

FACTORS THAT CONTRIBUTE TO SUCCESSFUL LONG TERM  
ALCOHOL AND DRUG RECOVERY

A Project

Presented to the faculty of the Division of Social Work  
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MASTER OF SOCIAL WORK

by

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Division of Social Work

Abstract  
of  
FACTORS THAT CONTRIBUTE TO SUCCESSFUL LONG TERM  
ALCOHOL AND DRUG RECOVERY

by  
Shannon Edmiston  
Stephanie Robinson

For many clients addicted to alcohol and/or drugs, it can be difficult to obtain and maintain sobriety. The purpose of this study was to explore the factors that contributed to successful long term sobriety from alcohol/drugs. This qualitative content analysis research study investigated factors that contributed to successful long term sobriety from drugs/alcohol of two men and seven women by use of convenient non-probability sampling. The top three themes found in the study were: spirituality and having a purpose as factors that contribute to long term success, relapse acts as a motivator to sobriety, and gaining control over addiction by practicing the commitment to change. Those participants that stated they had been clean from alcohol/drugs for five years or more were considered to have experienced successful long term sobriety from alcohol and drugs. Implications for social work practice and policy are discussed.

\_\_\_\_\_, Committee Chair  
Maria Dinis, Ph.D., M.S.W.

\_\_\_\_\_  
Date

## DEDICATION

We dedicate this research project to everyone who has ever suffered from alcohol and other drug addictions; to their family and friends who have felt helpless at times, who have given their support, their love and encouragement. This is dedicated to the providers, counselors, social workers, scientists, doctors and researchers who spend endless hours finding solutions, treating, and defeating addiction.

## ACKNOWLEDGEMENTS

I am forever grateful to God for giving me the strength and courage to survive a life of drug addiction, and turn it into a life filled with Joy. Thank you to my mom and dad who believed in me, even when I did not believe in myself. Their encouragement, patience, and knowledge have kept me on the right track and given me the tools I need to succeed. To my son Tyler, I want you to be inspired and know that you can do anything that you set your heart to. Thank you to my brother Scott, Amy, Brooke and Pierce for being very supportive throughout this journey. To Zaria and Sawan, your friendships are a source of motivation, and I appreciate you in my life.

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Thank you to Gary Weston and Peggy Chapman whose kind actions helped me start down the path into my professional MSW career. – **Shannon Edmiston**

I would like to thank Shannon, my amazing thesis partner; it was a privilege and an equal pleasure to embark on this project with her. I would like to express my sincere appreciation to my husband, Michael, and sons Bryan and Michael II, for their never-ending love, encouragement, and tireless support of my dream to pursue a higher education. - **Stephanie Robinson**

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## TABLE OF CONTENTS

	Page
Dedication.....	vi
Acknowledgements.....	vii
Chapter	
1. INTRODUCTION.....	1
Background of the Problem.....	3
Statement of the Research Problem.....	6
Purpose of the Study.....	6
Research Question.....	7
Theoretical Framework.....	7
Definition of Terms.....	11
Assumptions.....	12
Justification.....	13
Delimitations.....	15
Summary.....	15
2. LITERATURE REVIEW.....	17
Historical Background.....	17
Addiction .....	20
Relapse.....	29



Recovery.....	31
Gaps in the Literature.....	42
Summary.....	43
3. METHODOLOGY.....	44
Research Question.....	44
Research Design.....	44
Study Population.....	48
Sample Population.....	49
Instrumentation.....	49
Data Gathering Procedures.....	53
Data Analysis.....	54
Protection of Human Subjects.....	55
Summary.....	55
4. DATA ANALYSIS.....	57
Demographics of Study Participants.....	58
Contributors to Long-Term Sobriety from Alcohol and Drugs.....	58
Spirituality/ A Personal Relationship with God.....	60
Importance of Goals and Purpose.....	64
Effects of Relapse on Sobriety.....	66
Gaining Control Over Addiction.....	71
Summary.....	75

5. CONCLUSIONS AND RECOMMENDATIONS.....	76
Conclusions.....	76
Recommendations.....	79
Limitations.....	81
Implications for Social Work Practice and Policy.....	81
Conclusion.....	83
Appendix A. Interview Questions.....	85
Appendix B. Consent to Participate in Research.....	86
References.....	88

## **Chapter 1**

### **INTRODUCTION**

The researchers are interested in this topic due to their involvement working with adults having experienced drug and alcohol abuse and its related trials. It has been the experience of the researchers that adults suffering from drug and alcohol abuse have been studied and treated in a number of ways. From CAT scans to MRIs with the development of new technologies and evolving brain scanning techniques, scientists have made incredible strides in researching the area of addiction. Researchers have been successful in identifying the reasons associated with drug addiction as being a combination of the three factors of environment, use of psychoactive drugs, and heredity; and are beginning to focus on the genetic variations that contribute to the development and progression of the disease (Inaba & Cohen, 2000). Individuals who have not recovered from drug and alcohol abuse often experience deficits in their lives which include estrangement from family, unstable employment, and loss of social freedom due to incarceration. Physical and mental effects of chronic alcohol and drug abuse include, but are not limited to, homelessness, poverty, illness, and hunger experienced not only from those suffering from their addictions, but by family members that have been directly affected by the actions of the substance abuser (Inaba & Cohen).

The addition of community sponsored treatment programs geared toward assisting members of the population suffering in this area may ultimately decrease the stigma presently attached to substance abusers, and may therefore lead to increased participation in treatment programs of this type. Those with a history of substance abuse

who experience successful treatment may realize an increase in social functioning by way of reducing homelessness unemployment, fractured homes, and the need for increased funding required combating the difficulties that arise from substance abuse. In addition, by lessening the criminality that typically accompanies substance abuse, costs in the law enforcement arena as in the areas of incarceration, law enforcement, and personal security would ultimately decrease the financial burden that now lies on Federal, State, and local Governments, saving the nation billions of dollars each year (ONDCP, 2001).

In terms of social work practice, findings from this research could be the firm foundation that supports the way funding for governmental services and other sources are developed enabling social work programs to support their clients in a manner that is consistent with their needs. Research in this area can ultimately lead to the overall decrease of addiction and increase a client's positive contribution to their community, society, family, and their employer. The research for this study will focus on factors that contribute to successful long term recovery from drug and alcohol abuse and factors that contribute to relapse, and their relationship to individuals participating in regular physical exercise, embracing a religious/or spiritual foundation, upholding a healthy diet, and maintaining positive family/social relationships. This chapter will provide further insight into the population of individuals in long term recovery by reiterating the research questions associated with this project. There will be an examination of the overall purpose of the study and a review of the theoretical frameworks informing the research. In addition, this chapter will provide a section in which common terms used in the research are defined, and a section in which the assumptions and justifications of the

research are stated. Moreover, this chapter will discuss the limitations of the research, and will provide summaries of the first chapter and the subsequent chapters. The following section includes statistical data set forth to provide insight into the intricacies and complexities enmeshed within the specter of alcohol and drug addiction.

### **Background of the Problem**

Alcohol and drug addiction is affecting a growing number of Americans of all ages. A 2014 report from the Substance Abuse and Mental Health Services Administration estimated that 17.0 million Americans aged 12 or over were classified with alcohol use disorder, and 7.1 million Americans in that same age range, reported illicit drug use disorder, with 2.6 million Americans reporting both alcohol use and illicit drug use disorders. Additionally, in 2014, an estimated 27.0 million Americans, one in 10 people (10.2%), reported to have used an illicit drug in the past 30 days, with 139.7 million Americans of the same age group reporting past month alcohol use (SAMHSA, 2014). Of these numbers, approximately 23.5 million people aged 12 or older required treatment for an alcohol abuse problem or in the area of illicit drug use causing the cost to American society to reach an estimated \$184.6 billion per year (Gustafson, Shaw, Isham, Baker, Boyle, & Levy, 2011). Moreover, 51% or half of America's high school seniors report some form of illicit drug use during their lifetime, with marijuana being the most widely used illicit drug and the one mostly contributing to numbers supporting drug use increase (Johnson, O'Malley, Bachman, & Schulenburg, 2004). According to the National Institute on Drug Abuse (2014), in 2011 more adolescents aged 12-17 (65 %) received treatment for the use of marijuana than that of alcohol (42.9%). The presence of

substance abuse in the adolescent years can affect the normal developmental processes associated with maturing brain function, lead to long term negative effects for the young person in the areas of education and social development, and set the stage for some adolescents to continue to use drugs into adulthood and throughout their lifetime.

Addiction and substance abuse are disorders that are highly prevalent throughout the United States. Addiction is defined as a recurring, relapsing brain disorder that is symbolized by obsessive drug seeking and use, despite evidence and awareness of destructive circumstances (National Institute on Drug Abuse, 2014). Addiction is a primary, progressive, chronic disease with predisposing features similar to that of other chronic illnesses, such as asthma, diabetes, and cardiovascular disease, as well as the genetic component of heredity. The duration of the condition of addiction is greatly influenced by a variety of factors including tolerance, behavior, environment, and the conditions associated with an individual's reaction to proper treatment modalities, as well as the ability to for the individual to self-manage a supportive lifestyle (McLellan, Lewis, O'Brien, & Kleber, 2000). The treatment of addiction has similarities associated with the treatment of other chronic diseases. The individual receiving treatment for addiction requires regularly scheduled observations of their treatment progress, early interventions to detect difficulties, and appropriate interventions to promote and ensure positive results from planned treatment (McLellan, 2002).

Substance use disorder as defined by the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) is categorized as mild, moderate, or severe to indicate the level of problem severity, a determination that is made according to the number of

criteria diagnostically met by the involved individual. Substance use disorder occurs when the persistent use of alcohol and/or drugs leads to significant social distress or functional impairment promoting disability, health problems, and difficulties meeting major role obligations at school, work, or home (Seligman & Reichenberg, 2012).

According to the DSM- 5, a diagnosis of substance use disorder is found when there is evidence of social impairment, diminished control, precarious use, and pharmacological criteria (SAMHSA, 2014).

