to how she should conduct herself. Zoe’s resentment and distrust might be because she felt that her life was being controlled by others, which might resonate with her experiences from her childhood and family when growing up. She talked about parental control, discord and not living up to gender role expectations which she found distressing. In Quote 31 she described other women she knew, who had met their gender role expectations, being like “caged animals” that needed to be let out.

The research assistant and I further discussed the reasons for Zoe’s incoherent narrative. There may have been a range of reasons for Zoe’s incoherent narratives in the Quote 31 and 32 in Appendix 16, for example, it might have been a traumatic experience for her recounting the event involving the police and social services. There were other occasions in the focus group discussion where she struggled to provide coherent details around traumatic and emotional experiences. Holmes (2006) suggest that people can struggle to narrate traumatic stories coherently if they have not resolved/processed their trauma responses/memories. Zoe was recruited on the day of the focus group and therefore did not have as much time to consider what might be
involved in the task. For example, Zoe commented that she “could not be bothered” when she found one of the card sort topics particularly taxing. Zoe may have felt uncomfortable opening up about personal matters in a group setting, she said that she hoped others in the group would forget what she had spoken about. She further talked about trust issues throughout the focus group. She also mentioned feeling tired and she was still using drugs. It is likely that a combination of all of these factors were present and accounted for the lack of coherence in Zoe’s narrative.

In summary, utilising the hermeneutic process, in our discussion, which involved considering small chunks of data alongside the transcript as a whole, we were able to conclude that Zoe struggled with emotional and relational difficulties and used drugs as a way to cope. This conclusion supported my original analysis.

5.3.4.3 Presentation and discussion of the early findings with a DIP drugs worker

Some qualitative methodologies stipulate that the findings should be taken back to the participants to determine if the findings resonate with participants’ perspectives of their narratives. However, within IPA the value of doing this is debatable. Interpretative Phenomenological Analysis considers the researcher to be the analytical tool and part of a participant’s meaning making process, therefore the researcher’s interpretation of the data may not necessarily be easily recognised by the participant after the interpretation process.

I thought that a credibility check with the participants could raise a number of ethical issues. The participants were considered to be a vulnerable group, for example due to their mental health problems. Therefore, what is a safe manner in which to present sensitive findings, which have been through an interpretative analytical process, to an already vulnerable group? For example, my position as a psychology student, which some participants were aware of, may have affected how participants perceived my interpretations about their mental health. How would Zoe have felt if I had presented the findings of ‘paranoid thinking’ to her? Would she have felt labelled? Would she have felt exposed and even more wary of the mental health services and interventions?
There are further ethical considerations with credibility checks with participants. The prospect of volunteering to talk about sensitive experiences in the relative safe haven of anonymity is a very different proposition to being confronted with a version of that experience which has been scrutinised and analysed by researchers. This could leave participants feeling labelled, diagnosed, exposed, shamed and threatened rather than enlightened and illuminated. Whilst this method of taking the findings/data back to the participant might have its use within a therapeutic setting, research is not therapy and the researcher’s role is not that of a trained therapist. Bearing these considerations in mind and the practicalities of trying to further engage with a hard to reach group, a presentation of the early emergent findings (themes) was presented to a DIP drugs worker, who was knowledgeable about the participant group’s experiences.

The credibility checks with the DIP drugs worker were to determine if the findings resonated with her experiences of working with the participant group and the potential implications for policy and practice. This process was also to help further develop the interview schedule for Part Two. (See Appendix 20 for a schedule of questions).

The DIP drugs worker thought the findings relating to participants’ traumatic childhood experiences such as sexual abuse and the continued chaotic and traumatic experiences were typical of the DIP client group with which she worked. A discussion ensued about whether being a victim of sexual abuse was confined to female DIP clients only. The DIP drugs worker suggested that male DIP clients could also be victims, some of which might be MAPPA clients. This raised the important point of amending the exclusion criteria for Part Two, to include those DIP clients with MAPPA sex offending status.

A discussion about participants’ own experiences of being parented and their struggles to parent their own children led to an exchange of ideas about how the research might impact on policy development and delivery. In particular about supporting participants in their own parenting endeavours. This also further highlighted that participants’ experiences of parenting their own children should also be included in Part Two.
5.3.4.4 Self-reflective process: Further credibility checks

The self-reflective process helps to identify and mitigate the researcher’s own preconceptions from unduly biasing the research and analytical process (Smith et al., 2012). This was achieved by reflective note taking about group dynamics and participants during the focus groups and from identifying my orientation in relation to the research before the focus group research began as outlined in Chapter 1 (see also Appendix 10). This process helped to maintain a healthy questioning during the analytical process and when managing the focus groups. An overview of some of the reflections are provided here. Other reflections are presented throughout the Part One Focus Group Study: Findings, Chapter 5.2.

In Focus Group 3, Kevin disclosed that he had committed murder in his young teenage years. I considered what impact this had on me during the focus group and how it might have affected my interpretations.

I was shocked at this level of violence. I had assumed from my experience working in the UK Government Home Office policy that most DIP clients were petty offenders. This also affected how I felt about this participant during the focus group. I was more vigilant and monitored for signs of aggression from this participant. Being made aware of the violent nature of participants in a face-to-face situation also made me wary in subsequent focus groups and in the semi-structured interviews. My increased vigilance was further compounded by the friction and conflict between Kevin and David throughout the focus group, which is discussed in Chapter 7, Section 7.6.3. David had disclosed that he had been the victim of an attempted murder. Kevin’s physical appearance and demeanour may have increased both mine and David’s feelings of unease. Kevin was tall and well-built and he was very loud and dominated the group discussion. David was slender and his demeanour was timid, he spoke quietly and was much less talkative.

On reflection, as the focus group progressed and Kevin unveiled his story I was able to see a vulnerable young boy who had been brought up in a criminal family network. One of his childhood memories was that of his father breaking open a safe at the dinner
table. Kevin was only 14 when he committed the murder and had then spent the rest of his childhood in institutions. On reflection I asked myself, what led a 14 year old to commit murder? Was he scared, did he commit murder out of fear or even self-defence? Did he understand fully what he was doing when he committed the murder? He appeared regretful about the murder and there was a sense that this was a traumatic period in his life. He struggled with trust issues especially with those who were in positions of authority, which might have been from his experiences of authority figures during his time spent in young offenders’ institutions for his murder conviction. Kevin may have sensed some of my unease because he reassured me that he did not view psychologists as authority figures to distrust. I felt this demonstrated Kevin’s ability of insight and inner reflection. He was insightful about many other aspects of his behaviour too, for example he seemed to ‘win’ over David during the course of the focus group. Kevin made attempts to befriend David, for example, calling him mate, engaging in discussion with David, seeking his opinions and asking David for help with some forms during the coffee break. I wondered if Kevin sensed David’s animosity towards him and felt the need to address this. It was clear that Kevin also felt uneasiness towards David – calling him “mate” on one occasion with a loaded tone and saying “this one’s lively isn’t he?” However, Kevin corrected himself and softened his tone by then asking David what his name was. This was one of the moments where I felt that the focus group was a minefield where emotions and thought processes were being ‘worked out’ and negotiated and where enemies or allies were constantly being decided upon for members of the group. I also felt this was an emotional battlefield I had to carefully navigate throughout this focus group and some of the other focus groups too.

By recognising my emotions and thoughts, I was able to see beyond the violent murder label to be able to understand Kevin’s story better. This was an important learning experience for me and crucial during the interpretative and analytical stage: I realised I needed to be open minded, suspend my own judgements and my own concerns for my personal safety to see and understand the child he had once been. Many of the participants spoke about childhood traumas, which had profound impacts on them as adults especially in relation to their drug use and in their journey of relapse and recovery. Understanding participants’ childhood experiences from their own
perspectives was a key finding from my research and will be discussed in more detail in the findings and discussions sections. This learning is something that will be of great value in my future profession within psychology and as a researcher.

5.3.5 Considerations, challenges and benefits of adapting IPA for focus groups

5.3.5.1 Striking the balance between the ideographic vs the group collective dialogue

IPA has been adapted for use in focus groups (Palmer et al., 2010). Its adaptation in focus groups has also been open to criticism (Tomkins & Eatough 2010). For example, studies, which have ignored the influence of the group dialogue and opted to use individual dialogue only, question the rationale for using a focus group design (Tomkins & Eatough, 2010). Studies which have eclipsed the ideographic accounts in IPA focus group studies have also been criticised epistemologically (Tomkins & Eatough, 2010). Several studies have used both the individual and group level data such as Tomkins and Eatough (2010) and Palmer et al. (2010), albeit with adaptations to IPA. Striking a balance between these considerations in the PhD research was therefore necessary to stay close to the ideographic ethos of IPA whilst also capitalising on the benefits of a focus group design. For example, in Quote 11a (Section 5.2.4.5), the benefits of using a focus group design are evident - the participants challenged each other in a manner I would not have felt comfortable adopting and challenged each other about issues I had not considered. The group dynamics and interactions also prompted revelations for participants (Quote 1, Section 5.2.3.2) and a deeper understanding of their thoughts (see Quote 45, Appendix 16). These group dynamics and interactions provided rich detailed data which led to nuanced and novel findings, without eclipsing participant’s individual experiences. Ensuring participants’ individual experiences were evident was aided further by giving participants the freedom to disagree with each other if they wished (see Quote 11a/b in Appendix 16 and Quote 24, Section 5.2.8.3) and facilitating the group to allow the voices of quieter members to be heard. Agreement among group members was also a source of interesting and rich detailed data (Quote 19a Section 5.2.7.2 and 19b in Appendix 16).
5.3.5.2 Benefits and further considerations

The use of an IPA approach provided a detailed and in-depth analysis of participants’ experiences as narrated in the focus groups, however adapting IPA for a focus group design was time consuming. Furthermore, the analysis, which required exploring group dynamics and interactions, added extra time onto the interpretative process.
CHAPTER 6.1 - PART TWO SEMI-STRUCTURED INTERVIEW STUDY: METHODOLOGY AND METHOD

6.1.1 Chapter overview

This chapter provides the study design, an overview of participants’ demographic, substance misuse and criminal justice programme status and a reminder of the research questions. How the interview schedule and questions were developed from the Focus Group Study findings is covered along with examples of the questions. Details about the procedure, including recruitment, the analytical methodology (IPA) and credibility checks also feature. A discussion of the interview as a data collection method is considered. Ethical approvals and permissions as well as a comprehensive overview of IPA are covered in Chapter 4, Section 4.11.

6.1.2 Research questions

The findings from the Focus Group Study suggest that these broad questions were of relevance and importance to the participant group and therefore remain relatively unchanged for Part Two – the semi-structured interviews. An overview of how the findings from the Focus Group Study were used to develop a semi-structured interview schedule is outlined Chapter 5.3. Section 5.3.3 and Chapter 6.1, Section 6.1.3.1, Table 9.

1. How do Class A drug misusing (ex)/offenders experience and make sense of their journey of relapse and recovery in relation to their significant life events and relationships?

2. More specifically, how do they make sense and experience this within the ‘context’ of their family upbringing, family and other relationships, significant life events such as trauma, bereavement, loss and their psychological health?

3. How has this ‘context’ impacted on their experiences and meaning making of their first substance/drug use, their continued use including lapses, relapses and during periods of recovery including sustained recovery?
6.1.3 Design and materials

A flow diagram of the Semi-structured Interview Study is provided in Figure 4.

6.1.3.1 Interview questions and schedule

*Development of the interview schedule and the semi-structured questions*

The topic areas for the semi-structured interviews were developed from the focus group themes, which are contained in Table 9. These were then developed further into questions with sub-questions or prompts, with the exception of those concerning criminality. Criminality was not included as a main topic for questioning in the semi-structured interviews because of the restrictions the NHS ethical board had raised about criminal disclosure. However, for some participants criminality was closely associated with their recovery. If participants chose to talk about their criminality in general terms they were permitted to do so. In some cases participants were asked about aspects of their criminality where the interviewer felt it was relevant and appropriate. However, this had to be carefully weighed against the risk of participants disclosing information about their criminality, which could compromise the confidentiality clause. (A more detailed discussion of this can be found in Chapter 4, Section 4.11.4 and Chapter 7, Section 7.3).
Figure 4: Flow Diagram for Semi-structured Interview Study (Part Two)

Part Two: Semi-structured Interviews (N=17)

Interpretative Phenomenological Analysis (IPA)

Relapse & recovery status from Class A drugs at time of interview and participant name:
- Over 2 yrs recovered (N=8)
  - Freddy
  - Harry
  - Gale
  - Luke
  - Veronica
  - Stacy
  - Rebecca
  - Isabella
- 1-12 months recovered (N=4)
  - Jim
  - Jay
  - Adam
  - Bruce
- Lapsed/relapsed (N=5)
  - Terry
  - Olivia
  - Zachery
  - Mark
  - Walter

Credibility checks:
- Independent IPA specialist
- London IPA network group
- Supervision
- DIP drug workers
- DIP clients in recovery.

Reflective note taking

Findings → implications for theory, policy, practice & further research
Table 9: Interview Topic Areas Developed From Themes From the Focus Group Study (Part One)

<table>
<thead>
<tr>
<th>Topic areas for semi-structured interview study</th>
<th>Specific focus group superordinate themes the topic areas were developed from</th>
</tr>
</thead>
<tbody>
<tr>
<td>Childhood experiences.</td>
<td>Difficult and/or traumatic childhood experiences</td>
</tr>
<tr>
<td>Relationships – past and present.</td>
<td>Struggles with complex and tense relationships</td>
</tr>
<tr>
<td>Psychological health.</td>
<td>Challenges and struggles with mental and psychological health</td>
</tr>
<tr>
<td></td>
<td>Reasons to use drugs, to lapse or relapse – a coping mechanism</td>
</tr>
<tr>
<td>Significant life events before first use and during drug use, lapse, relapse and into recovery.</td>
<td>Reasons to use drugs, to lapse or relapse – a coping mechanism</td>
</tr>
<tr>
<td></td>
<td>Ways of coping with life ‘the mundane to the extreme’.</td>
</tr>
<tr>
<td>Managing significant life events and normal everyday life.</td>
<td>Ways of coping with life ‘the mundane to the extreme’.</td>
</tr>
<tr>
<td></td>
<td>What helps recovery and to prevent lapses/relapses</td>
</tr>
<tr>
<td>Experiences and meanings attributed to being involved in criminal behaviour.</td>
<td>Criminality – pathways, turning points and U-turns</td>
</tr>
</tbody>
</table>

The interview schedule included the following listed questions, a copy of the full interview schedule is available at Appendix 14.

- What does recovery mean to you?
- Looking back on your recovery what do you think has helped you to stop using drugs?
- Can you describe to me what was happening in your life before you used Class A drugs?
- Can you give me an example of what was happening in your life on occasions when you have relapsed?
- Can you describe to me what your health and well-being is like now in recovery and during drug use?
Can you describe your family life when growing up?

What relationships do you have now that you consider are important to you?

Presentation style of the questions and further inclusion of questions

The schedule was a semi-structured questionnaire and was used as a guide. Some participants required more prompting questions than others. The interview questions were designed to be as neutral as possible to minimise leading the participant and to minimise my preconceptions for example, the expectation of adverse childhoods. A conversational style approach was thought to be the most effective and appropriate interview style to adopt (Hucklesby & Wincup, 2010). It was thought that a more convivial and a less formal approach would produce a more naturalistic setting to resemble a conversation rather than a formal interview structure. This was for two main reasons. 1). To allow me to respond to and adapt to each participant’s discussion, persona and emotions. 2). To help me to build trust quickly and make the participant feel as comfortable as possible. This was because it was anticipated that this group might have difficulty trusting the researcher (Flores, 2012). It was also thought that a formal interview style for this group might resemble an interview situation with the police or a probation officer. However, the interview style adopted also meant that being able to control participants’ criminal disclosures was at times perilous (Hucklesby & Wincup, 2010). See Chapter 7, Section 7.3 for a discussion on this.

Further questions, where appropriate, were asked in subsequent interviews to include areas and topics that previous participants had felt to be of importance. For example, the intergenerational impact of substance use and cultural divisions in families where participants had been brought up in a different culture and country to their parents. Prompting questions were also added where some questions did not elicit an ample response. For example, ‘What was life like growing up?’, could elicit a response such as ‘good’, or ‘brilliant’. Therefore questions such as ‘did you have contact with your grandparents?’, or ‘what was your school life like?’ were asked to provide a further prompt and more detailed answers about a participant’s childhood. This often revealed that participants’ childhoods may not be defined as “good” or “brilliant” by others. Further questions such as ‘how do you spend your day/week now?’ were added to elicit a response on how participants coped with life in their present recovery.
6.1.4 Participants

6.1.4.1 The research cohort

A detailed overview of the research cohort is provided in Part One, which also applies to Part Two participants and is therefore not repeated here.

6.1.4.2 Demographics and criminal justice programme management status

There were 18 participants for the Semi-structured Interview Study, this included 7 women and 11 men. One of the women participants was later found not to be a Drug Intervention Programme client so was not included in a full IPA analysis. The age range was 32 to 63. The majority of participants (N=13) were White British or White Other. Two of the participants were Asian (N=2), two were Black Caribbean (N=2) and one participant was Black Other (N=1).

The question relating to relationship status was problematic for some. The demographic questionnaire indicated that at the time of the interview N= 4 were in relationships, N=3 were widowed, N=10 were single and N= 1 was divorced. However, it must be recognised that a participant could be widowed or divorced and currently be in a relationship. Some participants, although they described themselves as single, later stated in the interview that they were in ‘some sort of relationship’. However, on the demographic form they did not want to categorise their relationship. For example, one participant was currently going through a break up with their partner. This demonstrates how quantitative data gathering from this group can be problematic. Further qualification during the interviews helped to clarify quantitative demographic questions that were prima facie presumed to be straightforward.

Seventeen participants had been DIP clients at some point. This included N=1 who was a current DIP client, N= 6 who were current DIP clients but who had also been a past DIP client and N=10 who had been past DIP clients. Other criminal justice programme status included three participants who had been Prolific and other Priority Offenders (PPO) at some point. This included one participant who was a current PPO. A further participant was also an Integrated Offender Management (IOM) client and
another participant was a current Multi-Agency Public Protection Arrangement status (MAPPA) client. Some of the other participants may also have been IOM clients but they were not specifically asked this. (See Table 10).

### 6.1.4.3 Participant’s substance misuse and rationale for inclusion criteria

The original selection criteria required participants to have been in recovery for at least 6 months. However, at the time of the interview, \( N=5 \) of the participants had lapsed, relapsed or were currently still using although 4 of them were able to discuss lengthy periods of recovery in the past and for some this was the recent past. One of these participants was not able to talk about any periods of abstinence from Class A drug use, although he was able to talk about reduced periods of drug use. Furthermore, he was a current DIP client and met the main inclusion criteria so was therefore included in a full IPA analysis. A summary of the other participants’ drug use included two who were clean from Class A drugs \( (N=2) \) for less than 6 months, \( N=2 \) who were clean from Class A drugs for 6-12 months and \( N=8 \) who were clean from Class A drugs for over 2 years. (See Table 11).

It was difficult to recruit participants who fitted the original criteria of ‘at least 6 months in recovery’. This did reflect the cycle of relapse, lapse and recovery that this group experience. The researcher’s definition of recovery, stated on the advertising materials and in communication with drug workers, was ‘those who had been in recovery from Class A drugs for at least 6 months’. From the perspective of the researcher, this meant those who had not taken Class A drugs for at least 6 months prior to the interview. However, predefining what ‘recovery’ meant was interpreted differently by both the drug workers making the referrals and by those who came forward to take part in the interview. Some participants had lapsed or relapsed at the time of the interview, although most of them were able to talk about past periods of recovery, including the recent past. It was clear that the term ‘in recovery’ was a ‘process’ which participants were going through and engaging with and was itself a changing landscape. These participants were therefore able to provide valuable information about this changing landscape.
6.1.4.4 Further inclusion and exclusion criteria

Participants had to meet two main inclusion criteria, a) their main drug of choice or misuse was Class A drugs such as heroin, crack or cocaine, and b) they had to be either a current or past DIP client. Participants could also be a PPO, IOM or MAPPA (sexual offender) client. MAPPA (sexual offending) clients were included in Part Two because the interviews were conducted on a one-to-one basis with the researcher only. Therefore, personal safety and ethical considerations of other participants were not required. The exclusion criteria (other than the addition of MAPPA - sex offenders) was the same as that in Part One, for the Focus Group Study.
Table 10: Participant’s Demographic Data and Criminal Justice Management Programme Status for Semi-structured Interview Study (Part Two)

<table>
<thead>
<tr>
<th>N</th>
<th>Male or female</th>
<th>Age</th>
<th>Ethnicity</th>
<th>Relationship status</th>
<th>Current DIP client (CD) Past DIP client (PD)</th>
<th>Current PPO client (CP) Past PPO client (PP)</th>
<th>Other criminal justice status</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>M</td>
<td>38</td>
<td>Asian</td>
<td>Divorced and single</td>
<td>CD and PD</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>M</td>
<td>45</td>
<td>White British</td>
<td>Single</td>
<td>PD</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>M</td>
<td>63</td>
<td>White British</td>
<td>Widowed (not in a relationship currently)</td>
<td>PD</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>M</td>
<td>48</td>
<td>White Other</td>
<td>Single</td>
<td>PD</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>F</td>
<td>37</td>
<td>White British</td>
<td>Single</td>
<td>No</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>F</td>
<td>45</td>
<td>White British</td>
<td>Single</td>
<td>CD and PD</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>M</td>
<td>38</td>
<td>White Irish</td>
<td>Single</td>
<td>CD and PD</td>
<td>CP</td>
<td>PP</td>
</tr>
<tr>
<td>8</td>
<td>M</td>
<td>46</td>
<td>Black Caribbean</td>
<td>Single</td>
<td>CD and PD</td>
<td>CP</td>
<td>Integrated Offender Management (IOM)</td>
</tr>
<tr>
<td>9</td>
<td>M</td>
<td>38</td>
<td>Asian</td>
<td>Single</td>
<td>CD and PD</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>F</td>
<td>42</td>
<td>White British</td>
<td>In a relationship</td>
<td>PD</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>M</td>
<td>42</td>
<td>White British</td>
<td>In a relationship</td>
<td>PD</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>M</td>
<td>37</td>
<td>White Other</td>
<td>Single</td>
<td>CD</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>M</td>
<td>52</td>
<td>White British</td>
<td>Widowed</td>
<td>PD</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>M</td>
<td>45</td>
<td>Other – Nigerian</td>
<td>Single</td>
<td>CD and PD</td>
<td>No</td>
<td>MAPPA (Conviction for rape).</td>
</tr>
<tr>
<td>15</td>
<td>F</td>
<td>32</td>
<td>White British</td>
<td>Single</td>
<td>PD</td>
<td>PP</td>
<td></td>
</tr>
<tr>
<td>16</td>
<td>F</td>
<td>55</td>
<td>White Other</td>
<td>Widowed (not in a relationship currently)</td>
<td>PD</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>17</td>
<td>F</td>
<td>41</td>
<td>White British</td>
<td>In a relationship</td>
<td>PD</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>18</td>
<td>F</td>
<td>46</td>
<td>Black Caribbean</td>
<td>In a relationship</td>
<td>PD</td>
<td>No</td>
<td></td>
</tr>
</tbody>
</table>
Summary Table 11: Participant’s Substance Use From the Semi-structured Interview Study (Part One)  (N.B. dash, indicates where no information is available).

<table>
<thead>
<tr>
<th>Number and pseudonym</th>
<th>Clean time from Class A drugs and most recent use.</th>
<th>Main drug of choice and length of use</th>
<th>Using Class A drugs at time of interview: Y/N</th>
<th>Current length of clean time from Class A drugs (at time of interview)</th>
<th>Other substance use at time of interview. (- missing data)</th>
<th>Current alcohol use (Yes (Y), No (N), Occasional (O) Quantity?)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1: Freddy</td>
<td>Clean for 2 years. Last used 2 years ago. Had 3 months clean time in the community. The remaining clean time was in prison.</td>
<td>Heroin</td>
<td>N</td>
<td>Y</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>2: Harry</td>
<td>Clean from all drugs for 10 years. Last used 10 years ago.</td>
<td>Heroin and later crack</td>
<td>N</td>
<td>Y</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>3: Walter</td>
<td>Still using, but reduced, clean for one month in the many years he has been using (over 30 years). Not able to talk about recovery very much. Was able to talk about heavier use and when this happened.</td>
<td>Cocaine</td>
<td>Y</td>
<td>No</td>
<td>Yes. Drinks 5-7 days a week 3-4 pints a day.</td>
<td></td>
</tr>
<tr>
<td>4: Terry</td>
<td>Clean for 2 years but last used one day ago, currently going through a full relapse, which started about one month ago.</td>
<td>Heroin and crack</td>
<td>Y</td>
<td>Yes</td>
<td>Yes. Drinks 7 days a week about 2 litres a day.</td>
<td></td>
</tr>
<tr>
<td>5: Veronica</td>
<td>Clean from Class A drugs for 2 and half years.</td>
<td>Crack and heroin.</td>
<td>N</td>
<td>Y</td>
<td>No</td>
<td>N.</td>
</tr>
</tbody>
</table>
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<th>Other substance use at time of interview</th>
<th>Current alcohol use; Yes (Y), No (N), Occasional (O). Quantity?</th>
</tr>
</thead>
<tbody>
<tr>
<td>7: Jim</td>
<td>Clean for 3 months from Class A drugs whilst in prison but used other drugs in prison. He used heroin once when he came out of prison but has been clean for 5 months.</td>
<td>Heroin</td>
<td>N</td>
<td>Y</td>
<td>6 months</td>
<td>Yes</td>
</tr>
<tr>
<td>8: Zachery</td>
<td>Had 9 years of clean time then relapsed. His most recent clean time has been for about 4 months but he lapsed and used cocaine a week ago.</td>
<td>Heroin and cocaine powder</td>
<td>Y</td>
<td>Subutext</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9: Jay</td>
<td>Had been clean for 28 months then lapsed, has now been clean for 6 months.</td>
<td>Heroin</td>
<td>N</td>
<td>Subutext</td>
<td>N</td>
<td></td>
</tr>
<tr>
<td>10: Gale</td>
<td>Clean for 4 and a half years.</td>
<td>Heroin and crack. 18 years</td>
<td>N</td>
<td>Y</td>
<td>No</td>
<td>O</td>
</tr>
<tr>
<td>11: Adam</td>
<td>34 days clean but has had 2 years’ clean time in the past.</td>
<td>Heroin and crack</td>
<td>Y</td>
<td>Subutext</td>
<td>N</td>
<td></td>
</tr>
<tr>
<td>12: Mark</td>
<td>Last used the previous day to the interview. He has reduced his use. He did have clean time for 2 and half years in the past.</td>
<td>Heroin</td>
<td>Y</td>
<td>Subutext</td>
<td>-</td>
<td></td>
</tr>
</tbody>
</table>
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<th>Other substance use at time of interview</th>
<th>Current alcohol use; Yes (Y), No (N), Occasional (O), Quantity?</th>
</tr>
</thead>
<tbody>
<tr>
<td>13: Bruce</td>
<td>Last used 9 months ago. Sometimes uses cannabis.</td>
<td>Heroin</td>
<td>N</td>
<td>Y</td>
<td>Methadone (20mls). Is hoping to go into rehabilitation to help him stop his methadone use.</td>
<td>Y. 2-3 days/week, 2-3 pints a day. Had past problems with alcohol. Had consumed beer a few hours before the interview.</td>
</tr>
<tr>
<td>14: Luke</td>
<td>Had been clean from all drugs and alcohol for 4 years whilst in prison. Has been in the community for about 4 weeks.</td>
<td>Crack and cocaine</td>
<td>N</td>
<td>Y</td>
<td>No</td>
<td>N.</td>
</tr>
<tr>
<td>15: Rebecca</td>
<td>Has been clean from all drugs for 2 years.</td>
<td>Heroin and crack</td>
<td>N</td>
<td>Y</td>
<td>No</td>
<td>N.</td>
</tr>
<tr>
<td>16: Isabella</td>
<td>Clean for 3 years.</td>
<td>Heroin and crack</td>
<td>N</td>
<td>Y</td>
<td>No</td>
<td>N. (Rarely)</td>
</tr>
<tr>
<td>17: Stacy</td>
<td>Clean from Class A drugs for 2 and half years. Has had periods of recovery in the past around when she was pregnant. Used heroin for 18 years &amp; crack for 12 years.</td>
<td>Heroin and crack.</td>
<td>N</td>
<td>Y</td>
<td>Methadone (40 mls).</td>
<td>O. A glass of wine at the weekend.</td>
</tr>
<tr>
<td>18: Adele</td>
<td>Last used Class A drugs in her early twenties. Is a Class C user, has been clean for 12 months. (She is NOT a DIP, PPO or IOM client).</td>
<td>Cannabis (skunk)</td>
<td>N</td>
<td>Y</td>
<td>No</td>
<td>-</td>
</tr>
</tbody>
</table>
6.1.5 Procedure

6.1.5.1 Procedure for recruiting for the Semi-structured Interview Study and determining participant’s suitability

Recruiting participants: Challenges and successes

To help increase recruitment for Part Two, a further 3 DIP teams and their ‘sister’ services were approached, with the consent of the deputy director. This included attending and presenting the research proposal at three DIP team meetings and in some cases meeting with the DIP managers. Posters and leaflets were provided at the premises where clients accessed the services. (See Appendix 6, Figure 2a/b for a copy of the leaflets). To further help recruitment a theatre company which received referrals from the DIP teams and several peer mentor networks connected with the drugs rehabilitation organisation, was also approached and provided with the advertising materials. (See Appendix 6 Figure 2a/b).

Recruitment for Part Two was challenging, in particular with recruiting those who were in longer term recovery. For the purposes of this research ‘longer term recovery’ was defined as two years or more. This time period is generally accepted within the drug services as a reasonable amount of recovery time to be considered stable enough to be involved in peer mentoring and other volunteering tasks. To help recruit those in longer term recovery some participants, where appropriate and with their consent, were asked to pass on leaflets to those whom they knew were in longer term recovery, (also known as a ‘snowballing’ technique in the literature). This provided one further participant. The advertising leaflets were also amended when targeting those in longer term recovery. This was in recognition that peer mentors and volunteers were unlikely to have a DIP worker and the recovery criterion was changed to ‘12 months plus recovered’ to reflect the longer term recovery status. This was based on feedback from a peer mentor, who also advised me in email requests to peer mentors and volunteer groups to reiterate anonymity and to emphasise that past criminal histories would not be the subject of enquiry in the research. See Appendix 6, Figure 2b, for a copy of the revised advertising leaflet.
The difficulty in accessing those who were in longer term recovery was most likely because they no longer accessed the mainstream DIP services. Furthermore, DIP teams now hold clients for shorter periods (for example 12 weeks) before they are referred onto other services. In the past it was customary for the DIP teams to hold clients for up to 2 years and beyond. Staff at the DIP teams were therefore asked to look through past case files and identify any potential participants. Whilst this method was effective with one DIP team it was not effective with the other 3 DIP teams. This may have been due to staff resources and in one team organisational changes taking place.

To further help recruitment the Narcotics Anonymous and Cocaine Anonymous groups which had links with the DIP teams, were approached. However, this was not successful. The researcher was informed by a peer mentor that this was most likely due to the confidential and anonymous nature of the groups. Two of the group organisers were unwilling for a researcher, who was a non-drug user, to attend the groups to hand out leaflets. This method of recruiting was not pursued further.

**Successful means of recruiting**

Most of the participants for Part Two were self-referrals and had seen the advertising materials in the centres, which they attended for their rehabilitation, longer term recovery groups or they worked for the services as volunteers or mentors. Another successful method of recruiting was through word of mouth from the DIP workers themselves, who worked with some of those in longer term recovery. Other referrals came from DIP or drug workers who had regular contact with the participant group. This relied heavily on the researcher being able to build a good working relationship with the DIP and drug workers. This was challenging given the high turnover of staff and organisational changes which took place during the 15 months recruitment period.

**Dropout rate and further recruitment challenges**

Ten participants, who made initial contact, did not take part in the research. They gave a number of reasons which included, health problems, work and educational commitments, returning to rehabilitation for alcohol detoxification, disengaging from the services and in some cases the participants did not return the researcher’s messages.
Two of the participants did not meet the two main criteria, which were, Class A addiction and the DIP client status, so were not invited to attend an interview.

It was difficult to recruit participants who met the original criteria of ‘at least 6 months in recovery’. Whilst efforts were made to bolster recruitment of those in longer term recovery some participants were less than 6 month recovered or had lapsed or relapsed at the time of the interview. However, this is reflective of the changing cycle of relapse and recovery of this group who, from their personal experiences were able to provide valuable insights about transitions into and out of recovery.

6.1.5.2 Procedure during the interview

All interviews took place in a room at the rehabilitation organisation’s premises or at one of their sister organisations at a time convenient to the participant, the researcher and the trained counsellor. Most of the participants were familiar with the premises where the interviews took place.

Participants were asked to read an information sheet, including a section about confidentiality. Participants were given a consent form to read and initial. This included their permission to tape record the interviews although in some cases verbal consent to commence recording was taken first. Participants were also asked to complete a demographic questionnaire which provided the basis for the ice breaker questions and to establish where the participant was in their current recovery. For example; ‘when was the last time you used Class A drugs?’ and ‘what was your main drug of choice when you were using?’ (See Appendix 5 for a copy of the demographic questionnaire).

Participants were offered refreshments and provided with a brief overview of the purpose of the research by the researcher. They were informed that they would be asked questions about their journey of relapse and recovery from Class A drugs. Based on feedback from the focus groups to help to provide a comfortable and informal setting, participants were informed they could choose not to answer questions and that they could take a break at any time during the interview. Participants were informed that the interviews would be approximately 45 minutes in duration although if
participants wanted to talk for longer and time allowed they were permitted to do so. Therefore, some interviews lasted for over an hour. However, extra time was not always available. This was due to participants not arriving on time and running over into the allocated debrief slot with the counsellor. Efforts were made at later interviews to allow time for late arrival (although an hour for most participants to respond to all of the questions was found to be adequate).

Participants were offered the debrief session with a trained counsellor at the end of the interview. One participant accepted the offer. Participants were also given a debrief by the interviewer which consisted of information about the rehabilitation organisation’s counselling services if they were still accessing the DIP services and how to access support for counselling and psychological health and wellbeing in the community. For example, via their GP, MIND and in some cases CRUSE bereavement. Participants were thanked for their time and given a £5 supermarket voucher for taking part and their travel costs were reimbursed. In some cases the interviewer provided further information about the research for participants who enquired.

For one participant who was upset during the interview and did not take up the offer of a debrief session with the counsellor afterwards the researcher informed a member of the DIP team. The researcher enquired at a later date about the participant and was informed that they were fine.

### 6.1.5.3 Procedure for IPA analysis

A full IPA analysis in line with Smith et al. (2012) was conducted on 17 of the participants’ transcripts, an example of Rebecca’s analysis is provided in Appendix 22. Steps 1 – 6 were completed for each participant’s transcript before moving on to the next:

1. Immersion in the data: To help immerse myself in the data I conducted all transcribing and read each transcript twice before making initial notes and highlighting relevant text.

2. Reflexive note taking after each interview and during the analytical stages helped me with the steps outlined here.
3. Initial noting on the transcripts consisted of the following types of comments:  
a) descriptive - for example, details of events or relationships which held  
significance for the participant;  
b) linguistic - how participants used language such as metaphors, pauses,  
stutters, tone and emotion;  
c) conceptual - which involved a move towards an interrogative and  
interpretative approach using reflection and questioning of participant’s  
meaning making.  

4. Themes were then developed from the comments. The hermeneutic process  
was used whereby the part (a small “chunk of data”) is interpreted in relation  
to the whole (comments across the whole transcript). The (PhD) research  
questions influenced this stage of the analysis, which is a recognised process  
in IPA (Smith et al., 2012).  

5. Themes were then clustered together and superordinate themes were identified.  
This involved looking across the data for patterns. This was achieved by using  
the following techniques: abstraction, subsumption, polarization,  
contextualisation, numeration and function (Smith et al., 2012). This process  
creates a set of superordinate themes and themes which are aspects of the  
superordinate theme.  

6. Themes were then arranged in to a visual structure using PowerPoint. Each  
theme was coded to identify to which participant it belonged. This code also  
identified participants’ quotes which were also coded and collated in a Word  
document. This provided a clear audit trail, which could be used in the iterative  
process during the amalgamation of all participants’ data (Step 6) and a check  
for the recurrence of themes across the participant group (Step 8).  

7. The next step involved amalgamating the data from all participants to produce  
a master taxonomy of superordinate and themes. This was achieved by using  
hard copies of all participants’ visual theme structures and re-arranging them  
using the techniques described in Step 4. This involved using Post It Notes and  
cutting up participants’ theme structures. I captured my reflections and  
thoughts of the developing themes on video which helped me with the iterative  
and hermeneutic process. I further made hand written notes about my thoughts,  
reflections and my analysis. For example, using the ‘abstraction’ technique, the
following themes from 15 participants’ visual theme structures, were grouped
together: participants’ experiences of severe abuse such as violence and sexual
abuse, damaging emotions linked to family members and themselves, feelings
of not belonging or fitting in to their families, society or mainstream school,
conflict and turmoil in the family and problem and risky behaviours including
during early teens. Using the ‘subsumption’ technique these grouped themes
were given the tentative superordinate theme title of ‘adverse childhoods’. This
was developed further into the superordinate theme ‘experiences of abusive
childhoods – links to damaging emotions and problem behaviours’ and its
corresponding themes, which were represented by 14 of the participants.

8. Credibility checks were undertaken to ensure that high quality and standards
were embedded throughout the methodology and during the analytical stages
(see Section 6.1.5.4, also see Chapter 8, Section 8.6.1).

9. The recurrence of themes was checked: Smith et al. (2012) suggest that at least
a third of participants should be represented at the superordinate theme level to
warrant inclusion in the final taxonomy of themes. All themes met this
benchmark.

10. The final taxonomy of themes was then ordered into a ‘logical sequence’
(Smith et al. 2012), which is described in detail in Section 6.2.2.

6.1.5.4 Procedure for credibility checking in the interview study

Credibility checks were carried out with my supervisors, an independent IPA specialist
and the London IPA network group.

For the credibility check with an independent IPA specialist, I presented the themes
and examples of how participants represented them, including some examples of
participants’ quotes. The advice from the independent IPA specialist helped me to
focus and bring forward phenomenological aspects in one theme where the labelling
was thought to be too descriptive. However, the analysis was considered to be
comprehensive and phenomenological in scope.

A further credibility check with the London IPA group was conducted. I presented my
main findings, themes and a selection of participants’ supporting quotes. The London
IPA group agreed with my interpretations of participants’ narratives and with my final theme headings. One group member questioned my sample size which she thought was large for an IPA study. However, I explained that I conducted a full IPA analysis on all participants but that it was time consuming and added a considerable amount of time onto my research.

6.1.6 Ensuring high quality and standards in the research

To see how high quality research was achieved in the Semi-structured Interview Study and across the research process see Chapter 4, Section 4.12; Chapter 8, Section 8.6.1; and Appendix 21.

6.1.7 The interview method – value, merit and critique

Qualitative methods such as interviews, can help to raise participants’ voices to the foreground. This is particularly important with populations such as drug misusers and offenders who are regarded as ‘hidden’. This means they are difficult to access, engage and retain within research and furthermore might be unwilling to disclose personal information about their drug use and offending behaviours (Neale et al., 2005). The ‘hidden’ status of such populations can further lead to misunderstandings of a particular phenomenon, such as drug use (Rhodes, 2000). However, qualitative methods such as the interview technique can help the researcher to build rapport with drug misusing populations so that they are more willing to disclose personal information about sensitive topics (Neale et al., 2005).

The interview method can provide an opportunity for the drug misusing offender to tell their story in their own words. With the appropriate epistemological approach and analysis (for example IPA) their words and narrative can be transformed to illuminate the ‘realities’ and meanings attributed to this hidden and much maligned world. Through this method and the methodological approach the hope is to humanise the often fearful preconceptions held of the ‘drug using criminal’ so that explanation and understanding can be heard, for some, for the first time. This is especially important within a political arena where the omnipresent public vote looms, drowning out the voices of the ‘underserving’ and where a power imbalance exists (see Chapter 2). One of the more ambitious aims of this research was to influence policy to help improve
service provision for those DIP clients with severe Class A addiction problems and offending behaviour, to help them in their journey of sustained recovery. Fitzgerald (2000) acknowledges for qualitative research to affect policy it must be able to persuade and influence the public first. Fitzgerald (2000) argues that Maher and Dixon [and colleagues] (1999) achieved this in a qualitative study exploring the impact of policing practices among heroin users in Australia. They were able to humanise their stories by illustrating their struggles, suffering and the impact of policing practices on users’ health.

The hope in this research is also to humanise participants’ stories. This will require an in depth understanding of who the participant group are, what meanings they attribute to their lives before drug use, during drug use and into recovery. The hope is to allow the person, the child once within, to be seen and heard instead of the labels of ‘criminal’ and ‘drug user’, dominating those within the political arena (including myself). To engage with this population and truly hear their stories requires a suspension of judgement including those held by the researcher. A powerful means by which to do this is to hear participants’ stories told by them in their own words about the pathways they have travelled before their drug use and to hear their continuing struggles and battles in relapse, recovery and beyond. The key to being able to [attempt to] suspend judgement rests within the hermeneutic epistemological approach such as IPA and in particular the use of reflexivity. The interview method is a powerful means of data collection by which to achieve these aims.

