

Drugs and Recovery: A Qualitative Study in Atlantic Canada

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Abstract

Drugs have posed to be an ongoing struggle for many individuals in Canada today. This qualitative study of 14 drugs users in a small city in Atlantic Canada exposes their drug-taking experiences. Using qualitative methods, this inquiry focuses on the addiction process and on treatment, recovery and relapse. The analysis elaborates on the hopeless and forlorn lives of the participants. Findings also reveal that long-term care is expensive, costly, and inaccessible to the typical addict. The report recommends that government-funded long-term care be made available to recovering addicts so that they can circumvent relapsing into drug use.

Key words: drug abuse, addiction, treatment, recovery, relapse, Atlantic Canada

Rationale

Drugs typically cause biochemical reactions in the body and drug addiction frequently is a continuing, compulsive, relapsing disorder that persists despite serious harmful outcomes (Cami & Ferre, 2003; Heyman, 2009;Marhe, Waters, Wetering, & Franken, 2013; Schwabe, Dickinson, & Wolf, 2011). These addictive elements stimulate enjoyable feelings or relieve angst and may soon turn into compulsive use. Sustained drug use could lead to tolerance, physical dependence, desensitization, craving, and relapse.

In the city where this study was done, the Drug Rehab Services (2013) relegates drug use to about .15% or 20, 000 people out of a population of about 137, 346.Indeed, this percentage represents a sizeable proportion of the city's population making illicit drug-taking behaviour a serious and grim one. Drugs most commonly used by the sample of participants in this study were marijuana, cocaine, narcotics and synthetic opiates, LSD and hallucinogens, and prescription drugs.

Questions that this study seeks to answer are: What does the addiction process involve? To what extent are the lives of addicts affected? Does treatment lead to recovery? What elicits relapse? In answering these questions, this inquiry looks at the poignant and distressed lives of the participants during the addiction process and their on-going struggle to and the treatment, recovery, and possible relapse.

Theoretical Framework

The *social environmental model*, the *gateway hypothesis*, the *conditioning/reinforcement model*, and the *trans-theoretical template of change* are pertinent to this inquiry. The *social/environmental model* emphasizes how distinct, and marked the impact of family dysfunction, and peer pressure can be on the development of addictions. Most addicts come from challenging families that are stressful, traumatic, and disturbed (Chassin, Patrick, Andrea, & Craig, 1996). Lack of parental support and control along with childhood distress are crucial reasons as to why adolescents turn to drugs.

The *gateway hypothesis* (Kandel, 2002) is attendant with three interrelated observations - first that there is a growth in the sequence of drug-use; second, that earlier use of drugs is largely associated with a later use; and third that drugs used earlier, such as alcohol or tobacco may be correlated with later marijuana, or other illicit drug-use (Karaszia, Crowther, & Galioto, 2013; Lessum, Hopfer, Baberstick, Timberlake, Ehringer, Smolen et al., 2006). These three observations are considered to be the relevant causal factors of progression toward the use of illicit drugs in the future.

Conditioning/reinforcement models focus on additive behaviors, such as tolerance, withdrawal, physiological responses and rewards ((Blume, 2004; De Wit, 1996; Carroll, 2000). Based on B. F. Skinner's conditioning approach, this hypothesis posits that reinforcement principles govern compulsive drug use.

When an addict uses drugs, he or she feels pleasure or a 'high,' and this positive stimulant sends an affirmative message to the brain. The user then wishes to experience the euphoric feelings repeatedly. However, as tolerance sets in, these blissful sensations diminish, and the addict finds that pleasurable rewards only surface sporadically. The *trans-theoretical template* of change (Prochaska & DiClemente, 1983) offers a cohesive context for understanding planned behaviour and intercedes change through five stages, namely, precontemplation, contemplation, preparation, action, and recovery. The first of the five stages is precontemplation, when users have no desire to change in any way. The second stage of contemplations causes the addict to begin to think about mending his or her behaviour. During this time, addicts usually consider the pros and cons of making the adjustment. The preparation stage is when the person is planning on commencing a behaviour change soon. In the action stage, addicts, generally, make conscious efforts to modify their behaviour. In the final stage, users progress to recovery striving to prevent relapse (Prochaska & Velicer, 1997).