Along with the negative affects substance abuse and addiction have on the individual, their family and friends, community, various businesses, society, and government resources, there are also the long term affects that occur which include liver disease, unintentional injury and death (CDC, 2014). For example, in 2013, excessive alcohol use was responsible for approximately 88,000 deaths among working ages adults between the ages of 20 - 64 years. Over half of those deaths were as a result from excessive alcohol use in the form of binge drinking which consists of on an occasion 5 or more drinks for men and on an occasion 4 or more drinks for women (CDC). Successful long term recovery from alcohol and drug use will produce positive results for the individual, their families, and for society as a whole. Research has shown that individuals that are able to sustain recovery from alcohol and drug use decrease their affinity for criminal behavior, and improve their biological, psychological, social and occupational functioning (NIDA, 2011).

### **Statement of the Research Problem**

People who are struggling with substance abuse and addiction often have difficulty maintaining their sobriety and successfully refraining from alcohol and drugs. It would be useful to determine what factors contribute to support individuals in long term recovery from alcohol and drugs in order to allow them to maintain a sober lifestyle. While there is some research that examines certain barriers to treatment for people suffering with substance abuse and addiction, and why people may have difficulty with successful treatment to stop drinking or using drugs, there is little research that focuses mainly on identifying the factors in the lives of those individuals that contribute to and are related to successful sobriety from alcohol and drugs. This study will attempt to bring more awareness into the relevant factors that exist and serve to increase a person's rate of success in sustaining long term recovery from the use of alcohol and drugs.

### **Purpose of the Study**

The purpose of this study is to determine the factors that contribute to successful long term alcohol and drug recovery, and the factors that contribute to relapse. The secondary purpose of this study is to further the amount of research that exists on this topic. There is currently a minimal amount of research on the factors that contribute to long term success from alcohol and drug abuse and the relationship that exercise and diet play therein. The results of this study may serve to inform the micro, mezzo and macro levels of practice in social work



### **Research Question**

This study will investigate the following research questions: What are the key factors that contribute to successful long term recovery from drug and alcohol addiction? What factors contribute to relapse?

### **Theoretical Framework**

This study will utilize the social learning theory and the addictive disease theory. The research will explain the social learning theory and the addictive disease theory followed by a discussion of how these theories can be applied to this research.

#### **Social Learning Theory**

One theoretical framework that will guide this research is social learning theory. Social learning theory states individuals learn or acquire their behaviors from within the context of their social environment. Individuals learn both conforming and deviant behaviors based on reinforcement of both conforming and deviant behaviors (Alexander, 2010). This theory suggests that individuals learn by way of observing those around them operating within the context of social environments promoting acts related to nurturance and kindness, as well as in environments that inversely promote socially unacceptable and deviant behaviors. In relation to this theory, Zastrow & Kirst-Ashman (2004) maintain that much of human behavior is learned through one's life experiences and events, and this learning occurs throughout the course of a person's entire life. They further emphasize that the social learning theory provides a framework that takes into account the total person as they function within the dynamics of their environment. It emphasizes the importance of recognizing that events that occur in the lives of

individuals, shape behaviors across cultures and life circumstances, and factor into both normative and dysfunctional actions, thoughts, and feelings (Thyer & Myers, 1997).

Social learning theory provides a positive approach that supports the notion that while an individual's behaviors develop through learning them from others, undesirable behaviors can also be unlearned as well. Many people who engage in drinking alcohol or using drugs do so through the process of observing others. An individual need only to observe another engaging in and performing the behavior associated with alcohol and/or drug use in order to adapt that behavior (Zastrow & Kirst-Ashman, 2004).

A person may see their family and friends drinking alcohol or using drugs, so in turn they start to drink or use drugs simply by virtue of watching the behavior occur in their presence. People learn much of their behavior from observing the behavior of those with whom they tend to mingle with on a social level, and they modify their behavior accordingly (Horejsi & Sheafor, 2006). Family viewpoints and social acceptance toward the use of alcohol and/or drugs tend to reinforce for members their level of participation in addictive behaviors (Shen, Locke-Wellman, & Hill, 2001). When behaviors surrounding and promoting alcohol and drug use remain in a culturally sanctioned social climate, such as in the case of career functions, recreational activities, or family norms, the consequential effects of these behaviors is often seen as acceptable, contained, justified, or otherwise controlled (Inaba & Cohen, 2000). For one to have a successful treatment outcome, a change in this pattern of behavior is essential. The person in treatment must learn to develop positive behaviors that promote their well-being in order

to empower themselves in their quest to achieve successful long term sobriety from alcohol and drugs.

### **Application of Social Learning theory**

Utilizing social learning perspectives in this study will allow for an exploration into the relationship of the study participants and their personal environments. Empirical evidence dictates that it is possible for individuals to learn drug and alcohol use through observations and social contact (Hayaki, Herman, Hagerty, de Dios, Anderson, & Stein, 2011). If individuals learn substance use from peers and other influences from their social environment, these same individuals can unlearn these negative behaviors and replace them with positive behaviors. The individuals that are seeking recovery from alcohol and drugs, they must make the conscious choice to refrain from drinking and/or drug use. They must then involve themselves with people and engage in behaviors within situations that do not include the use of alcohol and drugs. Using social learning theory as a guide, people that can observe and learn from the healthy alternatives chosen by others seeking to promote recovery from alcohol and drug use can learn for themselves by what means they can live without relying on the use of mind-altering unhealthy substances. Just as the individuals modeled their drinking and drug use by observing individuals in the media, peers and family members, they can also learn to maintain sobriety by modeling others who are making healthy life choices. By promoting healthy living through the use of exercise and nutrition they can change from the destructive pattern of drinking and using drugs, and practice behaviors that promote and support successful recovery from alcohol and drugs.

### **Addictive Disease Theory**

The addictive disease theory, sometimes called the medical model, states that addiction is a chronic and progressive disease of the brain. It is a condition that is characterized by altered brain structures and functioning that is realized with the introduction of certain drugs that are abused. This theory promotes the concept that the condition of addiction is achieved when an agent or drug is introduced to a susceptible host or user in an environment that is open to drug misuse (Inaba & Cohen, 2000).

Operating under this theory is the assumption that addiction is characterized by intoxication or uses that is present throughout a given day, with the person involved in the drug use experiencing a strong desire to continue to use. There is a loss of control seen on the part of the person using the drug that creates an inability to lesson or stop the use altogether. Drug abuse is continued despite serious negative consequences inflicted in the biopsychosocial domains of the person involved in the drug use (Seligmen & Reichenberg, 2012).

### **Application of the Addictive Disease Theory**

By applying the disease theory to this study, the researchers will be able to explore the action of drug use on the brain. All drugs of abuse have common effects and do damage to the reward pathways that exist deep within the brain. Damage to these pathways is what appears to keep drug seekers in the state of addiction. Long term use of drugs changes the brain at a level that prevents the brain from having the ability to return to its original state after the drug use has ended, confirming the notion that the addicted brain is a unique entity and is structurally dissimilar to the non-addicted brain (Lesnher,

1997). Correcting the brain imbalance would assist in the recovery of the addicted individual. Healthy diet complete with foods that replenish important vitamins and minerals may be one way to start the damaged, addicted brain on the road to recovery. Previous research has shown the benefits of exercise on brain neurotransmitters of persons suffering from depression. This research may offer insight to practitioners of alcohol and drug rehabilitation facilities into the benefits of tailoring their recovery operations to meet the needs of their clients in a nutritionally holistic fashion. In turn, this may assist addicted individuals to address relapse. By bringing awareness to the factors that contribute to long term recovery from alcohol and drug use, and the factors that contribute to relapse, the researchers may aid in affecting an increase in the positive social functioning of the involved individual.

### **Definition of Terms**

The following terms are used throughout this project and are relevant to substance abuse, addiction, and substance abuse treatment.

**Addiction:** This is a psychological and physiological dependence on a certain substance that results in withdrawal symptoms and increased tolerance when the chemical is unavailable (Barker, 1996). Moreover, addiction involves the process that may be pleasurable in the beginning and subsequently becomes destructive to the user and others (Inaba & Cohen, 2000).

**Drinking:** This refers to consuming beverages that contain alcohol (Callaghan, Taylor, & Cunningham, 2007).

**Factor:** This refers to an element that actively contributes to an accomplishment, result, or process (Webster's, 1999).

**Long-Term:** A term of 5 years or more used for the purpose of this study (Webster's, 1999).

**Relapse:** The recurrence of using or drinking after the behavior had been removed by intervention or in the course of therapy (Barker, 1996).

**Recovery:** This involves the process of individual change that sees a disorder as less important in one's life as the person makes the effort to achieve positive social functioning, satisfaction and well-being in their lives (Levine, 2002).

**Rock Bottom:** A term used to describe the experience of an individual reaching an undeniable level of consequences associated with their alcohol and/or drug use before they are able to terminate the usage (Hiller, Narevic, Webster, Rosen, Stanton, Leukefeld, & Kayo, 2009).

**Using:** This refers to the habitual use of drugs and/or alcohol (Webster's, 1999).

### **Assumptions**

There are numerous assumptions related to those individuals that find themselves addicted to alcohol and drugs. These assumptions include: 1) Everyone is susceptible to alcohol and drug addiction; 2) Individuals involved in addiction are genetically predisposed to addictive behavior; 3) Addiction and substance abuse are chronic conditions that are widespread within the United States; 4) Alcohol and drug addiction are conditions that are curable; 5) Individuals involved in alcohol and drug addiction

want to be free of their addiction; and 6) The participants are individuals in the Sacramento County, CA area who voluntarily participated in the study.

### **Justification**

Drug and alcohol addiction is a condition that shows no racial, sexist, or religious bias, and is one that affects individuals across all walks of life. According to a 2009 report from the Office of National Drug Control Policy (ONDCP), the price of addiction to society results in billions of dollars annually proffered from consumers and the government in the form of increased taxes to fund detention centers, prisons and jails, salaries of law enforcement officers, increased insurance costs, and enhanced prices in goods and other services. In addition, the high cost extends from that of the monetary to the even greater related cost associated to the loss of human life (ONDCP).

Many individuals in society utilizing social services are those people that are suffering with substance use and addiction. The resources used by these individuals could be made available to individuals and families; those that are in need that are not addicted to drugs and alcohol. If more people suffering with addiction were in treatment related to addressing the addiction, they would have less of a need for general social service assistance programs, therefore allowing the distribution of resources and services to be directed to those in need, whose lives have not touched by addiction (Rice, 1999).