The interview method can employ either a structured or an open ended question format. An open ended format allows participants an opportunity to speak from their own perspective without too many restrictions being placed on them by the researcher. The open ended style can also permit rapport to develop between the researcher and the participant. The hope being that this produces a richer and more detailed first hand narrative account (Smith, 1996). The open ended style semi-structured interview is therefore the method most usually favoured when using IPA (Smith, et al., 2012).

Semi-structured (face-to-face) interviews were used in the second part of this research to allow a more in-depth questioning of potentially sensitive topics than is appropriate
in the focus groups. However, this is not to undermine the rich quality of data concerning sensitive topics that participants in the focus groups revealed. (The benefits of using the focus group design to produce rich data are discussed in Chapter 5.3, Section 5.3.5).

6.1.7.1 Criticisms and challenges of the interview method with a drug misusing offender population

Neale et al. (2005) recommend that researchers should undertake comprehensive training in qualitative approaches (such as interview techniques) which can pose extra challenges with drug misusing and offender populations (Hucklesby & Wincup 2010; and Turnbull & Skinns 2010). Semi/unstructured interviews can provide flexibility for the researcher to react to and pursue emerging lines of enquiry and to allow participants more flexibility to decide what to talk about (Smith, 1996). However, Hucklesby and Wincup (2010) note caution when using such methods with offender populations where controlling participant’s criminal disclosure is much more difficult. Furthermore, the interactive nature of semi or unstructured interviews means that researchers need to be aware of how their interactions might influence participant’s responses. For example, such techniques can foster participants to disclose sensitive topics (such as sexual abuse), and researchers therefore need to be mindful of their reactions (such as shock or upset) which may unduly influence participant’s responses (Neale et al., 2005). Interview techniques require the researcher to build rapport and trust to access rich and detailed information which, with a drug misusing offender population presents its own ethical, safeguarding and legal challenges. These challenges will be discussed further in Chapter 7.
CHAPTER 6.2 - PART TWO SEMI-STRUCTURED INTERVIEW STUDY: RESULTS SECTION

6.2.1 Chapter overview

This chapter presents the four superordinate themes from the IPA analysis of Part Two: the Semi-structured Interview Study. A general overview of the findings is provided followed by a more detailed account of each of the superordinate themes and their corresponding themes. Self-reflective thinking features to help provide context and understanding to participants’ accounts. Participants’ quotes are presented to support the development of and illumination of the themes, some of which can be found in Appendix 24. The more traditional format for IPA studies is to present the findings section separate from the extant literature which some argue helps to raise participants’ voices to the foreground (Smith et al., 2012). This approach has therefore been adopted.

6.2.2 Introduction

Four superordinate themes were developed from the data, these were:

1. Experiences of abusive childhoods – links to emotions that were experienced as damaging/harmful and problem behaviours.
2. The divergent and damaged selves – links to substance misuse.
3. Drug use to cope and survive dangerous events and trauma/responses
4. Managing trauma – transitions into and out of recovery (this includes, internalised will, relational connecting and processing capabilities).

There was high representation by participants across all four superordinate themes. Smith et al. (2012), suggests that a third of participants should be represented at the superordinate theme level. Over three quarters of participants were represented in three of the themes and a further theme was represented by all participants, (see Appendix 23 Table 1: Recurrent theme check for superordinate themes for Part Two: Semi-structured Interview Study).
Some of the themes were linked, a reflection of the complexity of participants’ lives, which will be discussed where necessary. It is traditional with IPA to display and order themes into a “logical sequence” (Smith et al., 2012, p. 109). I have, therefore, chosen to order participants’ experiences of abusive childhoods first (‘Experiences of abusive childhoods – links to emotions that were experienced as damaging/harmful and problem behaviours’ – Superordinate Theme 1). This is because many participants considered this to have links to their later Class A drug use and problems in their adulthood. Furthermore, the developmental theories which have helped to shape the scope and direction of this research acknowledge the influence that childhood experiences can have on adult development and substance misuse. I ordered the theme on ‘The divergent and damaged selves – links to substance use’ (Superordinate Theme 2) next because it built on and linked with some of the sub themes from Theme 1. The theme about why participants used drugs was ordered next (‘Drug use to cope and survive dangerous events and trauma/responses’ – Superordinate Theme 3) because this linked with and built on from many of the participants’ experiences from Themes 1 and 2. Superordinate Theme 4, ‘Managing trauma - transitions into and out of recovery’, was ordered last. This was because it linked with and built on experiences from the previous three superordinate themes.

In keeping with the epistemological and phenomenological underpinnings of the methodological approach I have used, it should be acknowledged that these themes are my interpretation of participants’ interpretations and sense making of their experiences, including their interpretations looking back on their childhood experiences. The methodological approach used does not seek an absolute truth of those experiences but a version of a ‘truth’ that participants hold to have some sort of meaning for them. Staying close to the ideographic nature of IPA I have used quotes from all 17 participants to ensure that participants’ “distinctive voices” are heard and therefore participants’ variations on themes are provided. I feel this offers a rich and nuanced insight into how different individuals experience and makes sense of their journey of relapse and recovery as well as showing the complexity of these journeys.
6.2.3 Overview of the main findings:

Participants used drugs and other substances to cope with a range of dangerous and stressful experiences which they perceived to be traumatic and distressing. These included adverse and abusive childhoods, severely negative and damaging emotional experiences, mental health problems and relational trauma (including with how they related to themselves). Everyday ‘normal’ living could also present as a crisis or traumatic response for participants. Recovery was about learning to manage those trauma responses by learning and applying internalised will (e.g. motivation), relational connecting (support networks), (re)building the self and having processing capabilities (e.g. reflection & rational thinking). Transitioning out of recovery showed an absence of these recovery experiences. A detailed account of each theme is now provided.

6.2.4 Superordinate Theme 1: Experiences of abusive childhoods – links to emotions that were experienced as damaging/harmful and problem behaviours

Many of the participants had abusive childhoods, which included exposure to violence, sexual and/or mental abuse. These abusive childhoods were linked to a range of emotions they experienced as damaging and harmful. The impact of participants’ adverse childhoods was followed by chaotic teens, which involved for example, substance use, emotional and behavioural problems. Some participants viewed their chaotic teens as a means of acting out or reacting to their adverse childhood experiences. Some tried to escape the abuse and their problems by running away or by using substances. Substance use was further viewed as a means of coping with their abusive childhoods or to fit in and belong. Some further attempted to fit in or belong by joining criminal gangs or hanging out with the “wrong crowd”. Feeling different and not belonging were closely linked with Superordinate Theme 2 - The divergent and damaged selves.
6.2.4.1 Neglect, abuse, turmoil: damaged bonds and unhealthy upbringings

Both Veronica and Olivia were sexually abused in their young childhoods. Veronica talked about multiple abuse by her step father and a family friend from the age of 6. Quote 1 illustrates the damaging impact this had on Veronica’s childhood, she became a troubled child, dropped out of school and exhibited behavioural problems. Another participant, Olivia was abused by her father’s friend and his son. Neither of them were able to inform an adult of the abuse during their childhoods. (See Olivia’s Quote 46, Appendix 24).

**Quote 1:**

**Veronica:** It was sexual abuse, sexual abuse. So but obviously at 6 you know you’re not going to run away from home but as the years went on I knew something is not right and he used to say it’s not right we need stop, like we need stop like I was doing it with him but. Erm, it just went on and on and on and I started not going to primary school I was bunking off primary school just sitting in the park and then I was doing stupid things at home like writing on the walls. You know my Mum said I was a right bitch from the age of 6 but obviously she didn’t realise what was going on and erm, she said since I turned 6 I just changed into this horrible child and she never like me at all she didn’t like me at all and when I look back on it now I understand why coz I used to write on the walls and you know like getting attention and stuff like that so I ended up at 14 just disappearing.

Some participants witnessed violence between their parents or their parent’s new partner or were subjected to the violence themselves. Some described the violence being fuelled by alcohol. Six participants mentioned substance misuse among their parents. (See Jim’s Quote 2 and Rebecca’s Quote 3).

**Quote 2:**

**Jim:** Yeah, yeah, yeah she did come back some nights and me Dad never raised, raise a hand to her and she used to come back drunk and beat him up. That did go on for a couple of years.
Both Rebecca and Adam protected their mothers during the violence from their mother’s partner or by their father. However, they felt betrayed when their mothers defended the abusers instead of them. This caused resentment, hatred and conflict between themselves and their mothers. Rebecca’s mother “kicked” her out of the family home (in her teens) rather than the abusive partner. Rebecca began “hanging out with the wrong crowd” and living in an estate with drug users, which eventually led to her heroin use. Both Rebecca and Adam reacted violently to their situations. Rebecca was arrested for trying to kill one of her mother’s violent partners. Adam was arrested after threatening his mother with a knife and was subsequently put into a care home. However, he was unable to tell the psychiatrists about the violent abuse he had suffered by his father. Another participant, Jay, felt betrayed by his mother who defended his father’s disproportionate cruel and physical punishments. His father eventually “kicked” him out of the family home.

Many other participants’ damaging childhoods involved tension, turmoil and conflict, which they experienced as extremely distressing. Veronica, Freddy, Harry and Gale talked about the conflict, tension and turmoil among themselves and other close family members. Veronica was teased and taunted by her mother and her siblings for a physical condition she had. Veronica’s mother was particularly unsupportive and blamed Veronica for her behavioural problems, and called her a “bitch”, “useless” and “horrible”. If Veronica ran away to escape the sexual abuse her mother made her sleep outdoors. (Veronica’s mother was unaware of the abuse). This further added to Veronica’s distress and negative feelings about herself.

Freddy mentioned a lot of family conflict between himself and his parents; whilst he accepts blame for his bad behaviour he also recognised that his parents did not
understand him and there were other tensions in the family. For example, he was one of 7 children, he felt “lost” in his family and felt that no one gave him any attention. He talked about his father in a manner which led me to believe he had died during his childhood, however when pressed further he explained that his father’s absence was because he worked a lot.

Two participants, Harry and Gale, did not talk about any extreme violent, sexual abuse or neglect. There was no mention of substance misuse among their parents or siblings either. However, they talked at length about complicated family dynamics. Harry discussed a complex relationship with his mother, which he described as a “battle of wills”. He further described his mother as emotional, unpredictable and domineering. He went on to talk about how he felt his relationship with his mother had negatively affected his adult relationships with women. He avoided intimate relationships with women. This will be discussed in more detail in later themes.

Gale talked about the rivalry, conflict and feuds among close family members while she was growing up. She thought this was partially due to a family secret, that her father was not her biological father. This had been kept from Gale and her sister while other family members were aware. Gale was told the secret in her late teens by a drunk neighbour. Gale felt she had always been treated differently (inferior) to her sister by some family members (who were non biological family). She felt upset when she was ignored and shunned by those family members. She questioned her mother on many occasions about this but her mother was dismissive of Gale’s upset and concerns.

Terry, Jim and Stacy specifically talked about the impact of parental divorce and separation. Parental divorce or separation was mentioned by many participants as a time involving conflict, upset and turmoil in the family before, during and afterwards. It also involved moving geographically for some participants, which further contributed towards disruption and turmoil. For Jim the process of his parents’ separation was long and protracted and involved his mother disappearing for weeks to be with other men, often returning intoxicated and violent. Stacy talked about the damaging impact her mother’s affair with her older brother’s friend had on the family who were “up in arms” when her parents separated. Stacy considered family life to
have been OK prior to her mother’s affair but reacted to it by “acting out” and misbehaving. However, Terry was relieved when his parents eventually separated.

For many participants the family home felt like a battle ground involving rivalry, conflict and changing allies and enemies. For many this also included violence and other forms of abuse. Participants also experienced a lack of support and care from the authorities (school system and/or care system). For some, school and the care system was another place where they were victimised and felt unsupported. (See Veronica’s Quotes 1, 6b; and for Quotes 50 and 51 see Appendix 24).

This theme relates to the superordinate theme by illustrating the variations of abusive childhood experiences. It touches on how some participants normalised the adverse experiences but most felt a range of extremely negative emotions linked to their childhoods. These are discussed next in the theme on destructive emotions (Section 6.2.4.2).

### 6.2.4.2 Destructive emotions – links to self, family and childhoods

Participants experienced emotions such as fear, anger, rejection and hatred which they felt were damaging and destructive and which they linked to their childhoods. This included how they felt about themselves, parents or other close family members and about their childhoods in general. This theme relates to the superordinate theme by highlighting the damaging emotions that participants felt were linked to their adverse childhood experiences and relationships, including how they related to themselves. (The impact of internalised negative emotions on participant’s sense of self and identity is discussed in Section 6.2.5)

Damaging emotions which participants linked to their parents or close family members included, fear, anger, hatred and resentment. Adam (Quote 4), hated both of his parents, in particular his father who was violent towards him and his mother. However, he also felt betrayed (mentioned earlier) when his mother reunited with his father after a period of separation. There were several other participants who hated their parents or a parent’s partner, due to the abuse they suffered from them. Some also experienced fear where violence or sexual abuse was present in the family home. However, when
Zachery talked about his father’s violent alcoholic abuse towards his mother he appeared disconnected from it rather than emotional like other participants (see Zachery’s Quote 47, Appendix 24). Jim’s accounts of the violence in his family were also void of emotions. Terry wanted to kill his father when he was growing up although it is not clear why. He felt oppressed and did not feel part of his family. He felt relieved when his parents finally separated.

**Quote 4:**

**Adam:** Yeah so I hated my Dad for what he’d done then I hated my Mum for going back because as soon as we went back it all started again.

**PI:** Was your Dad violent towards you? Your Mum?

**Adam:** Yeah, I’ve had proper like fist fights with him. I’ve hit him with snooker cues everything when we were younger.

Gale spoke about her hatred and resentment towards her sister who was treated in a superior manner by biological family members (as outlined earlier). She felt anger towards her parents for keeping a family secret for many years. Jay resented his sisters, whom he felt were treated better than he was by his parents.

Participants also talked about how their adverse childhood experiences made them feel about themselves. For example, unloved, uncared for or rejected by their parents and family. Jay and Zachery felt unloved in their childhoods. Zachery in Quote 5 struggled to accept love in his adult years from his girlfriend’s family which, he suggested was because he had never felt loved when he was growing up. He cited this as one of the reasons for a relapse.

**Quote 5:**

**Zachery:** Yeah but the thing to be fair to them to be fair to them but what they were see *(stutters)* what they were giving me yeah I’d never had that in my life. They were giving me proper love yeah. At Christmas in my Mum and Dad’s house *(name of
Quote 5, continued from previous page:

Zachery: place) yeah growing up Christmas came as Christmas ok we’d be given our plates of food in front of telly. I’d never have that hug or kiss off my Mum oh hello darling I’m back from work. Don’t get me wrong she was a good Mum but I don’t think she knew how to, to show me love.

When Jim’s parents separated he felt his mother only visited, (which was rarely), when she had financial problems and not because she wanted to see him. However, unlike other participants his account was void of emotions in relation to his mother. He did however, talk about emotions from his childhood in relation to his Grandfather and his first girlfriend. He was upset when his Grandfather died and when his first girlfriend, with whom he had children, during his teens died. He expressed emotions (sadness) over these losses but did not with the loss of his mother, (due to her abandoning him). This might have been because his mother was abusive and caused conflict and hurt and the loss was gradual over many years. However, the loss of his Grandfather and girlfriend was sudden, permanent and there was no mention of these relationships being abusive.

During the interview when participants were discussing these experiences, many displayed their strong emotions. This included those who were not able to articulate their emotions. For example, by sounding angry, upset or looking visibly tearful. Terry became very angry when asked about his childhood and his father during the interview. I did not therefore, continue to pursue these lines of questioning but opted to try and calm the situation by moving to other topics. I also decided to cut the interview short when Terry vocally let me know that he was fed up with the interview process and his speech had also become slurred. This participant’s high level of anger during the interview might have been for several reasons. Terry was in the process of a full relapse and had taken Class A drugs within the previous 48 hours of the interview, which may have been the reason for his slurred speech. When I had spoken to Terry several months earlier he had been in recovery and was participating in an educational course and was living in a hostel. He was articulate and did not appear angry or under the influence of Class A drugs. However, he had recently been asked to leave his hostel because he was considered to be recovered enough to move into another type of (less supportive) housing. This he found distressing and unfair. He was angry and it
appeared to be a trigger for his relapse. His anger could also have been linked to feelings from his past childhood relationships and experiences I had asked him to talk about. The effects of the substances he had recently consumed may also have been a contributing factor to his mood. It may well have been a combination of all of these factors.

Another participant Mark became very tearful every time I asked him about his childhood or parents. He was not able to talk about his young childhood, he felt he had disappointed his parents. It transpired during the interview that he had used crack within the previous 24 hours of the interview. Again it is likely that there was a combination of factors contributing towards Mark’s emotional state. Participant’s emotional states during the interview process will be considered further in the Chapter 7.

Other damaging emotions participants felt about themselves from their childhood experiences included low self-worth, feeling horrible or that they were naughty or did not care about themselves. Veronica in Quote 6a/b, who was sexually abused, described how she felt useless and horrible.

**Quote 6a:**

*Veronica:* I don’t really remember I just remember feeling just useless, just useless all the time and my Mum used to say I was useless all the time and I was no good and you know. I used to suffer from ‘eczema’ really badly.

**Quote 6b**

*Veronica:* God you know I can even remember coz I was hardly in there. I was hardly in school and like I said I used to get bullied and taunted about my eczema it was horrible. I never had the right uniform and I never had this, I never had that, whereas all the other girls had the right uniform. Mine was always second hand or it was horrible. It was a horrible feeling there was no confidence whatsoever so I took the other way out and I just started running away, running away and doing whatever and shit like that.
What is interesting to note is that Stacy (in Quote 7), was the only participant who talked about her emotions within the context of a mental health condition during her childhood. Stacy was angry that she was placed in and out of the care system by her mother at a time when she needed her mother’s help with her depression, self-harming and suicide attempt.

**Quote 7:**

**Stacy:** I think from about 12 or … I tried to kill myself when I was youngster and self-harm-

**PI:** Was that when you were taken into care?

**Stacy:** Yeah and self-harm things like that and it was never it was always back then they always saw it as acting out, attention seeking and I think if they looked more serious there was more to it. Coz I’ve always had patches where I get very low.

Happiness was not an emotion that participants were able to talk about in relation to their childhoods. A small number of participants initially said that they had a “good” or “happy” childhood. However, further questioning revealed that most had suffered extremely abusive childhoods. These contradictions could be for several reasons. The abuse was the norm and they had not experienced what a ‘good’ childhood was and were unable to recognise or understand positive states (Schore, 1994; and Schore & Schore, 2008); their childhoods may have appeared better or good in comparison to their years of chaotic and traumatic substance use in their adult life, describing childhoods as ‘good’ or ‘happy’ was the expected response and talking about abuse was a much more involved and difficult discussion for them. There is a considerable amount of research within the trauma literature which suggests that those who have suffered trauma can have difficulty recalling or talking about such experiences (Holmes, 2006; and Van Der Kolk, 2014). There was evidence of memory blocks for both Gale and Olivia which will be discussed in Chapter 6.3, Section 6.3.2.1. Years of substance use could also have affected long term memory and substance misusers can have difficulty recognising, describing and reflecting on their emotions (Tronnier 2015). It is likely that one or more of these were contributing factors for these participants.
How participants felt about themselves and in relation to their family or school peers seemed to manifest in feeling different to others or that they did not fit in or belong in their family, at school or among their ‘mainstream’ peers. This will be discussed more in the theme about the divergent and damaged selves.

6.2.4.3 Attempts to escape the problems and abuse

6.2.4.4 Reacting/acting out and risky behaviours

These two themes link to the superordinate theme by illustrating participants’ varied reactions to their abusive childhood experiences and the damaging emotions they felt.

Many participants made attempts as they got older into their teens to escape their problems or the abuse they suffered, however for some this happened in their earlier childhood too, see Veronica’s Quote 1. One means of escaping was in the form of running away from home or truanting from school. Some viewed themselves as naughty but others, looking back, were able to recognise that their behaviour was acting out and reacting to their adverse childhood experiences (see Stacy’s Quote 12, where she acknowledges she was only a child). This capacity to reflect, understand and reason will be discussed in more detail in the superordinate theme about ‘managing trauma – transitions into and out of recovery’.

Some participants used substances to escape their problems, for example, glue sniffing, alcohol and later drug use. Substance use was also viewed as acting out or reacting to their problems or the abuse they suffered. Adam (Quote 8) began substance use as a means to fit in and belong because he wanted to escape his home life, which he disliked.

**Quote 8:**

**Adam:** Looking back on it now I started smoking cannabis because I wanted to feel like I belonged somewhere. To like fit in with I suppose how would I explain it like, like that classroom I went and they were all posh with the blazers and brief cases even though my Mum and Dad had their own house all of my friends ninety, 98% of them all came from council estate backgrounds. So I was like as if to say in with the in crowd sort of thing. I wanted to feel part of something because I’d left like my home life was *shit.*
Olivia in Quote 9 had a moment of realisation in the interview where she connects her experiences of being abused with her first use of drugs.

**Quote 9:**

**Olivia:** You asked me what was going on in my life when I started using and thinking about it I started being abused at 8 and the last time you see I was scared of doing counselling in case there was more the last time I remembered I was 13 which I think ties in with, I haven’t said it but I used to glue sniff and drink and stuff I think it ties in with that time wise but I’ve never noticed it before.

As mentioned above some participants did not acknowledge directly that their behaviour was acting out or risky but normalised it. Terry (Quote 10) normalises his criminal behaviour during his childhood.

**Quote 10:**

**Terry:** Yeah well not so much crime but yeah say if they wanted somewhere burnt they would pay us to do it and you know what I mean. And that’s how, so off we got we was given quite a (pause) a good, good life for youngsters and then there was a couple of other chaps they weren’t a generation older we was a couple of in ‘betweener’ coz we was all smoking cannabis doing all shit speed I think was about the first, amphetamine I can’t stand it I had a little bit of it and it ain’t for me.

**Terry:** I supposed everyone’s at one time but no we were, we were sort of like (name of place) and you know, you do without realising it being part of a gang who will accept you here and you know you’re manipulated when you’re that age you are. (Sombre, regretful tone).

Zachery (see Quote 53, Appendix 24) was only 14 years old when he first used Class A drugs. He normalised being around alcohol growing up. This may have been because Zachery’s father gave him orange juice laced with vodka from the age of 6 or 7 years old. However, Zachery also acknowledged how the drugs affected his ability to mature and develop emotionally in his teens, although he also alludes to the detrimental impact that the lack of love he felt growing up had on his emotional capacity in adulthood (as mentioned earlier). He thought his drug use had affected his ability to love or to feel emotions. Jim (Quote 52, Appendix 24) smoked cannabis, which he obtained from his older brother who used drugs, from age 6. This was around the time his Grandfather, with whom he had a close bond with, died. He further considers that this was related
to the time when he began to “go off the rails and turning to drugs and getting high”. Normalising risky behaviours will be discussed in more detail in the superordinate theme about the divergent and damaged selves.

Some participants became involved in criminal behaviour in their childhoods, which included being arrested by the police. For two participants this involved violence against a parent or parent’s partner, which was a reaction to the physical abuse in the family. Some participants also experienced homelessness, this included ‘sofa surfing’, living on the streets or in a YMCA. It led on to further ‘risky’ behaviours in participants’ teens, such as substance use and criminal activity. For example, Jay (Quotes 48, Appendix 24) talked about the detrimental impact that living on the streets had on him, after his father “kicked” him out of the family home. Other ‘risky’ behaviours included some of the participants becoming teenage parents. For many participants their parents were either unaware of their children’s problem behaviours, they did not care or were unable to cope with it. (See Jim’s Quote 52 in Appendix 24 and Veronica’s Quote 1 and 6a).

6.2.5 Superordinate theme 2: The divergent and damaged selves – links to substance use

This superordinate theme represents the three different ways that participants thought about and treated ‘the self’. It includes experiences from both their childhood and adulthood. Participants felt different to others and that they did not fit in or belong in their families, school or mainstream society. This was also present in their divergent and damaged ‘selves’ identities too. Participants dealt with these different ways of viewing and treating ‘the self’ often through Class A drug use and other substances including alcohol and prescribed medication. When they had to be ‘normal’ in recovery they struggled and used drugs to cope.

6.2.5.1 Felt different to others

There were various contributing factors which made participants feel different to others growing up. These were related to their family, school and (mainstream) peer environment. They continued to feel different to others in adulthood.
Within the family participants felt and thought that they were treated differently to other family members or that they did not feel part of the family. This was for a variety of reasons including abuse, being “kicked” out of the family home and complicated and distressing family dynamics.

As mentioned previously, Veronica was sexually abused and someone also attempted to abuse her in a children’s care home. She was the only one who was abused in her family. In an attempt to escape the abuse she asked her father if she could live with him but he refused. Veronica felt that her other siblings ‘clicked’ with her father but that she did not. She eventually stopped having contact with her father. Veronica was teased at home by her mother and her siblings, and was bullied and teased at school. If Veronica ran away from home to avoid the abuse her mother, who was unaware of the abuse, made her sleep outdoors. Veronica felt that her mother made her feel that she was “horrible” and “useless”. All of these experiences made Veronica feel and think that she was different to others in a negative way, she felt she was not part of her family and did not feel that she fitted in at school. Her reaction was to run away from school and home and to hang out with others who used drugs or substances. (See Veronica’s Quotes 1, 6a/b).

Bruce (Quote 11) was taunted and victimised by his father who teased him about his dress style and appearance. This contributed towards Bruce feeling that he was different to others including his siblings and peers at school. He eventually left home in his early teens and became part of the “sex, drugs, and rock and roll scene”, where he felt he belonged.

**Quote 11:**

**Bruce:** He used to just pick on me all the time. Just pick on me constantly pick on me.

**PI:** What did he say?

**Bruce:** Just look at you, look fucking green hair. I went but I never done it that Rachel done that to me. My sister Rach. You know my sister used to dress me like a doll, like a punk rock doll. But I looked good for my age you know what I mean. You know
Jay felt unloved, that he was the “black sheep” in the family and thought that his parents treated his sisters better than him. He thought that he had not lived up to his cultural or parental expectations. His father inflicted particularly harsh punishments on him. Jay was removed, against his wishes, from mainstream school to be home educated by his father. He reacted by misbehaving and his father eventually “kicked” him out of the family home during his early teens. Jay’s family environment contributed towards him feeling different.

Feeling different to others included feeling unwanted, rejected or abandoned by parents. For example participants who were “kicked” out of the family home or where their mothers chose to stay with abusive partners rather than protect them (e.g. Adam and Rebecca). Further abandonment and rejection was felt by participants who were put into the care system or were brought up by other family members such as a sibling or a Grandparent. Rebecca was abandoned by her mother and brought up by her Grandmother until the age of 10, when her mother demanded her back. However, her mother had numerous violent alcoholic partners and was unable to provide a stable and safe environment. Rebecca was distressed when she was not allowed to continue to live with her Grandmother and she was not permitted by her mother to have contact with her father. Rebecca thought that her life would have turned out better if she had stayed with her Grandmother, (whom she continued to have a close bond with in her adult years).

Stacy in Quote 12 talked about reacting or acting out for attention after a turbulent time in her family. Stacy’s mother eventually put her in to care because she was unable to cope with Stacy’s problem behaviour, including glue sniffing. Stacy was then placed into the care of her older sister however, she described a childhood where she brought herself up. She then became pregnant at the age of 17 and shortly afterwards began taking Class A drugs. She links her drug use to not being able to cope after her relationship with her baby’s father broke down.
Quote 12:

Stacy: Mum sort of like I just think she got to a point where she couldn’t cope and I was playing up, I was playing up for attention not realising the stress I was putting on her because I was only a child. But she saw me doing things like glue and that and she saw and screamed oh she’s going to be like my brother and panicked and put me in care and took me out and put me in and this went on for a few years and then like I said I ended up with my sister.

As mentioned in section 6.2.4.2 participants felt destructive and damaging emotions in their childhood, these were internalised and linked to how they felt about themselves (e.g. horrible, worthless, naughty) which contributed further to them feeling that they were different.

Many of the participants did not feel part of mainstream schooling and had extremely negative experiences of school including being bullied, misbehaving and truanting. School was an environment where they felt unable to concentrate because of the abuse they were dealing with, problems they felt unable to deal with or where they felt they did not fit in or belong. Some (e.g. Veronica, Gale, Bruce, Freddy) were bullied at school or felt unsupported and disliked by teachers (see Veronica’s Quote 1 and 6b). Some acted out at school and were expelled or frequently in trouble with teachers (e.g. Jim, Jay, Adam, Harry, Rebecca, Zachery, Stacy).

Some participants attempted to fit in/belong or escape their problems and the abuse by using substances or joining criminal gangs or hanging out with the wrong crowd. Substances included glue sniffing, alcohol and cannabis use and for some this progressed very quickly on to Class A drugs during their teens. Participants’ reactions to their situations further marginalised them from their family, school and mainstream society contributing towards making them feel even more different. For example by becoming involved in substance misuse and criminal behaviour both of which are ‘hidden’ activities and which isolated them further from mainstream schooling and peers.
6.2.5.2 Damaged selves

There were a range of damaged selves evident in how participants talked about themselves, these included a lost, rebellious, negative, disorganised and addict self. This was how participants described themselves and the identities that seemed to dominate or stand out from their accounts. Some participants appeared to have multiple selves, for example, an ‘addict self’ present alongside a ‘rebellious self’. This included how participants felt, thought and treated ‘the self’. This theme relates to the superordinate theme by illustrating the range of damaged and divergent selves among participants’ identities and the links to substance use.

Some participants felt lost, describing themselves as having no direction or that something was missing. These thoughts and feelings continued into their adult years, for example Freddy in Quote 13 viewed drug taking as a means to fill his lack of direction.

**Quote 13:**

Freddy: I had no direction I just went wherever I wanted to go. And I’m thinking that’s not life and every time you’re thinking that’s not life you’re looking for a fix. So it’s, it’s a vicious circle you’re basically in your right state of mind but then you need you’re looking for your fix.

Harry, Isabella and Gale experienced a sense of being lost when they experienced sudden life changes or transitions. Both Harry and Gale felt they had lost their freedom when they became young parents. Harry used alcohol and then Class A drugs to cope with his fears over his lost freedom and parental responsibilities. Gale felt she had lost her freedom to work and socialise and blamed her baby for this. Isabella identified strongly with her ‘career self’ and with being a highly functioning mother and wife. Her life changed when she stopped working to care for her sick husband who then died. She “fell apart” and turned to heroin to cope with her lost identity and the loss she felt after her husband’s death.

Some participants strongly identified with a rebellious or deviant self. This included hanging out with the wrong crowd, criminal gangs and being in trouble with the police.
or teachers during their childhoods. For most this continued into adulthood in the form of drug taking and criminal behaviour. Harry identified with the “reprobates” at school and was frequently in trouble with teachers and his parents for misbehaving (also see Olivia’s Quote 9, and in Appendix 24, Stacy’s Quote 54 and Bruce’s Quote 55). Some viewed their rebellion or deviancy as a means to gain attention (see Olivia’s Quote 14, Stacy Quote 12 and Veronica’s Quote 1).

Quote 14:

**Olivia:** I think that’s another element of using is a rebellious thing to do and I still like it now even now at my age, walking down the street with a spliff, why? I could be arrested that’s crazy, but there’s an element of ow look what I’m didn’t. I used to have a Mohican it’s the same kind of thing and that you know it’s nuts. But I think that ties in with why I’m using. So I don’t know a safe way to rebel is what I need. I can’t dye my hair because of my stroke my hands don’t work very well.

Terry felt rebellious about many aspects of his life including in his current ‘recovery’, where he had relapsed. He had a strong anti-establishment attitude towards probation, prison, hospitals, the rehabilitation organisations and the Government. He strongly identified with his criminal behaviour throughout his life. During his relapse he was drawn back to his old criminal and drug taking ‘friends’. As mentioned previously in Section 6.2.4.2, Terry was very angry during the interview and articulating his rebellion might have been his way of expressing his anger. Another participant, Bruce, (see Quote 55 and 56 in Appendix 24) considered himself to be a rebel during his childhood and in his adulthood.

Some participants felt very negative about themselves during both their childhood and adult lives. Many still struggled with these negative feelings about themselves in recovery too. Olivia (Quote 14) and Harry felt self-conscious. Harry thought he was “vulnerable and imperfect” and that people would discover that “most of the time I didn’t know what I was doing”. Olivia further demonstrated her self-consciousness by continually seeking approval throughout the interview process, for example by asking if her answers were Ok. Zachery, Veronica and Stacy described themselves as worthless. Sometimes participants’ negativity about themselves was described as an
emptiness or something missing that needed to be filled, which in their cases they had done so with drugs or substances.

Some participants (for example, Terry and Luke) tried to create better images of themselves. Their narratives were full of contradictions and their identities appeared disorganised. For example, Terry talked about having a moral compass but this was some kind of criminal code of conduct. His narrative was dominated by deviant and criminal behaviour. He thought he was a “man of his word” because he had committed to attending the research interview but he demonstrated on many other occasions that he was not.

Luke viewed himself as a well-rounded person and someone who had emotional strength especially in relationships. However, he suffered from severe mental health problems and had recently served a lengthy prison sentence for rape whilst high on crack. He regarded his mental health and his conviction to be due to his addiction to Class A drugs. The addict identity was also very prominent in him. In Quote 15 he talked about having addictive tendencies to other things in life such as the gym, women or food. He felt as though he had merely focused his “addictive personality” onto something else. Luke’s severe mental health conditions (depression, anxiety and OCD) may also have accounted for his narrative and his identity appearing disorganised or contradictory. At times, during the interview process, he was hysterical and at other times solemn. He seemed to struggle with formulating who he was and focused on creating an idealised image of himself. Conducting an interview with someone exhibiting extreme emotions and behaviours alongside confusing and contradictory narratives, was disturbing. My feelings might have been exacerbated by the knowledge of his rape conviction and because I was 5 months pregnant at the time it made me feel more protective about my own personal safety.

**Quote 15:**

**Luke:** ‘I’m an *addict* it doesn’t matter what it is, it could be food it could be sport you know once I get into something I pursue it with vigour. Erm which in, in some cases might not be all bad coz if it’s a positive thing that I’m doing then it’s good but if its drugs obviously I’ll be having conversation like this.’
Jim, (Quote 57, Appendix 24) appeared to have a lifelong need for substances and was unable to cope unless he was taking either illegal drugs or prescribed medication (including illicitly). Many other participants had struggles with other substances such as alcohol or prescribed medication. Some participants, like Luke, felt that they had merely switched their addictions in their recovery from Class A drugs to other things including other substances, rather than conquering addiction.

Some participants (e.g. Luke, Freddy, Jay, Terry) were so consumed by their addict self that they blamed all of their bad decisions in life on their addiction(s). They were unable to see beyond it to examine any other reasons for their decisions or choices or the things that had happened to them in their lives. Their addiction was like a separate entity or living thing controlling their lives. Some referred to it as an addictive personality. The ‘addict self’ was prominent especially for those participants who were lapsing or relapsing at the time of the interview, for example Terry.

### 6.2.5.3 Drug use to cope with ‘normality’ and the mundane

This theme relates to the superordinate theme because it demonstrates how participants treated their divergent or damaged selves in recovery when they attempted a normal life. It links to substance use because participants often turned to drug use and other substances when they were trying to cope with that normality.

In previous themes participants talked about not having a ‘normal’ life in childhood or during their years of substance misuse and for some they normalised deviant, criminal and adverse childhood experiences. It is therefore, not surprising that participants struggled to cope with a normal everyday life, when they had little knowledge or experience of what normal life meant. This could be finding housing, managing a home such as paying bills or finding legitimate paid employment or maintaining a social life or relationships. Most of the participants had never earned money legitimately but had supported themselves through criminal activity. Many employment opportunities were therefore off limits due to their offending backgrounds, creating further barriers for them to navigate. Terry in Quote 16 talked about struggling to know how to make money legitimately. He had never had a
legitimate paid job. Some participants, (see Terry Quote 16 and Jim Quote 58, Appendix 24) acknowledged their desperation to have a normal life away from drugs and crime. However, trying to maintain normality for many participants was a trigger for using and lapsing or relapsing during recovery.

**Quote 16:**

**PI:** What do you worry about?

**Terry:** Not doing things I said I’d do (very agitated). Not having to worry about where am going to get a dollar from next without having to go out and commit crime. There’s no (?) in my life whatsoever (mumbles, he’s eating some of the refreshments I’ve brought with me).

**Terry:** Sorry, normality nothing normal in my life (he’s eating some of the snacks). But am juggling it around where I can be with people that I meet just say on the canal or whatever and they wouldn’t guess what I do or what I am.

**PI:** When you are say, what I am, what do you mean?

**Terry:** Like never guess that I’ve never had a job or I never went to school or I, I don’t do, do you know what I mean and then I hear them talking about. So you know what I mean well I can’t really tell them this now but. I’ve done a counselling course and it, it got to a point where you have to be your own guinea pig say and you need to share things with that and normally you have to base it on your own life, which I found a bit weird so I had to make things up to tell them rather than go yeah I’d tell them what actually happened in there, they’d be like whoa no one would even speak to me or come near me.

Many participants struggled with relationships and maintaining a social life. Terry regarded people as “slippery” and would “rather be with some nice coke” instead. Olivia, Bruce and Luke also used drugs to help them cope in social situations. Many participants struggled with relationships even when these were not described as physically or mentally abusive. For example, some participants struggled with managing long term monogamous relationships. Zachery thought that “addicts do not settle at home”. He talked about having many affairs and he left several girlfriends when they became pregnant because he felt unable to cope with the responsibility of fatherhood. Most of the participants who had children struggled to cope with parenting. The female participants had either had their children removed by social services or
other family members had taken responsibility for them because they were unable to manage. Freddy (Quote 17) struggled to deal with the “normal” routine of looking after his children during his recovery.

**Quote 17:**

**Freddy:** To tell you truth I feel down sometimes, not all the time but now the kids have gone to school I feel down. As soon as they’re back or when I see them I’m myself. I’m jolly you know coz they are always interacting, dad’s what’s this, coz that’s what I like and even when I’m at work and I used to come back I looked forward to coming home because that’s normality. *Coz* it’s I’ve missed so much even in that two years. Words can’t express nothing can express.

Gale spoke about her struggle in recovery to manage a home such as paying bills, budgeting and furnishing it (she had been a prostitute and homeless for most of her adult life). Mark relapsed when his life was going well, he had a long term relationship, a job and friends. In his most recent recovery he demonstrated knowledge of what he needed to do to attain a “normal functioning” life which he had done in the past. However, he was unable to maintain this for any length of time and was only able to maintain basic survival with the help of his drugs. His desire for survival might have been a deeper reflection of the political war torn country he had grown up in. He considered himself lucky to have survived when many of his friends had been killed (see Quote 18).

**Quote 18:**

**Mark:** Everything, everything. Guns, guns like mafias you know everyone. So it, it was you know it was like a worst situation. YEAH, YEAH, YEAH. It was so I am happy I survived that time. A lot of my friends a lot of the people who is die about from that time.

**PI:** They died?

**Mark:** YEAH, YEAH.

Some participants struggled to deal with “normal feelings” during recovery. Zachery in Quote 19 illustrates this struggle. He felt he had to deal with “normal feelings”, which returned after years of him numbing them with drug use. Others struggled to
cope with feelings such as guilt, shame and everyday stress. Zachery touches on how, what might be considered normal emotions for others, are not necessarily treated or experienced as such by the participant group. Dealing with emotions will be discussed in more detail in the theme about drug use to cope and survive trauma/response in Section 6.2.6.

**Quote 19:**

**Zachery:** Because and then a lot of people, I think a lot of people they tend to they say OK I’m going to stop taking drugs but what, what people sometimes may be the facilitators what they’re not prepared for, they’re not prepared for if I stop taking drugs then that part of my brain is no longer getting that, that cocaine that heroin is going to start to, to is, is reborn if you like do you know what I mean its starts to act normal. So sometimes some people don’t know about…what’s happening to me…I remember with me I was watching a movie and I started to cry me Zach you know I was watching a movie I thought what’s happened why am I so tearful you know what you mean. A lot of that comes out a lot of people , a lot people do addicts do and at that, that stage they start to take again coz they suppressing coz they don’t understand what’s happening to them yeah.

Participants’ idea of “normality” was dealing with everyday life, relationships (non-abusive ones) or emotions in recovery. Some used the word “normal” and were aware of their struggles with what they considered should be normal everyday life. Some were also aware that they struggled to have “normal relationships” that were not abusive or complex. Others were aware that these were triggers for lapsing or relapsing. (Awareness and reflection will be discussed further in the theme about managing trauma and transitions into and out of recovery in Section 6.2.7.4).

**6.2.6 Superordinate theme 3: Drug use to cope and survive trauma/responses**

Participants used drugs and other substances to cope with a range of traumas/responses including difficult emotions, mental health problems, relationships (including how they related to themselves) and trauma/responses they experienced from their past and present. This included trauma responses to events and dangers, such as bereavement and abusive partners. Many participants also experienced everyday “normal” life as traumatic which could lead to a (re)lapse or heavier drug use to help them cope.
Managing sustained recovery was about managing these traumas and crisis points. This is discussed in Superordinate Theme 4.