Methodology

Data was obtained from 14 in-depth, qualitative interviews conducted from October 2012 to December 2012 in a city in Atlantic Canada.

The interview method

The interviews consisted of a clear sequence of questions that were semi-directed, open-ended, and in-depth. They reflected on recent behaviour and enabled the researchers to discuss the issue of drug use perceived by the subjects.

The interview protocol

After going through the ethical review process which emphasized the sensitivity of the data and the size of the sample, approvals were acquired from Addictions Centre and Horizon Health in the city. Clients who were on the Methadone Maintenance Treatment Program (MMTP) were then contacted. From those contacted, using the snowball technique, names of other prospective participants were collected. After explaining the nature of the research project to potential participants, interviews were conducted.

The interview sample

The sample of 14 participants, accessible during the interview period, was composed of 7 men (M1 – M7) and 7 women (F1 – F7), signifying a gender balance. The participants ranged in age from 23 years to 43 years. At the time of the interviews, 1 participant (n=1) was currently residing in a residential treatment program, and 13 (n=13) were living on their own in the community and on their journey to recovery. Ten (n=10) held high school diplomas while 4 (n=4) were community college/university-educated. Out of the 14 (n=14) participants, 6 (n=6) were unemployed, 4 (n=4) were employed, 2 (n=2) were on disability assistance, 1 (n=1) was self-employed, and 1 (n=1) was a student. The majority of the participants (n=13) were Caucasian, while 1(n=1) participant was African Canadian.

The interview process

All interviews were conducted at either the agency (Harvest House or Addiction Services), or in the place that was most comfortable for the participant (parkor quiet restaurant). Topical questions were asked in specific areas of interest. During the interview process, discussion was encouraged so that participants could elaborate on their childhood experiences, substance use, their daily activities before and after recovery, treatment, and recovery processes.

The first section of the interview consisted of biographic data such as age, marital status, number of children, place of employment, and level of education. This was followed by a group of specific questions on drug use during the life of the participants. The second group of questions targeted the interviewees' experiences throughout their addictions. The third set of questions dealt with participants' desire and motivation to recover and seek treatment and how intervention changed their lives. This section also included questions as to whether the respondent had relapsed or was on the road to recovery. Interview data were initially coded based on key themes that emerged such as a) the drug-taking experience, b) treatment c) recovery and d) relapse and on-going struggle.

The interviews lasted for approximately two hours in length and were tape recorded, transcribed verbatim, and checked for accuracy. Questions were worded in a simple manner and elaborated as the occasion arose. Many a time sub-questions were asked around the main question to draw out the necessary information.

With the ethical review in place, all participants were provided a consent form which they read with the interviewer. They were then asked if they fully understood what it meant and if they were comfortable going ahead with the interview. All participants signed the consent form willingly and there were no drop outs during the interview process. All respondents were reassured that the information they provided would be kept confidential.

Method of analysis

Using the grounded theory approach (Glaser & Strauss, 1967) consistent themes were drawn from interview data. Transcribed interviews were coded, and variables were marked on the basis of age, gender, and occupation. Quotes that were forceful, persuasive, and convincing were highlighted and marked off for referencing. Lucid themes that emerged were on participants' background, the onset of addiction, the addiction process, and treatment/recovery/relapse. Data analysis was conducted at two levels. First, analyzing the personal accounts of the participants – *what* was said, *how* it was said, and *why* it was said. Second, by applying psychological constructs and concepts to the personal accounts – to analyze *why* drug users endured those experiences in light of relevant studies, theories, assumptions, and premises.