The goal of this research is to clearly identify the factors that contribute to long term recovery from alcohol/drug use and the factors that contribute to relapse, therefore affecting a positive increase in the functioning of the individual, family, community, and society. The objective resulting from this research is to illuminate the benefits of

increased social support, healthy diet, and regular exercise as a complement to treatment, and gain the support from Federal and local governments to encourage participation and to fund programs that are modeled after the findings of this study. Increased funding would provide the social work professional with valuable resources to assist clients who are actively engaged in addiction, as for these clients it is much more difficult to maintain stable relationships, housing employment, and successful management of mental health symptoms.

Although working with clients that are suffering from addiction may present a challenge to the helping professional, social workers have a commitment to serve these clients in need as set forth by the guidelines of the National Association of Social Workers' (NASW) Code of Ethics. The primary mission of the social work profession is to enhance the well-being of members of the population and to help individuals meet their basic needs, with particular attention placed on the needs of people who are vulnerable, oppressed, and impoverished (Reamer, 2009). The ethical principles that guide the social work profession include empowering clients through the core values of: (1) Service. Social workers primary goal is to address social problems, and help those in need; (2) Social Justice. Social workers challenge oppression and discrimination; (3) Dignity and Worth of the Person. Social workers respect inherent individuality and cultural diversity of others; (4) Importance of Human Relationships. Social workers recognize that human relationships serve to maintain, promote, and enhance the well-being of persons, families, groups, and communities; (5) Integrity. Social workers are trustworthy professionals; (6) Competence. Social workers develop and enhance their



professional skills, and practice within their level of expertise (NASW, 2016). Providing interventions and services for individuals in recovery from alcohol/drug use, using the Social Work Code of Ethics as a guide, will promote the empowerment of the individual, and serve to enhance the relationships between the individuals, and their families and communities.

### **Delimitations**

This research project does not include quantitative data to further explore possible factors or meaning related to additional activities or other support received by the individuals that volunteered to participate in the study. The information retrieved by the researchers is limited to that of individuals residing in the greater Sacramento, CA area who volunteered to participate in the study. The survey instrument used was created by the researchers, and further testing would be needed to increase the validity and reliability of the survey instrument. Information related to age of participant or if the presence of additional social support was obtained by some individuals compared to that of others was not factored into the study. The researchers cannot guarantee the accuracy of the answers that were self-reported by the study participants.

### **Summary**

Chapter 1 included the introduction, the background of the problem, the statement of the problem, the purpose of the research, and the related theoretical framework. In addition, Chapter 1 contained operational and conceptual definitions of terms, and a section that described the limitations of the project. Chapter 2 is a review of relevant literature with sections covering the historical background, process of addiction,

addiction and the brain, addiction and relapse, different models of recovery, and gaps in the literature. Chapter 3 is a description of the methodology. In Chapter 4, the data retrieved for this study is examined and analyzed. In Chapter 5, the summary of the findings is presented as well as recommendations and implications for social work practice.

## **Chapter 2**

### **LITERATURE REVIEW**

The literature review will be organized into the following four main sections: historical background, addiction, relapse, and recovery. Each section is further divided into sub-sections. The historical background is broken down into early pharmacological uses of drugs and alcohol by humans, and relevant laws passed that limited the use of drugs and alcohol in order to prevent people suffering from addiction and related health concerns. The second section discusses what addiction is, the process of diagnosing addiction, and the brain and addiction. The third main section discusses what is relapse and relapse prevention. The fourth section addresses recovery, and the different models for recovery. This literature review ends with a section discussing the gaps identified in the literature. These specific themes were chosen in relation to the research questions. The following is a brief historical background about the origins of drug and alcohol use.

#### **Historical Background**

There are about 60 commonly used plants that produce psychoactive substances. The earth produces over 4,000 plants that to some degree are psychoactive, and have been around for millions of years. These include coca leaves, tobacco leaves, tea leaves, opium poppies, peyote, marijuana, various fruits and grains that are fermented and distilled to make alcohol (Ratsch, 2005). Substance use and abuse has been around as long as people have walked the earth. Some evidence suggests that Neanderthals were using stimulant plants such as ephedra at least 50,000 years ago; and as early as 12,000 years ago, at the start of the Neolithic period, man was using psychoactive drugs (Narr,

2008). On the walls on rock that date back as far back as the fourth millennium B.C., there are pictures of people making beer out of barley. Ancient Chinese drank intoxicating rice beverages, carbon dating of jugs found in Jiahu, China to around 8,000 B.C. American Indians used peyote as part of their spiritual practices (LeCroy & Holschuh, 2012). The pharaohs in Egypt passed out beer to keep the laborers building their pyramids. In 4,000 B.C., Sumerians found they could mix alcohol and opium and alcohol and have a stronger effect. The Peruvians discovered they could absorb more from the chewed coca-leaves juice if they mixed it with charred oyster shell in 1450 A.D. In 1855 England, they inhaled nitrous oxide to get cheerful and high. A few years later England started injecting morphine into the bloodstream (Inaba & Cohen, 2011).

### **Alcohol and Drug Laws**

The first law was passed in San Francisco which prohibited the use of opium in “dens” in 1875. Two years later congress passed a law that prohibited Chinese from importing opium. What followed was high black market trade. In 1906, the Pure Food and Drug Act required all foods and drugs to be accurately labeled, and it prohibited interstate commerce of misbranded drugs, drinks, and food (Inaba & Cohen, 2011). The Opium Exclusion Act passed in 1909, banned the smoking of opium and tried to put in place a worldwide reduction of the production of opium. In 1914, the Harrison Narcotic Act gave the federal government control over the sale of opium (Acker, 1995). In 1920, the Volstead Act implemented the Eighteenth Amendment prohibiting the sale and manufacturing of all alcoholic beverages. This was done behind the idea that alcohol

abuse was the cause of poverty. During the thirteen years Prohibition was in effect, it is reported that cirrhosis of the liver and other alcohol related diseases declined dramatically. Violent crimes dropped by two-thirds, there was fewer domestic violence incidences and almost nobody was drunk in public. While these were positive outcomes the Prohibition created, the negative consequences included the illegal distribution and smuggling by mobsters. When Prohibition ended in 1933, the mob turned to the drug trade of heroin and cocaine (Inaba & Cohen, 2011).

In the 1930s, scientists began to study behaviors that were associated with drug and alcohol use. They surmised that people addicted to drugs were morally flawed and lacked will power, and excluded addiction as a health problem. This view shaped public opinion and created an emphasis on punishment instead of treatment and prevention. The laws that followed include the Marijuana Tax Act in 1937, the Drug Abuse Control Amendments in 1965, and the Crime Control Act in 1990 (Inaba & Cohen, 2011).

In 1953, Rufus King, chairman of the American Bar Association's committee on narcotics talked about his personal views in the *Yale Law Journal*:

The true addict, by universally accepted definitions, is totally enslaved to his habit. He will do anything to fend off the illness, marked by physical and emotional agony that results from abstinence. So long as society will not traffic with him on any terms, he must remain the abject servitor of his vicious nemesis, the peddler. The addict *will* commit crimes-mostly petty offenses like shoplifting and prostitution-to get the price the peddler asks. He *will* peddle dope and make

new addicts if those are his master's terms. Drugs are a commodity of trifling intrinsic value. All the billions our society has spent enforcing criminal measures against the addict have had the sole practical result of protecting the peddler's market, artificially inflating his prices, and keeping his profits fantastically high. No other nation hounds its addicts as we do, and no other nation faces anything remotely resembling our problem. (p. 748-749)

This was certainly true in inspiring more black market drugs to be available in the country, and made the government spend billions of dollars in treating people suffering from addiction as criminals. When the United States Government realized that they could be more effective in prevention, and treatment rather than punishment, they shifted their focus. It was in 1963 that the federal government passed the first law that provided assistance to local treatment centers for under the cover of mental illness. Proposition 36 in California gave treatment options for first time offenders (Inaba & Cohen, 2011).

### **Addiction**

Over the years, alcohol and drug addiction has been studied and treated in many different ways. With the development of new technologies and ways that we can scan and study the brain, scientists have done incredible work in the area of addiction. They have identified many of the biological and environmental factors and are beginning to search for the genetic variations that contribute to the development and progression of the disease. The causes that lead to deadly problems for addicts have been carefully examined as a way to solve to the problem. There have been many different explanations, including a genetic predisposition to addiction, social factors, and certain

chemical imbalances that lead to drug seeking behaviors. Finding the cause of addiction is agreeably in its infant stages. Because of the availability of potent and purified forms of drugs, and the advanced mechanisms for getting them into the body, it is likely that the severe drug addiction that we see today is a new phenomenon (Durrant, Adamson, Todd, & Sellman, 2009).

### **The History of Addiction**

While it is not documented in early colonial times, we can assume that some of our ancestors were suffering from addiction. Narcotic medications were popular in London, and came to the colonies with the first settlers. We do have an understanding of what opiates do the body and how easily they can create dependence. There is sufficient documentation that reveals over the counter medications being sold to the public in the 1700s (Hanson, 2008). These were different drugs with the main ingredient opium. They were marketed to relieve colds, fever, rheumatism, pelvic disorders, baldness, diarrhea, and even athlete's foot (Inciardi, 1990). A New York catalogue in 1804 listed 90 different brands of elixirs, by 1858 a Boston paper had included 600 more, and by 1905 the number grew to over 28,000. There were no government regulations, and a person could simply order any quantity from their grocer, postmasters, and apothecaries (Inciardi). The American Civil War was the first war where soldiers were offered pain relief. It was during this time that addiction was first named as the "soldier's disease" (Hanson, 2008).

In 1898, the Bayer Laboratories of Germany started marketing a less addictive form of the poppy and advertised it as the “heroic” drug. It was sold in cough remedies. This trade name was later dropped and heroin became part of our language as a generic term. It is estimated that in the early 1900s, one in every four hundred Americans were addicted to opiates. Sears and Roebuck sold cures for morphine addiction that was primarily alcohol. They also offered a cure for alcoholism that was a tincture of opium (Hanson, 2008). It is easy to see how this early exposure to drugs promoted addiction in our culture.