6.2.6.1 Emotions and mental health

Participants struggled to manage a range of painful emotions such as anger, hurt, fear, loss, loneliness, guilt and shame. Many of these emotions were linked to their childhoods as mentioned in the earlier theme, in section 6.2.4.2, but they continued to struggle with them as adults. Some of these emotions also manifested in diagnosed mental health conditions in participants’ adult lives before, during and after drug misuse. The most prominent mental health problems were depression, anxiety and stress. Drug use was also a means by which to experience positive emotions. This theme links to the superordinate theme by illustrating the range of emotional traumas that participants experienced and many coped with these by using Class A drugs, prescribed medication or other substances.

Some participants used drugs to numb or to block emotional pain as a means to cope. This could be emotional pain from violent relationships, abusive childhoods or dealing with the guilt and shame from their chaotic drug using and criminal lifestyles (see Rebecca, Quote 20).

**Quote 20:**

**Rebecca:** You know when I was on drugs I had no emotions anyway I couldn’t cry if I wanted to cry I was just numb.'

Harry struggled with loneliness, shame and depression and used drugs to cope with those feelings (see Quote 21).
Quote 21:

Harry: Generally I would end up just loneliness that kind of thing would lead me back to the methadone.’ And my failure relationship with my daughters’ mother kind of led me to, I felt very depressed around that, I didn’t have any contact with my children. I felt very, a lot of shame around being an absent father and I think it got to a point where alcohol wasn’t helping with any of that. I felt as though in a strange kind of way that I could take heroin and take some kind of responsibility for my life.

Other participants used drugs to cope with mental health problems (see Gale’s Quote 59 Appendix 24). Jim in Quote 22a/b talked about using drugs to cope with feeling depressed. Many participants realised that their drug use made their mental health problems worse however this was not always a deterrent that would lead them to abstain from drug use. Some participants who did abstain were then reliant on prescribed medication to help manage their mental health problems.

Quote 22a:

PI: Severe depression OK. So how long do you think you’ve had depression for, how long have you felt low?-

Jim: I reckon since, since my partner died and I blocked it out and I tried to block it and the fear and the emotions for about 15, 20 years that I was a full blown user.

Quote 22b:

PI: When I asked you how long you had felt depressed for and you said it was when your partner died when you were 19 and you just wanted to block everything out how did you block it out?

Jim: Drugs. Heroin.

PI: Did you take heroin knowing that’s what it would do or?

Jim: Yeah. Yeah coz you’re it makes you live in your own little world, no pain and no feelings. It just blocks everything out.

Olivia (Quote 23) and Gale (see Quote 60, Appendix 24) who both suffered from post-natal depression, recognised links between their mental health and drug use. Olivia
self-medicated with drugs so that she did not feel anything. She suffered severe anxiety, depression and heard voices too.

**Quote 23:**

**Olivia:** No I had post-natal depression after my son was born I was put on anti-depressants but I didn’t stay on them because I was using. I think that’s what I’ve done all my life really is medicate myself.

Isabella, Gale and Zachery talked about the rush of emotions that they had to deal with in recovery when the numbing effects of the drugs wore off. This was a trigger for (re)lapse. Zachery (Quote 24 and 19) felt that drug use from the age of 14 had stopped his emotional development. He struggled to recognise what his emotions were and how to manage the intensity of them when they returned during his recovery. These were triggers for him to (re)lapse.

**Quote 24:**

**Zachery:** When you start taking drugs at 14 yeah subconsciously what you’re doing you stop growing yeah you stop, stop. You have a birthday 15 and 16 but if you start at 15 you remain at 15 yeah. Now I remained at 15 until when I was clean. I didn’t have a birthday coz I suppressed all the normal things that you feel, yeah you know am, am, you suppress that. I know that I didn’t know how to be a Dad, I didn’t know how to be brother, I didn’t know how to be a son, I didn’t know how to do anything coz drugs took all that away from me because drugs suppresses all feelings and emotions. You know the pleasure, pleasure part of your the brain, I was getting elsewhere I wasn’t getting it normally like how Joe Smith gets it in the world. I was getting mine through drugs. So every time I saw a certain drug or a certain girl I, I associated that my brain said aargh that’s (relaxed sound) I associated with pleasure you get what I’m saying. I kind of stopped growing.

Drug use was both a coping mechanism for participants to deal with emotional trauma but it was also a means by which to achieve positive emotions that eluded them especially during their abusive childhoods and difficult teens, as mentioned in the theme in Section 6.2.4.2. Rebecca used drugs to relax her. Adam talked about using Class A drugs to feel happy (to get high) and then other drugs to calm him down. Gale viewed drug use and then methadone as a means to feel comfort. She talked about
“weaning” herself off methadone. These metaphors to me, produced imagery that appeared very maternal, like a baby being weaned off milk and having their comfort blanket removed slowly. There were other examples where Gale positioned herself as a child, abdicating responsibility for herself and relying on the intervention of a more responsible adult, including her own parents, during her recovery.

6.2.6.2 Relational trauma

Participants continued to struggle with relationships in their adulthood, this was with partners, their children, family members and others. Drug use was a means of coping and managing some of these relationships however for most this further added to their relationship problems. Not all participants felt this way, Veronica (Quote 26) thought that crack had saved her life when she was in a violent relationship because she felt it had given her the confidence to stand up to her abusive partner. However, Veronica also acknowledged that other abusive partners had caused her to relapse.

Quote 26:

Veronica: No 7, he was 7 at the time (Veronica’s son). And then so I started taking the crack and I started getting confidence with the crack and then I started you know sort of like sticking up for myself and then I remember one day him coming home and I knew the way the front door shut I just knew that was it I was going to get it for whatever reason so I picked up this knife and I said to him one of us is going to die tonight if you put your hands on me, coz I’d been smoking the night before and I was like (agitated noise) I was agitated as well so I said one of us is going to die to tonight and if it’s going to be you it’s going to be you or if it’s going to me but you’re not going to keep hitting me for no reason. And then from that day he never touched me again yeah from that day.

Many other participants, like Veronica, experienced violent or mentally abusive relationships with partners. Stacy’s partner was a violent drug user, when she asked social services for help they took custody of her child, her child was returned but she was unable to cope with the traumatic experience and relapsed. Stacy’s sister therefore raised her son. Stacy continued to live in fear that her ex-partner would find her or her son and harm them both. Another participant, Rebecca, considered intimate relationships to be “dangerous” and avoided them in her most recent recovery. She felt
rejection over a recent relationship and viewed intimate relationships as a trigger for relapse. Rejection was something she had experienced in her childhood too, where she was in and out of the care system and given to various relatives to be looked after.

Some male participants (for example, Freddy, Zachery, Harry) were unable to commit to long term monogamous relationships and further struggled when they became fathers. Substance use and Class A drug use was a means by which they could escape those responsibilities. Zachery (Quote 27) used drugs to cope with parental responsibility for his two children, who were born within 3 months of each other, from two different partners. Zachery relapsed years later when a different partner became pregnant with his child. He repeated his previous behaviour and had several affairs during his partner’s pregnancy.

**Quote 27:**

**Zachery:** I would say my problems started, real problems started I would say as early as early as ‘91 when I had when I had, my first two children yeah erm and that’s when I really started becoming a problem but I was in denial, you know what I mean I was in denial –

**PI:** Were you with your partner at the time?

**Zachery:** Yeah I was with two partners at the same time and erm and but, but by a bad, bad coincidence they both got pregnant at the same time right so my son and my daughters are like 3 months in between them. Erm and then I started my whole behaviour changed, my whole behaviour changed.

Participants struggled with relationships with their family members in their childhood due to the abuse but this also affected their family relationships in their adult years. Adam (Quote 4) Terry, Veronica and Rebecca (Quote 3) felt resentment and anger towards their mothers in their adult years for not protecting them against their abusive fathers or their mother’s partners when they were children. This continued to cause conflict with family members, feuds or arguments which could cause lapses, relapses or heavier drug use. Adam (Quote 28) talked about the impact that his abusive father’s death had on him and his relationships with other family members. He argued with his
sister and mother and relapsed, spending his inheritance on crack and returning to criminal behaviour.

**Quote 28:**

**Adam:** I didn’t speak to my sister and then he died in about 2007 and that’s when my sister phoned me and that’s what I can’t understand she, she like (pause) I said to my Mum I would have sold the house from underneath him if I could have. Because like that’s the best thing I think he could have done was die because like of what he’d done and erm yeah well he didn’t write me out of the will. I’d erh after about 9 months… my sister knew where I was and how to get in contact with me but she never told the solicitors coz I think in the back of her mind she was thinking if I don’t ever get hold of Adam I’ll have the lot. And then I was getting about £60,000 but I spent that in 7 weeks on crack and then I started doing burglary and which I hadn’t done for 20 odd years and that’s when I went to jail from there and then went to treatment.

Participants such as Jay, Olivia, Adam, Bruce and Luke also talked about using drugs to cope socially and to help them feel they fitted in and belonged (mentioned previously in Section 6.2.5.1). Some participants used drugs to cope with traumatic and abusive relationships from their childhoods, which still caused them distress in their adult years. As discussed in Superordinate Theme 2, Section 6.2.5, about the divergent and damaged selves participants struggled to cope with relating to themselves in a healthy and positive manner and used drugs to cope with this.

### 6.2.6.3 Past and present trauma

Participants talked about using drugs to cope with a range of dangerous events and trauma responses from their past and present (e.g. childhood abuse, prostitution, coping with a sick relative and being the victim of rape). Some participants talked about drug use in their adulthood to cope with past trauma reactions from their abusive childhoods (for example, Rebecca, Adam, Veronica,). Veronica (Quote 29), confronted one of her childhood abusers when she was an adult but relapsed when the trial against her abuser collapsed.
Quote 29:

**Veronica:** Yeah I just kept on relapsing and after the trial I relapsed again. You see what I mean it was just like one relapse after another and every time I tried to pick myself up I relapsed.

Walter, Isabella, Jim and Stacy used drugs to cope with bereavement. Isabella (Quote 30) described how she was grief stricken and overwhelmed with sadness when her husband died. Adam (Quote 28), was unable to deal with his anger when his father died. However, Adam’s anger appeared to stem from his (unresolved) feelings of anger towards his abusive father resurfacing from his childhood. Some of the female participants suffered the loss of their children to the care system or when they gave them to relatives to look after, this was also a trigger for drug use.

Quote 30:

**Isabella:** I had my melt down basically because I think from being a professional person that had a very disciplined and routine and busy life, juggling the kids and nursing my husband and having a very demanding job to suddenly giving up my job and the kids are at school and not knowing and then the grief finally just catching up with me that’s when I started taking Class A drugs, I was 51.

6.2.6.4 The ‘normal’ everyday life is a crisis

Coping with everyday “normal” life could be very stressful for most participants and they often experienced it as a crisis leading them to drug use or heavier use. For example, finding and maintaining housing, managing finances and finding legitimate paid employment. Other everyday crises could include a ‘crisis of thought and feeling’ where they felt unable to cope with their thoughts or feelings, which could be due to past or current problems, trauma responses or difficult relationships.

Isabella (Quote 31) described how she relapsed when she was unable to cope at Christmas without her two children who had been taken into care because of her heroin use and subsequent arrest.
Quote 31:
Isabella: That was the first year after 4 or 5 months of not using anything but erm the idea of the whole Christmas thing and sitting in this hostel on my own and my kids are being looked after by someone else.
PI: Were they with a foster –
Isabella: Yes with a carer yeah. Erm so that was just deeply heart breaking (attempts to laugh) because obviously along with being sober you feel it so much more as well the realisation of what a mess you’ve made of everything so. Yeah so that’s when I relapsed it lasted about a week and then I quickly pulled it back together again and erm I haven’t since so that’s it.

6.2.7 Superordinate theme 4: Managing trauma – transitions into and out of recovery (internalised will, relational connecting, processing capabilities)

Transitioning into recovery was about learning healthier coping mechanisms to deal with what participants considered to be traumas and crisis points in their lives (as outlined in the previous superordinate theme). When participants relapsed or lapsed their experiences began to change and their narratives lacked internalised will (e.g. motivation), relational connecting (support networks and (re)building the self) and processing capabilities (e.g. reflection and rational thinking).

6.2.7.1 ‘I want to’ – internalised motivation, engagement and proactive participation

When participants were experiencing recovery they were motivated, engaged and proactively taking part in the recovery process and in (re)building a life away from drug misuse. This theme relates to the superordinate theme by illustrating some of the healthier ways that participants coped with what they considered to be traumas and crises.

A healthier means of coping involved proactively engaging and taking part in (re)building a life away from drug misuse. For example participants were proactive in asking and seeking help in their recovery from drug workers, probation officers, peer
support groups, professionals or selected family members. Rebecca was proactive by geographically moving away from her drug taking associates and Gale deleted all of her dealers’ phone numbers. Some participants chose not to get involved in intimate relationships with anyone using drugs and others were only willing to remain with partners who also entered recovery.

Participants proactively sought and implemented healthier ways of coping with their emotions or mental health. For example, some found pleasure in hobbies or sports. One participant used homeopathic remedies instead of substances or prescribed medication to manage her depression and stress. As mentioned in a previous theme dealing with the return of emotions after abstaining from drugs was a trigger for participants to lapse or relapse. Learning how to reconnect with emotions in a healthier way could prevent this from happening for example Isabella (Quote 32).

**Quote 32:**

**Isabella:** Another thing I’ve mentioned in a few of the women’s groups that I used to go when I was really struggling through the detox thing every morning I made a list of all the good things that I enjoyed and it was my first coffee, my first cigarette erm and then it was like anything that had any twinge of pleasure about it whether it was like oh I want to watch this programme oh I would write it down and by the end of the day I’d have 8 pleasurable things that had happened. Erm and for whatever reason just listing these positive things made the whole day a positive thing you know what I mean.

Participants proactively engaged in a range of distraction techniques to cope with intrusive thoughts as well as their emotions. For example, Rebecca had a structured week which included volunteer work and hobbies with her son such as horse riding. Having a structured day or keeping busy was an important part of filling empty space and time which could be too easily filled with intrusive and stressful thoughts and feelings. Participants volunteered or became peer mentors and a minority entered paid employment. Others entered educational courses or were preparing to do so. (Participants, who were in more sustained recovery, had busy lives and this was one of the reasons why it was so difficult to recruit this group in the research). Participants, who were particularly engaged in their recovery, talked about plans for their future,
which involved aspirations for education, employment and relationships including with their estranged children.

Some of the participants considered that will and motivation to engage in recovery had to be internal and not forced, for example, Zachery (Quote 33).

**Quote 33:**

**Zachery:** With drug addiction the key thing of getting back to normality is motivation that’s *the key thing is motivation* if you haven’t got that there’s no way you can do it. And talking to some people about motivation people say to people you will relapse… that’s another go to court case and I’m up for say burglary and the judge says to me well you know Zach I’m not going to send you to prison you will go to rehab thats never works it has to come from within here yeah, it has to you have to feel that feeling, you have to be at a rock bottom to want to cut it to yourself free from that.

6.2.7.2 (Re) building the self

Some participants moved away from the addict self-identity as they (re)built a life away from their drug using lifestyles and associates or friends. There was an active search for a better and improved self. For some this might take the form of looking back at what they could have achieved with their lives if they had not been ‘addicts’. They used this as a motivation for planning a future with goals and direction involving education and potential employment opportunities. They had a positivity about their futures which they had not experienced during their drug use. They felt that they were changing or had changed. For many this included a realisation that they had wasted their lives, they acknowledged the negative and harmful aspects their drug use had entailed (see Freddy’s Quote 34).

**Quote 34:**

**Freddy:** This reacting and you know I just feel like when I was using I never put my life to use but now I’m not using if I can I know I’m 38 and people say change is never too late it was Mr Churchill said that I think. That’s why I want to go in to college. Get a part time job slowly, slowly. It doesn’t have to be so much money just so I can
Some participants found fulfilment, self-worth and self-esteem through working in the services or as peer mentors to help others with substance misuse problems. This further filled an emptiness they had felt in their lives for many years and during their chaotic drug using lifestyles (see Stacy’s Quote 35). Others attended support groups to fill the void.

**Quote 35:**

**Stacy:** It’s very therapeutic when you can help somebody else who’s going through what you’ve been through and you can make a difference in their life. It’s just giving something back and it makes my life worth something rather than… I’ve always felt worthless *(shaky voice)* before. When I was taking drugs I didn’t think I was worth much you know. I didn’t deserve anything better than being a working prostitute and being on drugs. That was what I was worth you know coz of all the bad things that had happened to me in my life so obviously I was brought up to meant to that nothing ever good was going to happen and I don’t feel like that anymore. I feel like I am worth something and I can do a lot of good in my life and I have done a lot of good it the last two years, two and a half years. I’ve helped a lot of people. And to me that makes all the difference. I mean like I’m involved in *(name of the rehabilitation organisation)* I do voluntary work. We’re going to open a new the new Saturday service here. I do the *(name of another rehabilitation organisation)* and *(name of rehabilitation organisation)* which is an alcohol service. I do service user involvement. We’ve just started up a new group for them, we do a women’s group twice a month where I do jewellery making, me and another couple of service user women. We do arts and crafts, card making we do all sorts, erm decoupage all sorts of stuff. Jewellery making with proper gems. We’ve just bought all this really nice jewellery making stuff and I’ve made some really good jewellery so I’ve got a lot in my life and it’s very fulfilling.

For those participants, who were in longer term sustained recovery (4 years plus) their experiences of their drug use were more distant both in time and with how they identified with this part of their life. They did not identify as much with an addict self and for some they did not identify with it at all. For example, these participants spoke more about managing their lives now rather than about their addiction. They talked about their professional identities, their relationships with their families and the day to
day structures and activities that filled their lives. However, those participants who had been in recovery for a shorter period of time, talked more about managing their addictions in relation to their day to day lives. For example, Veronica needed to learn how to manage her life in recovery making it more balanced so that she would not relapse. She felt she had achieved this because in prison she did not have to focus on looking after her children and was able to “work on just me”. She further attended courses about her drug use, self-esteem and confidence. She described the experience as “I found myself”. Veronica’s Quote (36) encapsulates this changing self and becoming a better self to manage her recovery.

**Quote 36:**
Veronica: Saw a different life and I saw a different me, I felt a different me.

6.2.7.3 Connecting with others

Participants connected with others in their recovery. This involved asking for and accepting help and trusting others, something that participants struggled to do (see Zachery Quote 61, Appendix 24). Connecting with others involved attending support groups, peer mentor groups, help from practitioners, (e.g. drug workers) and selected family members. The quality of the support was also important to participants. It needed to include empathy, understanding, care and trust. Establishing quality support could take time for participants.

Harry spoke about the damaging impact his relationship with his mother continued to have on his intimate relationships with women. He attended support groups to help him with those struggles. Rebecca (Quote 37) felt that her probation officer understood her and she continued to seek support post her probation period.

**Quote 37:**
Rebecca: Yeah you know there’s a few fair people in here that says it how it is, which I like you know and they don’t wind around beat the bush they tell you. My probation officers quite supportive I still have contact with them. I’m not on probation I still go for the odd coffee with her you know she’s someone I feel I can talk to she understands me as well.
Adam (Quote 38) struggled with his emotions and concerns over his finances however he attended a Narcotics Anonymous meeting, which prevented him from relapsing. He thought the group provided empathy and understanding.

**Quote 38:**

Adam: I know when I’m happy, I know when I feel sad but I don’t know if it’s like shame, guilt or other, other emotions. I can’t put, put a name to each one. And even this Saturday just gone I was coming to an NA meeting it was here and I had an infection in my mouth, I was a bit pissed off because I didn’t have much money and I was worried about money and my head just went. And if I saw a dealer in the street alright Adam there’s a bit of gear there, I think I would have used.

Gale (Quote 39) thought that talking to others in groups and a close friend about her problems and her depression prevented her from lapsing and relapsing.

**Quote 39:**

Gale: I talked to people and like friends they help do you know what I mean. Just by talking it helps. I think I’m in a better place than I was a couple of weeks ago I much more happier OK I’m still in debt but I’ve got it I’ve gone down the right road and I’ve just got to take it as it comes you know what I mean. There’s no chance I’d have a relapse coz I’m not that silly because the way I see it is if you’re going to have a relapse what’s that going to do?

Managing relationships in a healthier way was also part of connecting with others. For some this involved reconnecting with their children or family members from whom they had been estranged. However, this was a slow process and many were cautious about it in their early recovery. For some this was because they struggled with those relationships and this could be a trigger for using. However, participants such as Freddy and Rebecca, felt that being drug free and reconnecting with their children motivated them to remain abstinent. In recovery these participants struggled with parenting and there was a role reversal in their parent-child relationships when their children assumed the responsible adult role to support their parent’s abstinence.
For some participants avoiding damaging relationships was a healthier coping mechanism to help sustain their recovery. For some participants family support in recovery was with siblings or Grandparents. Some participants still struggled to reconcile with their mothers due to damaged relationships from childhoods. Some participants had no family members but considered their friends in recovery to be like family. Gale felt a strong desire to reconcile with her parents and her wider family in her recovery but she was also unsure of her mother’s support. This might have been due to unresolved feelings from her childhood where she was treated differently by different family members and there were times when her mother had been unsupportive of her concerns and feelings. Despite the conflict, secrets, shame and rivalry which were part of growing up in her family she still had a strong desire to integrate with them.

Participants such as Harry (Quote 40) had to learn how to engage and communicate with people again during recovery. This was because participants (such as Harry) isolated or distanced themselves further from people during their drug misuse and many of them used drugs to cope with difficult relationships or to cope in social situations (which is outlined in a previous theme).

**Quote 40:**

**Harry:** Erm, kind of as well erm you know learning to communicate with people. I really feel as though I had to start from the beginning around a lot of stuff.

For many participants healthier relationships also included building friendships away from their drug using associates. Stacy recognised that her drug using associates did not care about her but only cared about her money. She recognised that she needed caring, supportive friendships to help her manage her recovery, which for her did not include drug users.

Having close supportive relationships with others was a means to deal with worries, problems, traumatic events and ‘crises of thought and feelings’. Problems and worries could be resolved with support, feelings could be put into context and managed and mental health problems could be eased.
6.2.7.4 Having the capacity for acceptance, to reflect, to understand and to reason

Participants who experienced more sustained recovery, were able to reflect, understand and have insight into their drug use behaviour. They were able to recognise and realise the harms their lifestyle had caused as well as the benefits of their recovery. Having the capacity to process and weigh up the risks and benefits was important for participants to find healthier coping mechanisms to deal with their problems, worries, thoughts, feelings and mental health.

A number of coping mechanisms were employed by participants to manage emotions and prevent relapses. This included rationally thinking through feelings instead of emotionally reacting (Rebecca’s Quote 41) and being able to understand, reflect and recognise emotions which Adam (Quote 62 in Appendix 24) learnt to do on a counselling course.

**Quote 41:**

**Rebecca:** Like the other month when I felt myself stressed and that and I found myself putting my feet on the seat on the train on purpose, waiting for someone to tell me to take my feet off so I could rip that person’s head off but I realised what I was doing you know and maybe I go to a meeting you know I’ll get support somewhere. You know I’m quite honest about how I feel and stuff like that now and erm yeah I just think anything you know, you know, you’re angry, you’ve fallen out with someone it’s going to pass you know. And if you’re going to go out and use drugs for the sake of a little argument that might last a week when then you could be put back on drugs for 10 years and you till you die. I look at all the pros and cons and most of the time when I’m angry I do still think about the consequences like if I were to use the consequences so yeah.

Many participants had realisation moments in their recovery and in the interview too about themselves and their drug use behaviour, which involved reflection and insight. For example realising that using drugs did not solve their problems, stop emotional pain or alleviate mental health problems (Stacy Quote 42). Stacy realised that she could deal with her emotions if she had support and opportunities to talk about her problems. This helped her acknowledge and accept some of her past adverse experiences which enabled her to let go of her past drug using life and move forward in her recovery.
Reflecting on the benefits and successes in recovery was also a means to help motivate continued recovery (for example, Veronica and Isabella). This involved positive imagery, feelings and thoughts. Understanding that the recovery process was slow and for some a lifelong endeavour also helped participants maintain and manage their recovery. This may have been because during recovery participants experienced time differently, it was much slower and they had to learn to adjust to this (Gale in Quote 43). However, this altered experience of time during recovery helped participants to have perspective and distance from their drug using life, to be able to reflect on the harms of their drug use. They were able to identify and recognise the risks to their own lives as well as the harm they had caused others. This ‘new’ perception of time also allowed participants to see beyond their addiction and to examine possible reasons for their addiction. Some participants recognised that their family environments and abusive childhoods had led to their drug use. Others were able to examine and understand other reasons that might lead them into lapses and relapses, for example, mental health and emotions, relationships and past traumas. They could then look to other healthier coping mechanism to deal with these triggers.
6.2.7.5 Transitioning out of recovery

Recovery meant different things to participants. Some, who had lapsed or relapsed at the time of the interview, still considered themselves to be in recovery whilst others did not. This theme was developed from participants who were in recovery and looking back on previous lapses/relapses and from those 5 participants who had recently lapsed or relapsed at the time the interview took place.

When participants had lapsed or relapsed their experiences of the recovery process changed although some of them still considered that they were in recovery. There was a lack of some or all of the experiences outlined in the previous themes in this superordinate theme. Participants were drawn back into their drug using lifestyles and criminal activities. These participants were transitioning back into their old ways of life. They had given up on the recovery process and some were gradually dropping out of commitments, educational courses, hobbies and connecting with others. They isolated and avoided people and their support networks (see Terry Quote 44a/b).

For those participants who had lapsed or relapsed at the time of the interview their experiences lacked internalised will, proactive participation in both the recovery process and in building a ‘normal’ life. They were disengaged or disengaging from the services, support groups, educational courses and other aspects of ‘normal life’. They were also very negative and appeared unable to talk about their drug use behaviour and recovery behaviour with any great insight, understanding and rational thinking. Some of them seemed to have accepted that they were an addict and had no motivation to continue in the recovery process. Terry’s (Quote 44a/b) intense anger and lack of any rational thinking or processing was evident throughout his interview. Terry had begun to isolate himself by dropping out of educational courses, appointments and his support groups, where he felt he no longer fitted. He was sabotaging the “normal” life he had built during his recent recovery.
Quote 44a:

**Terry:** I got strapped up with things to do like meetings and college and that I just and you know that’s what’s really made me the way I am now I’m a bit pissed at it really because I knew I shouldn’t have given it another chance and that coz I knew it would go wrong.

**PI:** Did you why?

**Terry:** Not me going wrong. Just everyone patting oh I don’t know, they’re just not my kind of people, they’re really not they just erh I think there more back stabbing and more nasty corruptness on the good side so called good side than there is on the bad side.

**PI:** Yeah who would you say supports you at the moment?

Quote 44b:

**Terry:** No one no. You don’t. You get like oh how you doing and all that but when you actually want something from them its my hands are tied on that, that’s official. I don’t ask no one for nothing. I don’t, I don’t owe no one money, I don’t ask no one for nothing.

Walter (Quote 45) had not experienced any lengthy periods of past recovery. He was a highly functioning cocaine user. He had managed to sustain a long term marriage, employment and housing. Walter had reduced his drug use after spiralling into heavier use to cope with his wife’s death. He had previously spiralled into heavier use to cope with other family bereavements in the past. Walter exhibited very few signs of insight, reflection or understanding of his drug use behaviour. He had the opportunity to attend bereavement counselling but did not pursue it. Walter had no desire to stop using cocaine and had no plans or goals for stopping his drug use. He was defensive of his drug use behaviour and in denial of the drug use harms. Denial and defensive narratives were also apparent for other participants transitioning out of recovery who had experienced a lapse/relapse.
Quote 45:

**Walter:** Yeah, yeah, yeah everything is bollocks it’s all gone, I couldn’t care less about nothing. Yeah so, yeah my quality of life’s got a lot better and erh as I say it’s just if I can afford I might get something or if I had money (*mumbles a lot*) you know I sort of you know. I haven’t got behind on me rent I got that under control. (*Mumbles I’m unable to understand him*). I say alright but if you can afford it you ‘aint’ doing anybody no harm. I would never go out and steal you know as I say erh I got a spare bit of money yeah I might go and get half a gram it doesn’t matter.
CHAPTER 6.3 - PART TWO SEMI-STRUCTURED INTERVIEW STUDY: DISCUSSION

6.3.1 Chapter overview

A brief overview of the findings from each superordinate theme is provided and discussed alongside the extant psychological theories and empirical studies, which offer supporting explanations and further understanding of the findings. This comprises the second part of my literature review but is not intended to be an exhaustive review (Smith et al., 2012). This section also offers another opportunity to reflect and develop interpretations further, which is a recognised process within IPA (Smith et al., 2012). Implications for policy, practice and further research are introduced in this chapter but will be covered in more detail in the Summary and Conclusion Chapter 8.

6.3.2 Superordinate theme 1: Experiences of abusive childhoods – links to emotions that were experienced as damaging/harmful and problem behaviours

This section addresses the research questions concerning participants’ experiences of their childhoods, family, upbringing and other significant early life events such as trauma and psychological well-being in relation to their substance misuse.

Most participants experienced severe adversity in their childhoods, which included violence, sexual or mental abuse. These abusive childhoods were linked to a range of damaging and destructive emotions which they felt during childhood such as fear, anger, hatred, worthlessness and rejection. These feelings were linked to close family members or themselves. Participants’ adverse childhoods were followed by chaotic teens, which involved substance use, criminality, homelessness, school exclusion, teenage pregnancy, emotional and behavioural problems. The behavioural and emotional issues were viewed by some participant’s as a means of acting out or reacting to their childhood experiences. With no supportive adults to turn to for help including parents, school teachers and the authorities, participants expressed themselves in destructive and damaging ways. Early substance use was felt by some
as a means to escape the abuse or their problems, to feel they fitted in or belonged somewhere (because they felt that did not belong anywhere else) and as a means to cope with their chaotic teens. Drug use in adulthood was also a means to cope with the impact and effects of these adverse childhoods.

6.3.2.1 Neglect, abuse, turmoil: damaged bonds and unhealthy upbringings

Many of the participants experienced severely abusive and neglectful childhoods. The findings are consistent with quantitative research which has demonstrated that those with addictions have a high prevalence of historical childhood abuse and neglect for example in those with alcohol addictions, in drug misusing populations (Huang et al., 2012; Cohen & Densen-Gerber, 1982; and Rohsenow et al., 1988) and among drug addicted prisoners (Chen & Guetaz, 2016). Two participants, who did not experience the extreme forms of abuse and neglect, still experienced dysfunctional and harmful family environments involving conflict, turmoil, separation and loss, which they found very distressing. The findings are also consistent with qualitative studies. Watson and Parke (2011) found that Class A drug users had experienced a range of childhood abuse, neglect and trauma. This involved parents and included rejection, loss, death and psychological abuse. Larkin and Griffiths (2002) also found childhood abuse and trauma (death, divorce, rejection, addicted parents) among drug and alcohol misusers. Conford, Umeh, & Manshani, (2012) found similar childhood adversities among opioid users.

The findings further support childhood developmental trauma theorists such as Van Der Kolk (2003) who suggests that adults, with histories of childhood trauma responses as a result of physical and sexual abuse, are more likely to have substance misuse problems. One participant, Mark, found it difficult to talk about his childhood but spoke about the detrimental impact of experiencing political turmoil and conflict during his teens in his country. He spoke with anger and hatred about the political conflict, and blamed that for ruining his future prospects. He felt “happy” to have survived when many of his friends were killed in the conflicts. This lends some support to Van Der Kolk’s (2008) theory, which further suggests that conflict, war and community violence are also dangerous events that can have profound effects on some
children although Mark was a teenager when he experienced this type of trauma it had a profound impact on him. However, his substance misuse when compared to other participants was perhaps not as chronic or severe. His substance use began in his early twenties and he had managed a stable job, (his own business), a long term relationship and stable housing for a lengthy period of time. During periods of recovery he had also regained elements of this until he relapsed again. Most of the other participants had not managed this degree and length of stability during their lives.

The effects of traumatic responses can be varied, for example, Van Der Kolk (2014) suggests that those who have suffered severe prolonged childhood sexual abuse which starts at a young age, are particularly prone to memory loss of such events. Studies have supported this (Chu, Frey, Ganzel, & Matthews, 1999). One participant, Olivia exhibited signs of memory blocks when recounting her childhood, when she was sexually abused by her father’s friend and his son from the age of 8 until her teens. During the interview Olivia stared in a trance like fashion (a fixated stare into the room for several seconds) when asked questions about her childhood, a difficult, or a dangerous time in her life. Olivia explained, when asked about her trances, that she was trying to recall events but was sometimes unable. Holmes (2006) acknowledges that the narratives of victims of childhood abuse can be incoherent, include trance like states and factual rather than emotive accounts. “Traumatic memories seem to exist in a ‘raw’ sensory form, in which a coherent verbal account is hard to elicit.” (Holmes, 2006, p. 100).

It should be recognised that Olivia’s difficulty recalling events may also have been due to her years of substance misuse and a stroke she had suffered. It is likely that a combination of these may have affected her memory. However, the impact of her abusive childhood was evident in her reluctance to seek further counselling which she feared might uncover further trauma memory. It was clear that this was not a topic that I could pursue in greater depth during the research interview. This has implications both for ethical and safe guarding considerations in research with vulnerable people. Olivia was offered a debrief session with a trained counsellor afterwards but she declined.
Participants experienced many broken or damaged bonds with parents and for some also with other family members. These took many forms, for example, separation, (Jim, Terry and Stacy) violence (Rebecca, Adam and Jay), abuse (Veronica, Olivia) and neglect. Whilst it was not possible to clearly ascertain which type of attachment strategies were prevalent for each participant, on the whole there was clear evidence that participants experienced extremely damaging relationships with parents and/or close family members growing up. Furthermore, for some participants it was clear that they had no supportive adults to turn to for help and in some cases they felt unsupported by the school system, social services and the authorities. The lack of parental support for many was because the parents were the perpetrators of the abuse or did not provide adequate parenting. Some participants avoided their parents during times when they had problems or were faced with crises. These findings would lend some support to attachment theory studies, which have found insecure ambivalent and insecure avoidant attachment strategies among those with addictions. Bartholomew (1990) and Schindler et al. (2009) found fearful-avoidant styles and (Thorberg & Lyvers, 2006, 2010) found insecure attachment styles. Carlson, Cicchetti, Bartnett, & Braunwald, (1989) found that 81% of children who had experienced trauma (abuse and neglect usually by mothers) had disorganised/disorientated attachment strategies.

Many participants experienced conflict, separation/divorce and loss among their parents which they found very distressing. Some participants witnessed domestic violence and some were also subjected to violence themselves. Family systems theory suggests that the parent’s relationship can have an effect on a third (the child) and that children are intense ‘parent watchers’, (Minuchin et al., 1978; Dallos & Vetere, 2012; and Cooper & Vetere, 2005). Furthermore, when there is a problem with the parents’ relationship, such as violence or conflict, it can have a detrimental impact on the child (Minuchin et al., 1978; and Dallos & Vetere, 2012). For example, on their cognitive development, their expression and restraint of violence and aggressive behaviour (Browne & Herbert, 1997), increased risk of being involved in interpersonal violence in adulthood either as victims or perpetrators (Whitfield, Anda, Dube, & Felitti, 2003) and repeating patterns of domestic violence within their own families (Cooper & Vetere, 2005). Many participants experienced elements of these. For some their experience of ‘parent watching’ in a violent family home environment involved them
feeling betrayed, defending their mothers against their violent father (or Mother’s partners) and getting involved in violent conflicts with a parent/parent’s partner themselves (Cooper & Vetere, 2005). For example, Jay felt betrayed by his Mother’s loyalty towards his abusive father. This affected the quality of his relationship with his Mother, a pattern which continued into his adulthood. Jay also talked about his violent behaviour throughout his life. Many of the other participants also spoke about their violent behaviour. This is discussed further in Theme 2, ‘The divergent and damaged selves’. Another participant, Rebecca, tried to protect her mother and sister from her mother’s violent and abusive partners. Harmful parent-child relationships have been noted in the qualitative relapse and recovery literature for example, Larkin and Griffith (2002); Madanes et al. (1980); and Preli and Protinsky (1988). Furthermore, Macfie et al. (1999) found that children who had experienced abuse or neglect were more likely to exhibit role reversal and become the protectors of parents or siblings in stressful family story stem situations, than children who had not been abused. These findings would lend some support to family systems theory, which acknowledges the damaging effect of some parent-child relationships. However, Cooper and Vetere (2005) acknowledge that there is less research about the effects of domestic violence among step-parents and other family units and also in relation to women being violent to their male partners, for example Rebecca’s Mothers abusive partners and Jim’s violent Mother.

However, harmful patterns of parent-child relationships do not always involve the extreme forms of conflict such as violence (Byng-Hall, 1995). For example, Harry’s complex relationship with his mother which he felt had affected his ability to form and maintain intimate relationships with women in his adulthood. Gale talked about secrets, shame, rivalry and conflict among her family members. Gale also repeated these patterns when she (like her mother) found herself pregnant by an undesirable man out of wedlock and refused to inform her family who her baby’s father was. Gale continued to keep secrets from her family even during her recovery. Secrets, shame and divided loyalties were a dominant rhetoric among extended family members and across generations in Gale’s family. Family system theory suggests that some patterns of behaviour, communication (or lack of it) and emotional expression can be repeated
across generations (‘replicative scripts’) and continue to have a detrimental impact on an individual’s well-being (Byng-Hall, 1995).

6.3.2.2 Destructive emotions – links to self, family and childhoods

Participants experienced extremely negative emotions during their childhoods. These included fear, anger, hatred, betrayal, abandonment and rejection which they felt towards family members (e.g. parents, parent’s partners or siblings) or which they internalised. (The impact of internalised negative emotions on participant’s sense of self and identity is discussed in Section 6.3.3.). Van Der Kolk (2008) acknowledges that children who have suffered developmental trauma can experience these damaging affective states. Furthermore, children can react to such extreme negative emotions with behavioural problems, which was evident with many of the participants in this study, (see Sections, 6.3.2.3 and 6.3.2.4).

Both Jim and Zachery appeared to be disconnected and shut off from their emotions when they talked about the violence in their families. Emotional reactions to trauma can include deregulation of emotions including numbing or cutting off from those emotions (Van Der Kolk, 2014). Terry was able to express emotion (anger) but was unable to explain why he wanted to kill his Dad. Van Der Kolk (2008) suggests that those with traumatic backgrounds (e.g. family violence or dysfunctional and damaging families) can have difficulty processing, comprehending and articulating what has happened to them because the trauma has affected these capabilities during key neurobiological and anatomical brain developmental stages. When individuals are asked to recall or are reminded about such experiences they can re-experience the trauma with the same effects and are unable to articulate the event (Van Der Kolk, 2014). This has ethical and safeguarding implications for research involving those who have experienced such trauma. I had to be mindful of this when pursuing such questions with each participant. Participants were all offered counselling sessions with a qualified counsellor afterwards. However, some studies have found beneficial effects for participants in recounting trauma reactions during research (Sammut Scerri et al., 2012, and Campbell, Adams, Wasco, Ahrens, & Sefl, 2010). Participants in both the Focus Group and Semi-structured Interview Studies also experienced positive benefits
such as a feeling of a sense of purpose that talking about their experiences might help others.

Most participants talked about damaging, destructive and negative emotions as opposed to mental health issues in their childhoods. There was only one participant (Stacy) who talked about a childhood mental health condition. Damaging and destructive emotions continued to feature strongly into participants’ adult years. However in adulthood participants also linked some of these emotions to diagnosed mental health problems as well as to their drug use. The wider literature acknowledges the prevalence of co-occurring mental health and substance misuse among adults (Strathdee et al., 2002). The findings lend some support to affect regulation theory and modern attachment theory (Flores, 2012; Khantzian, 2012, 2014; Schore, 1994; and Schore & Schore, 2008). However, Schore (1994) further suggests that the development of mental health problems are embedded within dysfunctional emotion regulation which begins in infancy and early childhood. This also includes regulating positive affective states. I hypothesise that strong damaging emotions experienced and felt in childhood with this group (because of their abusive and adverse childhood experiences) was a precursor and predisposing factor in the development of their later onset of mental health problems as well as being linked to their substance misuse. This will be discussed further in Section 6.3.4.1 about emotions and mental health.

The influence of damaging triadic relationships between participant’s siblings, their parents and other extended family members was evident. For some participants there were feelings of inequality, unfairness, hatred and resentment towards siblings whom they felt had been favoured by their parents and other family members (e.g. Gale and Jay). These destructive emotions and patterns of relating and communicating continued into their adult years with the same family members, little seemed to have changed over the years. Family system theory suggests that some patterns of communication and relating to family members ‘get stuck’ (‘replicative scripts’) and can continue to exert unhealthy influences on an individual’s psychological well-being (Dallos & Vetere, 2014; and Byng-Hall, 1995).
6.3.2.3 Attempts to escape the problems and abuse

6.3.2.4 Reacting/acting out and risky behaviours

The impact of participants’ abusive and adverse childhoods was followed by chaotic teens, which involved substance use (e.g. Adam, Olivia, Zachery, Jim) criminality (e.g. Terry), homelessness (e.g. Jay, Veronica) school exclusion (e.g. Jim), and emotional and behavioural problems including “hanging out with the wrong crowd” and being in gangs. This is supportive of the childhood trauma literature (Van Der Kolk, 2008) and the wider quantitative research (World Health Organisation, 2002; and NSPCC, 2011). Some participants were able to make links from their chaotic teens and abusive childhoods to their substance use. Many of these behaviours, including substance misuse, were viewed as a means to escape the abuse and their problems as well as a reaction to their horrific childhoods. Others normalised it, this will be discussed further in Section 6.3.4.3 and 6.3.4.4.