Findings

The findings focused on

- a) The addiction process
- b) The path to treatment
- c) Recovery and
- d) Relapse and on-going struggle

a) The addiction process

All participants (n=14) went through the gruelling addiction process. Most did not experiment with their first drug thinking they were going to become users. The process usually began through simple association with other addicts to harmlessly trying out a particular drug because it made them enjoyable and pleasant. Some participants stated the following:

I remember the exact day I started using heroin. My friend picked me up and brought me something that I thought was cocaine. Once I smoked it and was told it was heroin, I fell in love with it instantly. I really did not think it would get to me, I thought I would just do it and it would not bother me. (M-7)

Coke, it made me feel good. But when it becomes a point that you have to do it is not fun anymore. It was never good enough...I was always looking for my next pill whether I liked it or not (F-5).

Drugs made me feel good. I was like superwoman. I would clean the house from top to bottom...Eventually, I was not happy anymore. I was miserable and cranky all the time even when I was high. I was a mess. (F-7)

The instant liking and positive association with heroin has been documented (Steinmiller & Greenwald, 2007), with an indication that over the past decade there has been an alarming increase in the use of heroin in North America. As with other drugs, the initial reaction to first-time users is one of euphoria, exhilaration, and elation. After a while the drug becomes a need or a want. The individual then become desensitized to that particular drug and it becomes a craving, leading to addiction. The process of addiction could lead to a growing detachment between craving and pleasure (Berridge & Robinson, 1995).

Participants in this study went through distress and torment during the addiction process. Drug-use to them was an automatic, mechanical type of behaviour explained in the following way:

I would wake up...if I even slept at all the night before. I would get high or look for a way to get high. I would go all day....hustle. I sold a lot of drugs and ran a couple of shacks...my life was nonstop. I was completely lost. (M-2)

It was the same thing every day. Sometimes I would spend my day looking for a fix. I would not get a fix until 10-11 at night and then I would be up until early morning until I crashed. (F-2)

A propensity for impulsivity and automaticity (non-intentional) has been reiterated in various studies related to drug-taking behaviour (Hogarth, 2011; Robinson & Berridge, 2003; Tiffany, 1990). These two tendencies are tied in with enhancing drug-dependence and are comorbid with drug-use. Impulsivity is an essential factor in the initiation and continuation of drug use (Reed et al., 2012).

Alongside, automatic processes that are generally unintentional, involving less control are similarly associated with compulsive substance use behaviour (Farris, & Ostafin, 2008). Describing their disheartened, and gloomy lives, during addiction, some respondents stated:

Drugs consumed my life. I was a prostitute; I would sell drugs to get drugs. (F-2)

There was no structure in my life. There was no light in sight. My life was a mess. Living for the high was the only thing I had to look forward to. (F-6)

My days consisting from stealing, selling drugs, robbing people; my girlfriend at the time would sell herself/walk the streets. (M-3)

I stole almost everything from my mom. I would break in at night and sleep in the basement so I did not have to sleep on the streets. (M-1)

Prostitution has been associated with drug-use (Baker, Case & Policicchio, 2003; Dalla, 2000; Murphy, 2010). Addicts are usually desperate to acquire resources such as food, clothing, and shelter to sustain them and hence sink to a dismal lifestyle. Stealing and thievery are resorted to not necessarily for monetary reward but rather for symptomatic relief (Grant, Brian, Odlaug, & Kim, 2010). Most wandered around looking for their next fix to offset their cravings and feelings of withdrawal. In the process of experiencing high levels of psychological distress, these users placed themselves at an augmented risk of acquiring sexually transmitted diseases including HIV (El-Bassel, Simoni, Cooper, & Schilling, 2001), while others broke the law and ended up in prison.