### **Diagnosing Alcohol and Drug Addiction**

By 1932, the American Psychiatric Association had created a definition of drug abuse mainly for legal purposes. It based their definition on social acceptability, culture influences, and legality. It applied to nonmedical, illegal drugs use. These select drugs were those that had mind altering properties and considered to be undesirable, inappropriate harmful and threatening (Ball, Brill, Glasscote, Jaffee, Sussex, 1932). It excluded alcohol. In 1952 the first edition of American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* defined alcohol and drug abuse under Sociopathic Personality Disturbances. The symptoms involved moral weakness and deeper psychological disorders (American Psychological Association, 1952). In 1966, the American Medical Association's Committee on Alcoholism and Addiction defined “misuse” as the physician's role in wrongfully administering stimulants to patients in the course of therapy. The term “abuse” was defined as the patient self-administering these



drugs without medical supervision in large doses that might lead to tolerance, abnormal behavior and psychological dependency (NCMDA, 1973).

By the third edition of the *Diagnostic and Statistical Manual of Mental Disorders* published in 1980, the American Psychiatric Association defined substance abuse and substance dependence as conditions from substance abuse alone. This brought in cultural and social factors and put an emphasis on dependence as a tolerance to drugs and withdrawal from them as components for a diagnosis. They defined abuse out as problematic use, and interference with social or occupational but without withdrawal or tolerance (American Psychological Association, 1980). Seven years later the DSM was revised to include Psychoactive Substance-induced Organic Mental Disorders and gave equal weight to physiological symptoms, such as tolerance and withdrawal, and behavioral factors such as impaired control over use. It included alcohol dependence and abuse, amphetamine or similarly acting sympathomimetic dependence and abuse, cannabis dependence and abuse, cocaine dependence and abuse, hallucinogen dependence and abuse, inhalant dependence and abuse nicotine dependence, opioid dependence and abuse dependence and abuse PCP dependence and abuse and sedative hypnotic or anxiolytic dependence and abuse (American Psychological Association, 1987).

The *Diagnostic and Statistical Manual of Mental Disorders* was revised again in 2000. It classified substance use into two categories, dependence and abuse. Abuse is defined as a maladaptive pattern of substance use leads to clinical impairment or distress

in at least one area of functioning in the past 12 months. These are: 1) recurring substance use that results in failure to fulfill school, family, or work roles; 2) recurring substance use in situations that are dangerous physically; 3) recurrent substance related legal issues; and 4) continues to use substances in spite of having persistent social or interpersonal issues related or exaggerated by use. They cannot have met the criteria for dependence for this substance in order to be diagnosed with abuse. The criteria for dependence is a maladaptive pattern of use leading to impairment or distress during last 12 months as manifested by three of the following: 1) the need for more of the substance to reach the desired effect; 2) withdrawal syndrome or using to avoid withdrawal; 3) using more of the substance in larger amounts or over a longer period than intended; 4) unsuccessful efforts to quit; 5) given up important occupational, recreational, family or social activities in order to use; 6) spends a lot of time in activities to obtain, use, or recover from the effects of use; and 7) continues to use even with the knowledge that using is causing physical or psychological harm. These factors must be persistent and continued in order to qualify for dependence (American Psychological Association, 2000).

The important change that has been made to the *Diagnostic and Statistical Manual of Mental Disorders- V*, published in 2013, is that it does not separate abuse and dependence. Instead it uses the term substance use disorders, which are classified into levels of severity, mild, moderate, and severe. A criterion for craving has been added and the substance use related legal issues criterion had been deleted. Cannabis and caffeine withdrawal have been added as new disorders. New specifiers include “in a controlled environment” and “on maintenance therapy” as needed. Each new edition of the

*Diagnostic and Statistical Manual of Mental Disorders* has improved on ways a person who is suffering from addiction can be diagnosed in order to find the treatment they need (American Psychological Association, 2013).

### **Components of Addiction**

There are two components to addiction, the psychological (or mental) and the physical (or biochemical). Bernstein (2008) refers to psychological dependence as a “condition in which a person uses a drug despite its adverse effects, needs the drug for a sense of well-being, and becomes preoccupied with obtaining the drug. However, the person can still function without the drug.... the physical dependence or addiction which is a physiological state in which continued drug use becomes necessary to prevent an unpleasant withdrawal syndrome” (p 352). These physical and mental mechanics can create a state of depression and lethargy that an addicted person experiences. At a physical level, most addicts are in a declining or poor state of health. When they are high, they are in a euphoric, painless state of mind and are numb to the damage drugs and/or alcohol are causing to their body. When the addicted person is sober, he/she has no energy; and minor aches and pains are intensified (Bernstein, 2008). Due to the severe nutritional deficiencies that follow long-term drug or alcohol abuse, they can become physically spent. These deficiencies accelerate poor health and put the person in a physically lethargic condition. At a mental level, they have a difficult time finding joy or happiness in anything while they are not under the influence. At some point, an addict surrenders to the idea that they must be high in order to experience anything at an emotional level. They must be high to celebrate an accomplishment, to escape sadness

(Robinson & Berridge, 2000). They must be high to solve problems, to enjoy sex, to have meaningful relationships, to work or to play. The addict really believes and operates on this principle, numb to the fact that the quality of their life and relationships with others are on a down spiral (Bernstein).

### **The Brain and Addiction**

There is another biophysical aspect to this scenario, which is created by the drug's interaction with the body's natural chemistry. Some of the body's natural chemicals act as a built-in reward system that encourages us to eat, exercise and procreate. Other natural chemicals act as painkillers that activate when we physically injure ourselves or are experiencing pain. These natural chemicals are directly related to our drive to maintain our physical well-being in one way or another:

Drugs stimulate the rewarding system makes them popular and dangerous to the individual's health and life. The motivation-rewarding system is regulated by numerous neurotransmitters, among them dopamine, that is released in the nucleus accumbens (NAC) and synthesized by the neurons located in the ventral tegmental area (VTA). There are other substances that modulate the activity of the dopaminergic neurons in the VTA, such as serotonin, acetylcholine, gamma-amino butyric acid (GABA) and glutamate. The activation of the VTA and its consequent activation of the NAC, enhance the release of neuromodulators such as endorphins and endocannabinoids, thus generating the subjective sensation of pleasure. (Caynas, Contreras, Diaz, Gomez, & Romano, 2010, p. 456)

In addition to the presence of drug metabolites in the system and the memories associated with drug and alcohol use, the physical brain of the addict also identifies the drug or alcohol as an aid that either enhances or restricts the release of these natural chemicals. In some cases, the brain identifies some drugs as superior to the body's natural chemicals. The brain then substitutes the drugs or alcohol for the body's natural chemicals. As the person starts to use drugs or alcohol on a regular basis, the body becomes depleted of key nutrients and amino acids (Amino acids are the building blocks for the body's natural chemicals) (Robinson & Berridge, 2000). These nutritional deficiencies prevent the body from receiving the nutritional energy necessary to produce and release the natural chemicals. The drugs take over the functions of the body's natural chemicals and the person's brain and body get fooled into thinking that the drugs or alcohol are the natural chemicals. When drugs or alcohol is present in the addict's system, the physical perception is that the body chemistry is working and all is well. When drugs and/or alcohol leave the addict's system, the brain and body perceive a deficit of its natural body chemicals. This adds to the lethargy and lacks of enjoyment an addict experiences when not under the influence of drugs or drink (Robinson & Berridge). This condition is what adds to the addict's compulsion and drive to do more drugs or drink more alcohol, despite the often life-threatening consequences an addict is faced with on a day-to-day basis. The drug or alcohol is misidentified as an aid to the production and release of the natural chemicals when, in fact, it is suppressing the body's ability to manufacture them (Robinson & Berridge).

## Causes

So what causes some people to become addict and not others? Whether a person is genetically or bio-chemically predisposed to addiction or alcoholism is a controversy that has been debated for years within the scientific, medical and chemical dependency communities. One school of thought advocates the "disease concept," which embraces the notion that addiction is an inherited disease, and that the individual is permanently ill at a genetic level, even for those experiencing long periods of sobriety (Chang, Fowler, Kassed & Volkow, 2007). Similar to other chronic diseases such as diabetes, heart disease, and asthma, there are periods of remission but the disease never goes away. Another philosophy argues that addiction is a dual problem consisting of a physical and mental dependency on chemicals, compounded by a pre-existing mental disorder (i.e. clinical depression, bipolar disorder, or some other mental illness), and that the mental disorder needs to be treated first as the primary cause of the addiction. This is addressed as a co-occurring disorder. A third philosophy subscribes to the idea that chemical dependency leads to "chemical imbalances" in the neurological system (Chuan-Yun, Xizeng, & Liping, 2008). It is likely that all of these factors are involved with people suffering from alcohol and drug addiction.

## **Relapse**

During the 1970s, relapse was not addressed as part of the treatment plan. When a person relapsed it was often justified that the person had not yet hit rock bottom or they were not ready for recovery (Fields, 1998). Relapse “has been conceptualized as a dynamic process which an abstinent person gives in to the urge to resume substance use” (Colwill, 2012, p.1). It is separate from a “slip,” meaning one-time, or a “lapse,” which refers to a brief occurrence of use. Generally, relapse is considered to be part of attempting to change any chronic behavior, and not perceived as a failure (Colwill). According to The National Institute on Drug Abuse (2013), people with substance use disorders have similar relapse rates to those who have similar chronic medical illnesses such as asthma, hypertension and diabetes. However, with people who suffer from addiction, a have stigma that is associated with relapse. It can create feeling of hopelessness, guilt and shame. Therefore, while it must not be excused, it must be accepted (Inaba & Cohen, 2011). Recovering addicts should never feel like they cannot start again.

In 1985, researcher Marlatt proposed a cognitive-behavioral model of the relapse process. It centers on the individual’s response to a high-risk situation. If the person does not have the coping skills or confidence to deal with the situation, they are likely to relapse (Marlatt & Witkiewitz, 2004). There are common complications that occur during the initial phase of treatment that can be a factor in relapse. Due to the toxic effects of prolonged drug or alcohol use, most people have mild to severe cognitive impairments.

These kinds of deficits can impair the person suffering from addictions' ability to fully understand what is needed to formulate a treatment plan, find useful coping skills and minimize cravings (Inaba & Cohen, 2011). Most treatment facilities are time limited and cannot help the person move past the "foggy brain."