Studies have also found high prevalence rates among offenders who have experienced historical childhood abuse and neglect (Fox et al., 2005). Longitudinal developmental studies, exploring risk and protective factors in offending behaviour, have found that harmful family and parenting environments may have an influencing effect on impulse control, hyperactive and risky behaviours, which are also strong risk factors and predictors of offending behaviour (See Farrington, 2015 for an overview). Some consider that there might be common risk and protective factors involved in the development of drug misuse, criminal behaviour and mental health problems (Crighton & Towl, 2008). However, exploring participants’ criminal backgrounds further in this study was limited by the restrictions the NHS ethical board had imposed on the research.

6.3.3 Superordinate theme 2: The divergent and damaged selves – links to substance use

This section addresses the research question about participants’ experiences of their psychological well-being in particular, which has links to participants’ childhoods, family and relationships (including with themselves) in relation to their substance use, lapses/relapses and periods of recovery.
Generally participants did not relate to themselves in a healthy manner and this battle continued for many during periods of recovery. They had very fragmented and damaged self-structures and tenuous identities linked to their adverse childhood experiences. Many of them spoke about feeling different to others or wanting some kind of normal life. Using drugs and substances was a means to feel they fitted in or belonged somewhere. When participants attempted to be ‘normal’ in recovery they struggled to cope and this could lead to a lapse or a relapse. Coping with living a ‘normal’ life is also discussed in Section 6.3.4.4, in relation to Superordinate Theme 4.

6.3.3.1 Felt different to others

6.3.3.2 Damaged selves

6.3.3.3 Drug use to cope with ‘normality’ and the mundane

Participants talked about and treated themselves in a very negative manner this included low self-esteem, self-worth, (e.g. Veronica & Zachery) lack of self-care, (e.g. Rebecca), feeling self-conscious (e.g. Olivia) and some described themselves as “horrible” or “bad”. For some these were feelings they had also had during their childhood and teenage years. They felt different to others around them including family members, school peers and others as they became adults (e.g. Terry felt as though he did not fit in or belong in recovery). How parents, family members, school and for some the authorities had treated them were central to these feelings. Many participants had very fragmented self-structures which lacked coherence. These fractured and tenuous identities or (multiple) selves were ‘tested’ to the limit when some participants were in recovery and where there were expectations upon them to build and live a “normal” life with a routine away from their drug using lives. For some this was overwhelming and they lapsed or relapsed.

These findings lend some support to self psychology theorists such as Kohut (1977) and Wolf (1988), Levin (1991) and others such Khantzian (2014) and Flores (2012), who suggest that substance misuse is an attempt to repair a damaged sense of self (due to insecure and unresolved attachments and abusive childhoods). These theorists
further suggest that self-esteem, self-worth, self-soothing and self-care are damaged in those with addictions. Drug use would therefore be viewed as an attempt to address those feelings of being lost, empty, having low self-esteem and self-worth which many participants described. Freddy (Quote 13, Section 6.2.5.2) demonstrates this by talking about using drugs when he felt particularly lost and when he would try to search for some sort of direction and meaning in his life, feelings he remembered from childhood. Larkin and Griffiths (2002) in their qualitative study found that drug use was a means to fill a void or emptiness in their participants’ “lack of identity”. Their participants cited drug use as a way of coping with low self-esteem and self-loathing.

Khantzian (2012) suggest that those with addictions struggle with self-care. This was very evident among the participants and at times I found the severity of it disturbing. For example, Harry’s physical and mental health had deteriorated to such a point that he almost died. He was relieved when he was looked after in hospital, an experience which helped prompt him into recovery.

The quantitative literature has also found links between low self-esteem and drug use and self-esteem and offending behaviour (Oser, 2006). However, the findings are contradictory as to whether high or low self-esteem is linked to offending behaviour and whether narcissistic personality disorders are also involved (Matsuura et al., 2013; Donnellan, 2005; and Baumeister, Smart, & Boden, 1996). Oser (2006) suggests an inflated self-esteem might be a defence mechanism. The self-esteem and drug misuse studies are also contradictory as to whether high or low self-esteem is involved. Some studies have found low self-esteem to be a predictive factor in drug use among young people (Frisher, Crome, Macleod, Roger, & Hickman, 2007) however other studies have given this less support (Donnelly, Young, Rebecca, Penhollow, & Hernandez, 2008). The contradictory findings in the quantitative studies may both be correct but a more accurate description might be a problem with regulating self-esteem. The theories, literature and the findings in this thesis suggest that self-esteem is only one aspect of a person’s self-structure that forms a sense of self and which is adversely affected in those with substance misuse problems. Therefore, any measurement of self-esteem should consider that it forms part of a wider set of psychic structures involved in a coherent sense of self. This could further explain the contradictory findings among
the quantitative literature which generally isolates self-esteem assuming it to be a
singular entity when it is not. Quantitative studies might therefore benefit from more
comprehensive measurements of self-esteem which consider the wider psychic
structures of the self.

What was also interesting to note in this research was that there was a concerted effort
from participants to search for and to try and understand who they were. Their search
was to understand a ‘self’ which departed from their drug using self or identity. It must
be acknowledged that part of this concerted effort may well have been due to the
research process which prompted participants to make sense of their narratives. The
analysis revealed that participants’ search for a sense of self was pervasive, profound
and enduring, and for some it was a lifelong endeavour. For example, some
participants felt they could have been a better person and had a better life if their
childhoods had been different. They felt they had lost this better self. Jay and Terry
(partly) blamed their parents for this ‘lost self’. For these participants it felt like a
constant endeavour to search and to form a coherent sense of self. Luke, Terry and Jay
appeared to be in search of a better self but their narratives were full of contradictions.
Veronica (Quote 36, Section 6.2.7.2) talked about seeing a “different me” and feeling
“a different me” when she had time “to spend” on herself, during her recovery in
prison. Furthermore, some participants struggled with their sense of self especially
during difficult life transitions. For example, Isabella struggled when her husband died,
she left her career and stopped caring for her two children. Her identity had been
strongly linked to these. She talked about “falling apart”. Khantzian (2012) and Levin
(1991) both suggest that those with addictions have difficulty with a comfortable or
stable and enduring sense of self.

Research within the qualitative recovery addiction field has focused on self-identity
issues, identity transformations or transitions (e.g. Biernacki, 1986; McIntosh &
McKeganey 2000a; and Kellog, 1993). This has been largely from a sociological
perspective rather than a psychological perspective examining the intra psychic
structures of the self. Identity transformations or transitions have particularly focused
on participants’ recovery when they were trying to form a new identity away from
their drug using addict identity (Bierancki, 1986; McIntosh & McKeganey, 2000a;
Kellog, 1993; Rodriguez & Smith, 2014; and Turbico, 2008). However, with some of the participants in this study the search for a sense of self had links to their childhoods and pre drug use and was not always in relation to a period of recovery, which Larkin and Griffiths (2002) also found among substance misusers. Shinebourne and Smith (2009), Rodriguez and Smith (2014), Larkin and Griffiths (2002), using psychological methodologies and perspectives, have also found self-identity issues in their qualitative studies with substance misusers but they have not embedded their research within the self psychology framework or understanding outlined above but have used Biernacki (1986) and Kellog (1993) identity theories.

Other psychological theories used in empirical studies to understand substance misusers identities is dissociative identity disorder, which includes multiple identities being held by one person. However, Shinebourne and Smith (2009) suggest the findings are inconsistent. Whilst some participants appeared to hold multiple identities it was not possible to ascertain from this research if any of them were experiencing dissociative identity disorder. Narcissistic disorders have been found among those with addiction problems (Van Schoor, 1992 and Ulman & Paul, 2006). Determining the degree of “pathological narcissism” in the participants was not the focus of the PhD, however, there was some evidence of participants experiencing many key elements. For example, anger/rage, low self-esteem, denial, (e.g. Terry & Rebecca), acting out/rebellious behaviour (Bruce, Olivia), anxiety and depression, which Levin (1991) suggests is more severe in those with drug addiction. I found the levels of aggression with some participants, during the interview, disturbing (e.g. Terry, Rebecca and Jay). I also found the amount of violent crime and behaviour in which the participant group across both studies had been involved particularly shocking and surprising, especially given that this was also evident during their teenage years (e.g. murder, knife crime, physical assaults and rape). The generally held belief among the DIP policy staff (including myself) was that this group were largely acquisitive offenders and not violent offenders.

Self psychology theory offers the most compelling understanding of the participants’ findings in relation to this subordinate theme. It may well be able to add a further layer of context and understanding from a psychodynamic developmental perspective on the
intra psychic structures of the self in addition to existing theories about self-identity issues, for those with drug addictions.

Attachment theory helps to further understand participants’ negativity towards themselves. For example, those with secure attachments view themselves in a more positive manner, that is they consider themselves to be valuable, lovable and have higher self-esteem than those with anxious attachments (Bartholomew & Horowitz, 1991). Adult attachment research (Mikulincer & Shaver, 2008), supports the contention that this is because their internal representations of the ‘self’ have been formed by positive affirmations from primary caregivers. Securely attached people therefore have no need to use defensive strategies such as inflating their self-esteem or other disproportionate defensive emotional expression during adverse situations. Their stable sense of self can cope unlike the participant group in this study.

6.3.4 Superordinate theme 3: Drug use to cope and survive trauma/responses

This section addresses the research question pertaining to participants’ significant life events, relationships and psychological well-being in relation to their drug use, lapses and relapses.

Participants struggled with emotions, mental health problems, relationships (including with how they related to themselves) and adverse life events including those from their childhoods. They experienced these as traumatic and distressing and used drugs to cope. What was surprising was that many participants struggled with ‘normal’ everyday life too and considered this to be so distressing that it could lead to lapses and relapses. This is consistent with qualitative studies such as Mullen and Hammersley (2006) who found that drug use was a means of dealing with problems concerning relationships, emotions, trauma and managing day to day (‘normal’) living among heroin users. Daniulaityte et al. (2007) cited first use and continued use of crack to be associated with women drug users’ emotional problems and traumatic events. Heavier crack users cited abusive and traumatic childhoods. However, Daniulaityte et al. (2007) also suggests that crack use is linked to earlier use of alcohol and cannabis.
The study does not however, offer any contextualisation from an attachment or trauma perspective.

### 6.3.4.1 Emotions and mental health

Participants suffered from a range of mental health problems such as depression, anxiety, stress, bipolar disorder and schizophrenia. Van Der Kolk (2003) suggests that adults, with histories of childhood trauma reactions as a result of physical and sexual abuse, are more likely to have substance abuse problems, borderline, antisocial personality, dissociative and affective disorders. Ruggiero et al. (1999) found that drug and alcohol misusers, who had experienced dangerous events in childhood including sexual abuse, neglect, emotional and physical abuse had the highest scores of poor mental health. In particular experience of sexual abuse by a family member had the most severe impact on mental health.

The quantitative literature suggests that those with drug use problems are more likely to suffer with mental health problems (Strathdee et al., 2002) and offenders with substance misuse problems are more likely to have mental health problems than offenders without substance misuse problems (Ruiz et al., 2012). Flores (2012) recognises that mental health problems are a common co-occurring issue among those with severe addictions. He highlights research which suggests various links between addiction and mental health these include:

- mental health problems can exist prior to substance use and be independent of substance use
- substance use can cause mental health problems
- substance use can imitate mental health symptoms
- substance use can make mental health problems worse
- withdrawal from the substances can imitate symptoms, worsen or cause mental health problems
- mental health problems can imitate substance use symptoms

(Centre for Substance Abuse Treatment (1994, No. 9) as cited in Flores, 2012)

There was evidence that participants experienced some of these links between their drug misuse and their mental health. Modern attachment theory (e.g. Schore, 1994,
suggests that some mental health problems are developed in childhood from dysfunctional affect regulation of emotions due to insecure attachments to parents and abusive parenting. Most participants experienced abusive and traumatic childhoods, damaging relationships with parents and damaging negative emotions during childhood. In adulthood many participants suffered with mental health problems and could not regulate their emotions. Schore (1994), Schore and Schore (2008) provide an overview of the neurophysiological/biological evidence to further an understanding of the neuroanatomical mechanisms involved in the development of dysregulation of affective states and other self-regulatory dysfunctions believed to be involved in the development of various mental health problems. Cole (2016) considers that dysfunctional emotion regulation and a dysfunctional ability to understand and appropriately express and calm emotions (developed in childhood) are influential in the development of mental illness. However, Deklyen and Greenberg (2008) propose that the role of emotion regulation is likely to be only one risk factor among many other wider influences (e.g. genetics, environmental, family stress and trauma). It is likely that protective factors such as positive peer relationships also exert modifying influences upon risk factors (Deklyen & Greenberg, 2008). These theories therefore suggest that mental health problems pre-date the drug use problems. They also imply that weakened self-regulatory structures would be susceptible to worsening mental health through drug use. The participant group experiences would lend some support to these theories.

The findings are consistent with qualitative substance misuse studies. For example Healey et al. (2009) found that substance misusers with a bi-polar diagnosis used drugs and substances to affect moods (up or down regulate) and to deal with depression and stress. Healey et al. (2009) conclude that their participants were self-medicating however they do not offer any comprehensive theoretical context. Conford et al. (2012) found that opioid using participants suffered depressive symptoms before their drug use and linked their depressive symptoms to their adverse childhoods. Drug use and illicit use of medication were a means to cope with depression. Conford et al. (2012) also do not provide any theoretical context for their findings.
Participants also used drugs to manage a range of negative and damaging emotions in their adulthood. This lends support to affect regulation theorist such as Flores (2012) and Khantzian (2014) who suggest that substance use is a means to regulate negative affect states. Schore (1994) has further highlighted the evidence base that affect regulation is also involved in regulating positive affective states. Participants spoke about taking drugs to feel happy and calm. Positive emotions were largely absent from their accounts of their childhood experiences. I hypothesis that participants used drugs to up regulate their emotions because they had not experienced or learnt how to regulate positive moods in childhood due to insecure attachments to parents/primary care givers and to adverse childhood experiences.

Some of the participants spoke about being unable to recognise and understand their emotions especially during recovery when their emotions returned after being numbed or distorted from years of drug use. Tronnier (2015) and Khantzian (2012) suggest that drug users often struggle to reflect, understand and recognise their emotions. Zachery in particular discussed how he thought his emotional development had stopped in his teens. Modern attachment theorists such as Mikulincer and Shaver (2008) would suggest that difficulty with identifying, understanding and describing emotions may well stem from childhood developmental attachment problems. For example Mikulincer and Shaver (2008) provide an overview of evidential studies which conclude that those with experience of insecure attachments, including avoidant and anxious, have difficulty understanding, describing and identifying their emotions.

6.3.4.2 Relational trauma

Participants used substances and drugs to cope with difficult and/or abusive relationships. Some participants in recovery avoided intimate relationships, because they felt unable to cope and felt these could cause them to lapse or relapse. For example, Rebecca felt that relationships were “dangerous”. Some of the male participants struggled with monogamous relationships. Others struggled to manage in social situations such as Olivia, Bruce and Terry and used drugs to cope with how they felt in these situations. Terry who was going through a relapse at the time of the interview, found people to be “slippery” and preferred to be with some “nice coke instead”. This is consistent with studies such as Healey et al. (2009) who found that
substances were used to feel normal and to fit in during social situations including among family members.

The trauma literature suggests that those who have suffered childhood abuse and trauma responses have difficulty with relationships in adulthood (Whitfield et al., 2003; Riggs, 2010; and Van Der Kolk, 2014). The findings also lends support to Flores’ (2012) and Khantzian’s (2012) theories which view addiction as a mechanism to help those manage relational problems in those who have experienced difficult childhoods due to insecure attachments to parents/primary caregivers because of childhood abuse, neglect and trauma. Early attachment experiences provide an internal working model for how to relate to others throughout the life cycle. If those have been abusive then this provides an unhealthy internal working model for future relationships and interactions with others (Bowlby, 1973). The findings also lend support to Padykula and Conklin (2010) who consider the role of self-regulation and early attachment-trauma in later substance misuse.

These findings are further consistent with the empirical literature (Watson & Parke 2011; and Larkin & Griffiths 2002). Kreis, Mette, Gillings, Svanberg, & Schwannauer, (2016) found dysfunctional and adverse relationships were linked to both substance misuse and offending behaviour. This included adverse and traumatic childhood experiences and difficult relationships with partners. Substance misuse was cited as a means to cope with early adverse childhoods. Kreis et al. (2016) also situate their findings of female substance misusing offenders within an attachment, trauma and self-regulatory theoretical framework. Family systems theories alongside these frameworks were not considered.

Some of the female participants who experienced violence growing up were involved in very violent and mentally abusive relationships with partners in their adulthood. This is consistent with the literature. Miller and Downs (1993) found that 70% of women in alcohol misuse treatment centres had experienced domestic violence. Over 65% had experienced severe violence from a parent growing up and 66% had experienced sexual abuse during childhood. Dallos and Vetere (2009), using a family systems theory approach, recognise that women who have been involved in violent
relationships continue to become involved in them because they have not been able to
learn the signs of a dangerous relationship to then avoid them. They are unable to bring
enough information forward to cope and therefore everything is unsafe. These attempts
to cope result in an impaired ability to assess risk and avoid dangerous relationships.
Family systems theory also suggests that those who experience conflict and violence
in the home are at an increased risk of being involved in interpersonal violence in
adulthood either as victims or perpetrators (Whitfield et al., 2003).

Family system theory can also provide some context to the triadic influences of
adverse and difficult relationships among participants’ family members and how
participants experienced them. Some participants viewed their parent’s difficult and/or
abusive relationship had contributed towards the ongoing violence and conflict they
experienced in the family. For example where participants’ mothers had defended their
husband’s violent or cruel behaviour towards the participants. Adam felt betrayed by
his mother who had not protected him against his violent father. These feelings
continued after his father’s death which led Adam to further conflict with his mother
and sister and then onto a full relapse. For Adam these negative emotions (e.g. anger)
fuelled those relationships making it difficult for any reflective and rational thinking
to take place (Dallos & Vetere, 2014) and therefore contributed towards his lapses and
relapses. Some of the other participants experienced violence in the home growing up
and exhibited very violent behaviour during their teens and adult years (outlined
previously). The substance misusing offender literature suggests strong links to
acquisitive criminal behaviour (see Chapter 2) rather than violent behaviour. Losel and
Farrington (2012) have suggested a number of both risk and protective factors involved
in those who are exposed to violence in childhood and who then exhibit violence in
adulthood. Protective factors include secure parent-child bonds and appropriate
supportive responses from wider family, school and the community. Further research
to examine violence among severe Class A drug users should be explored.

6.3.4.3 Past and present trauma

Participants used drugs to cope with a range of trauma responses from their adverse
experiences in childhood and more recent adult lives. These included loss,
bereavement and being the victim of violence including rape. Participants appeared to
be unable to regulate their reactions to extremely stressful and traumatic situations and had no alternative coping strategies or support networks to help them through these difficult periods in their lives. As outlined elsewhere these findings lend support to affect and self-regulation theories (Flores, 2012; Khantzian, 2014; and Padykula & Conklin, 2010). Furthermore, Van Der Kolk (2003, 2014) argues that those who have experienced childhood trauma have not learnt to develop effective coping strategies to deal with future trauma and stress because no one has helped them to understand and manage emotions to help them soothe and calm.

Participants’ drug using lifestyles entailed chaotic and risky behaviours, often leading to dangerous and risky situations, which some participants normalised. For example, violent criminal behaviour and prostitution. Van Der Kolk (2008) suggests that those who have suffered traumatic and abusive childhoods have a reduced capacity to assess danger resulting in them placing themselves in risky situations.

6.3.4.4 The “normal” everyday life is a crisis

Participants struggled to cope in recovery with ‘normal everyday life’, such as paying bills, managing and maintaining a home and seeking legitimate paid employment. When participants had to be “normal” and do “normal” things in recovery this could be a trigger for lapses and relapses, (as mentioned in Chapter 6.2, Section 6.2.5.3). For this group normal everyday life could present as a very traumatic or stressful experience. As discussed in Chapter 6.2, Section 6.2.5.2 participants tenuous and fragmented ‘selves’ could not cope. These findings are consistent with some of the qualitative literature. Harris et al. (2005) acknowledged the difficulty of managing normal everyday life away from drug use among their female sample. However, Daniulaityte et al. (2007) found that attempts at normal life were a motivational factor in recovery or to control crack use.

I hypothesise that participants’ struggles with “normal” life was because they had very little understanding or experience of what normal life was due to their adverse and abusive childhoods. (E.g. normal life growing up for this group involved chaos, traumatic events, stress and conflict). They had no frame of reference on which to draw on and their tenuous and fragmented ‘self’ was unable to cope. Furthermore, research
suggests that those who have experienced [childhood] trauma can over react to minor stressful situations due to hyperarousal - a result of being vigilant to past threats, traumas and dangers. Reactions can also include avoidant behaviours where people dissociate, cut off or become numb from either their internal states and/or to external stimuli (Van Der Kolk, 2003). Many participants experienced this and drug use was a means to achieve this cutting off or numbing from their internal states as a way of coping with external stimuli.

The childhood developmental trauma literature offers a more compelling understanding of the findings among the participant group than the PTSD literature. As outlined in the Chapter 3, Van Der Kolk (2008) and Van Der Kolk et al. (2005) argue that PTSD is unable to account for the complex issues found among those with childhood trauma. These include affect dysregulation, reduced or absent awareness of danger, self-hatred and attachment disturbances, many of which were evident among the participant group, (demonstrated in many of the themes). More research on developmental trauma within substance misusing populations is required (Bernstein, 2000).

6.3.5 Superordinate theme 4: Managing trauma – transitions into and out of recovery (internalised will, relational connecting, processing capabilities)

This section places more emphasis on addressing the question relating to the cycle of relapse and recovery, with a particular emphasis on recovery. A quick discussion on how participants defined recovery is provided first before moving on to a discussion of the themes.

6.3.5.1 Transitioning into and out of recovery – defining recovery?

Managing recovery was about learning how to manage the trauma responses covered in Section 6.3.4, which participants cited as their reasons for drug use, lapses and relapses. This is consistent with the qualitative literature (Mullen & Hammersley, 2006), although their study lacks any substantial theoretical context and offers a descriptive account of participants’ narratives.
Participants experienced transitions into and out of recovery on many occasions throughout their life. Participants varied in how they both experienced and defined recovery and relapse (Senker and Green, 2016). For some recovery involved abstaining from all substances (for example, alcohol, methadone, subutex, prescribed medicines and all drugs) for others recovery might still involve the use of some substances. For some a lapse was a one off use of Class A drugs for others this felt more like a relapse (e.g. Isabell). For some a full relapse included getting involved in their old criminal and drug using networks and lifestyles again (e.g. Terry) as well as using substances.

Transitioning into and out of relapse and recovery was very much an individual process with a changing landscape which each participant described and experienced differently despite there being commonalities across the participants. It was not an experience with a definite start and end point but a lifelong struggle with life itself as well as with substances. This is consistent with studies by Davidson et al. (2008) and Senker and Green (2016). Flaherty, Kurtz, White, & Larson, (2014) also found that recovery was a lifelong endeavour which included ‘cycles’ of improving health, (including emotions) relationships, spiritual growth and personal growth such as self-respect, self-regard and honesty. Flaherty et al. (2014) situate their findings within structural models of recovery however they describe a linear staged approach which is contradictory to their participants’ descriptions of a ‘cyclic’ lifelong struggle. Senker and Green (2014) using sociological theories and constructs, more fully recognise the value of illuminating ‘idiosyncratic’ recovery journeys and more accurately describe recovery as cyclic rather than linear.

Structural descriptive models of recovery and sociological theories and constructs are unable to situate participants’ past psycho-social experiences and suggest links to their current struggles in recovery. The findings presented in this thesis alongside the extant developmental psychological theoretical framework, are able to achieve this and offer another lens through which to view recovery. This requires looking at the participant’s past to be able to situate their current struggles within recovery and to therefore understand an individual’s own (cyclic) recovery journey. Understanding recovery
through this lens within a therapeutic setting, which clinicians and theorists such as Flores (2012) and Khantzian (2014) have done, may well provide a valuable starting point in addition to understanding the staged approach of recovery that Flaherty et al. (2014) propose. Orford (2008) further recognises that addiction research has been divorced from the theories used within therapeutic settings and this has been detrimental to the addiction field. This research has gone some way to addressing this gap.

Generally participants who were transitioning into recovery or in more sustained recovery used a variety of healthy coping mechanisms to deal with what they perceived to be crises points or trauma responses (outlined in Sections 6.3.5.2-6.3.5.5). When participants were transitioning into lapses or relapses these experiences changed and there was an absence of some or all of the healthy methods of coping detailed in this theme such as: internalised will (e.g. motivation), relational connecting (support networks and (re)building the self) and processing capabilities (e.g. reflection and rational thinking). A discussion of these themes are now provided.

6.3.5.2 ‘I want to’ – internalised motivation, engagement and proactive participation

Some participants considered motivation had to be internally driven rather than forced by family or the criminal justice system however not all participants felt this way. Wider studies also provide conflicting information. Mullen and Hammersley (2006) found that participants cited internal and external motivations for entering recovery, which included the authorities, illness and children (Brown et al., 2015). However, a lack of internal motivation led to relapses. Brunelle et al. (2015) found that motivation could be from both external sources, including coercion by criminal justice authorities or internal, such as participants’ desire to improve their psychological health or their social life. Although Miller (1998) suggests that motivation resides within the individual taking ownership for the desire to change. Smith and Ferguson (2005) found that will power was important in recovery and in maintaining recovery in their prison based drug misusing sample. However, Brunelle et al. (2015) and Miller (1998) acknowledge that a practitioner’s empathic attitude can influence a client’s motivation for change. Participants in the Focus Group and Semi-structured Interview Studies
noted that empathy from drugs workers and peer support groups was important in their recovery.

DiClemente and Prochaska (1998) consider that motivation accumulates over time during a person’s cycles of relapse and recovery. They therefore consider that any attempt at recovery is helpful in creating future motivations for change. This might explain why studies including this PhD research, have contradictory findings. Participants might be unaware of the accumulative effect of motivations over their many cycles of relapse and recovery and identifying what worked in participants most recent recovery might present an easier question to address. This has important implications for Government led programmes such as the DIP which have an element of coercion and where there has been controversy around the effectiveness and morality of coerced based rehabilitation programmes (McSweeney, Stevens, Hunt, & Turnbull, 2007).

Lord (2010) argues that motivating change among prison based populations with personality disorders such as a narcissistic disorder presents particular challenges. McSweeney et al. (2007) suggests that these include the coerced nature of the criminal justice system (externally forced motivations for change are considered less effective with this population) and the ‘personality type’ which can be resistant to change in therapy (e.g. can reinforce denial). This has important implications for the participant group who have both offending backgrounds, are subject to criminal justice interventions and who may have a diagnosis of personality disorders of the self, all of which may be additional barriers to sustaining motivation and change in addiction recovery. These ‘added barriers’ might also account for this group’s difficulty in sustaining recovery over longer periods.

Many participants demonstrated their motivations by proactively engaging in making changes conducive to their recovery, a recognised process in successful recovery (Miller, 1998). Davidson et al. (2008) and Harris et al. (2005) found proactive engagement among those recovering from addiction problems. Some of the participants filled their lives with interests such as hobbies, healthier friendships (non-
drug using friends) and had goals and aspirations for their future, which are also recognised as positive stages of change in the recovery process (Miller, 1998).

6.3.5.3 (Re) building the self

Participants who discussed recovery, tried to build a more coherent and healthier sense of self and form a new identity away from their drug using lifestyle. They (re)-built a more coherent sense of self through their social support networks in different ways, such as working in the services, having healthier relationships, and taking part in group hobbies and activities. For some participants working in the services and helping others like them (“giving something back”) provided a means to feel fulfilled and to fill a void. This helped with their self-esteem and self-worth and provided a sense of direction and purpose that had been missing in their lives previously. Brown et al. (2015) and Johansen, Brendryen, Darnell, & Wennesland (2013) also found this among their female substance using participants. Flaherty et al. (2014) found helping others was part of the recovery process. Wolfe (1988), drawing on developmental self psychology and object relations theory, suggests that belonging to an organisation (e.g. working in the drug services, peer mentoring networks and group hobbies) provides a strong social identity that serves as an idealized self-object experience. This helps a person to feel they fit in and belong and has a positive affirming effect on the sense of self by increasing self-esteem and self-worth, providing cohesion to the previously fragmented self-structures.

Forming a new identity in recovery away from the drug taking identity is consistent with the literature (Smith & Ferguson, 2005; Shinebourne & Smith, 2009; Rodriguez & Smith, 2014; McIntosh and McKeeganey, 2000a, 2000b; Biernacki, 1986; and Kellogg, 1993). In the semi-structured interviews participants described fragmented sense of selves and tenuous identities before their drug use began and they continued to struggle with these during their drug use and into recovery. The sociological theories of identity transformations and transitions are unable to take this into account, unless integrated with theories of attachment, trauma, family systems and self-psychology.
6.3.5.4 Connecting with others

Some participants isolated themselves during their drug use but in recovery they began to seek and accept support from a range of people and organisations. Participants still struggled with a variety of problems such as relationships (e.g. family and partners), day to day living, mental health, emotions and other crises or traumas/responses. However, supportive networks and relationships provided a means to help participants cope with these issues and prevent them from lapsing or relapsing. Van Der Kolk (2014) acknowledges that supportive networks (including AA), which provide physical and emotional safety and security are essential in both coping with and healing trauma. Attachment theory postulates that relationships are an important part of functioning throughout the life cycle to continue to provide modulation for affect regulation. This is especially during times of stress and crises (Vetere & Dallos, 2003; Flores, 2012; and Mikulincer & Shaver, 2008) and trauma (Van Der Kolk, 2014). The findings are further supportive of the empirical literature, in both addiction and mental health recovery studies. Davidson et al. (2008) found that connecting with others and community involvement were helpful in recovery for both substance misusers and those recovering from mental health problems which Topor, Borg, Di Girolamo, & Davidson, (2011) found social networks were important in mental health recovery. Davidson et al. (2008) highlight other similarities in recovery between the two groups. Senker and Green (2016) consider that recovery is less well defined in addiction especially among the substance misusing offender population. Best (2014) suggests that the addiction field could benefit from mental health recovery models and concepts where recovery has been given much more attention, such as a focus on a meaningful life with purpose and quality rather than a ‘cure’.

The quality of that support was important for participants and needed to include empathy, understanding, trust and care. Many participants had struggled with trusting and caring relationships growing up and continued to do so during their drug use and in recovery. Flores (2012, p. 43) suggests that those with addictions can sometimes strive for isolation, can be overly self-dependent and self-reliant and can occupy the “extreme ends of the attachment-individuation continuum”. This is based on their internal working models of how to relate to others. They have learnt not to trust or rely
on others because this was their experience growing up from their parents/primary caregivers. Furthermore, Mikulincer and Shaver (2008) highlight research which suggests that those with secure attachments are more likely to seek support during times of stress and crises and they experience more beneficial effects from that support than those with insecure, pre-occupied and avoidant attachment styles. Brown et al. (2015) found women substance misusers had difficulty trusting others and that this was a barrier to seeking and maintaining support networks in recovery. Trust was particularly difficult for women who had experienced past abusive relationships and trauma. Van Der Kolk (2014) recognises that those who have suffered relational trauma struggle the most with reconnecting with people and in relationships and that connecting with animals can then offer a safe bridge to begin connecting with people. Rebecca found working with horses helped her in her recovery. In a biographical account of recovery from drug addiction, James Bowen befriended a ‘street cat named Bob’ this bond helped him to connect with people again (Bowen, 2012).

Recognising that trust and care were qualities that were required in their support networks and relationships was therefore an important step for participants in understanding healthier relationships and being able to accept help and rely on others. Adam felt it was important to have empathy and understanding by others like himself, through peer mentoring groups. Flores (2012) recognises that empathy and understanding at the peer level is central to groups that follow the AA and NA philosophy. Drawing on self-psychology theory, Flores (2012) argues this provides “emotional attunement”, which those with addictions have not experienced but which are necessary to fulfil their tenuous identities and fragmented sense of selves. Participants also felt they fitted in and belonged in the peer groups and some felt this for the first time in their lives. Self psychology theorists such as Kohut recognise the power of empathy to help people feel a sense of self-esteem and self-worth. It provides a healthy mirroring self-object experience, which has been lacking for them (Wolf, 1988). Flores (2012) further suggests that peer support groups such as AA and NA help individuals attach to relationships, as opposed to their drugs and further occupies their time which had previously been spent using substances. Adam was aware that attending groups took up so much of his time that he was concerned it was his new ‘addiction’. Adam pathologised his need for support. Whilst this may have stemmed
from his internal working model developed from abusive relationships growing up, Walent (1995) highlights how our culture and society contribute to making relationship dependency in adulthood pathological and shameful rather than a necessity. Walent (1995) suggests that therapists working with those with addictions therefore need to foster close relationships.

In my participant group, I hypothesise that participants’ need for trust, empathy, care and understanding was because these qualities were absent during their childhoods from the people and organisations (their parents/primary caregivers, care homes, school and authorities) who should have provided them. Based on the theories presented throughout this thesis, I further hypothesise that having these qualities in parents/primary caregivers and others during childhood and learning effective self-care strategies form part of a repertoire of protective factors during stress, trauma and adversity, which were mostly absent for the participant group. However, what is interesting to note is that despite some participants experiencing adverse and difficult family environments and relationship with parents some of them still wanted to reconcile with their family in their recovery. Attachment theory would suggest that insecure attachments can be as strong as secure attachments. This has important implications for therapy with this participant group who might therefore benefit from family systems therapeutic approaches to help foster healthier family relationships. However, this has to be weighed against the wishes of participants some of whom no longer wish to have contact with members who were particularly abusive.

Self-psychology theory advocates the quality of the therapist’s relationship as key in the therapeutic process. In particular the need to offer empathy to help repair a person’s well-being and self-esteem (Wolf, 1988). Psychodynamic and family systems therapeutic approaches such as those advocated by Dallos and Vetere (2009) state that the quality of the therapeutic relationship should be able to offer a secure base from which a person or family can explore and understand their adversities and difficulties. The findings alongside the extant literature and theories have important implications for the expectations and quality of practitioners’ working relationships with clients. Others such as Orford (2008) have acknowledged the importance of the therapeutic relationship with the client in addiction treatment. Family intervention studies with
substance misusers support the importance of therapist’s building trust and empathy with clients (Forrester, Holland, Williams, & Copello, 2014).

Some participants considered supportive networks to include those who still used drugs while others no longer associated with those who used drugs in their recovery. Partners who still used drugs could be particularly difficult to leave, Daniulaityte et al. (2007) also found this among (women) drug users. Quantitative relapse and recovery studies have found that recovery networks involving non-drug users are predictive of better treatment outcomes (Broome, Simpson, & Joe, 2002). Daniulaityte et al. (2007) found that drug using associates or partners could be “risks” for relapse among women substance misusers. However, Brown et al. (2015) found that such relationships were also viewed as sources of support among recovering women substance misusers, despite some of those family members being drug users. Brown et al. (2015) suggests that equipping those in recovery with skills and coping strategies to manage such relationships, such as setting boundaries, should be considered. I hypothesis that those participants who were in more sustained recovery were able to reflect and understand the risks that maintaining close contact with drug using associates posed and they were therefore able to avoid those networks or set boundaries to minimise those risks.

For some participants reconnecting and reconciling with their children was important. Nevertheless, participants struggled with parenting and some participants felt they had to learn how to be parents during their recovery. For example, Freddy and Isabella talked about their children looking after them and assuming a parenting role. This is consistent with family systems theory (Byng-Hall, 2002) and the literature on substance misuse (Prel and Protinsky, 1988).

There was a cycle of inter-generational abuse, neglect and childhood trauma present in participants’ narratives. Rebecca had been neglected and abandoned by her mother, a pattern which she was repeating with her own son. Her Grandmother (who had once taken on parental responsibility for Rebecca) had done so with Rebecca’s son during her severe crack use. He was having behavioural problems at school and was aware of his mother’s drug use and criminality. Rebecca also struggled to set boundaries with him during her recovery, which Brown et al. (2015) also found in their study. Jim who
was neglected and abandoned by his mother in childhood was unable to look after his
twin sons (who had lost their mother in childhood) therefore his father had taken on
this responsibility. Jim’s 21 year old sons were unemployed and heavy cannabis users.
The findings would lend some support to the family system theory literature which
recognises the detrimental impact that some inter-generational patterns of
communication and behaviour can have on successive generations (Byng-Hall, 1995,
2002).

These findings made me further consider the potentially damaging impact that these
participants’ chaotic lives was having on their own children, much like their own
parents lives had, had on them. Some mentalisation theorists suggest that mentalisation
which includes being able to identify, understand and manage emotions, needs,
behaviours and thoughts to manage internal states, is learned in childhood from
parents. However, this requires the parent to have mentalisation processes themselves
(Jurist, 2008). As outlined in previous sections, many participants struggled. The
specifics of how attachment bonds influence and interact with the development of
mentalisation is still being debated (Jurist, 2008).

The findings have important implications for therapeutic practice and the need to
consider a family systems therapeutic approach to concentrate on the whole family to
ensure that damaging roles and patterns of behaviour are not repeated in the next
generation, (Dallos & Vetere 2009) and who may also be susceptible to substance
misuse. Family systemic therapeutic approaches have been used to help young people
reduce drug use, criminal and delinquent behaviour (Cunningham and Henggler,
1999). A study evaluating the effectiveness of a family intervention programme with
substance misusers found that substance misuse reduced among parents and it helped
to foster better family functioning such as reduced stress and other psychological
problems among parents (Forrester et al., 2014). However, the study concluded that
longer term intensive interventions were required to help the children avoid substance
misuse, psychological ill health, violence and further deprivation and adversity.
6.3.5.5 Having the capacity for acceptance, to reflect, understand and reason

Participants in recovery were more aware of their emotions, the intensity of them and their need to manage them to avoid lapses and relapses, for example Rebecca. This would lend support to affect regulation theorists such as Flores (2012). Van Der Kolk (2014) suggests that healing trauma responses requires being self-aware, regulating emotions and accessing executive functioning abilities, to develop the capacity for reflective functioning. Participants in recovery exhibited signs of these in relation to managing and understanding the adversities they had experienced in life (past and present) and gaining an insight into their drug use behaviour. This involved self-reflection, insight and moments of realisation among participants. These finding are consistent with studies which found understanding, acceptance (Davidson et al., 2008), reflection (Smith & Ferguson, 2005) self-awareness and insight (Harris et al., 2005) were important in maintaining recovery.

Participants in recovery also experienced capabilities around thinking through their problems and adversities, which included weighing up costs, benefits and risks to help them manage their lives and their recovery, (Smith & Ferguson, 2005). For example, in recovery Gale talked through her problems with a friend to resolve them. Harris et al. (2005) found participants used effective problem solving skills to help manage triggers. Modern Attachment theory suggests that those with insecure attachments have less constructive coping skills. Those with more secure attachments are able to problem solve and utilise other cognitive abilities, such as reappraisal and seeking support from others, to deal with problems and stress and to help regulate emotions (Mikulincer & Shaver, 2008). Ford (2005) has highlighted research which has found that those who have suffered childhood trauma and abuse have reduced mentalisation, functional awareness, coping skills, emotional regulation and cognitive functioning abilities including problem solving skills. Furthermore, executive functioning skills such as reasoning can be one of several protective factors reducing the risk in the development of offending behaviours (Farrington & Welsch, 2007). This has further relevance for the participant group who have lengthy offending backgrounds.
6.3.5.6 Transitioning out of recovery

Participants who were transitioning out of recovery tended to isolate themselves, were in denial of their drug use and disengaged from their non-drug using lifestyles. There was an absence of all or some of the recovery experiences mentioned in Sections 6.3.5.2-6.3.5.5. Smith and Shinebourne (2009) also found denial and ambivalence in their study. Denial is a recognised part of the process of change model (Miller, 1998). What is interesting in the findings are the reasons why participants transitioned out of recovery. These were situations which participants considered either stressful or traumatic and which they felt unable to deal with. For one participant (Terry) it was the stress of being moved from a supportive hostel to a less supportive environment which led to his relapse. Another participant was upset and stressed about his father who was unwell and a further participant was in a violent relationship. As mentioned in previous themes anything and everything from the extremely stressful to the mundane could be a reason to lapse or relapse. This is consistent with the literature (Senker & Green, 2016). However, the theoretical frameworks presented in this thesis provide a convincing rationale about why participants were unable to cope during times of stress and perceived trauma and why they were unable to cope without the use of substances. Indeed why this group struggled with managing “normal” life including the more mundane aspects of life.
CHAPTER 7: ETHICAL, LEGAL AND SAFEGUARDING CONSIDERATIONS AND CHALLENGES IN THE THESIS

7.1 Chapter overview

The offending and drug taking backgrounds of the participant group presented specific ethical, legal and safeguarding challenges and considerations that warrant further discussion and required further navigating and managing during the Focus Group Study (Part One). These are discussed in this chapter. Key ethical, legal and safeguarding learnings from the thesis for research involving a drug misusing offender population are covered in the Summary and Conclusion Chapter 8.