Drug addicts essentially go through vicious cycle of, worthlessness, low self-esteem, shame, and negative stigmatization. Some of the participants in this study had this to say:

When I was high smoking crack, I felt like I was nobody. I was worthless and I hated myself. (M-5)

I had no self-esteem, I hated my life but I felt like I could do nothing about it. I was not good enough for anyone. No one wanted me to be around anymore, no one trusted me anymore. (M-3)

I just wanted to disappear and not think about my life or anything that [was] going on in it. (F-1)

I was feeling ashamed of myself. I felt like a low life...everyone looked down on me. (F-6)

Low self-esteem, and social stigma are widely associated with substance abuse in the general population (Gibbs, Rae Olmsted, Brown, & Clinton-Sherrod, 2011). Researchers have found a correlation between low self-esteem, depression, and injurious behaviours (Maccio & Schuler, 2012). Due to the low quality of life they experience, addicts find it problematic, and awkward to socialize as they are judged, labeled, and looked down upon. Low self-efficacy, social stigma, and minimal self-esteem dissuade users to seek the available services and implicate themselves with criminal behaviour (Lavack, 2007).

b) The path to treatment

In this study, all participants (n=14) were either undergoing treatment or had recovered from the drug-abuse experience. Some had relapsed after having recovered and were again in recovery. Admitting that one is an addict is not easy and a frustrating place to be in. Some of the narratives were:

I knew all along I needed help; I was just not ready to take that step. It terrified me to admit I had a problem. (F-6)

I was really lost. I could not find my bearings, I was delirious. I called my dad. I knew I needed help but how could I admit I was lost? (F-4)

A lot of times I knew I needed help but did not act on it. I knew I had to get help or I was going to die. (M-7)

I knew I had a problem but I was not ready yet. I had every excuse out there. A few months later I knew, something was telling me I had to do something but I was scared. (M-6)

These participants understood that they needed psychological help but had to be willing to seek it (Hess & Tracey, 2013; Lowinger, 2012). A crucial step in getting into a treatment program is to enhance the motivation to willingly perform a particular behaviour (Webb & Sheerhan, 2006). Behaviour is cognitively motivated and determined by intentions, goals and self-efficacy expectations along with outcome expectations (Bandura, 1998). One way to change cognitive thought is to provide information about the effectiveness of the intervention programs. Psychodynamic family therapy is an example of early systemic intervention. This includes diverse brief therapies that are behavioural, marital, and solution-focused.

Finding the most suitable treatment program is demanding, taxing, and exacting. In this study, most participants who were on opioids, utilized the Methadone Maintenance Program. Some had this to say:

I went to detox like 5 times...but then the last time I went like three years ago now I got on the methadone program. (M-7)

I got on the Methadone Program. (M-3)

I am on the [methadone] program for past 6 years. (F-5)

Really go to groups at the Methadone Clinic. I have support through the Methadone Program. (F-2)

When certain intervention programs did not work, some turned to the Methadone Maintenance program. Methadone is a prescription drug used to safely treat opioid addiction (MMT Guidelines, 2005). It is a harm reduction strategy to offset the spread of HIV and other blood-borne diseases. An effective form of treatment, it reduces criminal activity and enhances social productivity. The three stages of treatment are stabilization, transition, and the community phase. In the stabilization stage, individuals grapple with the notion that they have to refrain from all drugs. Counselling mostly addresses this issue as a standard part of the treatment process. In the transition phase of treatment, individuals learn to deal with acute withdrawal symptoms. The community stage entails developing short-term stability, establishing lifestyle balance, resolving injuries, and managing change. Even though the Methadone Maintenance Program is fairly effective for specific cases, the negative implications are that entrees into the program are simply switching one drug with another, and that participants are finding a harmless and inexpensive way to get high.

c) Recovery

Several participants in this study were in various stages of the recovery process. Others progressed to recovery:

I just kept telling myself I do not want to look like that and I want a better life for myself and my son. I am off the program now. I feel great. I was nervous at first but I know I can do it. There are counsellors at the clinic if you need to talk to someone (F-2)

I am clean now. I did my GED. I saw a psychologist and got some counselling. I did a couple of construction courses. This is the best my life has ever been. (M-2)