### **Relapse Prevention**

Identifying the causes of relapse can prevent a person suffering from addiction from further relapse. A trigger is often what unexpectedly impacts cravings and often leads to slips and relapse (Inaba & Cohen, 2011). Triggers can be an emotional state of exhaustion, impatience, depression, self-pity, expecting too much from others, overconfidence, dishonesty, or using mind altering drugs (Pharmacist Rehabilitation Organization, 1990). They can be caused by environmental cues such as people, places or things. These can be odors, noises, or places where a person has used before recovery (Inaba & Cohen). By working with a counselor the person can identify these triggers and find coping skills to manage to successfully the trigger when it occurs. By identifying these triggers, they can also manage their lives in a way to avoid the situations where they are exposed to these triggers. They can avoid certain neighborhoods, bars, and make new friends. Relapse prevention is now one of the key components in treatment planning. This gives the person in recovery the best tools in early recovery (Inaba & Cohen).



## Recovery

The way our culture views drug and alcohol addiction in society has changed a great deal in the last fifty years. Along with shifting societal attitudes, definitions regarding personal recovery have also shifted. Initially rehabilitation facilities only offered treatment to men who were suffering from alcoholism. All Alcoholics Anonymous Books were written to address to men. Eventually, women were allowed to attend meetings, and books started to include the pronoun she and her. According to Alcoholics Anonymous, recovery is a lifelong process. It can include multiple relapses but the goal is sobriety and abstinence from alcohol for life (AA, 2014).

In 2010, the Substance Abuse and Mental Health Services Administration set out to define recovery. After months of input from the mental health community, consumers, policy-makers, people in recovery, providers, family members and advocates, they developed a working definition of what recovery is. According to SAMHSA, recovery is “A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential” (SAMHSA, 2013, p.3). This includes four major dimensions. They are health, home, purpose, and community. They define health as “overcoming or managing one’s disease(s) or symptoms, abstaining from use of alcohol, illicit drugs, and non-prescribed medications if one has an addiction problem—and for everyone in recovery, making informed, healthy choices that support physical and emotional wellbeing” (SAMHSA, p.3). A home as have a safe and stable place to live. To have purpose is to engage in any type of meaningful daily activity such

as school, work, and being a productive member of society (SAMHSA). The community is the people that provide friendship, hope, love and support. SAMHSA also defined the guiding principles of recovery. They are hope and person-driven. Recovery can be achieved in many different ways. It is holistic and it is supported by peers and allies through relationships and social networks. It is culturally based and supported by addressing trauma. It involves the individual, the family, and the community (SAMHSA).

In 2010, the National Institute of Health funded a study that was directed by Dr L. Kaskutas, set out to define recovery. Their research about recovery had unveiled that the definitions currently used are not agreed upon by everyone, and they are not defined by people who have their own recovery, but rather expert panels and scientist (Public Health Institute, 2011). Researchers Kaskutas, Witbrat, and Grella started out with a group of 238 people on different pathways(12-step, treatment, medication-assisted recovery, moderation and doing it on your own). They were given 167 items that could potentially be in the definition of recovery. The group narrowed the list down to 47 items. They set up an on line survey with these items. Between July 15 and October 31, 2012, there were 9,341 respondents. Researchers ended up with 39 elements that make up the definition of recovery (Kaskutas, Witbrat, & Grella 2015). The authors state that “the items with the highest level of support were: [recovery is] handling negative feelings without using drugs or drinking like I used to—endorsed by 97%; being able to enjoy life without drinking or using drugs like I used to—98%; being honest with myself—99%; taking responsibility for the things I can change—98%; and a process of growth and

development—99%” (p. 90). This research can be useful for all treatment centers, and especially for people new in recovery to internalize what recovery means for them.

### **Treatment**

When a person is suffering from substance use disorders, it can be very helpful for them to be around other people who have had a similar experience in their life. The isolation that can come from early recovery can make sustainable recovery difficult. Peer support groups, mutual aid and self-help groups are all designed to give assistance, encouragement and guidance for a person who might feel hopeless, fearful or alone. The first of these groups was the Oxford Group. The Oxford Group, founded in the early 1920s, was the first movement of alcoholics coming together in fellowship to support member’s spirituality with practice of Christian principles. They were guided by following six principles:

1. Surrender to God of your understanding.
2. Examination of one’s conscience.
3. Confession of character defects to another.
4. Practice of making amends when someone has been injured.
5. Meditation and prayer.
6. Quiet time, following meditation and prayer (Cavanaugh, 1998, p.137).

Alcoholics Anonymous has grown to be a worldwide membership of over more than one hundred thousand alcoholic women and men that come together in fellowship to work on their alcoholism issues. The basis of the AA program is a conscious engagement

in working the 12 steps and 12 traditions of AA as outlined by AA World Services (2014). An important part of AA is to have a sponsor that guides the recovering person through the 12-steps. The 12-steps are a set of principles that are spiritually based. According to Bill Wilson, the co-founder of AA, if all the steps are practiced as a way of life, they can “expel the obsession to drink and enable the sufferer to become happily and usefully whole” (AA, 2014, p.15). These 12-steps are:

1. We admitted we were powerless over alcohol-that our lives had become unmanageable.
2. We came to believe that a Power greater than ourselves could restore us to sanity.
3. We made a decision to turn our will and our lives over to the care of God as we understood Him.
4. We made a searching and fearless moral inventory of ourselves.
5. We admitted to God, to ourselves, and to another human being the exact nature of our wrongs.
6. We were entirely ready to have God remove all these defects of character.
7. We humbly asked Him to remove our shortcomings.
8. We made a list of all persons we had harmed, and became willing to make amends to them all.
9. We made direct amends to such people wherever possible, except when to do so would injure them or others.

10. We continued to take personal inventory and when we were wrong promptly admitted it.
11. We sought through prayer and medication to improve our conscious contact with God as we understood Him, praying for knowledge of His will for us and the power to carry that out.
12. Having had a spiritual awakening as a result of these steps, we tried to carry this message to alcoholics, and to practice these principles in all our affairs (p. 5-8)  
There are also the Twelve Traditions of Alcoholics Anonymous that are set forth as a guideline for AA groups to follow Alcoholic Anonymous (2014). These traditions are:

1. Our common welfare should come first; personal recovery depends on AA unity.
2. For our group purpose there is but one ultimate authority-a loving God as He may express Himself in our group conscious. Our leaders are but trusted servants; they do not govern.
3. The only requirement for AA membership is the desire to stop drinking.
4. Each group should be autonomous except in matters affecting other groups or AA as a whole.
5. Each group has but one primary purpose--to carry its message to the alcoholic that still suffers.

6. An AA group ought never endorse, finance, or lend the AA name to any related facility or outside enterprise, lest problems of money, property, and prestige divert us from our primary purpose.
7. Every AA group ought to be fully self-supporting, declining outside contributions.
8. Alcoholics Anonymous should remain forever nonprofessional, but our services centers may employ special workers. AA, as such, ought never to be organized; but we may create service boards or committees directly responsible to those they serve.
10. Alcoholics Anonymous has no opinion on outside issues; hence the AA name ought never to be drawn into public controversy.
11. Our public relations policy is based on attraction rather than promotion; we need always maintain personal anonymity at the level of press, radio and films.
12. Anonymity is the spiritual foundation of all our traditions, ever reminding us to place principles before personalities (p. 9-14).

The book, *It Works How and Why* (2014), is the 12-steps and 12-traditions of Narcotics Anonymous. While they share many similarities, Narcotics Anonymous is inclusive of all people suffering from substance use addiction. Alcoholics Anonymous is only for alcoholics. In 1958, the co-founder of Alcoholics Anonymous Bill W., wrote *Problems and Other Drugs*. This pamphlet specifically addressed whether a person who is a drug addict, or nonalcoholic pill addict can be an AA member, or if a person who has a genuine alcoholic and is also a pill taker can come to AA meetings and state they are an

addict. Bill W. states that sobriety and freedom from alcohol is the only purpose that AA can have. He explains that many groups have tried to undertake too many purposes and failed. So that there “is no possible way to make non-alcoholics into AA members.....I can see no way of making addicts into members of AA” ( p.5). This still holds true for membership today. In AA meetings, participants have been excluded if they share they are addicts. Out of the need for people who were suffering from drug addictions of all sorts that were being denied fellowship at AA meetings, Narcotics Anonymous was founded in 1953. Initially there was little structure and they lacked a book and specific direction. In 1972, the World Service Office stepped in and brought purpose to the fellowship. They published a book for addicts, about addicts, by addicts. Membership exploded from Los Angeles, California to all the United States in a short time. Current research conducted by Witdrodt et al. (2012) found that people who attended meetings regularly remained abstinent, while those in the no attendance group reported the lowest pattern of abstinence.

Other self-help groups are available for people who want to separate out recovery and finding their higher power. They are based on evidence based practices and uses principles such as motivational interviewing and cognitive-behavioral-therapy. These include SMART Recovery, and Secular Organizations for Sobriety (SOS) (Brooks & Penn, 2003).

While self-help groups give the person suffering from addiction a support group, they are not designed to replace treatment. When a person has reached the point where

their lives have become out of control and they have hit rock bottom, they are in need of attending a treatment facility. There are many different treatment types of programs. While some of them are based on the 12-step model, many offer the recovering addict different options.

One of these programs is Narconon. According to Narconon International (2016), their program was established in 1966. They have centers on over 45 countries. The cornerstone to their 75%-82% success rate lies in their New Life Detoxification Program. It is a combination of exercise, sweating in a dry heat sauna, and a monitored regimen of vitamins, minerals, hydration and nutrition. L. Ron Hubbard developed the purification program as a way to rid the body of harmful toxins that interfere with the brain and body's ability to fully recover from addiction (Hubbard, 2002). The Narconon program does not have a time limit constraint, as they believe that it takes as long as it takes (Narconon International). The program consists of eight parts. The first is a drug free withdrawal. It consists of seclusion to a quiet place, drills that get a person out of their own head, and body assists that take away the painful experience that can go along with withdrawing from drugs or alcohol. There is always a withdrawal specialist there to provide special attention to the "student." The second part is The New Life Detoxification Program. The third is a book that teaches the person how to learn again. When a person has been using drugs or alcohol for a period of time, the brain can be damaged in a way that problem solving, abstract thinking, information processing and use and meaning of words can be difficult (Inaba & Cohen, 2011). The remaining five parts



of the program are designed to give the person life skills, and a return to their personal values. They help the person practice self-control and give the tools to never go back to using again (Narconon International, 2016).