7.2 Incentives to take part

Participants in this research were offered vouchers as incentives to take part, in recognition of the difficulty of engaging with this group and to therefore encourage participation (Hucklesby & Wincup, 2010). However, several participants were unaware that they would receive vouchers, lunch and reimbursement for travel but were none-the-less willing to take part. Vouchers (worth £5.00), were given because the offer of money raises a number of ethical and moral considerations such as the participants using the money to spend on drugs or other substances (Hucklesby & Wincup, 2010). Vouchers are therefore considered to be more ethical and moral (Seddon, 2006 and Hucklesby & Wincup, 2010). Offering large sums of money or vouchers can also set a precedent among a population which can then become a barrier to further researchers who are unable to offer this (Hucklesby & Wincup, 2010).

During my MSc research, which was conducted during several Government commissioned research projects, this had presented a problem and as a result I had to increase the incentives. I was unaware of this affecting my PhD research and this might have been because Government commissioned research on DIP was not as prolific during my PhD.
7.3 Criminal disclosure

The participants’ offending backgrounds presented a particular challenge during the research, including for the NHS ethical board who imposed extra requirements on the research to manage this. Participants were therefore required to consent to a confidentiality clause which required me to inform the authorities should I become aware of any detailed and specific knowledge of criminal behaviour not known to the police. Managing participants’ criminal disclosures during the research was at times challenging and precarious.

For many participants criminal behaviour was a part of their lives and for some it was closely related to their drug taking behaviour. Furthermore, the methodological approach I had used (IPA) encouraged participants to have more freedom to decide what they wanted to talk about. It was therefore difficult for some participants to avoid this topic and it was unrealistic to impose this expectation on them. To help avoid violating the confidentiality clause and jeopardising trust among the wider group, (if word got around) I therefore reminded participants that they could talk in general terms about their criminality and they could talk about offences that were known to the police, and for which they had been arrested, convicted or charged. In practice understanding and applying the terms of the confidentiality clause in a face-to-face interview or focus group situation was not always straightforward. It is unclear what constitutes ‘detailed and specific knowledge of an offence’. I therefore decided, after discussion with my supervisors and staff at the rehabilitation organisation, that this had to include knowledge of dates, times, specific detail of the offence and it had to be clear to me that the offence was not known to the authorities or that they had not been convicted, charged or arrested. On two occasions where I felt participants were in danger of breaking the agreed terms I had to cut the interview short. Hucklesby and Wincup (2010) have also noted the legal perils of criminal disclosure with this group in qualitative research where controlling participants’ criminal disclosure is much more difficult. There was an impact on my research of not being able to pursue some lines of inquiry. In some cases I was not able to further explore some interesting lines of enquiry concerning the links between participants’ drug taking and offending behaviour.
7.4 Impact on the participants of taking part in the Focus Group and the Semi-structured Interview Study: re-traumatisation and potential benefits.

Bernstein (2000) suggests that substance misusers and those in recovery are at an increased risk of lapses and relapses when recounting past trauma, which I had to be mindful of with the participant group. The British Psychology Society Code of Ethics (2009) recommends that debriefing sessions are offered to participants to minimise any adverse effects of the research process. Given the vulnerable status of the participants, and on the advice of the drugs workers, I also offered a debrief with a trained counsellor.

Overall participants in the focus groups found taking part in the research a positive experience. Bobby in Focus Group One found aspects of the task interesting and Samuel in Focus Group Three expressed his enjoyment of taking part by saying he wanted the task to continue for longer. Members in Focus Group Three remained behind after the focus group to have lunch together. Kevin in Focus Group Three said he had enjoyed the experience. Others felt a sense of camaraderie that they shared similar struggles in their journeys of relapse and recovery. Clare took up the offer of the trained counselling session and I hoped for her that the focus group had provided an opportunity for her to begin to address the sexual abuse she had suffered in her childhood. In the Semi-structured Interview Study Jay also took up the offer to have a debrief with the trained counsellor afterwards.

During the interview study (Part Two) Mark became very tearful and Olivia was concerned about uncovering further trauma memories so having a pre agreed protocol in place with the DIP staff was an important safeguarding measure in addition to the debriefs. However, at the end of the interview Mark was grateful for the advice given during the debrief session, on where he could get help and support in the community. Olivia wanted to know more about the research and wanted to talk further after the interview had ended. Research studies have noted the benefits participants gain from
taking part in research involving sensitive topics (Sammut-Scerri et al., 2012) and those involving Class A drug users (Daniulaityte et al., 2007).

One participant, Moses, who had been very engaging over the phone during the recruitment stage was especially quiet during the focus group and did not engage as well as other members in the discussions. It emerged during the focus group that Moses had a diagnosis of schizophrenia. He heard voices in his head. These interfered and competed with those of the participants during the focus group and this may have explained why he was more engaging in conversation over the phone than during the focus group. This participant may have benefited from taking part in the Semi-structured Interview Study instead of a focus group setting. A further participant (Harry) in the semi-structured interview study (Part Two) said that he would have preferred to take part in the focus group study (Part One). This might have been a reflection of his difficulty relating to women and he may have felt uncomfortable being interviewed by me. These concerns are something to be taken into consideration in future research with this participant group.

7.5 Safeguarding the researcher: physical safety and ‘self-care’

Due to the drug taking and offending backgrounds (including violent offences) of the participant group the researcher needed to be mindful of her own personal safety. I was advised to undertake a series of vaccinations prior to commencing the research, as mentioned in Chapter 4, Section 4.11.5, Hucklesby and Wincup (2010) have noted the potentially harmful illnesses that researchers can be exposed to when working with drug misusing offenders. Prior to participant contact, I was given the rehabilitation organisation’s protocols about personal safety with their client group. Neale et al. (2005) offer a number of safeguarding measures when working with a drug misusing population which were also used. Some of these are illustrated here.

Before each interview and focus group a risk assessment was conducted with the drugs/DIP workers about participants’ behaviour, in particular their past violent or sexual offending. The Semi-structured Interview Study (Part Two) included two participants who had recently been released from prison after a conviction of rape. After discussion with the drugs workers one participant was not invited to participate.
The other participant (Luke) had committed the rape whilst high on crack and had raped someone who was known to him, therefore the risk to my personal safety was considered minimal. Another participant (Kevin), in the Focus Group Study (Part Two) had displayed racist and aggressive behaviour towards a probation officer in the weeks prior to the focus group however his drugs worker felt he did not pose a risk to me or to the other participants. Furthermore, Kevin’s drugs worker, who was acting as a focus group facilitator, was also present in the room.

Conducting risk assessments with those who were in longer term recovery and who were no longer being managed by the DIP team was not always possible. However, the longer term recovered who worked in the services either as mentors, volunteers or as drug workers were deemed a low risk and the drugs workers referring them were confident in recommending them.

During the semi-structured interviews, where the researcher was alone with the participants, the following safety measures were implemented: I carried a panic alarm which was connected to the police, I informed the drug workers which participant would be attending and the anticipated duration of the interview, I positioned myself near to the doorway with a clear exit and where possible I conducted interviews in rooms with glass panels, near to the reception areas.

Neale et al. (2005) have noted the challenges of research involving this group who might present to an interview intoxicated and they suggest terminating the interviews. This was one of the reasons for terminating the interview with Terry. He had consumed Class A drugs 48 hours before the interview although his speech only became slurred after some time. The decision for terminating the interview was also based on his very aggressive behaviour and because I was concerned that he would disclose too much detail about his past criminal offences. Two participants, who initially agreed to take part in the research, were not followed up because they sounded intoxicated over the phone.

Managing participants’ behaviour, emotions and listening to their often harrowing accounts had to be carefully managed during the research. It was important to ensure
that I did not unduly influence participants’ accounts during the focus groups and particularly during the interviews (Neale et al., 2005). My extensive training in qualitative methods during my undergraduate, Masters and PhD degrees helped (Neale et al., 2005). Examples of navigating participants’ difficult behaviours, emotions and accounts are provided in Chapters 5.2, 6.2 and 6.3.

It was also important to consider the personal impact of listening to participants’ harrowing accounts multiple times (during transcribing and the analysis) and how to manage this. Indeed researchers have suffered nightmares, insomnia and other adverse effects from listening to distressing accounts (Cowels, 1988 and Sammut-Scerri et al., 2012). McGourty, Farrants, Pratt, & Cankovic (2010) suggest supportive networks, which are equipped to manage distressing accounts, can help to mitigate the adverse effects of vicarious trauma. I therefore talked to my supervisors about any particularly distressing accounts, I decided not to conduct transcription or analysis late in the evenings and factored in time to relax after analysis involving such accounts.

7.6 Conducting focus groups with drug misusing offenders – further ethical, legal and safeguarding considerations and challenges

The drug misusing and offending backgrounds of the participant group presented further ethical, legal and safeguarding considerations when developing the focus group design and managing the focus groups. This added extra time onto the research process.

7.6.1 Ethical and safeguarding considerations

The participants were considered to represent a vulnerable group and it was anticipated that the questions and topics in the focus group task might prompt discussions about sensitive topics. The NHS ethical board therefore stipulated that participants should also be given the option to talk from a generic perspective rather than from personal experiences. In the focus groups participants chose to speak from their own experiences. To help safeguard participants in a group setting, the card sort topics were open ended and did not ask specific details about childhood events, (e.g. the card sort topic ‘family’). To further safeguard participants if they chose to speak about sensitive
topics, I did not ask detailed follow up questions thereby allowing them to choose the level of detail they felt comfortable disclosing. For example, Clare disclosed that she had been sexually abused in her childhood and Ellen disclosed that she had been in a violent relationship. All participants were provided with the option of counselling afterwards with a trained counsellor.

7.6.2 Legal considerations

Participants’ offending and drug taking backgrounds required extra checks to safeguard participants and to satisfy some legal considerations in the focus group setting. This was to ensure that no rival criminal gang members were in the same group, no MAPPA sex offenders were part of the focus groups and that no court mandated restrictions were imposed on participants’ movements or proximity to victims or accomplices. These checks were conducted by the DIP staff before the focus groups began. This meant that when participants dropped out at the last minute, recruiting on the day of the focus group was very difficult. As a result focus group numbers were between 2-3 in each group rather than 4-5.

7.6.3 Facilitating difficult focus group dynamics

During the focus groups I became aware that some group dynamics caused friction and conflict among group members. The offending and drug misusing backgrounds of participants, which included violent offences, also made me extra vigilant during these encounters in the focus groups. For example, the tension and conflict between Kevin and David mentioned in Chapter 5.3, Section 5.3.4.4. Kevin disclosed he had committed murder and David disclosed he had been the victim of an attempted murder. David sat with his back towards Kevin, he interrupted and was dismissive of Kevin on many occasions and he did not read some of the card sort topics out (Kevin had disclosed he struggled with literacy). To ease the friction I gave Ellen the role of reading out the card sort topics in the next task.

I also had to be mindful of particularly vulnerable group members and the impact the group dynamic might have on them, for example Clare, who had disclosed being sexually abused in her childhood. There was an instance in the focus group between
Clare and Samuel when he invaded her personal space and she recoiled. Although there was a good rapport between them, Samuel was also flirtatious and whilst Clare reciprocated, I was mindful that Samuel could be taking advantage of Clare’s vulnerability. I was relieved that Clare had accepted the offer of a debrief with the trained counsellor afterwards.

7.7 Summary

Navigating and managing the ethical, legal and safeguarding considerations due to the participant groups drug taking and offending background was challenging but necessary to safeguard all of those involved in the research. A summary of some of the key learnings of these considerations is provided in the following Summary and Conclusion Chapter 8.
CHAPTER 8: SUMMARY AND CONCLUSION

8.1 Chapter overview

A summary of the findings is provided. The implications and contributions for theory, policy and practice are considered, this includes the development of a mapping tool, ‘The Addiction Lifeline’ (Love, 2016). Some suggestions for further research have been proposed within the Part Two Semi-structured Interview Study: Discussion Chapter 6.3, and they are considered further throughout this chapter. Finally methodological considerations including, the scope and limitations of the research are covered, along with key learnings and recommendations for future research involving the study population and IPA.

8.2 Summary of findings and further research

The main purpose and aim of the research was to explore the cycle of relapse and recovery of community based substance misusing (ex)/offenders, who were current or past DIP clients, from their own perspectives. The hope was to uncover areas of importance which impacted on participant’s relapse and recovery, with an emphasis on their childhoods, family, significant life events, relationships and psychological health. This was to address a gap in the literature where there has been a paucity of research using a qualitative approach (including the use of focus groups), with a Class A drug misusing and offending population, within a UK community based criminal justice setting.

The key aims of the research were addressed and are covered in extensive detail in the Part Two Semi-structured Interview Study: Discussion Chapter 6.3. Figure 5, The Wheel of Relapse and Recovery, provides a summary and overview of those findings, including hypothetical links. In summary and referring to Figure 5, the participants experienced extremely abusive childhoods and chaotic teens (shown in red in the diagram). They continued to struggle in their lives with relationships, trauma responses, normal life, damaged selves, emotions and mental health (shown in red).
Drug use, lapse and relapses were linked to these areas in red, with many participants using drugs to cope with those issues highlighted in the red areas. Managing recovery (shown in orange) was about learning to deal with the issues presented in the red areas in a healthier way. How participants experienced and managed their recovery in a healthier way, (including more sustained recovery), is highlighted in green. For example, supportive networks, reflection and understanding of drug use harms and the benefits of recovery. For participants who were transitioning out of recovery, their narratives and experiences lacked many or most of the issues highlighted in the green areas. This template could be used in further research with other substance misusing populations and to examine gender differences using a multi method approach with a larger sample size.
Figure 5: The Wheel of Relapse and Recovery: An Overview of the Findings Showing Hypothetical Links Between Themes for Part Two Semi-structured Interview Study
8.3 Contributions and implications for theory

A further aim of the research was to use theories from developmental psychology to inform the direction and scope of the research. These theories have not featured prominently within the Class A drug misuse relapse and recovery literature, despite the fact that they highlight links between co-morbidities and later substance misuse, for example, mental health and abusive childhoods.

The research has demonstrated that a framework of theories from a psychological developmental, attachment, trauma and family systems perspective provides the most compelling explanation and context from which to understand the participant’s cycle of relapse and recovery. This contribution to theory further highlights that one theory alone is insufficient to account for the complexity of the participants’ lives and that an integration of theories is required. Modern attachment theory has been a central influence in the theories outlined in Figure 6 in helping to provide some of that integration.

The framework of theories further suggests that a formulation of these theories and the corresponding therapeutic interventions (highlighted in Chapter 3 and Chapter 6.3), might provide the most powerful treatment intervention for this group to address their multiple co-morbidities. The theories and findings reported in this thesis further highlight the individuality of participant’s journeys and suggest that theory and treatment utilised together and tailored to address each individual’s journey, might provide the most effective treatment. Further research would be required to investigate this.

8.3.1 The value and limitations of a micro level understanding of first use, relapse and recovery

Several theorists such as West and Brown (2013) and Orford (2001) have offered a macro level overarching description of the behaviours involved in addiction. For example West and Brown’s (2013) PRIME theory, which includes Planning, Responses, Impulses, Motives and Evaluations, provides a macro level description of behaviours involved in the motivations of addictive behaviours and is influenced by a
behaviourist perspective. West and Brown (2013) have been heavily influenced from the field of tobacco research and their theory has been applied within this field. The focus of the theory is primarily concerned with how addiction is maintained and less so about how or why addictive behaviour first begins (Ogden 2012).

West and Brown (2013) consider their theory to have wide application to many addictive behaviours such as tobacco, alcohol, drugs and gambling. However, grouping all addictive behaviours together in one model ignores any differences that might exist among different addictive substances and among the individuals who predominantly consume those substances. For example, those who have severe addictions to crack and heroin present with particularly chaotic and problematic drug use behaviours such as chaotic lifestyles, including unemployment, homelessness, criminality and mental health problems (Edmunds et al., 1999; Bennett & Holloway, 2009a; Seddon 2006; and Moyle & Coomber, 2015). However, this is not characteristic for the majority of those who have addictions to tobacco only.

The ‘model’ or concept proposed in the thesis provides an understanding from a developmental psycho-social perspective of how and why addiction, relapse and recovery might occur among a specific group with severe crack and heroin addictions. The model is developed from participants own accounts of their journey into first drug use, maintenance, relapse and into recovery. The model provides a micro level nuanced understanding of the different ways that individuals from a specific group come to understand their journey of first use, continued use, relapse and recovery. The proposed model and the methodological approach used cannot therefore be applied to other addictive populations or addictive substances without further research. It must also be considered that the findings and the model proposed in this thesis might be specific to that population or group only. However, this possibility in itself presents an interesting finding - that there are important differences among addictive populations and/or substances, which has important implications for treatment development and provision.
Figure 6: Framework of Theories Developed from the Research Findings, Showing the Relevant Components of Attachment Theory and the Other Relevant ‘Core’ Theories: When Integrated They Offer a Psychological Developmental Attachment–Trauma Approach to Understand Addiction.
8.4 The Addiction Lifeline: Illustrating the complexity of participants’ lives - further contributions of the research

A further contribution of the research has highlighted the complexity of the participants’ lives before substance and drug use dominated and took a hold. It further highlights their continued struggles with life in their recovery. Figure 7, The Addiction Lifeline, is a mapping tool illustrating one participant’s journey of relapse and recovery. It was developed from Gale’s individual IPA analysis by taking standout themes (and aspects of those themes) and mapping them along Gale’s lifeline trajectory from childhood through to her adulthood alongside her journey into substance/drug use and into recovery. It provides an insight into the trauma responses, dangerous and distressing events, emotional and mental health problems and significant life events which had impacted on Gale before her Class A drug use began. It further highlights her continued struggles with her life in recovery and how she manages these in recovery to avoid lapses and relapses.

Mapping tools have been used to help clients and practitioners with addiction treatment needs and progress. The mapping tools used in the International Treatment Effectiveness Project (ITEP - Campbell, Finch, Brotchie & Davis, 2007) helped identify clients’ thinking processes with a focus on problem solving. However, these mapping tools did not include in-depth qualitative analytical techniques and therefore differ from the (multi-purpose) mapping tool presented here.

8.4.1 Potential applications of The Addiction Lifeline (Love, 2016)

I envisage that The Addiction Lifeline (Love, 2016) has several applications.

1. The Addiction Lifeline (Love, 2016) could be used in thematic or narrative qualitative research to help to illustrate individuals’ journeys to ensure that individual nuances as well as commonalities across findings are captured.

2. The Addiction Lifeline (Love, 2016) can illustrate the complexity of this group’s lives to a wider audience who are unaware of such complexities and where such knowledge sharing would help to further develop, policy, strategy and services for this group.
3. The Addiction Lifeline (Love, 2016) could be applied within a therapeutic setting for a therapist with their client to map out areas in the client’s life which require particular support and treatment in recovery.
Figure 7: The Addiction Lifeline: Showing One Participant’s (Gale) Journey of Relapse and Recovery

The Addiction Lifeline (Love, 2016)

PRE | DRUG USE | RECOVERY
---|---|---
Childhood | Teens | Adulthood

- **Gale** & sister not told they have different fathers. Rest of family know.
- Bullied at School
- Bullied by drunk neighbour, she had a different father.
- Beats her
- Talks to her friends about her problems.

**Drug use begins**

- Drinks heavily
- Uses drugs

**Drug use stops**

- Emotions, feelings or mental health

**Significant event or relationship**

- Leapse
- Relationships
- Traumatic event

**Response, impact or consequence of significant event or relationship**

- Event
- Relapse
- Drug use stops

**Has support from friends & groups.**

- Trusts builds with outreach worker.
- Numb the cold

**Feels depressed partner gives her heroin.**

- Drugs numb experience of prostitution.
- Drugs become the cold

**Feels depressed.**

- Conceals due to identity of baby's father from family.
- Gave up.佑er gets her baby's father.

**Suffer post natal depression & break down & abandon child.**

- Gale suffers from depression.
- Moves into flat on own with her child.
- Gale discovers she is pregnant 8 months into her pregnancy.

**Gale struggles to cope with her baby.**

- Gale struggles to cope with her baby. Moves into flat on her own with her child.
- Gale struggles to cope with her baby. Moves into flat on her own with her child.

**Partner arrested. Gale becomes a prostitute to support her family.**

- Homeless, lives under a bridge & is a prostitute for years.
- Gale becomes a prostitute to support her family.

**Struggles with triggers.**

- Outreach worker behinds Gale.
- Gale becomes a prostitute to support her family.
- Gale becomes a prostitute to support her family.

**Triggers.**

- Gale becomes a prostitute to support her family.
- Gale becomes a prostitute to support her family.

**Learn to use rational thinking.**
8.5 Further implications for policy, practice and future research

8.5.1 Addressing developmental trauma

The research has helped to highlight that this group have suffered childhood trauma and abuse. Some participants had never before spoken about their abuse and most had never sought help to address it. Given the links between the participant group’s trauma responses and their drug use to cope with their trauma reactions, it would therefore be prudent to specifically address trauma responses as part of their rehabilitation. Van Der Kolk (2014) suggests that both the mind and the body require healing from trauma. This involves self-awareness, accessing the emotional brain to regulate hyper and hypo arousal states and restoring executive functioning abilities. Bernstein (2000) acknowledges that those with childhood trauma and substance misuse issues require extra care when treating the trauma to guard against re-traumatisation of recovered memories which can lead to lapses and relapses. Bernstein (2000) offers a phasic approach in dealing with trauma in those with substance misuse issues. Further research is warranted to explore childhood developmental trauma among this group and effective treatment pathways.

8.5.2 Addressing and recognising multiple co-morbidities – a common pathway?

The participant group have multiple complex co-morbidities including, offending behaviour, polysubstance misuse, emotional and mental health problems, childhood trauma and trauma/responses in adulthood. This research has gone someway to providing an overarching hypothesis that there might be a common developmental pathway for these co-occurring morbidities. This is further supported in some of the quantitative literature concerning risk and protective factors among those with offending backgrounds, substance misuse, childhood abuse and developmental childhood trauma (Farrington, 2015; World Health Organisation, 2002; NSPCC, 2011; Felitti et al., 1998; and Van Der Kolk, 2014, 2003). There is a growing body of work recognising common pathways which might account for criminality, substance misuse and mental health problems (Crighton & Towl, 2008). Further research using multi
method approaches need to be conducted to examine if these co-morbidities share a common developmental pathway.

8.5.3 Addressing the inter-generational cycle of trauma, abuse and neglect

The research has also touched upon the issue of inter-generational cycles of trauma, abuse, neglect and other harmful family environments. Whilst this was not the intended focus of the PhD, it is an area that requires further research with this group. The participant group’s children had been exposed to a range of adverse circumstances, including being cared for by other relatives, taken into the care of social services, exposed to drug use, violence in the home and parents being imprisoned. Given the literature and empirical work presented in Chapters 3, 5.2 and 6.3 about the increased risk of substance misuse and mental health problems among children who have experienced such childhood trauma, it is imperative that a whole family systems approach is also considered. It must be recognised however, that many in this group have suffered severe trauma at the hands of some family members and it must be acknowledged that it is not always appropriate or safe to include such family members in a client’s rehabilitation. The client’s consent must be sought before including family members in their rehabilitation. Any therapy should be a collaborative approach which involves trust and empathy between the therapist and the client especially among a group who struggle with both of these concepts.

8.5.4 Defining recovery and future directions

The thesis has gone some way to address the gap in knowledge about what recovery is and what it means to a substance misusing offender group from a developmental psychological perspective. It has been able to illuminate some of the psycho-social processes and experiences involved. Transitioning into and out of recovery is very much an individual process with a changing landscape that each participant described and experienced differently despite the commonalities across the participants. It was not an experience with a definite start and end point but it was an ongoing struggle with life itself as well as with substances.
It is worth considering the context and meaning of the terminology of ‘journey’ used throughout this thesis. The term ‘journey’ was used within the DIP by the Home Office primarily to de-stigmatise this group, it was heavily influenced from the health sector. Interestingly none of the participants in the study referred to their experiences specifically as a journey. Perhaps a journey signified a specific starting point that can be easily determined and an end point, neither of which the participants could either define nor determine.

Recovery was about managing to cope with those life experiences, including from childhood, that participants considered to have contributed in some way to their drug use and relapse behaviour. Part of recovery was about managing and learning to live a normal life, building a coherent sense of self, self-regulation strategies and healthier relationships to bolster participants’ resilience in recovery. There were similarities in the findings with the mental health recovery literature, for example, Borg and Davidson (2008) Davison et al. (2008) and Topor et al. (2011). The addiction recovery field could benefit from learnings in the mental health recovery literature. More research needs to be conducted about recovery within the addiction field from participants’ own perspectives and which brings together theories used within therapeutic settings to offer a realistic context and understanding of those findings (Orford, 2008). For this group their experiences were complex and capturing those within the terminology of a ‘journey’ is perhaps an oversimplification.

8.5.5 The future for the DIP clients – implications for policy

Public Health England now have policy responsibility for the DIP. Furthermore, in recognition that many of the DIP clients have co-occurring mental health problems, they have brought together Liaison and Diversion schemes with the DIP to cater for co-morbid mental health issues among the DIP clients (Burton, Thomson, Visintin, 2014). This is a welcome move. However, the findings and wider literature presented in this thesis suggest that rehabilitation measures need to include therapeutic interventions to address emotional as well as mental health problems and trauma, including developmental childhood trauma.
The impetus for this research originated from my observations of working in the DIP policy, where I thought that addressing the Class A drug misuse only was detrimental to the support on offer for the DIP clients. This research has suggested that not only is it important to address all substance misuse problems with this group but that further investigation is required to examine the common pathways concept mentioned previously. Government and local Councils could go further by focusing their research funding resources to examine these as well as some of the other suggested areas for further research outlined in this thesis.

8.6 Methodological considerations, contributions and learnings

8.6.1 Ensuring high standards within qualitative research in the thesis

Neale et al. (2013) and Yardley (2000, 2008) have suggested a range of measures to ensure quality and high standards in qualitative research. Smith et al. (2012) have done so for IPA. A detailed overview of how these were followed and achieved in this research is outlined in Appendix 21. A brief summary with key learnings is now provided.

Credibility checks

Credibility checks were conducted in the Focus Group and Semi-structured Interview Studies as outlined in Chapters 5.1, Section 5.1.8.3; Chapter 5.3, Section 5.3.4 and Chapter 6.1, Section 6.1.5.4. For the Semi-structured Interview Study the credibility checks with an IPA specialist were to verify the data to ensure that my interpretations were derived from participants’ accounts and to ensure the theme headings were coherent and made sense. Furthermore, to ensure that my application of IPA was accurate. For the Semi-structured Interview Study it was clear that further analysis was required to develop some of the themes further. This resulted in the number of superordinate themes being reduced from 5 to 4 and the fourth theme featuring the label of trauma/responses. I had not considered that my interpretation of a traumatic event might differ from that of the participant group, who clearly experienced everyday living as stressful and at times traumatic. However, the IPA specialist suggested that a theme regarding powerful political influences being forced on to the
group could be included. I felt that there was not enough supportive evidence to
develop this into a theme. I further felt that the IPA specialist might have gleaned this
more from my presentation of my findings within the context of my political
background rather than from the participants’ own narratives. It is therefore important
to consider feedback from credibility checks within the same sceptical (questioning)
and iterative approach favoured during the IPA analytical process.

Credibility checks were also undertaken with an IPA London network group, drug
workers from DIP teams and recovered Class A drug misusing offenders. The IPA
group supported the findings and interpretations. The drugs workers, which also
included recovering drug misusing (ex) offenders felt that the findings resonated with
what they understood of relapse and recovery journeys.

**Training in IPA**

IPA is a relatively new qualitative methodology developed by Smith et al. (2012) over
20 years ago. I therefore undertook several workshops conducted by IPA specialists to
ensure I understood how to apply and conduct good quality IPA research. However,
adapting IPA for use with focus groups was not always a straightforward process,
(which I have discussed previously and which I comment on further in this chapter). I
also attended the IPA London network group regularly throughout my PhD and I was
an active member of the IPA online network. This provided me with opportunities to
trouble shoot any problems with my understanding, interpretation and application of
IPA within my PhD. The online group involved advice and support from the IPA
founder himself, Jonathan Smith and from other key IPA specialists. These resources
were an invaluable source of support and I believe helped me to produce high quality
IPA research.

**Reflexivity – mitigating my ‘political’ bias**

The reflexive process was essential in the research to mitigate unduly biasing the
research process, because of my unique political position in relation to the participant
group, due to my time working on the DIP policy. Reflexivity was addressed through
reflective note taking about each participant and about each focus group and interview
situation. I was also interviewed at the beginning of the research process about my biases, preconceptions and orientation towards the research. I was then interviewed towards the later stages of the research about my (renewed) understanding of the research and the participant group. This revealed that at the start of the research process I had viewed this group predominately through a political lens with the labels of offender and drug misuser dominating. This changed during the research process. Through my PhD training in psychology and my training in IPA, I was able to connect and empathise with the participant group. This enabled me to understand their vulnerabilities without the labels of offender and drug misuser dominating. This ultimately helped me to develop themes which provided an insight into participants’ experiences as vulnerable children and adults with multiple complex needs who struggled with their lives past and present and the impact this had on their ‘journey’ of drug use, relapse and recovery.

8.6.2 Adapting IPA for use with focus groups – some key learnings

A detailed description of how IPA was adapted for use with the focus groups in this thesis is provided in Chapter 5.1. The IPA adaptations were based on published papers by Tomkins and Eatough (2010) and Palmer et al. (2010). Since IPA’s inception it has been adapted and developed both within the field of psychology and other fields such as health and education (Smith & Shinebourne, 2012 and Smith 2004). It has been used in studies with couples, groups (Flowers et al., 2001; and Dunne & Quayle 2001) and using different data collection methods such as observational methods (Larkin & Griffiths, 2002) and diary extracts (Smith, 2004). For some these adaptations question the epistemological underpinnings of the methodology (Eatough & Tomkins, 2010). However Smith (2004, p.51) recognises the value in “pushing the boundaries” with for example data collation methods, as IPA develops further.

Innovation within methodology is never an easy task that will satisfy everyone’s perspective but the benefits can produce rewarding results. These have been demonstrated in the Focus Group Study which produced rich and detailed participants’ accounts. The in-depth analysis and interpretations, made possible by using an IPA ‘approach’ in the Focus Group Study (Part One), uncovered some interesting and novel areas to explore further in the second study (the Semi-structured Interviews).
There is a healthy debate about how IPA is adapted and developed for use with focus groups. This has been outlined in Chapter 5.1, and was taken into consideration in this research. I therefore used an IPA ‘approach’ terminology. This was after careful consideration of the debates I encountered in published work and among IPA network members during the course of the PhD research. This was achieved by discussion of my approach with a wide IPA network, including IPA specialists and exposing my ideas to critical appraisal. Whilst this was challenging it was an essential part of the research process and something that I will endeavour to do in future research when innovating methodological approaches, concepts and design.

The adapted IPA approach used in Study One captured a range of understandings, such as role, positioning, narrative and discourse which oriented the researcher towards what to pay attention to in Study Two. However, adapting IPA for focus groups was time consuming. On reflection this might not be the most efficient methodological approach to use with focus groups in future research where resources and time are limited. Furthermore, in focus groups with large numbers of participants, extrapolating the individual’s account might prove difficult and undermine the ideographic theoretical assumptions of IPA.

### 8.6.3 Ethical, legal and safeguarding considerations with the participant group – key learnings

There are a number of ethical, legal and safeguarding considerations involving research with a drug misusing and offender population. These are outlined in detail in Chapter 7. In summary the group were difficult to access, engage, retain and manage within the PhD research which added a considerable amount of time onto the PhD. A key learning would be to take these factors into consideration in future research with this group when determining timescales.

**Legal considerations – key learnings**

The participants’ offending backgrounds presented a particular area of concern for the NHS ethical board in relation to potential disclosure of criminal behaviour.
Participants were asked to consent to a confidentiality clause, which required the researcher to inform the authorities should she become aware of any detailed and specific knowledge of criminal behaviour not already known to the police. However, the interpretation of the full criminal disclosure clause was not always clear. For some of the participants, criminal behaviour was very much part of their lives, and asking participants to avoid discussing this was a constant management dilemma. This is an area which requires careful consideration and management in research with an offending population. Universities and other organisations conducting research may need to consider offering training and providing adequate protocols.

**Ethical and safeguarding challenges - risks and benefits for the participants**

The research has demonstrated that the participants represent a vulnerable group, which was anticipated. Therefore, the potential impact of the research process on participants required sensitive management. For example, re-traumatisation when recounting past trauma with substance misusers can lead to lapses and relapses (Bernstein, 2000). Whilst this required extra planning, the participant’s welfare must always be of paramount concern in research involving ‘sensitive topics’ with a vulnerable group. There are benefits for participants in taking part in research, which the research reported here would support (Daniulaityte et al., 2007 and Sammut-Scerri et al., 2012). Seeking advice and support from the drug and DIP workers including with the trained counsellor was essential to mitigate those risks. Building good working relationships with the staff was imperative.

**Safeguarding considerations for the researcher – key learnings and recommendations**

Using a qualitative approach which involves face-to-face contact with the group presents particular safeguarding challenges for the researcher, including physical safety and risks around vicarious trauma. These were managed throughout the research process by my supervisors and me. However, this is an area that warrants further exploration for researchers dealing with vulnerable groups or those which present extra risks to personal safety and where sensitive topics are involved (McGourty et al., 2010). Sammut-Scerri et al. (2012) suggest access to appropriate supportive networks and training to manage vicarious trauma. (Neale et al., 2005) suggest adequate training
to anticipate and manage risk to physical safety during face-to-face contact with drug misusing populations. Research organisations need to ensure that researchers are made aware of those risks before undertaking research with such groups and that safeguarding protocols are available.

**Focus groups involving drug misusing offenders – further ethical, legal and safeguarding considerations**

The offending and drug using backgrounds of the participant group presented extra ethical, legal and safeguarding considerations when designing and managing the focus groups. This included criminal background checks to ensure that rival gang members and known sex offenders were not part of the groups. Advice from the DIP and drug workers helped me to devise a risk assessment protocol for the focus groups. This required building trusting working relationships with the DIP staff. Whilst these measures were essential to safeguard all of those involved in the research myself included, they added a considerable amount of time onto the research project, something to be mindful of in future research involving this group.

**8.6.4 Limitations, scope and parameters of the methodological approach used**

**Sample size**

Sample sizes within qualitative research are much smaller than they are for quantitative. This is in recognition of the depth and detail required from the analysis and the epistemological underpinning in such methodological approaches. From my observations from taking part in the IPA networks and groups sample size was a hotly debated topic among PhD students under pressure to produce larger sample sizes to satisfy misplaced anxiety that more is better (including from faculty departments). However, IPA, with its ideographic focus, favours a particularly small sample size. Whilst Smith et al. (2012) do not state what the upper limits of an IPA sample size should be for a PhD, Brocki and Wearden (2006), in a review of IPA health psychology studies, found sample sizes ranged from one to thirty, although they do acknowledge a preference towards smaller sample sizes. At the start of my PhD, there was limited consistent guidance on the preferred number of participants for a PhD research using
IPA. Furthermore, I assumed I would only attain a handful of participants given the difficulty of engaging with this group in research. I therefore did not anticipate being able to recruit 18 participants in the Semi-structured Interview Study (Part Two) neither did I appreciate how time consuming analysing data from this number of participants would be. A smaller sample size should be a key consideration in research when using IPA especially when considering time constraints within a PhD project.

Amendments to the original study design - NHS ethical committee

The original study design included a series of psychometric measures to assess participants’ mental health and attachment styles. However, the NHS ethical board suggested these should be offered to participants in a follow up session to avoid participant fatigue. Given the difficulty of accessing and retaining the participant group this was not considered a feasible design so the psychometric measures were removed from the study. It was therefore difficult to make any firm assessments about participants’ attachment styles. Participants’ early family attachment bonds had to be interpreted from the semi-structured interview, (some of the topic areas in the interview were based on the research literature from the attachment field). An attachment style psychometric measure might have been able to add further supporting evidence to the findings.

Participants were asked about their psychological wellbeing and some spoke about specific mental health diagnoses but this did not always capture their current psychological health. Psychometric measures to assess participants’ current psychological wellbeing would have been able to describe and understand the participant group in further detail and might have contributed further to the evidence base on the mental health of community based substance using offenders at different stages of relapse and recovery.

Generalisability of findings – contributions to the field

Interpretative Phenomenological Analysis advocates a homogenous sample and is interested in understanding in depth and detail both the ideographic nature of that ‘group’ as well as any commonalities they might share. The emphasis on the ideographic - nuanced individual narrative and therefore small sample size, means that
the findings within IPA studies are not considered to be empirically generalizable but they can be theoretically generalizable (Neale et al., 2013). For example, the participants who were longer term recovered were those who worked or volunteered in the drug services. There may have been something specific to this group about their recovery that might not have been specific for others who were in longer term recovery and not working in the services. Theories can be postulated from the findings and these can be used to develop future areas of research and can have implications for existing theory, research, practice and policy thereby offering a wide ranging and generalizable contribution (Smith et al., 2012; and Neale et al., 2013). This thesis has gone some way to addressing this and contributing to the field.

Further reflections on IPA

The use of IPA helped to produce detailed and in-depth analysis of some of the psycho-social ‘processes’ and experiences involved in participants’ ‘journeys’ of relapse and recovery. However, capturing the complexity of these experiences when the analysis was abstracted to superordinate themes was challenging. Some IPA studies have favoured particularly concise superordinate theme labels. For example, “Childhood experiences” (Larkin & Griffiths 2002). The meaning is however lost in such labels; we all have childhood experiences so what do the authors mean by this label? (Further reading of the study provides more detail). However, I opted to provide more detail in my theme headings to try and capture participants’ experiences more accurately but it is perhaps unjust and unrealistic to expect that participants’ complex lives can be summarised into four superordinate theme headings. With this in mind I also chose other graphical representations to illustrate and capture this complexity (see Figures 3, 5 and 7).

8.7 Concluding comments

This research has demonstrated that it is possible, despite the difficulties accessing, engaging, retaining and managing the participant group in research, to overcome obstacles by using innovative methodological and method design to produce rich data that yields important and novel findings. Building positive working relationships with
the DIP staff and applying my training to manage face-to-face interactions with the participant group were also essential.

This research has further highlighted that a deeper understanding of this group can contribute to furthering our knowledge base in relation to theory, policy and practice about DIP clients, who represent a severe Class A drug misusing and offending population. The overarching hypothesis proposed, that a common psycho-social developmental pathway might be able to account for the complex co-morbidities found in this group, warrants further exploration.

This thesis has also attempted to highlight the value and merit of integrating what might appear to be disparate theories (including those used within therapeutic settings) into a framework of theories to provide a compelling and more rounded understanding of this group’s ‘journey’ of drug use, relapse and recovery. Future research with this group should consider multiple and integrated frameworks of theories.

Finally, this thesis supports the need for further exploration and research with this group (severe Class A drug misusing offenders). This could well have a profound impact on this group’s rehabilitation in terms of more sustained recovery and desistance from criminal behaviour and in developing preventative measures for the next generation.
REFERENCES


Tomkins, L., & Eatough, V. (2010). Reflecting on the use of IPA with Focus Groups: pitfalls and potentials. Qualitative Research in Psychology, 7, 244-262.


Appendix 1: Example of the research proposal presented to staff at the rehabilitation organisation
(N.B. names and other identifying features have been removed to protect the identity of staff and the rehabilitation organisation).

Summary and Background of Proposed Research

The cycle of relapse and recovery: substance misuse and the psychological health of substance misusers on a rehabilitation management programme.

Paper for Service Managers meeting: 13 July 2012

Researcher: Beverly Love, BSc, MSc, Grad member div. Forensic Psychology BPS.

Email: B.Love@surrey.ac.uk

Tel: ———
Summary and background of proposed research - The cycle of relapse and recovery: substance misuse & the psychological health of substance misusers on a rehabilitation management programme

Background
My MSc thesis\(^1\) evaluated the short term effectiveness of the UK Government’s Aftercare Drug Interventions Programme (DIP) for Class A drug using offenders. The research lent support to the two key outcomes of DIP, to reduce Class A drug use and offending behaviour. Participants’ levels of alcohol consumption were indicative of problematic drinking behaviour and an increase in cannabis use was found.

Substances used by participants ‘New to Caseload Group’ and ‘Post Interventions Group’ (3 month follow up stage) attending DIP.

The research also found that large numbers of participants had indications of mental health issues; depression, anxiety and stress. There was no significant improvement in participant’s psychological health at follow up stage 3 months later. A slight improvement in self esteem was found although this was not a significant difference.

Figures: 1. Depression 2. Anxiety 3. Stress Levels on OASE\(^*\) for Participants (New to Caseload & Post Interventions Group) on DIP.

Proposed research with \(^2\)

Based on some of the findings from the above research, the current aim of the proposed research is to examine the relapse and recovery of essentially Class A substance misusing offenders on community based rehabilitation programmes. Which are currently known as the DIP, PPO and in some cases IOM programmes. The research would be asking around 20-25 participants who are at different stages in their recovery journey what they think has helped or hindered them in their substance misuse recovery and what recovery and relapse means to them. Psychometric measures to examine psychological health & attachment issues would also be used given the lack of current data on dual diagnosis within this client group. Small focus groups would be used first to further develop any research.

\(^1\) The research was supported by the Knowle Office Volunteers and the Director of the Drugs & Alcohol Directorate at the time this research was conducted were given topics to help inform policy making decisions. A summary of the research was also available at www.duac.gov.uk in the archived section.
material. The overall aim of the research is to help to improve the services for this client group. There is little qualitative research which has asked this group these sorts of questions or investigated their psychological health and issues around attachment.