Right now I am clean and right now my life is the best it has been a long time. I cope OK during my recovery. I pray to God or talk with my counsellor to help me in the right direction. I try to cope with my stress by being around positive people as much as I can. (M-4)

Everything is really good. I could not ask for a better life. The staff at the clinic are awesome and a huge support for us. I play with the baby and talk with family about issues (F-5)

Recovery is a comprehensive process that encourages operative coping mechanisms with the decisive purpose of increasing resiliency (Harris, Smock, & Wilkes, 2011; Landua, 2007; Laudet, 2007; Marlatt & Gordon, 1985). This advancement in behaviour change means much more than mere abstinence; it also includes upholding sobriety. Multi-family group therapy sessions are utilized, strengthening the entire family rather than just the individual. Both families and individuals are taught to cope with psychological, emotional, and physical pain so that they can prevent relapse. Recovery is therefore a lifelong process, sometimes, independent of the counsel, and guidance of psychoanalysts.

d) Relapse and on-going struggle

Some of the participants made the following comments about their relapse and the tremendous effort it demanded.

I relapsed so many times throughout the years. I would get clean for a year and then go off, get clean for 6 months and then go off. Same pattern all the time. It is hard. I have been using hard drugs since my early twenties...I do not know anything else. The only time I feel accepted is when I am high. (M - 4)

[Relapse is] ongoing. [There is] always stress. I would use a day or two and I would take my medicine and then be just on my medicine for a few weeks or a month and then I may slip again. It is ongoing. (F-1)

You know getting clean in one thing...staying clean is another. This is when the real work begins. I would miss my family or think about how my life has turned out. I would use, take a pill to go to sleep or just to forget things. When I was out, I would be drinking and partying and I would get offered a line. (M-6)

Since being released from jail, I relapsed a few times. I was using and still dancing. I was smoking weed. More recreational now. I would do lines and do one line of coke. I have smoked the odd joint since. I have the few recreational drinks. It was more party mode. I felt guilty, ashamed and worthless, like a low life (F-3)

It is evident that recovery is still an on-going struggle and relapse more of a reality for some. The hope is that these recovering users will ultimately overcome their addiction. Based on the cognitive behavioural approach, the process model of addiction and recovery distinguishes between relapse prevention and relapse resiliency (Marlatt & Gordon, 1985). Relapse prevention occurs when addicts are still in the treatment stage whereas relapse resiliency correlates with recovery. This model of addiction has been successfully applied to not only drug abuse but to other types of addictive behaviours such as gambling, cutting, and eating disorders. In general, the model of coping works toward raising self-esteem, and self-efficacy and alleviates addicts' trauma and adversities. Recovery is a systematic and organized process that promotes operative coping mechanisms with the decisive objective to advance resiliency (Harris et al., 2011).

Implications and Conclusion

Even though most participants benefitted somewhat from the Methadone Program and were on the road to recovery, the possibility of relapse was always there. It is important to emphasize that abstinence is one of the best ways to keep off drugs (Defulio & Silverman, 2011; Tuten, Defulio, Jones, & Maxine, 2012). For struggling addicts, **long-term care** is imperative but is sorely lacking in the vicinity. There are a few government-funded long-term programs which are insufficient; and addicts require these therapeutic settings on an on-going basis to keep them off drugs indefinitely. The province therefore needs to offer *continuum* of service for substance users (The common sense for drug policy, 2013).

Some of the limitations of the study are related to the sample size (n=14) and methodology. Most of the participants were Caucasian which restricted the analysis to one ethnic group. There are restraints that emerge while using personal accounts, oral histories or life stories, and in-depth interviews. However, it was felt that the information collected from the 14 participants was sufficient to conduct a rigorous analysis leading to valid conclusions.

In sum, the use of illegal and prescription drugs is not only a health issue but a community matter of deep concern impacting all aspects of life. A holistic approach that takes into consideration the entire set of causes, namely, biological, physiological, social, and psychological is crucial in restraining, curtailing, and if possible, eradicating the drug problem.

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