### **Evidence Based Practice**

About 20 years ago, two researchers, Carlo C. DiClemente and J. O. Prochaska (1984) developed a Stages of Change Model. This model was designed to help people motivate and create change in their lives. As with any part of life that is hard to approach, such as bad habits, self-image, or changing a life-style, it can be a scary task, and it might seem impossible. However, if we break them up into parts, see them as steps, and follow a process, it can make the journey achievable. The first step is “Pre-contemplation.” In this step, the person does not want to change, or even see that they should. It is sometimes referred the denial stage. The second step is Contemplation. Here the person might start to think about the costs, and start to see benefits to lifestyle changes. There is openness only to consider that they might be willing to change. This can go on for years. No decision is made yet. The next stage is Determination, or Preparation, as it is this stage where the person makes the decision for change, and starts planning how that is going to happen. The next stage is Action. During this stage, the plan is put into in to action. Generally, this involves the people around them, so that there is an external confirmation of the plan, and it gives them support. The Maintenance can be seen around six months of sobriety. The person continues to work on the behaviors and identifying any triggers and using coping skills. It is at this point where the person can see the

benefits from quitting use. In the Termination stage the person has achieved long term success in alcohol and drug recovery. They are not consumed by the daily environmental cues that can trigger relapse (DiClemente, & Prochaska, 1984).

According to SAMHSA's National Survey on Drug Use and Health (2008), 9.4% of the population is in need of treatment. Of those who are in need, 8.4% of the population did not receive treatment. One of the factors that contribute to effective recovery is remaining in treatment for an adequate amount of time. Returning to people, places and things that can trigger a relapse is one of the biggest problems for an addict. The 12-step program can continuously remind participants that they are not in control, and that they have a disease. This type of mind conditioning can set people up for failure. This is where cognitive-behavioral therapy can be a big help in people to replace the mindset that they will always be afflicted with an incurable disease.

The National Institute on Drug Abuse (2016) refers to Cognitive-Behavioral therapy as a way to help patients recognize, avoid, and cope. They will recognize the situations where they are most likely to use substances, and avoid these situations and learn to cope with a range of problematic behaviors associated with substance abuse. CBT techniques are used by identifying the triggers that lead the person to use and replacing them with coping skill. Relief oriented symptoms focus on the reduction of negative psychological and physical symptoms while disputing the belief that it is ok to use drugs. Changing the paradigm from an all or none functioning can help the person move out of the "should" "oughts" and "musts" (Gilliland & James 2013).

When working with clients who are suffering from alcohol and drug addictions, the best practice approach is to use Motivational Interviewing. This counseling style is a technique that can help move a person in the direction of change and crates “change talk.” It is based on normalizing ambivalence about change, using the persons own values and personal motivations to create change. The counselor and the person suffering from addiction work together as a team. The counselor asks opened questions, uses active, reflective listening. They summarize what the person is saying to them, and they have an empathetic listening style (CSAT, 1999). This promotes an environment where the person is willing to overcome fear of change. When the person is in partnership with the counselor, they do not feel like they are being controlled or directed to do something they are not willing to do. Inviting the person to write their own goals, and how they are going to be achieved is a successful way to ensure they will feel ownership over their own recovery.

There are many private recovery centers that have different programs and payment plans. Depending on how much a person can afford to pay and what type of program they believe will work for them will be determining factors when they pick a center for them. Many people that are homeless or poor do not have many options as they need county referrals. Most of these centers are currently a combination of 12-step and evidence based practices.

### **Gaps in the Literature**

An extensive investigation on topics about addiction, relapse, recovery and treatment was performed. There is sufficient research and information on how drugs and alcohol affect the brain. Researchers have identified areas in the brain in which promote survival and is most effected by psychoactive drugs called the reward pathways (Inaba & Cohen, 2011). Research has identified heredity, genes, and environment as factors that might lead to addiction (Inaba & Cohen). However not much has been published as to what can be done to decrease alcohol and drug addiction before they start. It seems that we do have the information about what factors contribute to a person who could be identified before they fall into a substance use disorder. Just as with other type screenings for genetic disorders, addiction could be identified and addressed before it ever became an issue in someone's life. If there were more research in this area, it could be a way of ending alcohol and drug addiction forever.

Research conducted by Dr Kaskukas (2015) on defining what recovery is, has several limitations. One of them was that the population of 9,341 people included in their survey was all people that were comfortable with the online survey. Another is that these people were likely to be interested in the topic of recovery. Considering this was a longitudinal study, there could have been more research on people who change their views regarding moderation in favor of abstinence or abstinence rather than moderation. In Kaskukas' study, the number of participants who became non-abstinent was 37, which was too low to interpret its meaning

Another gap in the literature is on how effective 12-step models are for people in long term recovery. There is plenty of information from the Alcoholics World Services Inc. (2014) pertaining to the two million members world-wide. But due to the anonymity of the program, it is difficult at best to get any real data on how many people are still recovered after five years. Some Research in this area could lead policy makers in adjusting how money is spent in what types of programs.

Some of the limitations identified in the research pertaining to whether 12-step meetings predict abstinence included the ability to follow up with people for long term. They also relied on self-reporting data. There are many other factors that influence recovery that were not discussed as part of the study, so the measure of success cannot be based solely on attendance on 12-step meetings alone. There were no baseline measures, so previous treatment, relapse, and prior exposure to the 12-step program could have influenced the outcomes (Witbrodt et al., 2012). This research looks to identify the factors outside of 12-step meetings that go into long term successful recovery.

### **Summary**

Chapter two provided a review of the literature that is relevant to the research question. The sections discussed in this chapter included the historical background, addiction, relapse, recovery, and gaps in the literature. The following chapter will present the methodology.

## **Chapter 3**

### **METHODOLOGY**

The research design and the methodology used for this study are described in this chapter. The participants, including the criteria used to determine the qualifications to participate in the study, are reported along with a description of the sample population and the sampling technique. This chapter also includes a description of the instrumentation used to collect the data, and the reporting method. The final section describes the steps taken to protect human subjects.

#### **Research Question**

This study investigates two primary research questions: 1) What are the key factors that contribute to successful long term recovery from drug and alcohol addiction?  
2) What factors contribute to relapse?

#### **Research Design**

For this study, the researchers utilized a qualitative approach, together with a social constructivism philosophical assumption, ethnographic strategy for inquiry, and content analysis to identify emergent categories or themes. The following is a more detailed account of the framework for this research design.

#### **Qualitative Approach**

This approach is used when the researcher intends to gain understanding and knowledge of the human experience based on observations made in the field and analyzed in ways that are non-statistical. Frequently used qualitative methods for

collecting data include direct observation, participant observation, and/or face-to-face interviews. This method is conducive for a study that seeks flexibility for insight into a complex phenomenon that very little is known about and that we look to gain meaning. The data collected is in the form of words, text, and phrases, and the analyzing of data collected requires an interpretation of non-numerical research data for the purpose of identifying patterns of themes, relationships, or categories (Rubin & Babbie, 2013). These themes or categories are born from the research questions, terms used by the participants, concepts developed by reviewing the research data, and positions in the literature. To assist the researcher in gaining more insight into the world of the participant, qualitative research generally takes place in the environment typical to that of the participant (Neuman, 2003).

Using a qualitative research approach offers many advantages. Given that the researcher is in direct contact with the research participant, he/she is afforded the opportunity to record the mood and interaction of the participant within their own environment, therefore providing information that is certain to produce more comprehensive data for the researcher. The researcher is also able to control the interview and ask any necessary follow-up questions. In addition, the research participant is not limited in their response, but may answer questions in a more descriptive manner, affording them the opportunity to fully share their stories (Creswell, 2003).

There are some disadvantages that must be considered when utilizing a qualitative research approach, which include: 1) Fewer participants are interviewed, which limits the

input regarding a particular subject; 2) Data collection procedures may be expensive and labor intensive; 3) replicating a qualitative study is very difficult to achieve; 4) The face-to-face process of data collection may elicit a biased response; and 5) Researcher bias may affect the data collection, interpretation of the research, and design of the study (Creswell, 2003).

### **Social Constructivism**

This is the truth and knowledge that is created by individuals as they socially interact with their environments. Social constructivism is an informational framework whereby people seek to understand the world around them, and develop their individual meanings that are related to those experiences (Blundo & Greene, 2010). This paradigm acknowledges the belief that obtaining a true understanding of the world is derived by the way one is impacted by forces within the world. This understanding requires a means of interacting with a variety of individuals in order to develop some form of subjective meaning of their experiences (Walsh, 2013). It is the researcher's belief that the views and opinions of the participants regarding the key factors that contribute to long term recovery from alcohol/drug addiction, and the factors that contribute to relapse is based on the social, historical, and cultural experiences of the population. Therefore, it is important for the researchers to rely on the knowledge and understanding of the participants regarding this subject.



### **Ethnographic Strategy for Inquiry**

An ethnographic strategy for inquiry is closely aligned with the social constructivism model. Ethnography is a fundamentally qualitative research instrument that depicts a culture or way of life from the viewpoint of the individual who has knowledge of that culture. This approach assumes that the meaning of an experience cannot be described by words and actions alone and therefore must be studied by gathering data from individuals responding from the perspective of their lived realities (Cooper & White, 2012).

### **Content Analysis**

Once the data has been collected and transcribed, the researchers will organize the raw data according to categories and themes. Rubin & Babbie (2013) have defined qualitative content analysis as “a way of discovering patterns and meanings from communications” (p. 273). The themes or categories that arose from this research were based on responses to the research questions, terms used by participants, ideas that emerged from the data, and/or concepts in literature. There are two distinct coding methods used to isolate categories or themes from the raw data. The first coding method is the manifest method, in which the researcher codes the visible and surface subject matter contained within the text. The second coding method is the latent content that provides for the researcher to code the underlying meaning that is presented in the text (Cho & Lee, 2014). For the purpose of this study, the researchers employed both the manifest and latent content methods when coding the raw data.

The following advantages are associated with using content analysis: First, this method of analysis is economical in terms of money and time. Secondly, the coding procedure has the inherent advantage of being unobtrusive. Thirdly, there is no difficulty in correcting mistakes and repeating a portion of the study without having to start the entire research over.