**Benefits to** The change in Government has meant a change in funding avenues and devolution of budgets with a gradual move towards organisations proving or evidencing that what they provide works. It is therefore really important that organisations such as can provide evidence to commissioners that the services are effective. This will essentially be determined around a set of best practice focused outcomes, which are set out in the Updated Drugs Strategy Dec 2010. My research will encompass some of the best practice outcomes outlined below.

These best practice focused outcomes are:
- freedom from dependence on drugs and alcohol
- prevention of drug related deaths and blood borne viruses
- a reduction in crime and re offending
- sustained employment
- the ability to access and sustain suitable accommodation
- improvement in mental and physical health and well being
- improved relationships with family members, partners and friends; and
- the capacity to be an effective and caring person.

I will be provided with a copy of my research (including recommendations where appropriate) which it is hoped can use to help inform their service delivery and potentially to help with any commissioning processes in the future.

**Staff involvement:** Deputy Director (London) of and the service user forum counsel are supporting the research. Further support from all staff is required to help to recruit clients, offer support to clients if required after the focus groups and interviews and offer expert advice/feedback during the research process where necessary.

**Ethical and moral obligations:** All information will be anonymised, no real names will appear in the write up of the research, including if wish for the organisation to remain anonymous in the research. A copy of the research will be published and held within the library at Surrey University as a minimum requirement of the PhD. Participants can withdraw from the research at any time they wish to - clients/participants welfare is my priority when conducting research. Furthermore, when I have conducted research in the past with this client group they have found it to be a positive experience and some even expressed that they felt pleased (and proud!) that their opinions and contributions were being taken seriously and helping to improve the services they were part of. I also have to complete a rigorous ethical procedure at the University to ensure that both clients welfare and their confidentiality is protected, this will include as an organisation too. The University’s ethical procedure consists of a panel of experts who are very thorough in such matters. I am currently going through the NHS ethical procedure. The NHS have given my research a favourable ethical opinion subject to further clarification on some ‘minor’ issues. Furthermore, as a member of the British Psychology Society I am bound by a code of ethical standards which I have to uphold as part of my profession. This includes matters of client confidentiality.

**Timescales & start date of the research placement:** The placement began 2 July 2012. I currently estimate around 9 months to collect the qualitative data this might need revising if we conduct wider research involving quantitative data.

(N.B. The best practice focused outcomes are quoted from the HM Government’s Drug Strategy, 2010, p. 20).
Appendix 2: Tables Showing Information on the Development of the Card Sort Items

Table 1: Card Sort Items for the Card Sort Task Question: ‘What Do You Think Might Cause Someone to Relapse From Class A Drugs?’

<table>
<thead>
<tr>
<th>Card sort items for the card sort task question: ‘What do you think might cause someone to relapse from Class A Drugs?’</th>
<th>Source/s that informed each card sort item – (This is not intended to be a comprehensive list but to provide further information about the development of the card sort items to the reader).</th>
</tr>
</thead>
<tbody>
<tr>
<td>Feeling bored</td>
<td>Drug users and Drug workers</td>
</tr>
<tr>
<td>Being a parent</td>
<td>Attachment theory, attachment disorder theory, family psychodynamic therapy field</td>
</tr>
<tr>
<td>Feeling upset about something</td>
<td>Attachment theory, attachment disorder theory, co morbidity literature</td>
</tr>
<tr>
<td>Unable to deal with painful memories from childhood</td>
<td>Attachment theory, attachment disorder theory. Trauma literature.</td>
</tr>
<tr>
<td>Family when growing up</td>
<td>Attachment theory, attachment disorder theory. Trauma literature.</td>
</tr>
<tr>
<td>Feeling anxious</td>
<td>Affective disorders/co-morbidity literature, relapse and recovery literature</td>
</tr>
<tr>
<td>Not having friends</td>
<td>Attachment theory, attachment disorder theory. Trauma literature.</td>
</tr>
<tr>
<td>Friends</td>
<td>Attachment theory, attachment disorder theory. Trauma literature.</td>
</tr>
<tr>
<td>Feeling stressed about something that has happened</td>
<td>Attachment theory, attachment disorder theory. Trauma literature. Co-morbidity literature,</td>
</tr>
<tr>
<td>Feeling lonely</td>
<td>Attachment theory, attachment disorder theory.</td>
</tr>
<tr>
<td>Unable to deal with painful memories from the past</td>
<td>Attachment theory, attachment disorder theory. Trauma literature.</td>
</tr>
<tr>
<td>Unable to deal with painful emotions from childhood</td>
<td>Attachment theory, attachment disorder theory. Trauma literature.</td>
</tr>
<tr>
<td>Feeling depressed</td>
<td>Attachment theory, attachment disorder theory. Trauma literature, co morbidity literature</td>
</tr>
<tr>
<td>Not having a partner</td>
<td>Attachment theory, attachment disorder theory.</td>
</tr>
<tr>
<td>A partner</td>
<td>Attachment theory, attachment disorder theory. Trauma literature.</td>
</tr>
<tr>
<td>Unable to deal with current relationships</td>
<td>Attachment theory, attachment disorder theory. Trauma literature.</td>
</tr>
</tbody>
</table>
Table 2: Card Sort Items for the Card Sort Task Question: ‘What Do You Think is Helpful in Sustaining a Person’s Recovery From Class A drugs?’

<table>
<thead>
<tr>
<th>Card sort items for the card sort task question: ‘What do you think is helpful in sustaining a person’s recovery from Class A drugs?’</th>
<th>Source/s that informed each card sort item – (This is not intended to be a comprehensive list but to provide further information about the development of the card sort items to the reader).</th>
</tr>
</thead>
<tbody>
<tr>
<td>Having responsibility for looking after children/dependents</td>
<td>Attachment theory, attachment disorder theory</td>
</tr>
<tr>
<td>Help from a drug worker</td>
<td>DIP Policy, Drug workers, drug misusers</td>
</tr>
<tr>
<td>Partner</td>
<td>Attachment theory, attachment disorder, supervisors/practitioners</td>
</tr>
<tr>
<td>Supportive partner</td>
<td>Attachment theory, attachment disorder, supervisors/practitioners</td>
</tr>
<tr>
<td>Being a parent</td>
<td>Attachment theory</td>
</tr>
<tr>
<td>A volunteer job</td>
<td>DIP policy</td>
</tr>
<tr>
<td>Family</td>
<td>Attachment theory</td>
</tr>
<tr>
<td>A drugs worker</td>
<td>DIP policy, drug misusers</td>
</tr>
<tr>
<td>Being able to cope when upset, without having to use drugs</td>
<td>Affective disorders/co morbidity literature, relapse and recovery literature</td>
</tr>
<tr>
<td>Supportive family</td>
<td>Attachment theory, relapse and recovery literature</td>
</tr>
<tr>
<td>Not committing crime</td>
<td>DIP policy, literature about the links between Class A drug misuse and crime</td>
</tr>
<tr>
<td>Friends</td>
<td>Attachment theory</td>
</tr>
<tr>
<td>Something to do such as a hobby</td>
<td>DIP policy, drug misusers</td>
</tr>
<tr>
<td>Not hanging out with friends who take drugs</td>
<td>DIP policy, literature about the links between Class A drug misuse and crime</td>
</tr>
<tr>
<td>Not hanging out with friends who commit crime.</td>
<td>DIP policy, literature about the links between Class A drug misuse and crime</td>
</tr>
<tr>
<td>Feeling able to cope with stress without the need to use drugs</td>
<td>Affective disorders/co morbidity literature, relapse and recovery literature</td>
</tr>
<tr>
<td>Somewhere to live</td>
<td>DIP policy</td>
</tr>
<tr>
<td>A job that is paid</td>
<td>DIP policy</td>
</tr>
</tbody>
</table>
Appendix 3: Pictures of the Card Sort Tasks for the Focus Group Study (Part One)

Figure 1: Card sort task for question ‘what do you think might cause someone to relapse from Class A drugs? Includes topics (orange post it notes) such as, ‘friends’, ‘family’, ‘feeling depressed’, ‘somewhere to live’.

Figure 2: Card sort task for question, ‘What do you think is helpful in sustaining a person’s recovery from Class A drugs? Includes topics (in yellow post it notes) such as ‘being a parent’, ‘family’, ‘being able to cope when upset without having to use drugs’, ‘a volunteer job’, ‘somewhere to live’, ‘not committing crime’.
Appendix 4: Focus Group Schedule and Instructions  
(N.B. Information identifying the rehabilitation organisation has been removed)

Focus group instructions and schedule

Ask everyone to read the information sheet and complete the consent forms and small questionnaire first.

Please help yourself to drinks and biscuits.

Overview and introduction to the Focus Group discussion:

(6 minutes in total for this section)

Thank you all for agreeing to take part in my research.

If you would all like to grab a drink and then take a seat so we can begin.

I’m Beverly Love from the University of Surrey and I will be taking the group today. [Name of facilitator] is acting as my research assistant today and is here to assist me with things such as making sure I don’t run over time with each question. He is not here in the capacity of a drugs worker so anything you discuss today in this group is purely for the purpose of my research.

The aim of this group is for you to discuss a series of questions about relapse and recovery. You don’t have to talk about your own experience unless you want to and feel comfortable doing so. The main aim is for you to discuss a set of questions among other group members in a general way. You don’t have to say they are part of your own experience. There are no right or wrong answers.

The first two questions are in the form of a small group task, which I will explain and then there will be a further set of questions. We will take a coffee/cigarette break halfway through and then lunch will be provided at the end of the session. You will also be able to get any travel expenses paid for at the end of the session. The group discussion should take about 45 minutes.

Usually in a group discussion we create a set of rules about how we would like each member to conduct themselves in the group. So if you can each introduce yourself to the group (first names only) and say one rule you would like the group to stick to. I will go first: I’m Beverly and I would like the group to keep confidential anything personal that might be talked about today, that is not to discuss it outside of this group.

Card sort questions independently of the card sort

(13 minutes in total for this section and task 1)
After the first focus group the schedule was amended to include the cards sort task questions first and then the card sort task to allow participants more freedom to talk from their own perspectives.

‘What do you think might cause someone to relapse?’

‘What do you think is helpful in sustaining a person’s recovery from Class A drugs?’

**Card sort task 1**

The first question is set out on the paper in front of you: What do you think might cause someone to relapse? The paper is then split into three categories, ‘The Most Important’, ‘Quite important’, and ‘Not important’. On the orange post it notes are some suggestions that some people think are important in relapse and recovery. I would like you to discuss in the group each post it note and then agree among yourselves where you think each of the post it notes should be placed in the categories set out on the paper in front of you. If you are not able to agree that’s fine, it can be left to one side. The important thing is to discuss what you each think about what is written on the post it note in relation to the question at the top of the paper. There are no right or wrong answers. You can have as many or as few post it notes in each of the three categories. You will have about 10 minutes on this. To ensure that the Dictaphones pick up what you are discussing please can one of you read out either the number on the post it note or read out what it says on the post it note when you start to discuss in the group where you think it might go. I can give you an example if you would like me to? Please begin.

*(After 10 mins…)*

If you think there has been anything really important that has been missed out (e.g. that is not on the Post It Notes) please write it on the paper in the ‘most important category’. You can each write one of your own on the spare Post It Notes.

…………..

**Card sort task 2**

*(13 minutes in total for this section)*

I would now like you to do the same with this question; ‘What do you think is helpful in sustaining a person’s recovery from Class A drugs?’ using the same format. Please remember to read either the number on each post it note or read out what is on each post it note before you discuss where to stick it. (This is to help me when I transcribe the recording).

*(After 10 mins…)*

If you think there has been anything really important that has been missed out (e.g. that is not on the Post It Notes) please write it on the paper in the ‘most important category’. You can each write one of your own on the spare Post It Notes.
(Ask if they want a 5 min break). OK let's have a 5 minute break, please help yourself to drinks/biscuits and for those who would like to get some fresh air etc.. please ensure you return by (specify a time).

Further questions

(10 minutes in total for this section)

For the second part of the group I will ask you a few questions, which again I would like you to discuss among yourselves.

1. What do you think are the reasons for some people to start taking Class A drugs?

2. What do you think might be the reasons for some people to use a lot of Class A drugs, frequently over a long time and to become addicted to drugs?

Questions about their experience of the questions/focus group

(5 minutes in total for the final section)

I will be developing a set of interview questions for my research, and this is what you have so far been helping me to do. If I asked questions to service users about their childhood, upbringing, family and potentially questions about abuse or trauma do you think they would feel OK answering these sorts of questions in a confidential one to one interview?

Do you think service users will feel OK about being asked questions about any offending behaviour in relation to their substance use? (in a one to one interview).

(N.B. To be asked in first focus group only). This is the first of 4 groups we will be holding, do you think there is anything we could do better in the next group?

Debrief and option of counselling support

Thank you all for your time. I am recruiting for the next three groups so here are some flyers, please feel free to take some and give them to other service users you know who you think might be interested in taking part in the next group.

Please help yourself to lunch, we have this room until 1pm if you would like to stay here until then and eat lunch or bags have been provided if you would like to take away the lunch.

For anyone who feels that the discussion has raised any issues that you would like to discuss further with a trained counsellor, one to one, [name of counsellor] will be available in this room after 1pm. What you discuss with [name of counsellor] is not part of the research. If
you can let [name of facilitator] know and he will book you into a short session with [name of counsellor].

(Thank participants for taking part).
Appendix 5: Demographic Questionnaire for Focus Group Study (Part One) and for the Semi-structured Interview Study (Part Two)

Please tick which one applies:  
☐ Male    ☐ Female  

Age:  
___________

Ethnicity:  
☐ Black African    ☐ White British    ☐ Chinese    ☐ Mixed    
☐ Black Caribbean    ☐ White Other    ☐ Asian    ☐ Other

Current relationship status (please tick all that apply):  
☐ Married    ☐ Single    ☐ Widowed    
☐ Divorced    ☐ In a relationship    ☐ Other, please specify

Please tick which apply:  
(DIP= Drug Interventions Programme: PPO= Prolific and Other Priority Offender)

1. Are you currently a DIP client?  
☐ Yes    ☐ No

2. Are you currently a PPO client?  
☐ Yes    ☐ No

3. Were you previously a DIP client?  
☐ Yes    ☐ No

4. Were you previously a PPO client?  
☐ Yes    ☐ No

5. Are you currently using any illegal drugs?  
☐ Yes    ☐ No

6. Are you on a methadone or subutex script?  
☐ Yes    ☐ No

7a. If still using what is your main drug of choice?  ___________________________

7b. How long have you been using your drug of choice for?  ___________________

8a. If not currently using what was your main drug of choice?  ___________________

8b. How long did you use your drug of choice for?  ___________________

9. If not using now, how long have you been abstinent for?  ___________________

10. Typically, how many days a week do you drink alcohol?  ___________________

11. How much alcohol do you drink on a typical day? (Please state either in units. If stating in number of bottles or cans please specify type of alcoholic drink).  _______
Appendix 6: Flyers Advertising for Participation in the Focus Group Study (Part One) and the Semi-structured Interview Study (Part Two).

(N.B. Personal information including the identity of the rehabilitation organisation has been removed).

Figure 1. Flyer Advertising Participation for the Focus Group Study (Part One)
Figure 2. Flyer Advertising Participation for the Semi-structured Interview Study (Part Two)

(N.B. Personal information including the identity of the rehabilitation organisation has been removed).

Figure 2a. Six months or more recovered

Are you or have you ever been a DIP or PPO client with a Class A drug problem? Have you been in recovery for 6 months or more?

If YES, then you might like to take part in research about relapse and recovery to help improve service provision for people like you.

Travel expenses will be reimbursed, participation is voluntary and your name will remain anonymous throughout the research.

Figure 2b. Twelve months or more recovered

Are you or have you ever been a DIP or PPO client with a Class A drug problem? Have you been in recovery for 12 months or more?

If YES, then you might like to take part in research about relapse and recovery to help improve service provision for people like you.

Travel expenses will be reimbursed, participation is voluntary and your name will remain anonymous throughout the research.
Appendix 7: Information Sheet, Confidentiality Clause and the Consent Form for the Focus Group Study (Part One)
(N.B. personal information and identification of the rehabilitation organisation have been removed).

Participant Information Sheet

Title of research: The cycle of relapse and recovery of substance misusers.
Name of researcher: Beverly Love

You are being asked to take part in a focus group to help me with my research which is about service user’s experience of their relapse & recovery journey. The overall aim of the research is to help to improve service provision for people with drug misuse problems. Please read the following information and take a few minutes to decide if you would like to take part. If you have any questions please ask the researcher Beverly Love.

Participation is voluntary and will not affect the services or help you are given for your substance use problems. My research has been given a favourable ethical opinion by the University of Surrey and the London Bentham NHS Research Ethics Committee. If you decide to take part you will be given this information sheet to keep and be asked to provide your initials on a consent form.

The focus group will involve you helping to think about what sorts of questions should be asked to service users about their experience of their relapse & recovery journey. About 3 other people will be taking part in the focus group today. You will be asked to look at a set of questions that I have written and discuss if these questions are appropriate to use in research with service users. The focus group should last for about 35 minutes but you can talk for longer if you would like to. The focus group will be audio tape recorded with your permission. Your real name will not be used anywhere in the write up of the research or during the analysis of your information. Please read the section about confidentiality on page 3.

Any information you provide will be held for a short while in a securely locked room at the University of Surrey and will then be destroyed after the research has been
completed. You can withdraw from the focus group at any time without providing a reason.

The results of this research will be published in reports which will help to inform service provision for drug misusers. No identifiable data will be used in any publications or reports, this means that your real name will not appear in any published reports.

Refreshments such as food and drinks will be provided during the focus group. Travel expenses will be reimbursed at the end of the focus group. Please ensure you have a copy of your travel card/ticket or a receipt of purchase.

If you feel that the focus group has raised some issues that you would like to discuss further a drugs worker from (name of rehabilitation organisation) will be available to talk to you after this interview has finished at (rehabilitation organisation’s address). Or you can phone a drugs worker on (rehabilitation organisation’s telephone number).

If you would like further information about this study or if you have any concerns or complaints about how you have been treated during this research please contact my research supervisor, Arlene Vetere, at the University of Surrey by email on A.Vetere@surrey.ac.uk

Thank you for taking the time to read this sheet. I am happy to answer any questions you may have.
Confidentiality in this study

All information you provide in this study will be treated with sensitivity and care and will be kept anonymous. This means your real name will not appear anywhere in the write up of this research or in any published reports or during the analysis of the information you provide. All information is confidential. The only times that confidentiality cannot be guaranteed will be in the following cases listed below. Please be aware that this follows \textit{name of rehabilitation organisation} rules about client confidentiality to which you would already have agreed.

- If you disclose information that may indicate risk to children who are under the age of 18.
- If the researcher believes that you might cause danger to yourself or others.
- If you give specific detailed information which indicates that a crime has been committed.
- If you give information which indicates a possible terrorist threat.

If the researcher believes that during the focus group you might disclose such information she will advise you not to continue with that part of the discussion.

If you provide information that might break confidentiality based on the list above only, the researcher would seek advice from a \textit{name of rehabilitation organisation} manager first.
CONSENT FORM – CONSULTATION STAGE

Title of research: The cycle of relapse and recovery of substance misusers.

Name of researcher: Beverly Love

This research has been given a favourable ethical opinion by the University of Surrey and the NHS.

Please initial each box

- I consent to my personal data, as outlined above and in the information sheet, being used for this study and other research. I understand that all personal data relating to volunteers is held and processed in the strictest confidence and in accordance with the Data Protection Act (1998).

- I agree for the focus group session to be audio tape recorded.

- I voluntarily agree to take part in the focus group. I understand I am free to withdraw from the focus group at any time without providing a reason for this and without my medical care or legal rights being affected.

- I have read and understood the information sheet provided. I have been given a full explanation by the researcher of the nature, purpose and likely duration of the focus group and of what I will be expected to do. I have been given adequate time to consider my participation and agree to comply with the instructions and restrictions of the focus group.

- I understand and have read the above and freely consent to participating in this focus group.

Please can you provide your initials in the box below to indicate you agree to the above and would like to take part in the focus group.

Today’s Date: ..............................................

Name of person taking consent :........................................... date: .......................

Signed.......................................................................
Appendix 8: NHS Ethical Approval Documents for the Research

North Central London Research Consortium
3rd Floor, Bedford House
125 - 133 Camden High Street
London, NW1 7JR

17th July 2012

Ms Beverly Love
PhD Psychology Student
Department of psychology
University of Surrey
Rm: 23AC04
Guilford Surrey
GU2 7XH

Dear Beverly,

I am pleased to confirm that the following study has now received R&D approval, and you may now start your research in the trust(s) identified below:

Study Title: The cycle of relapse and recovery: Substance misuse and the psychological health of offenders on a community rehabilitation management programme.

R&D reference: 12MHS10

REC reference: 12/LO/0675

Camden and Islington NHS Foundation Trust

If any information on this document is altered after the date of issue, this document will be deemed INVALID.

Please ensure that all members of the research team are aware of their responsibilities as researchers which are stated in page 2. For more details on these responsibilities, please check the R&D handbook or NcCLoR website: http://www.ncclor.nhs.uk

We would like to wish you every success with your project.

Yours sincerely,

Mabel Sali
Senior Research Governance Officer

R&D approval 17/07/2012
1 of 2

REC reference (12/LO/0675), R&D reference (12MHS10)
14 June 2013

Professor Arlene Vetere
Professor of Clinical Psychology and Deputy Director, Clinical Psychology Doctorate,
Department of Psychology
University of Surrey
University of Surrey, Department of Psychology
Faculty of Arts & Human Sciences, rm:20AD02
Guildford, Surrey
GU2 7XH

Dear Professor Vetere

Study title: The cycle of relapse and recovery: Substance misuse and the psychological health of offenders on a community rehabilitation management programme.

REC reference: 12/LO/0675
Amendment number: Substantial Amendment One
Amendment date: 11 June 2013
IRAS project ID: 103461

The above amendment was reviewed by the Sub-Committee in correspondence.

Ethical opinion

The members of the Committee taking part in the review gave a favourable ethical opinion of the amendment on the basis described in the notice of amendment form and supporting documentation.

Approved documents

The documents reviewed and approved at the meeting were:

<table>
<thead>
<tr>
<th>Document</th>
<th>Version</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interview Schedules/Topic Guides</td>
<td>1</td>
<td>01 June 2013</td>
</tr>
<tr>
<td>Notice of Substantial Amendment (non-CTIMPs)</td>
<td>Substantial Amendment One</td>
<td>11 June 2013</td>
</tr>
</tbody>
</table>

Membership of the Committee

The members of the Committee who took part in the review are listed on the attached sheet.
R&D approval

All investigators and research collaborators in the NHS should notify the R&D office for the relevant NHS care organisation of this amendment and check whether it affects R&D approval of the research.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

We are pleased to welcome researchers and R & D staff at our NRES committee members’ training days – see details at http://www.hra.nhs.uk/hra-training/

12/LO/0675: Please quote this number on all correspondence

Yours sincerely

Dr John Keen
Vice-Chair

E-mail: nrescommittee.london-harrow@nhs.net

Enclosures: List of names and professions of members who took part in the review

Copy to: Ms Beverly Love

A Research Ethics Committee established by the Health Research Authority
## Attendance at Sub-Committee of the REC meeting in correspondence

<table>
<thead>
<tr>
<th>Name</th>
<th>Profession</th>
<th>Capacity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Miss Stephanie Ellis</td>
<td>Former Civil Servant</td>
<td>Lay Plus</td>
</tr>
<tr>
<td>Dr John Keen</td>
<td>General Practitioner</td>
<td>Expert</td>
</tr>
</tbody>
</table>
Appendix 9: University of Surrey Ethical Approval Documents for the Research

Ms Beverley Love
Psychology
FAHS

07 November 2011

Dear Ms Love

The cycle of relapse and recovery: Substance misuse & the psychological health of substance misusing offenders on a community based rehabilitation programme EC/2011/93/FAHS

On behalf of the Ethics Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the submitted protocol and supporting documentation.

Date of confirmation of ethical opinion: 7 November 2011.

The final list of documents reviewed by the Committee is as follows:

<table>
<thead>
<tr>
<th>Document</th>
</tr>
</thead>
<tbody>
<tr>
<td>Summary of the project</td>
</tr>
<tr>
<td>Detailed protocol for the project</td>
</tr>
<tr>
<td>Evidence of agreement of other collaborators</td>
</tr>
<tr>
<td>Information sheet for participants</td>
</tr>
<tr>
<td>Interviews Schedule, possible interview questions &amp; questionnaires 1 &amp; 2</td>
</tr>
<tr>
<td>Risk assessment</td>
</tr>
<tr>
<td>Recruitment advert</td>
</tr>
<tr>
<td>Protocol Submission Proforma: Insurance</td>
</tr>
</tbody>
</table>

This opinion is given on the understanding that you will comply with the University's Ethical Guidelines for Teaching and Research. If the project includes distribution of a survey or questionnaire to members of the University community, researchers are asked to include a statement advising that the project has been reviewed by the University’s Ethics Committee.

The Committee should be notified of any amendments to the protocol, any adverse reactions suffered by research participants, and if the study is terminated earlier than expected with reasons. Please be advised that the Ethics Committee is able to audit research to ensure that researchers are abiding by the University requirements and guidelines.

You are asked to note that a further submission to the Ethics Committee will be required in the event that the study is not completed within five years of the above date.

Please inform me when the research has been completed.

Yours sincerely,

Glenn Moulton
Secretary, University Ethics Committee
Registry

cc: Professor S Williamson, Chairman, Ethics Committee
Ms Beverly Love  
School of Psychology  
FAHS  

06 August 2012  

Dear Ms Love  

The cycle of relapse and recovery: Substance misuse & the psychological health of substance misusing offenders on a community based rehabilitation programme  
EC/2011/93/FAHS Fast-Track  

I am writing to inform you that the Chairman, on behalf of the Ethics Committee, has considered the Amendments requested to the above protocol and has approved them on the understanding that the Ethical Guidelines for Teaching and Research are observed. Please be advised that the Ethics Committee is able to audit research to ensure that researchers are abiding by the University requirements and guidelines.  

If the project includes distribution of a survey or questionnaire to members of the University community, researchers are asked to include a statement advising that the project has been reviewed by the University's Ethics Committee.  

Date of confirmation of ethical opinion: 7 November 2011.  
Date of favourable ethical opinion of amendment to protocol: 6 August 2012.  

The list of amended documents reviewed and approved by the Chairman is as follows:-  

<table>
<thead>
<tr>
<th>Document</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS NRES Confirmation of ethical opinion dated 16 July 2012</td>
</tr>
<tr>
<td>Consent form</td>
</tr>
<tr>
<td>Participant Information sheet</td>
</tr>
</tbody>
</table>

Yours sincerely  

Glenn Moulton  
Secretary, University Ethics Committee  
Academic Registry
Appendix 10: Interview Questions to the Researcher to Help to Establish the Researcher’s Orientation, Positioning and Preconceptions on the Research Topic and the Participant Group

Interview questions/topics to the researcher before the research began:

- Why are you doing this research?
- Why particularly are you interested in it?
- What are you interested in?
- What motivates you?
- What do you expect to find?
- What beliefs do you hold about what you might find – and what you are doing?
- Where did those beliefs come from?
- What have been the major influences on your thinking about your research question and concerns?
- What does the research mean to you?
Appendix 11: Establishing the Debrief for the Rehabilitation’s Counsellor With Participants for the Semi-structured Interview Study (Part Two) - Email Communication Between the Researcher and the Counsellor

(N.B. personal information and identification of the rehabilitation organisation have been removed).

Suggested debrief:

1. Finding out how the interview session was for the participant,
2. Finding out/asking them if they are OK,
3. If the participant is a current *name of rehabilitation organisation* client then you might have your own suggestions of what course of action you might want to take with them further?

Onward plan:

Finding out if they need to talk to anybody about anything further. If they do then this should be signposting them to their GP, or other services they can access themselves in the community.

I think the leaflets that you already provide in the rehabilitation organisation’s waiting room about the counselling directory would be our suggestion. I can also offer these leaflets and perhaps the phone numbers for (e.g. Samaritans and MIND) after my interviews with participants. Therefore if they decide not to take up a debrief session with you afterwards (bearing in mind the low take up of debriefs in the first study this may well be the case) they will at least have contact details of support if they choose to pursue this afterwards. I will also ask participants if they are OK at the end of the semi-structured interviews (Part Two), as I did in the focus group study, (Part One).
Appendix 12: Recurrent Theme Check for all Seven Superordinate Themes and Their Corresponding Themes for the Focus Group Study (Part One).

Red = low support; Amber = medium support; Green = high support.

For the re-current theme checking for the number of participants $N=1-3$ (10-30%) was considered to be low support; $N=4-6$ (40-60%) considered to be medium support; and $N=7-10$ (70-100%) considered to be high support for the theme. For the recurrent theme checking for the focus groups: 1 (25%) was considered to be low support; 2 (50%) was considered to be medium support and 3-4 (75% to 100%) was considered to be high support for the theme.

Table 1: Recurrent Theme Check for the Focus Group Study Showing Very High Support for all Seven of the Superordinate Themes.

<table>
<thead>
<tr>
<th>Superordinate and theme</th>
<th>Number of participants represented in the superordinate or theme</th>
<th>% of participants represented in the superordinate or theme</th>
<th>Number of focus groups represented in the superordinate theme</th>
<th>% of focus groups represented in the superordinate/ theme</th>
</tr>
</thead>
<tbody>
<tr>
<td>Difficult and or traumatic childhood experiences</td>
<td>8</td>
<td>80%</td>
<td>4</td>
<td>100%</td>
</tr>
<tr>
<td>Difficult and or traumatic descriptions of childhood</td>
<td>4</td>
<td>40%</td>
<td>3</td>
<td>75%</td>
</tr>
<tr>
<td>Damaging relationships with parents</td>
<td>4</td>
<td>40%</td>
<td>3</td>
<td>75%</td>
</tr>
<tr>
<td>Difficult or traumatic relationship in childhood</td>
<td>4</td>
<td>40%</td>
<td>3</td>
<td>75%</td>
</tr>
<tr>
<td>Familiarity with substances or drug lifestyle</td>
<td>4</td>
<td>40%</td>
<td>4</td>
<td>100%</td>
</tr>
<tr>
<td>Familiarity with crime/criminality</td>
<td>1</td>
<td>10%</td>
<td>1</td>
<td>10%</td>
</tr>
<tr>
<td>Struggles with complex and tense relationships</td>
<td>10</td>
<td>100%</td>
<td>4</td>
<td>100%</td>
</tr>
<tr>
<td>Relating in a negative way to others</td>
<td>4</td>
<td>40%</td>
<td>3</td>
<td>75%</td>
</tr>
<tr>
<td>Being a parent poses challenges to recovery</td>
<td>5</td>
<td>50%</td>
<td>3</td>
<td>75%</td>
</tr>
<tr>
<td>Negative and positive relationships with family members</td>
<td>7</td>
<td>70%</td>
<td>3</td>
<td>75%</td>
</tr>
<tr>
<td>Tensions with parents</td>
<td>6</td>
<td>60%</td>
<td>4</td>
<td>100%</td>
</tr>
<tr>
<td>Complex and tense relationships with partners</td>
<td>10</td>
<td>100%</td>
<td>4</td>
<td>100%</td>
</tr>
<tr>
<td>The role of friendships in drug using lifestyle and non drug using lifestyle</td>
<td>10</td>
<td>100%</td>
<td>4</td>
<td>100%</td>
</tr>
<tr>
<td>Superordinate and theme</td>
<td>Number of participants represented in the superordinate or theme</td>
<td>% of participants represented in the superordinate or theme</td>
<td>Number of focus groups represented in the superordinate theme</td>
<td>% of focus groups represented in the superordinate/ theme</td>
</tr>
<tr>
<td>-------------------------</td>
<td>---------------------------------------------------------------</td>
<td>----------------------------------------------------------</td>
<td>-------------------------------------------------------------</td>
<td>----------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Challenges &amp; struggles with mental and psychological health</strong></td>
<td>10</td>
<td>100%</td>
<td>4</td>
<td>100%</td>
</tr>
<tr>
<td>Mental health labels</td>
<td>6</td>
<td>60%</td>
<td>4</td>
<td>100%</td>
</tr>
<tr>
<td>Impact of psychological or mental health on their lives</td>
<td>9</td>
<td>90%</td>
<td>4</td>
<td>100%</td>
</tr>
<tr>
<td>Links between mental or psychological health and drug use</td>
<td>10</td>
<td>100%</td>
<td>4</td>
<td>100%</td>
</tr>
<tr>
<td>Trying to manage mental health in a healthier way</td>
<td>3</td>
<td>30%</td>
<td>2</td>
<td>50%</td>
</tr>
<tr>
<td>Struggles with addiction/addictive tendencies in other aspects of life</td>
<td>7</td>
<td>70%</td>
<td>4</td>
<td>100%</td>
</tr>
<tr>
<td><strong>Criminality – pathways turning points and U-turns</strong></td>
<td>10</td>
<td>100%</td>
<td>4</td>
<td>100%</td>
</tr>
<tr>
<td>Criminal and problem behaviour in childhood</td>
<td>4</td>
<td>40%</td>
<td>3</td>
<td>75%</td>
</tr>
<tr>
<td>Involvement in criminal lifestyle in adulthood</td>
<td>8</td>
<td>80%</td>
<td>3</td>
<td>75%</td>
</tr>
<tr>
<td>Rejecting vs accepting aspects of the criminal lifestyle</td>
<td>10</td>
<td>100%</td>
<td>4</td>
<td>100%</td>
</tr>
<tr>
<td>The links between crime and drugs</td>
<td>10</td>
<td>100%</td>
<td>4</td>
<td>100%</td>
</tr>
<tr>
<td><strong>Reasons to use drugs, to lapse or relapse – a coping mechanism</strong></td>
<td>10</td>
<td>100%</td>
<td>4</td>
<td>100%</td>
</tr>
<tr>
<td>Drug use to feel better (to stop feeling bad)</td>
<td>7</td>
<td>70%</td>
<td>4</td>
<td>100%</td>
</tr>
<tr>
<td>Drug use to stop/block painful and/or stressful thoughts</td>
<td>8</td>
<td>80%</td>
<td>4</td>
<td>100%</td>
</tr>
<tr>
<td>Drug use to cope with mental ill health and/or difficult emotions</td>
<td>7</td>
<td>70%</td>
<td>4</td>
<td>100%</td>
</tr>
<tr>
<td>To cope with trauma and on-going feelings from trauma</td>
<td>8</td>
<td>80%</td>
<td>4</td>
<td>100%</td>
</tr>
<tr>
<td>To cope with stressful relationships with family or partners</td>
<td>8</td>
<td>80%</td>
<td>4</td>
<td>100%</td>
</tr>
<tr>
<td>To cope with different types of stress – the mundane to the extremely stressful</td>
<td>9</td>
<td>90%</td>
<td>4</td>
<td>100%</td>
</tr>
<tr>
<td>Superordinate and theme</td>
<td>Number of participants represented in the superordinate or theme</td>
<td>% of participants represented in the superordinate or theme</td>
<td>Number of focus groups represented in the superordinate theme</td>
<td>% of focus groups represented in the superordinate/ theme</td>
</tr>
<tr>
<td>-------------------------</td>
<td>---------------------------------------------------------------</td>
<td>------------------------------------------------------</td>
<td>---------------------------------------------------------------</td>
<td>------------------------------------------------------</td>
</tr>
<tr>
<td>Ways of coping with life 'the mundane to the extreme'.</td>
<td>10</td>
<td>100%</td>
<td>4</td>
<td>100%</td>
</tr>
<tr>
<td>Healthy ways of coping 'structure, routine and support'.</td>
<td>10</td>
<td>100%</td>
<td>4</td>
<td>100%</td>
</tr>
<tr>
<td>Healthy Coping mechanisms: Learning /applying life skills (positive attitude towards self, honesty, rational thinking and communication skills)</td>
<td>9</td>
<td>90%</td>
<td>4</td>
<td>100%</td>
</tr>
<tr>
<td>Avoidance to cope 'a double edged sword'</td>
<td>8</td>
<td>80%</td>
<td>4</td>
<td>100%</td>
</tr>
<tr>
<td>Unhealthy (drug taking) ways of coping and surviving: crack, heroin and other substances.</td>
<td>10</td>
<td>100%</td>
<td>4</td>
<td>100%</td>
</tr>
<tr>
<td>What’s helpful in recovery/and to not use drugs</td>
<td>10</td>
<td>100%</td>
<td>4</td>
<td>100%</td>
</tr>
<tr>
<td>Positive Support from Others /not being alone in recovery</td>
<td>10</td>
<td>100%</td>
<td>4</td>
<td>100%</td>
</tr>
<tr>
<td>Insight/understanding in to reasons for your drug use, lapse and relapse behaviour</td>
<td>10</td>
<td>100%</td>
<td>4</td>
<td>100%</td>
</tr>
<tr>
<td>Developing, managing and maintaining life away from drug use/lifestyle</td>
<td>8</td>
<td>80%</td>
<td>4</td>
<td>100%</td>
</tr>
<tr>
<td>Changes required (in thinking/ socially)</td>
<td>7</td>
<td>70%</td>
<td>4</td>
<td>100%</td>
</tr>
</tbody>
</table>
Appendix 13: Information Sheet, Confidentiality and Consent Form for the Semi-structured Interview Study (Part Two)
(N.B. personal information and identification of the rehabilitation organisation have been removed).

Camden and Islington NHS Foundation Trust

Participant Information Sheet

Title of research: The cycle of relapse and recovery of substance misusers.
Name of researcher: Beverly Love

You are being asked to take part in an interview to help me with my research which is about service user’s experience of their relapse & recovery journey. The overall aim of the research is to help to improve service provision for people with drug misuse problems. Please read the following information and take a few minutes to decide if you would like to take part. If you have any questions please ask the researcher, Beverly Love.

Participation is voluntary and will not affect the services or help you are given for your substance use problems. My research has been given a favourable ethical opinion by the University of Surrey and the London Bentham & Harrow NHS Research Ethics Committee. If you decide to take part you will be given this information sheet to keep and be asked to provide your initials on a consent form.

The interview will involve being asked questions about your experience of your relapse & recovery journey. About 25 people with drug misuse problems will be taking part in the research in separate interviews. There are no right or wrong answers. If you do not feel comfortable answering any of the questions you do not have to provide me with an answer. You can indicate this by saying that you would prefer not to answer the question. You will also be asked to complete a small questionnaire.

The interview and questionnaire should last for about 50 minutes but you can talk for longer if you would like to. The interview will be audio tape recorded with your permission. Your real name will not be used anywhere in the write up of the research or during the analysis of your information. Please read the section about confidentiality on page 3.
Any information you provide will be held for a short while in a securely locked room at the University of Surrey and will then be destroyed after the research has been completed. You can withdraw from the interview at any time without providing a reason and any information you have provided will be destroyed in a safe manner.

The results of this research will be published in reports which will help to inform service provision for drug misusers. No identifiable data will be used in any publications or reports, that means that your real name will not appear in any published reports.

Refreshments such as snacks and drinks will be provided during the interview. Your travel expenses will be reimbursed and you will be given a £5.00 voucher for a supermarket for your participation in the interview, at the end of the interview. Please ensure you have a copy of your travel card/ticket or a receipt of purchase.

If you feel that the interview has raised some issues that you would like to discuss further, a trained counsellor, (name of counsellor and telephone number) will be available to talk to you after this interview has finished over the phone (telephone number). Please let Beverly know at the end of the interview if you would like to book a session.

If you would like further information about this study or if you have any concerns or complaints about how you have been treated during this research please contact my research supervisor, Arlene Vetere, at the University of Surrey by email on A.Vetere@surrey.ac.uk

Thank you for taking the time to read this sheet. I am happy to answer any questions you may have.
Confidentiality in this study

All information you provide in this study will be treated with sensitivity and care and will be kept anonymous. This means your real name will not appear anywhere in the write up of this research or in any published reports or during the analysis of the information you provide. All information is confidential. The only times that confidentiality cannot be guaranteed will be in the following cases listed below. Please be aware that this follows *(name of rehabilitation organisation)* rules about client confidentiality (that you would already have agreed to if you were a *(name of rehabilitation organisation)* client in the past or are currently).

- If you disclose information that may indicate risk to children who are under the age of 18.
- If the researcher believes that you might cause danger to yourself or others.
- If you give specific detailed information which indicates that a crime has been committed.
- If you give information which indicates a possible terrorist threat.

If the researcher believes that during the interview you might disclose such information she will advise you not to continue with that part of the discussion.

If you provide information that might break confidentiality based on the list above only, the researcher would seek advice from a *(name of rehabilitation organisation)* manager first.
PARTICIPANT CONSENT FORM – INTERVIEW STAGE

Title of research: The cycle of relapse and recovery of substance misusers.

Name of researcher: Beverly Love

This research has been given a favourable ethical opinion by the University of Surrey and the NHS.

- I consent to my personal data, as outlined above and in the information sheet, being used for this study and other research. I understand that all personal data relating to volunteers is held and processed in the strictest confidence, and in accordance with the Data Protection Act (1998).

- I agree for the interview session to be audio tape recorded.

- I voluntarily agree to take part in the interview. I understand I am free to withdraw from the interview at any time without providing a reason for this and without my medical care or legal rights being affected.

- I have read and understood the information sheet provided. I have been given a full explanation by the researcher of the nature, purpose and likely duration of the interview and of what I will be expected to do. I have been given adequate time to consider my participation and agree to comply with the instructions and restrictions of the interview.

- I understand and I have read the above and freely consent to participating in this interview.
Please can you provide your initials in the box below to indicate you would like to take part in the interview.

[Initials]

Today’s Date: ..................................................

Name of person taking consent: ....................................................... Date........................

Signed.......................................................
Appendix 14: Interview Schedule Questions and Prompts for Semi-structured Interview Study (Part Two)

1. Where are you now in your recovery? What does recovery mean to you?
   - Can you tell me about the time when you first thought about getting help for your drug misuse problems? What was happening in your life at that time?

2. Looking back over your recovery what do you think has helped you to not use drugs?
   - How do you get by /cope when things get tough?
   - What do you think has really helped you to sustain recovery (over a long time)?
   - What’s helped you get involved in recovery? What’s helped you keep going with recovery?
   - What advice would you give to your best friend about recovery or what advice do you think your best friend would give you about staying in recovery?
   - Can you describe to me what your life is like now you are in (long term) recovery? How is this different from when you were using drugs?
   - How do you feel about yourself now? Is this different to how you felt about yourself before you first used Class A drugs and during your drug use?

3. Can you describe to me what was happening in your life before you used Class A drugs?
   - How did you feel about yourself?
   - What did you think about yourself?
   - How did you deal with what was happening in your life at that time?
   - Can you describe to me what was happening in your life when you first used Class A drugs?
   - How do you think drug use impacted on what was happening in your life at that time?
   - What have been your reasons for using drugs at other times, can you give me an example of what was happening in your life on one of those occasions?

4. Can you give me a specific example of what was happening in your life on occasions when you have relapsed or lapsed? And how did drug use impact on what was happening in your life at that time?

5. Can you describe your health and wellbeing after drug use – in your recovery?
   Can you describe your health and wellbeing before your drug use? Can you describe your health and wellbeing during drug use?
   - Can you describe your psychological or emotional health before drug use, during drug use and after drug use?
• How do you think your drug use affected or impacted on your psychological health or mental health problem?
• Do you have or have you ever had a diagnosed mental health issue? Did you have these problems before you used drugs? When were you diagnosed?

6. Can you describe your family life when growing up?
• What was your childhood like?
• How did you manage/deal with what happened in your childhood?
• What are your relationships like now with your parents / other family members?
• How do you think your family life when growing up has impacted on your drug use? On your recovery? On times when you have lapsed or relapse?
• Did you have contact with your grandparents growing up?
• Did you know your Grandparents growing up?
• Do you have any memories of your grandparents growing up?
• Were your grandparents involved in your family life when growing up?
• Do you know what sort of relationships your grandparents had with your parents?
• What sort of childhoods/upbringings did your parents have?

7. What relationships do you have now that you consider are important to you?
• How do you think the relationships that you have now have impacted on your recovery?
• How do you think the relationships you have/had impacted on your drug use/?relapses, lapse?
• What were your relationships like with others (e.g. family, friends, partners, children/dependents) before your drug use and during your drug use?

8. Is there anything else you would like to add?
## Appendix 15: Transcription Key

<table>
<thead>
<tr>
<th>PI</th>
<th>The researcher</th>
</tr>
</thead>
<tbody>
<tr>
<td>-</td>
<td>Word cut off, or interruption.</td>
</tr>
<tr>
<td>The</td>
<td>Underlined word is an emphasis</td>
</tr>
<tr>
<td>(?)</td>
<td>Talk is too obscure to translate</td>
</tr>
<tr>
<td>[pause]</td>
<td>Pause</td>
</tr>
<tr>
<td>[long pause]</td>
<td>Over 10 seconds</td>
</tr>
<tr>
<td>LOUD</td>
<td>Capitals in the text, raised sounds</td>
</tr>
<tr>
<td>...</td>
<td>Indicates trailing off of thought or suspension of thought</td>
</tr>
<tr>
<td>[</td>
<td>Overlapping talk begins</td>
</tr>
<tr>
<td>]</td>
<td>Overlapping talk ends</td>
</tr>
<tr>
<td>‘post it notes’</td>
<td>To indicate when something is being read from the post it notes in the tasks.</td>
</tr>
<tr>
<td>“init”</td>
<td>Slang term or word they pronounced in that manner</td>
</tr>
<tr>
<td>(extra description of tone or gesticulation, or information by the PI)</td>
<td>Round brackets indicate extra description from the researcher for example, describes the tone/emotion of how something is being said or describes a physical action or gesticulation during the narrative.</td>
</tr>
</tbody>
</table>
Appendix 16: Participant’s Quotes for Focus Group Study (Part One)

(Transcripts are verbatim, including stutters and participants’ slang terminology. Identifying information has been removed. Participants’ real names have been replaced with pseudonyms).

Quote 2b (From Focus Group 1):

**Bobby:** I was stuck in the library because I couldn’t play the sports and then I would research things… and it’s just how your mind follows things… You know certain cactuses have this drug in it and then you read more about the drugs and then you try to find the people and then you go to senior, senior school from primary school and I was like looking at who was in to drugs you know and you try to like be friends with them. *(First half he stutters a lot and is a bit agitated).*

Quote 3b (From Focus Group 2):

**Continued from Quote 3a:**

**Clare:** So every time I would go back home, at that time I was living with my best friend Erika and erm she was like what is, what is, what is the matter with you, like what’s going on, the last like 6 to 8 weeks you come home every time you go to your mums house you’re just off key like you’ve got like a temper on you like (?). Just really (?) not your happy (?) normal self like. We were sitting down (?) and talking and (?) and both of we were talking and yeah it’s actually because this guy is here *(pause)* so I ended up telling everyone, it’s come out. No one’s defended my corner. So but for me at that point in time it was a thing of you know what I told everyone it was a weight being lifted off my shoulders. So as far as I was concerned *I’d dealt with it* *(voice pitch goes up)*. Then *(pause)* like I said the last 2 years like me and my Mum was just bickering and me and my sister was bickering and me and my brothers just bickering *(whispers this sentence)* just over “stupidness” mainly instigated by myself and I would just find things it’s like its what’s going on. Again it’s that thing of realising feelings of old. That I hadn’t actually dealt with the situation in full because I’m having problems this is why it’s happening so I’m in the process of dealing with that all of that now, so when things don’t just don’t go right or, you know I’ll hold back for as long as I can … so that’s it you know…

Quote 7b (From Focus Group 1):

**Alan:** I’ve never really been comfortable in my own skin. And that’s why I say I was an addict before I ever touched a drug erh. I’ve always, I can be with a hundred people and feel like an outsider. I’ve always needed some sort of prop as it were to be around people and erm, that led me down, when I first discovered cannabis at age 12 I actually
thought it was, it was saving me because it enabled me to sort of just be (pause) and it was comfortable.

Quote 8b (From Focus Group 4):

(Continues on from Quote 8a in Chapter 5.2)

PI: So that was after a period of using drugs and you went back to your parents when you were clean and then-

Tina: Well I was with my partner and we fell out so I moved in with my mum (pause) well I moved in with her like a couple of times I fallen out with my partner and at first I tried living with my Dad and he had me running round like even just little things like doing shopping you know come on we’re going shopping. I was like well I don’t want to go shopping you know why do I have to go shopping with you? Well come on you’re going shopping be for god’s sake leave me alone sort of thing I’m being serious (laughs) and erm that was it I weren’t living with him coz he’s telling me what to do so go back to my partner at least my partner don’t tell me what to do alright we might fight and argue but he doesn’t tell me what I do and then when I’m off you know what I’m saying –

Zoe: (?)But you do the shopping.

Tina: Pardon?

Zoe: But you do the shopping you know what I mean you probably don’t want to do it all.

Tina: I know but Yeah so like yeah so dropped my Dad on go back with my partner and another time I split up with my partner my mum moved me in her house and I was I like well no one else like would have me and I was finding it hard to get back in the housing system do you know what I mean. She was like right you go to go to the doctors you’ve got an appointment here, you’ve got an appointment here, you’ve got an appointment here (clicking her fingers each time on the words in italic) and everything I was like no man I don’t want my life to be about appointments everyday do you know so like I dropped my appointments and be back with my partner at least he don’t tell me I have to go there you know and yeah so – so I started using drink and drugs again, do you know what I mean.

Quote 10b (From Focus Group 3):

Clare: ‘Not having a partner’?

Moses: Yeah.

Clare: Yeah?

Samuel: Not having a partner? (Clare starts laughing at Samuel)

Samuel: I’m sorry, man… (Clare & Samuel are both laughing and Samuel is unable to finish talking)
Clare: Well I don’t know coz it terms of it can be horrific to not have a partner but it’s not something that triggers off a but, on the other hand if you don’t have a partner and you haven’t had someone for ages…and you just want to get off too … so yeah…
PI: So it depends on what type of partner?
Moses: Yeah.
Clare: So where we put it?
Samuel: I think you’re right, put it all in there. I know at the end of the day I know people say what’s quite important if you start separating these things but if there’s a break down in any of these things that’s the leak of it and you’ll end up using. You know. They all have to be put in place you know.
Clare: A partner and erm unable to deal with current relationships. (Samuel starts laughing) I think that’s the most important yeah.
They continue to talk about partners later on…
Clare: ‘A partner’?
Samuel: No (said decisively but very tongue in cheek and Clare laughs).
Clare: Again it’s like it’s a double weapon.
Samuel: It is a double edged sword.
Clare: If my partner would just flipping put his foot down and be man about his shit (Samuel erupts in laughter).
Clare: (Laughs too) (?)Don’t get me I’m not trying to take the blame away from him about being responsible but if he would just be a man about his shit I would, I’d be and I’d listen that’s the thing and I know it shouldn’t take a man to make you listen (?) you know, like, just someone alongside, we’d do it together anyway, did it together and do it together so .Yeah so I think that’s very important.

Quote 11b (From Focus Group 2):

PI: So do you think that there is a distinction may be between associates and [friends who aren’t part of perhaps the drug taking world or…?
Clare: associates and friends]
Moses: (Is sniffling but is acknowledging the conversation).
Samuel: Yeah. They’re still criminals. (Clare is also agreeing). That’s the criminals, they’re still criminal. And my, my what’s happened for me that I’ve noticed that always driven me back to drugs is I’ve been clean before but I’ve still been a criminal (whispers in disbelief) so I’ve ended up going back to drugs. Now I’m clean and I’ve given my life to the g.. to the Lord and I’m walking a straight path that for me has been so much more powerful, erm than any other time in my (pause) past of using. I’ve been clean for a year before it didn’t mean nothing I went back. You know what I mean but it’s the fact of maintaining my, my, my belief that’s helping me out as opposed to, OK I’m clean but I’m going to use, I’m, I’m digging a little h, hole for myself … if you know what I mean?
PI: Ok.
Clare: You say you don’t have friends but what about these, there, there, erm, erm I take it you go to church?
Samuel: Yeah
Clare: Yeah, so what about the relationships that you’re building or is it just…
Samuel: I, I, I have families.
Clare: OK.
Samuel: Yeah I do just have family. Erm, it’s all relatives. I mean I go to the church that is quite far away but it’s with my sister and my other sister and her family, and there, you know what I mean? It’s like a family union. I go out for Sunday lunch and all the rest of it. But at the moment I’m quite pleasant, I’m quite happy with it that way. At the hostel at (mentions the name of the hostel) a lot of people come to me and talk to me and this, that and the other and they’ll pretend to be your friend and try and borrow money off me and I’ll say no it’s not happening. But, or come and get tobacco off me or whatever, you know… [It’s not friends.
Pl: Ok. Moses what do you think?] what do you think about friends where you think it’s really important in, in…causing a relapse?
Moses: Erh, erh it is really important, yeah. (Nods his head).
Samuel: [It just so happens I don’t have friends.

Quote 17b (From Focus Group 4):

Tina: You know learning, learning new things and, and you know what I mean and doing whatever your learning enjoying it not being made to do it you know like I said being made to go shopping and stuff like that and being made to go to the doctors. Like I know now I have to but erh yeah just enjoying, enjoying things in what I’m doing and not being forced in to anything that I don’t want to be forced into and learning to say no to a lot. You know, no I can’t meet you at such and such a time no I can’t do this coz I’m doing something else you know what I mean and being honest with yourself and people around you. And letting people know where you’re at in your recovery you know and also sometimes you don’t have to let people know where you’re at and what you’re doing just erm coz I’m, I’m even though I’m quite quiet outgoing I do like to keep personal stuff you know so like so that’s another thing is I’m learning to speak. I got told off the other day by my Dad I was on the bus and I was rabbiting away and he was like Tina there’s a time and a place to be talking about stuff and then the other day like I said I’d seen me kids for the first time in a year and my son asked me something I was like God why is it and I was on the bus as well and I was like Tommy (her son) there’s a time and a place right for us to talk about stuff and I’d just learnt that from me Dad. And it’s about learning about myself and, and not only that I like passing on stuff as well if I know like I’m doing good by passing either something like information or erh I’m able to help someone else then that makes me feel good about myself and also its helping that other person and it makes them feel good about themselves. So yeah you know so I try and help out wherever I can but then sometimes I got to check in check in with myself… look at me I’m going on sorry
Zoe, (Zoe acknowledges). Yeah I check in with myself as well coz sometimes I’ve got to check my behaviour and erm coz, coz like being bi-polar sometimes like my Dad yesterday I was I, I needed help filling out a form and he filled out the form and he said that Tina lives in a fantasy world do you know what I mean and sometimes I do, sometimes I get carried away with myself and like I thought it was a joke but coz like my Dad actually does think I live in a fantasy world but what he doesn’t realise is I’m actually fulfilling my fantasy if you know what its I mean. It’s like yeah I’m going to the chocolate factory or chocolate sweet shop today you know what I mean and yeah he thinks I’m crazy but I’m not crazy I know what I’m doing and as long as everyone else knows what I’m doing then I’m not the only one thinking that you know... it’s a good laugh actually (laughs) and that’s what’s keeping me clean and laughing, I think laughing, I think everyone should laugh you know what I mean, if you can’t have a laugh throughout the day then yeah I’d rather keep a lid on the way that’s me personally.

Quote 19b (From Focus Group 3):

(The conversation is linked to Quote 19a in Chapter 5.2, Section 5.2.7.1)

Kevin: What Ellen said, what Ellen said there it took me two years to get an habit, right it took me two years and I was down in two years but when I did get it I’d be truthful like before the crack came along I used to enjoy the gear. I’ll be straight with you yeah I used to like it, I don’t like what anyone says it’s the best memory blocker going in the world, you got no cares, worries in the world –

PI: Did you find that’s why you were using too? (PI asking Ellen)

Ellen: Oh yes for a memory blocker, comfort, warmth (wrapping her arms around her) life doesn’t matter –

Kevin: -You get that glow –

Ellen: Like I can be a real worrier and I’ve got a real conscious too it was like nothing mattered, [nothing mattered –

Kevin: I know what Ellen you know who a thing the way I’d explain it to you is say if you have a bit of gear a rainbow comes over and it’s like glow you know with like a rainbow with all them bright colours that’s like how it feels inside (he demonstrates with his hands moving in the shape of a rainbow from his stomach radiating outwards).

PI: David would you say?-

David: Like the, like the wound heels –

PI: So you carry on taking because you? -

David: Yeah because didn’t have to deal with it -

PI: With what happened? -

Ellen: Because the effects would wear off and it would be like argh (makes a painful sound) I’d get the fear and panic -

Kevin: I fell in love with it and I thought it loved me but it didn’t it loved money.
David: Yeah eventually I came to London right and erh then erh through a drugs worker right a programme right (?) and she took me right to meet this private doctor who’s then given me a script right that everybody else who’s going to see him its ten or twenty five pound a week -

Kevin: Not Doctor (name of a Doctor)?

David: - Right but because of what had happened and he knew I was on benefits right he said look erm I’ve listened to Jane and “blargh blargh blargh” he says yeah I’m going to give you script for nothing he’s say yeah but you know eventually somewhere down the line you going to have to start paying for this and this went on for 18 months right getting the script for free I just take it to the chemist and I was getting likes 40 amps of methadone a day a strip Dexedrine and 8 Valium per day right and it’s costing me something like £42 a week from the Chemist right but I could use a third of that and I could sell the rest of it and that would pay for my chemist and I’ve had money all the time on me you know what I mean and I’d always have drugs to use so I was never without me drugs for years and I was with this doctor for 8 years.

Quote 20b (From Focus Group 3):

David: Using, not using, getting help, not getting help. You know just, just like Ellen said it can be anything, it can be good news, it can be bad news, you know I can be feeling great. And decide to reward myself. And my way of rewarding myself is by using you know. As much as your, yeah you know physically you’re hurting yourself Yeah I probably am hurting myself but that’s never the answer half the time, you know what I mean?

Quote 20c (From Focus Group 3)

Ellen: What I’m capable of doing and if I don’t get it done I then feel awful about myself and then (pause) if I start feeling bad about myself I can then spiral in to worst case scenario is self-loathing may as well just bung a needle in myself, fuck it, excuse my language. Erm and what else sustaining recovery is erm, not spending too much time alone like David said. Erm, doing some things in a day, that you might think this sounds a bit funny, that I have to fill in for example. Like I don’t want to open that red letter from the gas erm, you know stuff like that and that’s just kind of life stuff isn’t it. It’s that if all that comes in on top erm I’m in trouble again and I’ll want to run away from it so it’s kind of facing everything. Yeah. (saying through gritted teeth).

Quote 20d (From Focus Group 3)

Ellen: Can I just say something that I think is quite important for your research is erm I had a lot of clean time I had 11 years clean and then as I’ve said to you my initial relapse was a process and then over the last five years I’ve been in to a lot of treatment
centres in out, in out you know detoxing (?). “da, da, da, da, da”, and an area that I think people need a lot of support and it touches on a little bit of what Kevin was saying. I had almost become institutionalised. Yeah and I could stay clean in a rehab for the rest of my life put me out in the community and be responsible for myself and it got to the point where it’s just like all I know, knew what to do was to go and use. So to go from a HIGH support environment to back in flat where you were banging up and smoking crack. Is like so, such a massive jump, is where’s the support in that grey area? Do you know what I mean. You know where you go from having breakfast with 20 people to waking up on your own in your flat.

Kevin: I can relate to that.

Ellen: Do you know what I mean?

Kevin: I’ve been there like, I been in a situation where I’ve just said I’ve gone rehab and basically I’ve been like I’ve done primary like I’ve done (name of rehabilitation) and then 6 weeks there and then I went (name of a place) yeah. I had a few warnings there for having a relationship (mischievous laugh, Ellen also has a mischievous laugh). Anyway right erh, yeah so basically yeah whilst I was there I got all the support yeah I was there walking up all like glory and erh right but my experience and then they threw me out in the community and it weren’t the same I didn’t have that network like the way it felt, it felt like I’m starting all over again. And it was hard work. People need like… If you ever come into a situation when you do like qualify, if you’re ever involved in someone going to rehab and erm and then erh, after secondary they need that support after basically.

Quote 30 (From Focus Group 3):

Samuel: To find a counselling set up, and a meeting set up basically they’ve got me, erm, this guy (the research assistant who is also a drug worker) here has just got everything in motion for me and why I am today I’m very grateful to him to be honest with you, you know. So yeah definitely, definitely.

Quote 31 (From Focus Group 4):

Zoe: Probably because if you and me as women aren’t seen to get on you know another man could just walk in just because there’s some women always watching looking at you and saying you know who are you and erm you know what your boyfriend is the standard by who she respects you by but I’ve had that all the time its you know while I’ve been dealing with myself I’ve been looking around at people …that I don’t pick on but some people would pick on other people and I’ve realised that there are lots of other people out there that and if this women with the children over the road if they didn’t see her man coming in with the parking his car every evening and whatever seeing that she wouldn’t have any protection either, you know erm so –

PI: So what erm when it comes to what helps in sustaining recovery to, to stop –
**Zoe:** Balance, you need a, a healthy balance, healthy balanced home life which comes from understanding you know and it means that whoever’s erm observing and calling judgement there’s no prejudice you know and its really I mean a lot of generally a lot of sexism. Sex erm anti-female kind of advice been being given I find. Erm I like I lived away from *(name of a place)* and when I came back everyone of my friends has got children. It’s not necessarily the right way to do it because some of them people have gone crazy. Erm you know having children especially since now they’ve had their children people don’t say argh well done go away and do something else now like go and achieve some more goals other things. Let them out. Do you know what I mean? It gives me the impression that they’ve been caged you know erm *(laughs).*

**Quote 32 (From Focus Group 4):**

**Zoe:** No, this is about this is being away from family and having no partner and having to rely rather than being alone erm and then going out and seeking what I needed you know from my own resources it was being told erm while I suppose I was hibernating for a reason erm that there was something wrong and having to force open my door and admit and complain about myself when there wasn’t any worries and then erm object, from objecting I started to scream and shout at my mental health so I just thought oh shit I’d better keep my mouth shut you know and I just withdrew and then I started taking drugs that’s what you know I just knew I could just get stoned and you know just go away you know. I could either *(pause)* go away and get stoned or while I’m in the room with them in my mind plan my journey and go off and do it which is what I did you know erm so if they don’t read my mind you know then they would never know so I’m not going to tell them until they get a say… it’s really none of their business though- *(laughing).*

**Zoe:** I wasn’t really going to risk my roof over my head and because that is where I could kind of stay there but because like social services and police came involved because I was like an anti-social problem before they found out that I was innocent and I was being a victim I think erm they had to kind of look at me and from there I just had to own up and say yeah I spend a lot of the time sleeping erm you know my clothes are clean you know there’s not much house work to do, still I go out and I don’t buy you know my fridge isn’t over full but it’s got enough things and you know I’m just quite a basic person but they hadn’t quite understand that’s where I’m coming from it took the bloody police a hell of a long time to realise it that you know there are single women out there even if you are in a family or s, situation you know not where your partner lives with you but where you’ve got the children live with you but where you visit your partner or he visits you yeah he might be attached to his mother you know you’re still are a single erm female who is vulnerable you know -
Quote 33 (From Focus Group 2):

**Samuel:** This time round I’ve devised a system which is a higher power. Yeah you’re not running through the whole picture because that thought process has been, has been locked off, by Satan or whoever is controlling these negative forces.

Quote 34a (From Focus Group 4):

**Zoe:** I was erm using and erm in my recreation and rehab from family problems before it became a crime before you know my use of it was criminalised so erm …

Quote 34b:

*Zoe explains more about her relationships with family members…*

**Zoe:** Just a dissatisfaction that erm, erm the upheaval just with somebody erm, erm, erm disapproving decrying you just saying no you’re, you’re used to being in people’s midst because of the sanction of yes and all of a sudden it’s no you’re doing something wrong. Now if you’re not given a reason and an explanation and erm and especially if you’re supposed to withdraw yourself or withdraw something then you know there’s going to be like some sort of kind of disparity isn’t it erm, yeah you know *and that needs to be kind of dealt with immediately because the longer (whispering)* you can go away after an argument and then a week later then they go on a business trip or mother goes away on holiday and “da, da, da, da” and then a whole year passes by and you know during that time you stop talking you don’t pay your phone bill you can’t speak to them, you don’t meet and you know all that time who else do you … and that person is there as erm as a response as a purpose in your life and they’re not serving that purpose they’re, they’re kind of you know …

**PI:** Is that about your parents?

**Zoe:** Yeah mmmm.

Quote 35 (From Focus Group 4):

**Tina:** ‘Family’ (*long pause*) You see me giggling about it, sometimes I think no they’re, not, that important but I do love them loads erm it’s I don’t know –

**Zoe:** Quite important, most important? (*assertive tone).*

**Tina:** Quite important. Yeah quiet yeah we’ll stick them in the middle there like again yeah. Just not important flew for my brain there but like I say – (*amusing tone).*

**PI:** Why, why? -

**Tina:** Why? Coz I don’t know. I stayed clean (*pause*) before but then that might have resulted in me not having my family around me making me relapse again but erm so yeah I’d say they’re important to have around me but not (*pause*) in my life, life like where I’m “smothercated” you know because like my family they’re like that. They coz, coz when in my using days I actually stayed away from my family because I
didn’t, one, I didn’t like them seeing me in that, in that way two, they couldn’t stand it when I was in that way (laughs) if I was around them [so –

Zoe: Well they’re not important to sustain your recovery but they’re part of the reasons why you relapse.

Tina: But they’re keeping me relapse you know what I mean they are part of the reason why I relapse. Yeah but staying clean I wouldn’t say that they’re are the most important to me for staying clean. But yeah quite important now because I need to rebuild relationships with them so to me that’s important and if that if I can rebuild relationship with them being clean then I’d prefer it yeah, they’re quite important so most important. Yeah.

Zoe: (?) mmmm.

Tina: OK ‘A drugs worker?’ Yeah I love my drugs worker (laughs affectionately) I mean she’s the most important Yeah. (Laughs).

Zoe: I think quiet important because there’s something that I don’t have that’s most important and I do think in my family it might be my father that has refused to acknowledge why I do need a drugs worker because my father just won’t speak to me at all no not about anything.

Quote 36 (From Focus Group 3):

Kevin: And ever since then it’s been downhill for me I “aint” gone up hill right alright I might have had money but it’s downhill I’ve lost everything. I’ve lost everything but lucky enough I’ve still got that family support network. I didn’t cross that line yeah like alright I’m not judging anyone here like anyone its happened to but I’ve never done any dodgy moves on my family or anything you understand what I’m saying. You know I (?)like it can happen you know coz someone that’s why I’d never judge anyone on that you know what I mean but I did cross that line by getting addicted to the gear and basically I’ve become an arse hole I’ve done my family mentally and honestly I’ve done my family mentally, (Ellen agreeing) which ain’t good. I emotionally blackmailed my ma to give me a few (?) so I don’t go and get nicked I done it that way, I didn’t steal off them direct, I’ve done it mentally argh give us this…

Quote 37 (From Focus Group 3):

Kevin: Like my Dad brought up an instant the other day about my brother because my brother is causing a lot of trouble over in (name of location) and he asked me to talk to him and calm it down yeah because he’s having (?) anyway that’s another matter like he asked me to deal with it and me brother in law went and listen Stan don’t get Kevin involved he’s my brother in law, he’s name Kevin. Don’t get him involved he’s got his own issues getting him caught up I didn’t get involved because I don’t want to get caught up in that mix and you know I dealt with that, normally I’d go yeah alright and I’d be a people pleaser in the past so if people asked me to do something I would do it I wouldn’t retract know what I mean but now I can say no you know and that’s
the thing me not being on drugs. But as I’ve said before when I was on drugs, yeah I’d do it, I didn’t give a shit.

**Quote 38 (From Focus Group 3):**

**Ellen:** I was a late starter actually on Class A drugs. Erm, I had undiagnosed post-natal depression (*PI: interrupts and says OK*) and so I had my son while I was 26 erm and I was using heroin every now and then erm it was awful when I think back on it actually. But erm, when he was 6 months old it was like I had post-natal depression is what it was and then I, it’s the classic one I just thought, I won’t get addicted, it won’t happen to me, do you know what I mean? And then before I knew it I was scoring everyday, yeah so it was on the back of post-natal depression and not *erm* knowing how to ask for help.

**Quote 39 (From Focus Group 4):**

**Tina:** I think that’s most important if you’re depressed man that’s another big trigger for me. Personal which can set me back –

**Quote 40 (From Focus Group 2):**

**Samuel:** So what do you think is helpful in sustaining a person from recovery.

**PI:** From Class A drugs. (*Whispers*)

**Samuel:** Wow.

**Clare:** Yeah.

**Samuel:** OK.

**Clare:** So the first one is ‘having responsibility for looking after children or dependents’.

**Samuel:** Erm. (*long pause*) I don’t think… (*Clare laughs*) That’s stressful “bruv”. I mean because these are a double edged swords ain’t they?

**PI:** They are. They’re meant to be erm kind of open so that you can discuss what you think they mean and what you want them to mean -

**Clare:** On the flip side having responsibility when things are going good. Most definitely (?)(*Interruption from Samuel*) I even got time to (?) But get a phone call from the school (*clicks her fingers*) flip man I’m gone. And the thing is I don’t even have to get *angry* about it, it’s just. (*is said aggressively in a whisper*) and are you coming for a score. I’ll talk to you… even if I’m dealing with him like (?) it’s should have been dealt with 8.30, 9.00 he’s out 10.00. The doors shut front and doors shut and I’m making a phone call. Its, its, so it’s, it’s, it’s habit, the questions sustaining. (*long pause thinking about what to say.*) But at the same time (*pause*) when things are going good and there’s just that (*pause*) level of, of routine and err yeah just things like (?) school erm I’ve got things to be doing I’m quite active at my son’s primary school so there’s always be something going on there and there’s always something going on with family where someone needs a hand in the family  so it be, erm so I
supposed so that’s yeah dependents. So yeah it’s, it can be, I think that as well it can be really, really important, (Samuel interrupts and makes agreeing sounds) really important really, really important because if I’ve got things going on I haven’t got time to stop. Just so long as and but for me it’s that borderline h, my home life to be right. Like I had to be (pause) like it’s all good I’m running around all over the shop to help people and then I come home at the end of the evening and I come home and I’m shot that’s no good for me. It has to be making sure that he’s like eating at the right times and I’m there to do his homework do you understand? When it’s finished with (pause) just because we’ve finished early isn’t an excuse to run out and go out and make myself tired and running round after family again. So -
Samuel: Let’s look at the question again.
PI: What do you think, would you kind of -
Samuel: What do you think, what do you think is helpful in “susbstaining” a person, a person’s recovery from a Class A drugs.
Moses: (Whispers) (?)
Samuel: (Whispering and thinking over the question). Taking responsibility for looking after dependents. Yeah that’s one hundred per cent most important man.
Clare: What dependents? (Whispering to herself, thinking over the question)
Samuel: If you read the question in that way then yes it’s got to be. (Clare agreeing).

Quote 41 (From Focus Group 3):

Kevin: Yeah I go in there and listen and all I’ve done is give my name so I go there because I see other people who used to use and it makes me feel good seeing them clean and they’ve done it to where they are. And erh so that gives me support erh and the other thing what gives me support is I’ve come here, I come here today and I’m here tomorrow to see (name of staff member from the rehabilitation organisation) for a one to one and I’m seeing some other people. Basically I just keep busy by seeing people that, that for me that’s what I’ve got to do if I’ve got no appointments I won’t get up and rush out of my place.

Quote 42 (From Focus Group 4):

Tina: Alright ‘help from a drug worker’. For me my drug worker has been really important and she’s helped especially because I’m, I’m 7 weeks and 3 days clean she’s being like she’s been the one helping me sort everything out. Helping me get in to a routine. She’s actually away for a week this week and I’m actually on the way here I was coming here and saying to myself Tina you’re doing well even though she’s not you know because she’s on the phone like every day reminding me of like where I should be going and what, who I should be meeting so to me she’s been the most important with me staying cleaning and the minute. Yeah so …
Quote 43 (From Focus Group 2):

Samuel: Yeah I live in a hostel and I’m seeing this thing this drug I’m taking going on and on and I’ve seen people there look like death, look like walking death and that was me. And that’s the source of my strength yeah because I’m actually living it and seeing it every day you know it’s actually become my strength because I’ve had enough clean time to be able to look at it without saying Oh God I want to do that. And now I’m looking at it and thinking Oh my God look at the state of them you know what I mean look at them that guys dead you know. Why was he injecting, there’s you just look at them, (saying it in disbelief. Moses agreeing) you know look at them and these guys who were really gone, (Moses agreeing and saying Yeah, yeah, yeah) really, really gone. People that look just like death. But I am in that hostel you know. They’re trying to get me out but I’m there thinking no I’m fine here do you know what I mean. PI: So now that – yeah you can see that their lifestyle bit when you were in it, it might have felt automatic and easy but now you can see its not?

Samuel: They come and take my butts, they come and take my butts. (Exclaiming in disbelief). My butts, you know this is what I’m saying to you. So I, that is my that strengthens me you know what [interruption from Clare] (?)But to be honest I used to pick up butts you know what I mean (laughing in disbelief). I used to pick up butts myself. You know it just brings back memories. For me it’s a strength you know and I look at that other side of things and they walk in and the expression on their face is frustration or you know they’re want to try and borrow money from me and I’m just thinking oh god, I feel sorry for them. I feel what they’re feeling because I’ve been there and you got so when you’re saying it’s easier (long pause, sighs) when you’re in it, it might be easy–

Quote 44 (From Focus Group 3):

Kevin: No what’s happened with me erh like in the past I’ve got clean. I’ve erh been clean like two years and that before and then all of a sudden I’ve gone back in to a full relapse. But there’s been others times when I’ve been clean and I’ve re a lapse they call it a lapse a one off and I’ve learnt by that sometimes you can learn by a lapse. Because once erm when I erh used a bit of gear once what they call it because I didn’t understand about a full relapse and a lapse yeah. I thought basically you’ve picked it up you’ve, you’ve used. Anyway I was told yeah not to beat myself Yeah I was told yeah like Kevin don’t beat yourself up over it yeah, you have lapsed but you can learn from it you can basically take it on board what happened to you and try and deal with things differently.

Quote 45 (From Focus Group 3):

Clare: It’s like a personality for me in the sense I know I’ve got an addictive personality so is it yeah…
PI: What does that mean to you an addictive personality?
Clare: That I latch on to things very easily. Erm, erm, erm how can I put it? Like, I don’t even know how to describe it.
Samuel: If I like something I will take that thing to its extreme and I will wear it out. In actual fact I’m wearing myself out. But -
PI: So you were saying about the gym that you go to (Samuel spoke in the break about how he goes to the gym all the time and how he obsessively goes to the gym).
Samuel: Yeah I haven’t changed I’ve just changed my addiction to gym work instead.
PI: So what else would you say in your life that you might feel you apply that addictive type behaviour to…? Are there any other areas that you …
Clare: I supposed if I applied it maybe yeah erh…
PI: Because you said like you’ve got an addictive personality-
Clare: Personality, I supposed if I applied (coughs) myself to something that was positive then I supposed that it would mean I’d be focused on something. Yeah that’s a good question actually yeah I’d have something else to focus on my addictiveness would be like you say the gym I suppose it’s would yeah (realisation).
Samuel: I think, its healthy but its only healthy for a while even my gym work. It’s only healthy for a while. If I go on like this for another year I will be a monster and I wouldn’t, I can barely fit into my clothes now. So you know even if it was in making money. You know sooner or later you’ll fall in to the wrong hands (Clare agreeing) you know. I mean the way I was making my money before I was running around and remember we had this discussion. Basically the way I’d been riff-raffing it was legit but I was still meeting the wrong people. I had to drop all of that you know I just dropped all of that you know. (PI says OK to acknowledge what has been said) Because that lifestyle was not working for me and you were bumping into problems yeah. Now I work Ebay site yeah I don’t deal with any one. I do it PayPal. You get stuff delivered. It’s a totally different ball game it gives me time to spend with my kids. I’ve been taking them to school and been picking them up from school and come to places like this do you know what I mean? Erm I dropped the car. You know it’s just totally changed you know the whole outlook for me change, changed because my addictive personality would always take me deep to the deep end.
Appendix 17: Explanation and Examples of How Themes Were Discarded, Developed and Included

**Example 1: ‘Labels’ theme – discarding, developing and further interpretation**

In Focus Group 1 the superordinate theme ‘impact of labels’ and in Focus Group 2, the superordinate theme ‘labels’ were discarded. These were thought to be too descriptive. However, some of the themes were developed further and formed part of the amalgamated superordinate theme ‘challenges and struggles with mental health’ and the corresponding amalgamated themes ‘mental health labels’, ‘impact of psychological health or mental health on their lives’ and ‘addiction in other aspects of life’.

**Example 2: ‘From a large family’ sub theme and ‘descriptions of family life’ theme – weak impact evidence and relevance or too descriptive.**

Some themes were discarded because the evidence of the impact of the theme across focus groups or at an individual level was not substantial enough. For example, the theme ‘from a large family’ featured with a couple of the participants in Focus Group 3 and 4. However, the supporting contextual relevance of this, in relation to the research questions and aims, was weak and it was also considered too descriptive. This is not to undermine the significance that being part of a large family had for those participants. This is recognised in, for example, Freddy’s account with the theme ‘neglect, abuse, turmoil: damaged bonds and unhealthy upbringings’. Freddy felt that being part of a large family meant that he did not get attention and he felt lost in his family. However, there was not enough supporting evidence across the focus group accounts to warrant this as a theme.

**Example 3: ‘Relationships’ theme – duplication and further interpretative development**

In Focus Groups 1, 2 and 4, the superordinate theme ‘relationships’ and for Focus Group 3 the superordinate themes ‘how you relate to yourself’ and ‘family’ along with some of the corresponding themes and aspects of the themes became part of the amalgamated superordinate theme concerning relationships. This was then qualified further using
credibility checks and finally given the superordinate theme label ‘struggles with complex and tense relationships’. Some themes and sub themes were discarded because they were duplicates and others which related to ‘childhood’ formed a newly created amalgamated superordinate theme labelled ‘difficult or traumatic childhood experiences’. This was in recognition of the traumatic responses participants appeared to have about their childhood experiences and the continued impact these had on their journeys of relapse and recovery.

The development of the superordinate theme ‘struggles with complex and tense relationships’ is illustrated further in Figures 1-7. This provides pictorial diagrams of how the relevant themes from each focus group were amalgamated to produce an overall taxonomy for the superordinate theme. In figures 1-7, the colours represent which focus group the analysis originated. This helped to provide an audit trail of participants’ accounts although some themes were held by multiple groups in later stages of the development of the themes as in Figures 5 and 6. (Focus Group 1 - pink; Focus Group 2 -green; Focus Group 3 –orange; and Focus Group 4 –blue. The grey colour indicated where a new theme/aspect of theme ‘label’ was developed). The bold capital headings represent the superordinate themes, capital headings represent the themes and lower case font represent ‘aspects of the themes or sub themes to the themes’. The ‘aspects or sub themes’ helped manage the large data set. The page numbers and letters (Figure 5) were references to be able to identify where the analysis originated from in participants’ accounts to help manage the audit trail and locate participants’ supporting quotes in the transcripts.
Figure 1: Focus Group 1 analysis for themes relating to ‘relationships’: Showing SUPERORDINATE THEMES and aspects of themes.
Focus Group 2 analysis for themes relating to 'relationships': Showing SUPERORDINATE THEMES and aspects of themes

- RELATING TO OTHERS
  - Other people use you to get money from you.
  - Not trusting of people in adulthood – weary of offers of friendship

- FRIENDSHIPS
  - Drug taking friends are not real friends they’re associates
  - Avoiding friendships – unable/unwilling to form friendships
  - Criminal associates are not friends
  - Criminal associates are not helpful in recovery

- RELATING TO THE SELF
  - Negative about self in adulthood
Figure 3:

Focus Group 3 analysis for themes relating to ‘relationships’: Showing SUPERORDINATE, THEMES and aspects of themes.

HOW YOU RELATE TO YOURSELF

FEELINGS
- Dislike feeling lonely
- Feeling unwanted
- Does not feel comfortable opening up, talking about problems

NEGATIVE ABOUT YOURSELF
- Self hatred
- Learning to relate to yourself in a positive way
- Lucky & unlucky (lack of control)

FAMILY

NEGATIVE
- Negative feeling towards a parent in adulthood
- Managing family relationships
- Tensions with siblings in adulthood
- Difficulty managing being a parent
- Strained family relations during drug using (upset family with drug use)
- Deaths in the family (in adulthood, unable to manage)
- Do not have family in adulthood

POSITIVE
- Affection towards family members
- Close (criminal) family network
- Supportive family members (important in recovery)
- Spends time with family in adulthood
Figure 4:

Focus Group 4 analysis for themes relating to ‘relationships’: Showing SUPERORDINATE, THEMES and aspects of themes.
Figure 5: First draft of amalgamated themes across the four focus groups: Capital bold font represents superordinate themes, smaller capital font represents themes and lower case font represents aspects of the themes. Colours indicate the focus group (see Figures 1-4).
Figure 6: Second draft of amalgamated themes across the four focus groups: Large capital bold font represents superordinate themes, smaller capital font represents themes and lower case font represents aspects of the themes. Colours indicate the focus group (see Figures 1-4).
Figure 7: Third draft before credibility checks and final draft of the superordinate theme ‘Struggles with complex and tense relationships’ after the credibility checks. Superordinate theme is represented by large capital bold font and the themes are represented by smaller capital font.

Third draft before credibility checks.