Finally, this coding method does not require that the researcher possess any special training or expertise to use this technique (Rubin & Babbie, 2013). One disadvantage associated with using content analysis is that the communication of the data being researched must be recorded in some form in order to facilitate an analysis. Also, the material being analyzed must be precisely and exactly transcribed when using this coded method. In addition, the process of coding the categories or themes can be problematic if more than one researcher is engaged in coding; therefore, the rules concerning the classification of each particular category must be clearly and specifically defined (Rubin & Babbie).

### **Study Population**

The study participants, consisting of seven women and two men, were volunteers from the community who had a minimum of five years in recovery from alcohol and/or drugs. The focus of the interviews was on identifying the key factors that contribute to successful, long term recovery from alcohol and/or drugs, and the factors that contribute to relapse. The criteria for participating in this study included: 1) participants have a history of alcohol and/or drug use, and have been in recovery for a minimum of five

years; and 2) since being in recovery, participants have been able to maintain a healthy and productive lifestyle.

### **Sample Population**

This study was conducted on the campus of California State University, Sacramento, and at the Gateway Recovery House in Sacramento, California. The sampling method used for this study was purposive sampling. According to Rubin & Babbie (2013), the purposive sampling method focuses on the particular characteristics of the researcher's population of interest, and is utilized as follows: 1) when the researcher desires to find appropriately informative participants; 2) when it is necessary for the researcher to interview members of specialized or difficult -to - reach populations; and 3) when the researcher chooses to identify and interview individuals for particular types of cases. For this study, it was important for the researchers to interview individuals who met the research criteria specific to this population in order to ensure the selection of appropriate participants for this study. The sample size was nine participants who were contacted in person or by phone and asked to participate in this study. Participation in this study was strictly voluntary. All individuals, who were asked to be part of this study, agreed to participate.

### **Instrumentation**

Face-to-face interviews using standardized, open-ended questions were conducted with the nine individual participants. In preparation for these interviews, the researchers designed a standardized questionnaire consisting of eleven questions (See Appendix B).

The first three interview items were designed to stimulate responses pertaining to general demographic information. The following eight items in the questionnaire consisted of open-ended questions designed to inspire in-depth responses on the subject of alcohol and drug recovery. The researchers employed follow-up questions when data prompted by the interview items required further elaboration. The average duration of interviews was twenty minutes in length. All interviews were digitally recorded and conducted at a location and time convenient to the participant.

The use of a standardized form to facilitate questioning has a two-fold purpose. First, it is used to ensure that all nine of the interviews were performed in the same manner using a thorough and consistent process. This is found to be helpful when coding the material as it guarantees that complete data is gathered from each participant. Also, using the identical order of questioning assists the researcher in analyzing and organizing the collected data. Second, by utilizing a structured set of questions, it aids in reducing biases on the part of the researchers. One drawback of using this standardized interview approach is that it restricts the natural flow of conversation between individuals and prohibits the flexibility of the researcher (Rubin & Babbie, 2013).

The advantages of conducting an interview using open-ended questions are they allow for an unlimited variety of answers to the same question, and respondents are able to express themselves in their own words. Also, open-ended questions allow for creative and self-expressive responses to difficult and complex questions. The following are some of the disadvantages to open-ended questions that must be recognized: first, respondents

may differ in the amount of verbalization given to a question; second, participant responses are transcribed verbatim, a task that is labor intensive; third, responses may be highly detailed, but may not adequately address the question posed; fourth, the coding of participant responses may be complicated; and fifth, comparison of the assembled data may be somewhat difficult to achieve (Neuman, 2003).

The instrumentation associated with qualitative research ventures may provoke questions regarding the validity of the measures. While the use of open-ended questions during an interview may be used to enrich the research design, compromises to validity are intrinsic in the method. First, in a qualitative research project, one can expect to have fewer participants, which in itself undermines the overall generalizability and validity. Second, data that is obtained from personal interviews are not calculable as they are non-numerical. Data of this type produces responses that are not standardized, which therefore weakens validity. Third, face-to face-interviews promote comfort and intimacy, and ultimately may garner bias on behalf of the researcher.

Questions pertaining to the reliability of qualitative research methods must be considered when the instrumentation is being drafted. The difficulty in replicating semi-structured interviews encumbers the instrument's reliability. Responses to open-ended questions which are replete with detail harm reliability as they pose difficulty in analyzing and comparing data. Finally, subjective interpretation by the researcher is required when analyzing the content of the data. Data interpretations that occur in an inconsistent manner will compromise the reliability of a qualitative research study.

The interview process itself has an undeniable social characteristic, and is one that demands certain expectations and social norms. There are very specific rules that the researcher must adhere to when conducting a face-to-face interview with a study participant. The following are pertinent guidelines or steps to be followed when conducting effective research interviews (Rubin & Babbie, 2013). First, the appearance and demeanor of the interviewer are important factors to consider, particularly pertaining to the areas of dress, grooming, and attitude. As a general rule, the attire of the interviewer should be similar to that of the person being interviewed. If the researcher is one that is regally dressed, they may encounter some difficulty getting cooperation from the participant who is not dressed in a similar manner; if too poorly dressed the participant may not treat the researcher respectfully, or take the interview seriously. It is therefore important for the researcher to always be neat and clean in their appearance, and to be sensitive to the social cues of the participant. Secondly, the attitude of the researcher should always be one that is pleasant, and the researcher should communicate a genuine interest in getting to know and understand what the participant has to say. The researcher must be a good listener, and should be very familiar with the questions that he/she is asking the participants to respond to. It is important for the researcher to ask the questions at a comfortable, coherent pace for the participant and to do so without stumbling on the words and phrases contained within the questions. This will help make the interview a more relaxed and enjoyable experience, and serve to put the participant at ease. Third, the researcher must record the participant's answers accurately. The

recorded interview must be transcribed verbatim, without making any changes or corrections pertaining to sentence structure. Also, the interviewer should not paraphrase or summarize the participant's responses. Fourth, at the end of the interview, the researcher should always thank the participant for contributing to and participating in the research interview process.

### **Data Gathering Procedures**

Each participant was contacted by phone or in person, was provided a description of the research project, and asked if they would be willing to participate. The researchers then set up a mutually agreed upon time for the interview to be conducted. Interviews were conducted at the convenience of the participant, in a private classroom on the California State University, Sacramento campus, and in a private interview room at the Gateway Recovery House in Sacramento. Prior to the commencement of the interview, each participant was given a description of the research project, participants were informed that the interview for the project would be audio taped, and were asked to sign a consent form. A total of eleven standardized questions were posed to each participant in an interview which lasted between twenty minutes to thirty minutes in length.

Interviews began with the distribution of the informed consent document (See Appendix A). Study participants were allowed time to review the form and ask any questions about their participation prior to authorizing consent. Upon obtaining consent to participate, the interview began with the researcher switching on the digital recording device. Three general demographic questions were then asked of the participants,

followed by eight open-ended questions relevant to factors that contribute to long term alcohol and drug recovery (See Appendix B). Follow up questions were occasionally introduced for the purposes of elaboration or clarification. The average duration of the interview was twenty minutes. At the end of the exchange, participants were thanked for their time and contribution to the research project.

### **Data Analysis**

After the interview process was completed, the audiotapes for each interview conducted were transcribed into written text files using a word processing program. All raw data was transcribed verbatim with the exception of personal identifiers and proper names, which were omitted from the written record for purposes of confidentiality. Analysis of the written data was conducted by hand or through QDA Miner Version 4 (Provalis Research, Montreal, Canada), a program designed for the analysis of textual qualitative data. Data were coded under the themes of factors that contribute to long term sobriety, factors that contribute to relapse, and ways to gain control over addiction. The coding system first identified related segments by identifying notable differences and recognizing common themes. Then, the program scanned for manifest content of the codes that were highlighted. Finally, the data analysis checked for the latent content of the ideas most frequently coded within the themes. During the data analysis, the researchers determined the differences and similarities of the material collected, and identified the relevant themes, concepts, and ideas that emerged.



### **Protection of Human Subjects**

As required by California State University, Sacramento, a human subject's application was submitted to the Research Review Committee of California State University, Division of Social Work. This committee approved the proposed study and determined the project as "Exempt," indicating minimal risk to study participants. The approved protocol number for this research project was 15-16-041. The approval was received prior to the collection of any research data.

Participation in this research study was on a voluntary basis. During the interviews, participants were referred to by the use of a pseudonym. All information received during the interviews was held strictly confidential. Personal identifiers contained within the written transcripts were removed to ensure subject privacy. All audiotapes and transcribed materials were passcode protected on personal technological devices. The recorded data were destroyed by August 31, 2016, one year following the commencement of the study. This information was described in the participant's informed consent document, which was signed prior to parties beginning the interview (See Appendix A).

### **Summary**

Chapter 3 recounts in detail the methodology utilized in the study. The chapter focused on the nature of qualitative research and the process of content analysis used in the study. A description of the study population and the techniques involved in obtaining an appropriate sample were also included in the chapter. The chapter included a

description of the instrumentation designed to extract specific information from the sample. In addition, the chapter on methods explained the procedures for collecting and analyzing the data, and reviewed the measures taken to ensure the safety and privacy of the human subjects.

## **Chapter 4**

### **DATA ANALYSIS**

This chapter will present the results of the study through detailed description of the most meaningful data points regarding spirituality as a contributor to successful long term sobriety from alcohol and drugs, the motivating effects of relapse on sobriety, and gaining control over addiction by practice and commitment to change. Each of these themes will be informed through manifest and latent content of the data, including direct quotes from participants illustrating the common themes. To preserve the confidentiality pledged to the participants, data will be reported using: Reid, Ann, Glenn, Nancy, Joyce, Gwen, Jan, Beverly, and Cheryl. The chapter will first explore the demographic information of the study participants. Next, the emerging themes of the research will be outlined and discussed. The chapter concludes with a summary of the data provided by the participants. The primary objective of the study was to present investigation into the following research questions: 1) what are the key factors that contribute to successful long term recovery from drug and alcohol addiction? and 2) what are the factors that contribute to relapse? The purpose of exploring these particular questions was to gain insight into the capacity of individuals to make radical change to enhance their quality of life. The participants were asked three general demographic questions followed by a series of eight open-ended questions that intermittently prompted follow-up inquiries (See Appendix A). All open-ended questions were designed to elicit information from the participant's regarding the driving factors associated with successfully maintaining

sobriety as well as the circumstances that were the strongest contributors to affecting relapse. In addition to the themes developed from the two specific research questions, interview data were coded for meaningful conceptualizations of successful long-term recovery among the study participants.