Final draft after credibility checks.
Appendix 18: An Example of Why a Stand-alone Theme, Was Included in the Focus Group Analysis

There were only three participants, Zoe, Tina and Samuel who represented the theme ‘trying to manage mental health in a healthier way’. The discussion about managing mental health was more prevalent in Focus Group 4 (Tina and Zoe) than in Focus Group 2 (Samuel). This might have been because Tina was having professional support for her mental health issues and was very engaged in the process. This included her attending a dual diagnosis group (after the focus group that day). During the focus group it emerged that Zoe was also suffering with mental health issues, which prompted Tina to advise Zoe about the benefits of attending a dual diagnosis group. When Tina exhibited empathy and encouragement in response to Zoe’s mental health problems it created a more empathetic environment that encouraged Zoe to talk more openly about her mental health problems. This rapport may have therefore encouraged Tina and Zoe to think and talk more about how they managed their mental health. This was considered an important theme to include in the semi-structured interview study where mental health could be explored in a setting (one to one) which was considered to be more conducive to discussing sensitive topics in more depth and detail.
### Appendix 19: Examples of Analysis on Participants’ Accounts for the Focus Group Study (Part One): Showing Some Examples of How the Analysis Developed the Superordinate Theme ‘Struggles With Complex and Tense Relationships’

<table>
<thead>
<tr>
<th>Early emergent themes</th>
<th>Focus Group transcript analysis extracts relating to the superordinate theme ‘Struggles with complex and tense relationships’</th>
<th>Descriptive notes: Linguistic, descriptive Conceptual. Orange font reflects more than one of the above.</th>
</tr>
</thead>
</table>
| Drug use linked to friends. | **Focus Group 1:**  
**Bobby:** You know I can’t form relations because I’ve got underlying problems with autism or whatever. And I end up with you know people who are you know just looking for someone who’s got that kind of money to spend on gear you know.  
**Alan:** Are they friends though? They’re not really. They’re not friends. You know you take drugs out of those rooms and what do you really have you got in common with those people? Do you understand what I mean?  
**Bobby:** Sex, drugs, sex drugs, sex, drugs, sex, drugs - | Impact of Bobby’s mental health on his life to form friendships and relationships.  
Drug taking ‘company’ are not real friends. Alan challenges Bobby on the drug taking friends not being real friends. |
| Drug use linked to friends. | **Focus Group 2:**  
**Samuel:** Erh, ‘not having friends’. *(Contemplative tone).*  
**Clare:** *(Laughs loudly when she looks at Samuel).*  
**Samuel:** I would question that. You know why. I haven’t got friends. But then again all my friends are not friends they’re associates.  
**Clare:** Associates?  
**Moses:** *(Agrees).*  
**Samuel:** So not having friends are right... (?) the true meaning of not having friends means...  
**Clare:** Mean you don’t have...Yeah man.  
**Moses:** Yeah.  
**Clare:** Erh. ‘Friends’. Argh, you see now again, when you say “friends” if I’ve got my friends and they are around I don’t even thinking about it coz I’m my, we’re just on a different vibe. True friends I’m talking about (?). So when I’m around my friends it’s..  
**Samuel:** But the thing is I haven’t got any friends. *(long pause)* I haven’t got any friends. That’s the honest truth. I’ve got acquaintances and, and a sort of my Mrs, you know and an ex. I haven’t got any friends. | Clare is amazed that Samuel does not have any friends.  
Samuel repeats himself.  
Samuel hides away from others.  
Avoiding relationships/friendships. Perhaps there is only one type of friend he has ever known *(e.g. those during his drug taking and criminality).* |
Focus Group transcript analysis extracts relating to the superordinate theme ‘Struggles with complex and tense relationships’

Criminal associates are not real friends.
Avoiding friendships.
Unable to form ‘healthy’ friendships.

**Early emergent themes**

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<td></td>
<td>(Highlighted blue text also indicates initial noting)</td>
<td>Linguistic, descriptive Conceptual. Orange font reflects more than one of the above.</td>
</tr>
<tr>
<td>Criminal associates are not real friends.</td>
<td>(long pause) My lifestyle is derived from me just getting on courses that’s why my time is so hidden. Like if I go back to what I call friends they are either dealing in fraud, selling drugs, doing this or [doing that. Clare: Yeah, yeah] PI: So do you think that there is a distinction maybe between associates and [friends who aren’t part of perhaps the drug taking world or…? Clare: Associates and friends] Moses: (Is sniffing but is acknowledging the conversation). Samuel: Yeah. They’re still criminals. (Clare is also agreeing). That’s the criminals, they’re still criminal. And my, my what’s happened for me that I’ve noticed that’s always driven me back to drugs is I’ve been clean before but I’ve still been a criminal (whispers in disbelief) so I’ve ended up going back to drugs. Now I’m clean and I’ve given my life to the g.. to the Lord and I’m walking a straight path that for me has been so much more powerful, erm than any other time in my (pause) past of using. I’ve been clean for a year before it didn’t mean nothing I went back . You know what I mean but it’s the fact of maintaining my, my, my belief that’s helping me out as opposed to, OK I’m clean but I’m going to use, I’m, I’m digging a little h, hole for myself ... if you know what I mean? PI: Ok. Clare: You say you don’t have friends but what about these, there, there, erm, erm I take it you go to church? Samuel: Yeah Clare: Yeah, so what about the relationships that you’re [building or is it just... Samuel: I, I, I have families. Clare: OK. Samuel: Yeah I do just have family. Erm, it’s all relatives. I mean I go to the church that is quite far away but it’s with my sister and my other sister and her family, and there, you know what I mean? It’s like a family union. I go out for Sunday lunch and all the rest of it. But at the moment I’m quite pleasant, I’m quite happy with it that way. At the hostel at (mentions the name of the hostel) a lot of people come to me and talk to me and this, that and the other and they’ll pretend to be your friend and try and borrow money off me and I’ll say no it’s not happening. But, or come and get tobacco off me or whatever, you know... (It’s not friends. PI: Ok. Moses what do you think?) what do you think about friends you think is really important in, in...causing a relapse? Moses: Eh, erh it is really important, yeah. (Nods his head). Samuel: [It just so happens I don’t have friends.</td>
<td>Lack of trust of those people? Samuels friends are criminal friends. He is distancing himself from them. “ Me and them” use of language. Links between his drug use and criminality, which encourages his drug use. Samuel’s family are part of his support in his recovery. He is wary of others, outside of his family? He does not trust others.</td>
</tr>
<tr>
<td>Early emergent themes</td>
<td>Focus Group transcript analysis extracts relating to the superordinate theme ‘Struggles with complex and tense relationships’</td>
<td>Descriptive notes:</td>
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| Avoids relationships with a partner. | Focus Group 3:  
**David:** ‘Not having a partner’. I’d say that’s in between – *(They have created another category which is in between most important and quite important).*  
**Kevin:** Yeah to be honest with you I’m normally in a relationship but what I’ve felt this time I’ve got to step back a little bit and look out myself. -  
**Ellen:** Same, I’m single -  
**Kevin:** I know it sounds mad but I haven’t been getting involved, alright I’ve had a couple of things since you know I’ve been home *(from prison)* but you know – I won’t get into at the moment – | Kevin and Ellen are not able to deal with a relationship in early recovery.  
Kevin has had some involvement with women but nothing serious.  
He is normally in a relationship  
Kevin repeats himself |
| Complex intimate relationships. | Focus Group 4:  
**Tina:** Yeah. With a relationship?  
**Zoe:** No with anybody.  
**Tina:** [Or just getting involved with anyone.  
**Zoe:** Apart from... No I can’t be bothered from my family my Mum-  
**Tina:** What are they hassling you?]  
**Zoe:** well no she’s left me alone and she’ll let me do what I want but she watches me and she can tell what it’s like when I was on drugs what I’m like on drugs and what I was like before so she’s constantly nagging me and watching me but erm I think because of that and constantly being under surveillance I just assume everybody’s watching me and I really can’t be bothered even just erm I can’t tell the last time I’ve talked to somebody. *(Tina’s tone changes she expresses sounds of sympathy)* No I can’t be bothered I’d just have erm normal platonic interactions than anything personal. | Zoe avoids relationships people, friendships. Untrusting, issues with trust?  
Zoe feels she is being watched, feels exposed. Unable to cope with her relationship breakup.  
Talks about her mother. Difficult relationships. |
| Avoids relationships/people.  
Estranged from partner.  
Complex relationships with partner. | (Highlighted blue text also indicates initial noting) | |

(Transcripts are verbatim, including stutters and participants’ slang terminology. Identifying information has been removed. Participants’ real names have been replaced with pseudonyms).
Appendix 20: Schedule for the Credibility Checks With a DIP Drugs Worker for the Focus Group Study (Part One)

Brief schedule:

The idea of this session is for me to present my early analysis of the focus group data to you and for you to provide me with feedback based on your experience as a drugs worker with the participant/client group. My main questions to you would be:

1. Do you think the findings resonate with your experience of working with the client group?
   - If yes, in what ways and how?
   - If no, in what ways and why?

2. How do you think the findings could influence practice?

3. In what ways do you think you could use these findings -
   - in service provision?
   - in your day to day role working with this group?
Appendix 21: Quality and Standards Guide for the PhD Research

The following papers were used to help produce quality IPA and qualitative research: Yardley (2000); Smith (2011) and Neale et al. (2013). Some examples of how this was achieved in the PhD are outlined below.

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Implementation in this research</th>
<th>Source</th>
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</thead>
<tbody>
<tr>
<td>Table 1 (Yardley 2000, p. 219)</td>
<td>The focus group study (Part One) was presented to two drug workers who were also qualitative researchers; Part One including the findings, were also presented at the Society for the Study of Addiction PhD symposium in July 2012, July 2013 and Oct 2016. A poster presentation was presented at the Surrey University PhD conference in Feb 2014 for review and comment and the Surrey University Psychology conference in 2013, 2015 for comment. A presentation of the final findings was presented at the Society for the Study of Addiction conference in November 2016.</td>
<td>Yardley (2000)</td>
</tr>
<tr>
<td>“Commitment and Rigour”</td>
<td>Methodological competence was gained through attending IPA workshops, groups and qualitative training over the course of my degrees (BSc, MSc and the PhD) in psychology.</td>
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<tr>
<td>(includes ethical rigour)</td>
<td>I obtained NHS ethical approval which included defending my research proposal to an NHS ethical board. I obtained Local Research and Development ethical approval, University of Surrey ethical approval and approval from the rehabilitation organisation and their user forum. I ensured BPS ethical guidelines were followed, such as debrief sessions for participants.</td>
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<tr>
<td>“Sensitivity to context”</td>
<td>I worked within the drugs field for nine years, I familiarised myself with the relevant literature. My research placement within the rehabilitation organisation included involving the drug workers in the development of the study and questions. I conducted my own transcribing.</td>
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<tr>
<td>“Impact and importance”</td>
<td>The overall aim of this research is to help to inform drug misuse policy and practice. A summary of the research will be sent to the relevant Government department and to the rehabilitation organisation involved in the study. Recommendations for policy, practice and further research is a key outcome intended for this research.</td>
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<td>Criteria</td>
<td>Implementation in this research</td>
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<tr>
<td><strong>Training and relevant experience</strong>&lt;br&gt;BSc and MSc in (Forensic) Psychology which included qualitative theory and methods.</td>
<td>Methodological Training for the PhD: Attended two courses on how to conduct IPA research, attended IPA groups and engaged with an online IPA forum. I attended specific workshops about how to conduct focus groups and card sort techniques.</td>
<td>Neale et al. (2013)</td>
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<tr>
<td>Experience within the drugs sector: Nine years working within the Drugs and Alcohol Directorate in the UK Government Home Office, which included developing policy, reviewing and conducting research.</td>
<td>Research placement with a DIP team to gain an understanding of the client group. I built good working relationships with drugs workers and sought their help with the development of the research design such as the card sort items in the focus groups.</td>
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<tr>
<td>Table 1, from Neale et al 2013, p. 448) the following were of particular relevance for the PhD thesis:&lt;br&gt;“The analytical approach should be explained and the analysis processes”&lt;br&gt;“Findings should be related to formal constructs, relevant theories or broader policies, processes or treatment”</td>
<td>These are explained fully in Chapters 5.1 and Chapters 6.1&lt;br&gt;Chapter 5.2, 6.3 and 8 provide an overview of how the findings relate to relevant theories, policies, practice and treatment.</td>
<td>Neale et al. (2013)</td>
</tr>
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<td>Table 10 from Smith (2011, p. 24) was used as a further guide to produce quality IPA research throughout the PhD.&lt;br&gt;“A clear focus&lt;br&gt;“Strong data”&lt;br&gt;“Rigour – prevalence of a theme”</td>
<td>The focus of the PhD was on the relapse and recovery of drug misusing offenders in relation to significant life events such as relationships, psychological health and childhood and how these impacted on their relapse and recovery and drug use.&lt;br&gt;The data from both the focus group and semi-structured interview studies was rich and detailed.&lt;br&gt;Re-current theme checks as suggested by Smith et al. (2012) and Tomkins and Eatough (2010) were conducted. All 17 participants’ supporting quotes featured in the interview study including over four participants to illustrate each theme. For the focus group study suggestions by Tomkins and Eatough (2010) to include narratives from individual dialogues and from the focus group (collective voice) were included to illustrate themes.</td>
<td>Smith (2011)</td>
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<td>Criteria</td>
<td>Implementation in this research</td>
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<tr>
<td>“Elaboration of each theme”</td>
<td>Each superordinate and corresponding themes were given sufficient space to illustrate them fully. Credibility checks helped to ensure themes were developed further to the interpretative stage.</td>
<td>Smith (2011)</td>
</tr>
<tr>
<td>“Interpretative analysis rather than descriptive”</td>
<td>Examples of how participants illustrate each theme, which includes convergences and divergences is illustrated by the quotes chosen in Chapters 5.2 and Chapter 6.2.</td>
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<tr>
<td>“Analysis is convergent and divergent”</td>
<td>I attended workshops and sought advice and support with writing the PhD and how to present an IPA study. I also read widely about how to construct an IPA PhD thesis and also was supported by my supervisors.</td>
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<td>“Carefully written”.</td>
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Appendix 22: Examples of How the IPA Analysis Was Conducted on Participants’ Accounts for the Semi-structured Interview Study (Part Two). This analysis from Rebecca’s transcript helped to develop the following superordinate theme for Rebecca: ‘Traumatic childhood - violence, fear, hatred, neglect, rejection, abandonment and broken bonds’. This then helped to develop the superordinate theme ‘experiences of adverse childhoods – links to emotions that were experienced as damaging/harmful and problem behaviours’, during Step 7 (see section Chapter 6.1, Section 6.1.5.3), when the analysis from all participants was amalgamated to produce a master taxonomy of superordinate themes.

<table>
<thead>
<tr>
<th>Emergent themes</th>
<th>Extract from Rebecca’s Transcript</th>
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<td>(Highlighted blue text also indicates initial noting)</td>
<td>(Taken from Rebecca’s transcript)</td>
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<tr>
<td>Traumatic and violent childhood experiences</td>
<td>Rebecca: Well all sorts of problems you know I didn’t have the best upbringing my granny brought me up and then my mum decided she was taking back when I was 10 and erm I obviously I didn’t want to go back but my granny had to give me back because there was no signed papers or anything. My mum started drinking and I didn’t get on with her boyfriends I had murders with them you know. Just erm things like that but I at the end of the day I was the person that put drugs in my system so I don’t blame my mum anymore you know she didn’t help but you know you cant.. the way I look at it is I’m not going to dwell on the past I get on with my Mum since I’ve been clean. Totally different relationship and that and erm my family are a lot happier and that you know.</td>
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<tr>
<td>Traumatic relationships growing up</td>
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<td>Broken bonds with family members</td>
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<td>Difficult childhood - brought up by Grandmother but then mother took her back. Mum drank and her partners were violent. Rebecca didn’t get on with them. Rebecca doesn’t want to dwell on the past and doesn’t blame her mother anymore. (However, does she still blame her Mother? – this is in relation to where she previously blames her mother for not protecting her). Disruptive and inconsistent care and broken bonds.</td>
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<tr>
<td>Descriptive notes:</td>
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<td>Linguistic</td>
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<tr>
<td>Descriptive</td>
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<tr>
<td>Conceptual</td>
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<td>Orange font reflects more than one of the above.</td>
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<tr>
<td>Emergent themes</td>
<td>Extract from Rebecca’s transcript</td>
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<tr>
<td>Violence and fear in home growing up</td>
<td><strong>Rebecca:</strong> Yeah I hated them. Yeah. I tried to kill one of them. I pushed him down stairs but it was my Mum’s fault coz my Mum was scared coz he’d been drinking and she come in my bedroom with my little sister and he come in drunk and she was saying that she was scared and so when he came up top of the stairs and I pushed him back down again and but then the next day she stuck for him and threw me out so you know and I was looking at I wouldn’t let him touch my little sister neither coz he was just drunk. <strong>PI:</strong> Was he violent? <strong>Rebecca:</strong> Oh yeah he was horrible he put his foot through my bedroom door and everything I hated him. When he weren’t drinking he wasn’t that bad but when he was drunk he was a bastard. And I think if I had stayed there I probably would have killed him somehow or other. <strong>PI:</strong> So was he violent to your mum, you, your sister? <strong>Rebecca:</strong> Yeah well, no you know he called my sister a bitch and I went mental and erm I threw a bowl of custard at his head and that was it really</td>
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<td>Mother not protect her children</td>
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<td>Mental and physical violence in the home growing up</td>
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The analysis from Terry’s transcript helped to develop the Superordinate Theme 2 ‘The divergent and damaged selves – links to substance use’, during Step 7, (see section Chapter 6.1, Section 6.1.5.3) when the analysis from all participants was amalgamated to produce a master taxonomy of superordinate themes.

<table>
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<tr>
<th>Emergent themes</th>
<th>Extract from Terry’s Transcript</th>
<th>Descriptive notes:</th>
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<tr>
<td><strong>Feels stressed and used drugs to cope</strong></td>
<td>(Highlighted blue text also indicates initial noting)</td>
<td><strong>Linguistic</strong>&lt;br&gt;Descriptive&lt;br&gt;Conceptual&lt;br&gt;Orange font reflects more than one of the above.</td>
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| **Unable to deal with normal life/routine and used drugs to cope.** | **PI:** Have there been times when you’ve not used as much? *(Drugs)*<br><br>**Terry:** NO. Now I don’t use as much. Whereas before and then they were saying you know like you hear this and that. I used to spend roughly about £300, £400 quid a day on drugs. I used to get paid £350 a day yeah that’s without what, what I made like the “bunks” and the profits that was just my wages. *(He’s referring to non-legitimate means of earning money).* Yeah so we and we were skint every day erh like and so we done quite a lot of drugs but it’s only now that we don’t get those drugs again and you have to go out and do it and that’s when I started like the crime thing got up but still kept my principles my moral compass and all that on it.<br><br>**PI:** So do you feel that you are recovered now or in recovery now, how would you describe it?<br><br>**Terry:** No. I’ll never recover never. I won’t ever, ever be... For one I’m not even going to try anymore. I’m going to stick to what I do and am just the last two weeks I haven’t ate for about five days now. I’ve just got no appetite at all but it’s not to drugs, this is for shit I’ve got up here going on.<br><br>**PI:** What’s going on ?-<br><br>**Adam spent a lot of money on his drug use. Talks about his ‘pay’ as though it is a normal salary despite it being from selling drugs.**<br>**Normal for him to commit crime to fund his drug use – talks as though it is a normal legitimate job.**<br>**Does not feel he will recover from his drug addiction. He is unable to eat because he is worried about his housing situation.**
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<th>Emergent themes</th>
<th>Extract from Terry’s transcript</th>
<th>Descriptive notes:</th>
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<tr>
<td>Drug use and crime linked.</td>
<td><strong>Terry:</strong> I’ve got to move and I’ve got to do look on my own and I’ve got to put it all in boxes and move every time I’ve moved—&lt;br&gt;&lt;br&gt;<strong>PI:</strong> Where are you moving to? &lt;br&gt;&lt;br&gt;<strong>Terry:</strong> They should have given me a viewing to a place. &lt;br&gt;&lt;br&gt;<strong>PI:</strong> Is it another hostel or? &lt;br&gt;&lt;br&gt;<strong>Terry:</strong> It’s a shared house yeah but am taking that coz I just want to stay up this area but in the other gaff that I got to go if this one doesn’t go through you can’t drink in there you can’t smoke in there so I know it’s only going to be a little bit before I’m slung out of there you know. And it’s just pressure that I haven’t done nothing wrong I’ve been behaving myself all since I come out. &lt;br&gt;&lt;br&gt;<strong>PI:</strong> Not committing crime? <em>(I’m trying to clarify what Terry means by “done nothing wrong”)</em>. &lt;br&gt;&lt;br&gt;<strong>Terry:</strong> Yeah like committed you know and kept the drugs at bay for a long time just little bits just to you know and I’m the only sort of person that’s genuinely doing something about it and I’m getting fucked over for it. &lt;br&gt;&lt;br&gt;<strong>PI:</strong> What do you think would really help you to stay off the drugs? You know if you could kind of have anything — &lt;br&gt;&lt;br&gt;<strong>Terry:</strong> Just some money would do you know and some money I don’t have to look round through the DRUG AREA. Or bit of fucking stability in where I’m going to stay and that’s really. Oh I</td>
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<tr>
<td>(Highlighted blue text also indicates initial noting)</td>
<td><strong>Linguistic</strong>&lt;br&gt;<strong>Descriptive</strong>&lt;br&gt;<strong>Conceptual</strong>&lt;br&gt;Orange font reflects more than one of the above.</td>
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<td>Terry feels unsupported in having to find a new place to live. He feels very stressed with trying to find somewhere new to live and he has started to take drugs again.</td>
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<td></td>
<td>Is angry about trying to find somewhere new to live. Terry feels as though he does not deserve to be in this situation, he feels punished.</td>
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<td>Is feeling unsupported when he feels he has done a lot for himself to abstain from drugs. Although he contradicts himself – he has been taking some drugs during his more recent recovery.</td>
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<td></td>
<td>Aggressive language.</td>
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<tr>
<td>Emergent themes</td>
<td>Extract from Terry’s transcript</td>
<td>Descriptive notes:</td>
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<td>Desperate to feel normal.</td>
<td><strong>Terry (continues):</strong> was happy I was getting back in to me gym and my swimming and I’d probably resume my studies coz I’d like to that. But now I just can’t –</td>
<td>Was coping with a normal life and rebuilding a normal life but now feels he is unable to cope with normal life, of trying to find a new home. Terry is really worried about trying to find a new home.</td>
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</table>
| Does not feel normal, uses drugs to cope. | **PI:** When did you decide not to carry on with your studies, when was that?  
**Terry:** Last Friday.  
**PI:** Last Friday and what was happening that day?  
**Terry:** I’d just had enough. I was waking up stressed. Am killing myself with worry of this and that.  
**PI:** What do you worry about?  
**Terry:** Not doing things I said I’d do *(he’s very agitated)* Not having to worry about where am going to get a dollar from next without having to go out and commit crime. There’s no (?) in my life whatsoever (mumbles, he’s eating some of the refreshments I’ve brought with me).  
**PI:** Sorry no what?  
**Terry:** Sorry, normality nothing normal in my life *(he’s eating some of the snacks)*. But am juggling it around where I can be with people that I meet just say on the canal or whatever and they wouldn’t guess what I do or what I am.  
**PI:** When you are say, what I am, what do you mean? | Terry is struggling to live a normal life and find legitimate paid work. He is angry when talking. Violent and aggressive words and descriptions. Terry wants to be normal and have a normal life but struggles with this. |
<table>
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<tr>
<th>Emergent themes</th>
<th>Extract from Terry’s Transcript</th>
<th>Descriptive notes:</th>
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| Not able to lead a normal life – he’s never had one. | **Terry:** Like never guess that I’ve never had a job or I never went to school or I, I don’t do, do you know what I mean and then I hear them talking about (?) So you know what I mean well I can’t really tell them this now but. I’ve done a counselling course and it it got to a point where you have to be your own guinea pig say and you need to share things with that and normally you have to base it on your own life, which I found a bit weird so I had to make things up to tell them rather than go yeah I’d tell them what actually happened in there, they’d be like whoa no one would even speak to me or come near me.  
**PI:** Why? What if you told people what had really happened in your life?  
**Terry:** Yeah.  
**PI:** Really?  
**Terry:** I’ve just been (?) Yeah a lot of that was violence a lot of that was nasty shit we done but you know its …  
**PI:** Were you ever kind of beaten up or anything like that? *(Shakes his head)* No OK.  
**Terry:** No. I’ve lost a few. I’ve been “bush wacked”.  
**PI:** What does that mean?  
**Terry:** I’ve been targeted. | **Terry’s life has not been normal. Violence, drug taking and crime.**  
He recognises that his life has not been normal and struggles with this change to a normal routine life.  
**Terry’s life of violence, drug taking and crime was not normal.**  
**Violent and aggressive language and uses slang terms.** |
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<th>Emergent themes</th>
<th>Extract from Terry’s transcript</th>
<th>Descriptive notes:</th>
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<td></td>
<td><em>(Highlighted blue text also indicates initial noting)</em></td>
<td><strong>Linguistic</strong></td>
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<td></td>
<td>PI: Oh right, is that what it means?</td>
<td><strong>Descriptive</strong></td>
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<td></td>
<td>Terry: I had 27 holes in me in one go.</td>
<td><strong>Conceptual</strong></td>
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<td>PI: What does that mean “holes”? What punches someone? –</td>
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<td>Terry: Some big knife stabbing me to pieces.</td>
<td>Very violent lifestyle, is emotional and angry when he is talking about it.</td>
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<td>PI: Oh really. Obviously you survived though –</td>
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<td></td>
<td>Terry: Yeah a few of them was superficial but head smashed, really I should be dead.</td>
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### Emergent themes

Unable to cope with bereavement, which leads to depression and used drugs to cope.

Engaging with services to help his mental health and recovery.

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<thead>
<tr>
<th>Extracts from Jim’s transcript</th>
<th>Descriptive notes:</th>
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<td>(Highlighted blue text also indicates initial noting)</td>
<td>Linguistic</td>
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<thead>
<tr>
<th>Extract 1:</th>
<th>Jim has mental health problems and has to take medication to help him with his depression.</th>
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<tbody>
<tr>
<td>PI: And now that you’re ...are you taking any drugs at all?</td>
<td>Jim is engaged in getting help with his mental health problems.</td>
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<td>Jim: Just Subutext, 6mls of Subutext and anti-depressants.</td>
<td>Mental health problems in his family (his mother too, mentioned earlier in his transcript).</td>
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<tr>
<td>PI: And anti-depressants?</td>
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<td>Jim: That prison psychologist put me on anti-depressants and (?) sleeping tablet (?)</td>
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<td>PI: So have you got a diagnosis of depression?</td>
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<td>Jim: Yeah.</td>
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<td>PI: So how long have you that diagnosis for, do you know?</td>
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<td>Jim: I had been diagnosed with me GP but I think it was (?) years ago in prison (?) (background noise going on in the rehab) since I’ve been engaging here the GP give me a self-referral to (name of place) (tries to pronounce the acronym scheme) some mental health thing.</td>
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<td>PI: IAPT is it?</td>
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<td>Jim: Yeah that and they sent me a questionnaire that I need to fill it out and send back to them. But my sister has really bad mental health problems. She engages with them here (?) and (name of support service) all that and (?).</td>
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<tr>
<td>Emergent themes</td>
<td>Extract from Jim’s transcript</td>
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<tr>
<td>Used drugs to block emotional pain.</td>
<td><strong>PI:</strong> What mental health problems does she have?</td>
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<td></td>
<td><strong>Jim:</strong> Severe depression.</td>
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<td></td>
<td><strong>PI:</strong> Severe depression ok. So how long do you think you’ve had depression, how long have you felt low?--</td>
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<td></td>
<td><strong>Jim:</strong> I reckon since, since my partner died and I blocked it out and I tried to block it and the fear and the emotions for about 15, 20 years that I was a full blown user.</td>
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<tr>
<td>Used (Class A) drugs to cope with past trauma</td>
<td><strong>Extract 2:</strong></td>
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<td>Relies on medication to help with depression.</td>
<td><strong>PI:</strong> When I asked you how long you had felt depressed for and you said it was when your partner died when you were 19 and you just wanted to block everything out how did you block it out?</td>
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<td><strong>Jim:</strong> Drugs. Heroin.</td>
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<td><strong>PI:</strong> Did you take heroin knowing that’s what it would do or…?</td>
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<td></td>
<td><strong>Jim:</strong> Yeah. Yeah coz you’re in your own little world, no pain and no feelings. It just blocks everything out.</td>
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<td><strong>PI:</strong> So now that you’re off erm heroin erh how do you feel mentally now, emotionally?</td>
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<tr>
<td>Emergent themes</td>
<td>Extract from Jim’s transcript</td>
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<td><em>(Highlighted blue text also indicates initial noting)</em></td>
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<tr>
<td>Jim:</td>
<td>Good really good, really strong.</td>
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<tr>
<td>PI:</td>
<td>Do you feel low or kind of depressed at all?</td>
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<tr>
<td>Jim:</td>
<td>No, no. Am on me medication.</td>
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</tbody>
</table>
### Table 1: Participants Representing Each Sub Theme

<table>
<thead>
<tr>
<th>Superordinate themes</th>
<th>Sub themes</th>
<th>Participants representing each sub theme</th>
<th>Participants representing the superordinate theme</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Experiences of abusive childhoods – links to emotions that were experienced as damaging/harmful and problem behaviours</strong></td>
<td><strong>1.1 Neglect, abuse, turmoil: damaged bonds and unhealthy upbringings</strong> (N=14), Adam, Bruce, Freddy, Gale, Harry, Jay, Jim, Luke, Olivia, Rebecca, Veronica, Stacy, Terry, Zachery.</td>
<td>(N=13), Adam, Bruce, Freddy, Gale, Harry, Jay, Jim, Olivia, Rebecca, Stacy, Terry, Veronica, Zachery.</td>
<td>(N=14), Adam, Bruce, Freddy, Gale, Harry, Jay, Jim, Luke, Olivia, Rebecca, Veronica, Stacy, Terry, Zachery.</td>
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<td><strong>1.2 Destructive emotions – links to self, family and childhoods</strong> (N=10), Adam, Bruce, Freddy, Harry, Jim, Olivia, Rebecca, Stacy, Terry, Veronica.</td>
<td>(N=12), Adam, Bruce, Freddy, Gale, Harry, Jay, Jim, Olivia, Rebecca, Stacy, Terry, Veronica.</td>
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<td></td>
<td><strong>1.3 Attempts to escape the problems and abuse</strong></td>
<td>(N=13) Bruce, Freddy, Gale, Harry, Isabella, Jay, Jim, Luke, Olivia, Stacy, Terry, Veronica, Zachery.</td>
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<tr>
<td><strong>2. The divergent and damaged selves – links to substance use</strong></td>
<td><strong>1.1 Felt different to others</strong> (N=12) Adam, Bruce, Freddy, Gale, Harry, Jay, Jim, Olivia, Rebecca, Stacy, Terry, Veronica.</td>
<td>(N=13) Bruce, Freddy, Gale, Harry, Isabella, Jay, Jim, Luke, Olivia, Stacy, Terry, Veronica, Zachery.</td>
<td>(N=16) Adam, Bruce, Freddy, Gale, Harry, Isabella, Jay, Jim, Luke, Mark, Olivia, Rebecca, Stacy, Terry, Veronica, Zachery.</td>
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<td></td>
<td><strong>1.2 Damaged selves</strong></td>
<td>(N=11) Bruce, Freddy, Gale, Harry, Isabella, Luke, Mark, Rebecca, Olivia, Terry, Zachery.</td>
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<td><strong>1.3 Drug use to cope with ‘normality’ and the mundane</strong></td>
<td>(N=11) Bruce, Freddy, Gale, Harry, Isabella, Luke, Mark, Rebecca, Olivia, Terry, Zachery.</td>
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<tr>
<td><strong>Superordinate themes</strong></td>
<td><strong>Sub themes</strong></td>
<td><strong>Participants representing each sub theme</strong></td>
<td><strong>Participants representing the superordinate theme</strong></td>
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<td>3.2 Relational trauma</td>
<td>$N=12$ Adam, Bruce, Freddy, Harry, Jay, Jim Luke, Olivia, Rebecca, Stacy, Veronica, Zachery.</td>
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<td></td>
<td>3.3 Past and present trauma</td>
<td>$N=9$ Adam, Gale, Isabella, Jim, Olivia, Rebecca, Stacy, Veronica, Walter.</td>
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<td></td>
<td>3.4 The ‘normal’ everyday life is a crisis</td>
<td>$N=8$ Freddy, Harry, Isabella, Mark, Olivia, Rebecca, Terry, Zachery.</td>
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<td></td>
<td>4.2 (Re) building the self</td>
<td>$N=8$ Freddy, Gale, Harry, Isabella, Luke, Rebecca, Stacy, Veronica.</td>
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<td></td>
<td>4.3 Connecting with others</td>
<td>$N=12$, Adam, Bruce, Freddy, Gale, Harry, Isabella, Jay, Luke, Olivia, Rebecca, Stacy, Veronica.</td>
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<td>4.4 Having the capacity for acceptance, to reflect, understand and reason</td>
<td>$N=11$ Adam, Bruce, Freddy, Gale, Harry, Isabella, Luke, Rebecca, Stacy, Veronica, Zachery.</td>
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<td>4.5 Transitioning out of recovery</td>
<td>$N=11$ Bruce, Freddy, Harry, Jay, Mark, Luke, Olivia Rebecca, Terry, Walter, Zachery.</td>
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Appendix 24: Participants’ Quotes From the Semi-structured Interview Study
(Part Two)
(Transcripts are verbatim, including stutters and participants’ slang terminology. Identifying information has been removed. Participants’ real names have been replaced with pseudonyms).

Quote 46:

Olivia: Old (laughs) I had grandparents in (name of place) and we used to go up there every Easter holiday because my Mum was a teacher so we’d go up there for Easter holidays and I loved it up there coz I’ve got cousins and that and it was away from the bullying and the abuse the sexual abuse. Do you know what I mean? It was like a proper holiday do you know what I mean. My other Grandparents -

PI: When you say sexual abuse what was –

Olivia: My Dad’s friend and actually his son as well (quiet voice).

Quote 47:

PI: Why did your Dad use drugs? –

Zachery: No my Dad didn’t use but my Dad drank a lot. Yeah erm and I saw that… I say looking back on it now it kind of went over my head but his drinking made it that separation with my mum, I saw fights. You know what I mean I think that -

PI: Did your Dad fight with your Mum?

Zachery: Yeah.

PI: Would that be physical fights?

Zachery: Yeah physical, yeah physical, physical yeah and I saw that and at, at one stage growing up erm I thought at the way he was manhandling my Mum I kind of that was instilled in my head through my Dad you understand what I mean. But then when he left I was kind of grew up by a lot of girls I have a lot of girl cousins you know what I mean?

Quote 48:

Jay: So he, he, he’s decision was to kick me out of the house.

PI: So what age were you when he did that?

Jay: About 15.

PI: So where did you go?

Jay: Nowhere because basically my sister kept me for about three months and then after that I was just sofa surfing with like cousins and aunties and uncles and all that yeah. But I didn’t like it but like my mum kept on begging my Dad let him come back but my Dad was very, very strict and he’s like no, no he’s not coming back he’s a bad boy he goes around doing bad things and all that I don’t want no one like that in my house. But it wasn’t eh until like a good like when I was 17 that my, my Mum and Dad let me come back home but by that time I was too corrupted from the street life you know. (Nervous laugh of disbelief). Living like outside and hanging out with bad people doing bad things you know.
Quote 49:

Jim: It was basically around two or three years when me Mum and Dad were proper splitting up where she would going missing for a day or two and then days would turn into weeks and months and she would only come back when she owed money too. (?)

PI: And where would she go, do you know why she would go?

Jim: Drinking binges. Drinking.

Jim: Yeah, yeah, yeah she did come back some nights and me Dad never raised, raise a hand to her and she used to come back drunk and beat him up. That did go on for a couple of years.

Quote 50a:

Veronica: No, no, no its just you’re not going to school you’re not doing right. Back in them days they didn’t see… if you were naughty you were naughty you didn’t really have like any support I mean I used to bunk off school from the age of 6 I was sitting in a park on my own with no authorities ever wrote to mum or said I’m not at school.

Quote 50b:

Veronica: You know I remember going into school when I felt like it and the teachers throwing the books at me and saying well (dismissive sound) you might not need that so (dismissive noise) coz you’re never here. In this day and age it just wouldn’t happened it different so.

Quote 51:

Veronica: Yeah I went into voluntary care then I kept running away from there coz somebody in there tried to abuse me but I’d know better by then. Do you understand and I knew and I understood abuse and stuff like that so I started to running away from there and then they put me in a secure unit and I was there for like 9 months and then I met some geezer and I got pregnant you know what I mean it’s like so (makes a disgusting sound) –.

Quote 52:

PI: So when did you, you said that you used cannabis before so what age were you when you used cannabis?

Jim: Young age 8 or 9.

PI: Where did you –

Jim: My older brother he smoked it as well. So…

PI: And erh so when you started taking cannabis then when you were about 7 or 8 how did you get hold of it?

Jim: Brothers

PI: Oh yeah sorry you said.

Jim: Brothers and his friends and even before that it was glue and gas. So.
Quote 53:

Zachery: First time], Oh Ok I would have been about 14 yeah about 14. I started with erm I started experimenting with glue, yeah glue. It was erm glue erm and alcohol coz alcohol was around me, my Dad you know what I mean. Erm so I started on glue that didn’t, that, that I didn’t stay on that for long that was for about three months. Then I started pocketing and I would have been about well I would have, I would have come into cocaine well supposed the first time I came in to Class A drugs I was about 14.

Quote 54a:

Stacy: No it was that time back in the 60s] late 60s you’re talking yeah so it was like a case of (pause) my Mum loved my Dad but she was never in love with him. And she had an affair with a very younger man and my Dad left and this younger man moved in and my Mum married him. They’re still together now but at the time we thought she was just an idiot. But I was only 9 and I was very young and they were all my family were up in arms when my Mum married someone so young and this that and the other and my step Dad had a terrible accident in (name of place) he was a removal man and he was coming through the (name of place) and the driver of the lorry fell asleep and they went off the embankment. He ended up being cut out so my Mum had to be in (name of place) with him. And I misbehaved and started glue sniffing to get attention I ended up in care (pause) so I spent –'

Quote 54b:

PI: So when did your Mum split up from your Dad then? Was that about when you were 12 as well?

Stacy: No when I was 9 so I lived with them for three years until my Dad , my step Dad had that accident and then I went off the rails and …(exaggerates).

Quote 55:

Bruce: School wasn’t good. No school wasn’t good I’m just a rebel you know. I just wanted to not be the same as everyone else and I used to walk about when I was about 14 when The Sex Pistols came on the scene with their ripped jeans and things and me sister was a clothes designer right my older sister and she used to make me clothes with zips and all that on it and I used to get a lot of hassle when I was younger coz I was wearing different I was in to punk rock and things.

Quote 56:

Bruce: I was sitting in the park, boiling hot day having a beer three old bill came up and they started kicking me. Just get your fucking beer up and then they nicked me and gave me an on the spot fine for drinking beer in the park. It’s against the law to drink in the streets up there.

PI: Oh is it?

Bruce: In the park. I was just having a picnic, a sandwich and a beer, coz I had some beers left over from the festival and they’re horrible up there so I don’t want to ever go to (name of
a place) again to be honest with you. You know I just don’t get on with the police that well. I’ve got a bit of a mouth on me you know.

**Quote 57:**

**Jim:** The things that don’t help are more or less guaranteed to relapse if and when if I’m silly enough to take Valium any amount of Valium or these pills you’ve probably heard of them you probably have heard of them “Rivertrol”. They’re in 2 ml tablets people with epilepsy get them but one of them is equivalent to a having like three or four blue Valium that’s why I was taking me last time relapse and any time I’ve gone round the bend it’s been down to Valium or “Rivertrol”.

**Quote 58:**

**Jim:** You know the way police cells it says on the walls, “are you sick and tired of being sick and tired?” That’s, that was me the last few years I’d just had enough I don’t want to be a 50 year old man still going to jail and getting locked up and all that. I just had more than enough of that life. I just want to be a normal person. All day normal everyday things that other people take for granted I’ve never really had that so. All me life it’s been about drugs and crime.

**Quote 59:**

**Gale:** I must have had a bad day I was depressed or something, and I said to him let me have some of that.

**Quote 60:**

**Gale:** No I can remember vaguely part when I’ve talked to my psychiatrist and my doctor they’re reckon I’ve blanked it out of my memory. They reckon I was like trauma, traumatised (stutters). You know what I mean and with the post-natal depression coz I didn’t seek help like because I didn’t know I was suffering from it, they both of them have come to the conclusion that I’ve just blanked it out from of memory.

**Quote 61:**

**Zachery:** When they recruit people to work in erm the service (name of service) they say, “if you have a problem let us know and we’ll give you support”. I didn’t take that. I felt embarrassed. I felt no I’m beyond this you know what I mean.

**Quote 62a:**

**Adam:** And I wasn’t allowed to ask him any questions you had to empathy show empathy I don’t know if this is right or wrong. I said to him when, when the millennium was mentioned and you thought of like your fear of heights you could have been feeling like erm that fear and also a bit of guilt because you had your two little nephews with you and they wanted to do it but your fear was stopping their (?) so you could have had feelings of guilt as well and also that fear of heights. I said but when you went up there and that fear struck in I said when you came down the other side you were like happy as Larry and I said and you’d do it again and I said in my experience I said the fear of doing something is always a hundred times worse than when you actually do and that’s only that I can only say that to him coz of what I’ve learnt through in like treatment and things like that.
Adam: When I think about it like there’s 20 people and he said like write three good things about yourself and just get up and like my names Adam “blargh blargh blargh” the three things I wrote are “blargh, blargh, blargh” and then you’ll say the three from and just go like to meet different people right. I went, I’m loyal coz I’ve never been unfaithful in any relationship I’ve been in. I went honest and then when I think about it nearly all my life I’ve been dishonest. If me and you were selling drugs I wouldn’t be dishonest with you, the people I sell drugs with I’ve never had them over I’ve never had an extra bit or extra bit of money. I’ve been honest in that way but like burgling people’s houses and for and all that that’s dishonest and I think why did I write honest is that coz I wanted people to like me and all that. (Pause) And what’s the other thing I writ? Loyal, honest (pause) I can’t even think the third one. It was along them same lines like loyal, honest it wasn’t trustworthy it might have been reliable something like that. but the twenty years I’ve used for I haven’t been reliable to anyone apart from like myself I suppose…