### **Demographics of Study Participants**

Interviews were conducted with seven women and two men that qualified as having successful long-term recovery from drugs and alcohol addiction. All participants were over 35 years of age. The following pseudonyms were utilized in the reporting of interview data: Reid, Ann, Glenn, Nancy, Joyce, Gwen, Jan, Beverly, and Cheryl.

### **Contributors to Successful Long-Term Sobriety from Alcohol and Drugs**

A fundamental element of achieving long-term sobriety is that the person with an addiction finally comes to terms with the nature of their dependency, accepts that it is a lasting illness, and admits that it does in fact exist (Inaba & Cohen, 2000). According to Inaba and Cohen, there is no cure for addiction “because addiction has caused unrecoverable changes, alterations, and deaths to brain cells. Brain cells cannot be regenerated, so the changes caused by drug abuse are permanent. What we can do is arrest the illness, teach new living techniques, rewire the brain to bypass those addicted cells and give the addict in recovery a worthwhile life. It can’t be cured but addiction can be effectively prevented and treated” (p.398). It has been the practice of researchers focused on issues pertaining to addiction to commonly equate abstinence from substance use with that of recovery. Abstinence, however, is seen as a one-dimensional concept and is no panacea for an improved quality of life. The act of ending addictive behaviors does

not equal recovery. According to Conger (1994), ending addictive behaviors “does not mean recovery. Sobriety is an attitude, a life view that must reach every dimension of our being. Being sober in a body adapted to being drunk can only be a first stage of sobriety” (p.197).

Instead, much of the research literature today focuses on the substance-free individual being connected to systems of support and positive social relationships as a means of maintaining successful long-term recovery (Stecher, 2015). Recovery is a process that lasts throughout the lifetime, and is focused on healing, life improvement, and wellness. With a focus on improving social functioning and promoting a healthy lifestyle, addiction recovery can appropriately be understood to encompass a personal decision to maintain sobriety and healthy lifestyle choices, and to practice appropriate societal comportment (Stecher). The recovery experience is thought of as a process in many well-known clinical research studies that focus on the treatment of addiction (White, 2007). The transtheoretical model or stages of change is one such approach. Using this model, individuals changing a behavior, such as drug or alcohol abuse, move through a series of five stages: 1) precontemplation; 2) contemplation; 3) preparation; 4) action; and 5) maintenance (McNeece & DiNitto, 2002). In the precontemplation stage, individuals are not generally unaware that a problem exists. The contemplation stage sees the person become aware of a problem and begin to consider making behavior changes. In the preparation stage, the person is planning to make some change in the near future. The action stage sees the individual successfully changing their behavior. Maintenance is the stage where the individual continues the process of change in order to prevent relapse.

Although the stages are chronological, they do not automatically advance in a particular order. In addition, although relapse is not considered one of the stages it is factored into the change process as there is a likelihood it will occur. When relapse happens, the individual returns to some level on the aforementioned change continuum (McNeece & DiNitto).

While recovery is often realized through the stage change process, there is historical evidence to suggest that addiction recovery is at times stimulated by a positive, unexpected, and spontaneous event. An occurrence of this sort is known in clinical writings as transformational change or quantum change. These are events that often involve the individual living through an intense life altering spiritual, religious, or secular experience that changes their perception and previous patterns of substance use (White, 2007). When classifying recovery, consideration must be given to the existence of various styles and paths of transformation an individual may traverse on their journey toward discontinuing substance abuse. Recovery may be derived through diverse spiritual and religious pathways or with or without treatment, therefore the definition should be open to include all avenues that one travels to effect positive change in their lives (White). Study participants identified several areas of importance pertaining to the realization of successful long-term sobriety.

### **Spirituality/A Personal Relationship with God**

Given that the concept of reliance on a Higher Power is a common theme in a variety of alcohol and drug recovery programs (Sussman, Reynaud, Aubin, & Leventhal, 2011), it was not surprising to discover that many of the study respondents related their

success in maintaining long-term sobriety to having to relationship with God. Five out of nine study participants reported the importance of their relationship with God, connection to a higher power, and spirituality to maintaining long term sobriety. Ann stated, “I think first and foremost in having a relationship with a power that is greater than yourself... I identify that as God”. Reid had a similar viewpoint. He stated, “Long term sobriety for me has to do with my relationship with God. And that’s why I’m sober today.” The tendency and ability for human beings to reach beyond things that they are able to touch or see and idealize a divine paragon of virtue appears to be a universal human characteristic existing in every society throughout recorded time (Sellman, Baker, Adamson, & Geering,). The concept of transformation and recovery occurring by way of deific supernatural assistance is one that has been quite commonly reported. A number of high- profile examples of persons undergoing dramatic transformational change have been publicized throughout the years as people who had been plagued by addiction reported experiencing a recovery from their addiction by means of a God-like religious experience (Sellman, Baker, Adamson, & Geering, 2007). In each instance, after the encounter, the person ultimately went on to inspire recovery in others by establishing or endorsing a therapeutic model for recovery based on their experience (Sellman, Baker, Adamson & Geering). To this end, the attribution of God to positive change is a prevailing tenet that resides prominently in one of the world’s premier prototypical recovery organizations, Alcoholics Anonymous, and in many other related Twelve -Step programs (Alcoholics Anonymous, 1981). Consistent with the literature, more than half of the research participants reported that they attributed the realization of their recovery

to having a relationship with God, and a spiritual relationship with a power greater than themselves (As Bill Sees It, 1967). According to Canda & Furman (1999), “Spirituality relates to a universal and fundamental aspect of what it is to be human; to search for a sense of meaning, purpose, and moral frameworks for relating with self, others, and the ultimate reality. In this sense, spirituality may express itself through religious forms or it may be independent of them” (p. 37).

Conceptualizations of spirituality that promote having a personal relationship with God remain consistent with the literature. In Western society, the focus of spirituality resides in the belief that an intimate connection with God is obtainable and sustainable (Garfield, Drwecki, Moore, Kortenkamp & Gracz, 2014). Reid explained the necessity of spirituality, “I think it’s important for us to be spiritually balanced. I think when we’re not spiritually balanced that’s when our disease creeps in.” The word spirituality evokes distinctive meanings for everyone. For people in recovery the meaning is very special as often times it represents the difference between life and death (Johnsen, 2002). People experiencing issues with addiction have typically turned to their drug of choice to mask discomfort and emotional pain, or assuage physical desires. The addicted individual has been compared to a person consumed with the task of plugging up a dark empty hole that is in fact their addiction. In order to maintain sobriety, while satisfying that insatiable desire, the ever-present void is now being filled with a substance conducive to wellness. This is the comforting connection to spirituality (Johnsen). The drug seeking behavior that had been so prevalent in the person’s life does not dissipate with the introduction of sobriety. Instead the urges and cravings once so all-consuming and detrimental to the



individual's health, relationships, and overall social functioning have been replaced and redirected toward the spiritual realm (Johnsen). The direction-finding invocation of God in Twelve-Step addiction programs advocating behavior modification is a strategy that helps people in recovery feel they are not alone in their quest to disengage from participating in risky behaviors. This is due to God being customarily viewed as a source of strength and security against the evils that befall humankind. God is seen as a protector that will not let the people that believe in Him fall into the snares of their enemies (Kupor, Lauren, & Levav, 2015). According to Kupor, Lauren, & Levav, "...people treat God as an attachment figure and turn to God when they experience trauma, illness, and romantic rejection. These effects occur among both believers and non-believers, perhaps because broad cultural notions of God primarily represent God as a source of security" (p. 374). Cheryl who reported that she had been "clean and sober for twelve years on the fourth of this month", stated that her long term sobriety was effected by "Staying connected with people. Support networks. Family. Twelve-Steps. Go to church". Spirituality is an element that is uniquely open to interpretation by everyone. It may be associated with church attendance and organized religion, or it may be associated with the beauty of nature, like a sandy beach or the blue water of the ocean. Spirituality is open to customization; it may be manifested in any way a person wants it to be (Johnsen). For the person suffering from addiction, success in recovery relies heavily on the connection with the spiritual dimension. Individuals are able to successfully live a life of wellness and abstain from substance use when they promote and maintain a spiritual connection (Johnsen).

### **Importance of Goals and Purpose**

Three of the nine participants in the study reported the value of having goals and purpose as an important aspect of successful long-term recovery. Webster's II (1988), defines a goal as "the objective toward which an endeavor is directed" (p. 537). The rationale behind establishing goals is that they provide for the individual an aim and a sense of direction in life (Boyle, Hull, Mather, Smith, & Farley, 2009). Gwen commented about her use of goals, "...the biggest part of it is living the life the way that you imagined ...setting those goals and achieving them and having a happy life... like before you ever started using drugs or alcohol." For goals to be considered well-formed they must be reasonable and practical to allow for them to be attainable and not out of the range of achievement (Boyle, Hull, Mather, Smith, & Farley). A goal should also be measurable and underscore positive outcomes, therefore allowing the person working toward achievement to experience a sense of accomplishment and enhanced self-esteem once the goal is attained (Garvin, 2002). Cheryl stated "... just having a purpose, having goals. Setting measurable goals and obtaining them...It's so important to set those goals, and obtaining ...those little milestones helps." Developing a sense of purpose in life, which is derived from attendant goals and values, serves to motivate actions toward the direction of the preferred behavior, and is positively associated with an increase in feelings of well-being in persons suffering from issues related to substance abuse (Martin, MacKinnon, Johnson, & Rohsenow, 2011).

Beverly recounted that she was exposed to drug abuse in her childhood. In response to the interview item she stated:

A purpose. You have to have a purpose. I grew up...my parents were drug addicts...bikers, and so we do what we see. It's learned behavior. I really believe that, you know. And so I didn't want my daughter to grow up like me. I didn't want her to see me as a drug addict ... and she's in school because Mommy went back to school. Kids do what they see. I'm a single Mom and I want to be a role model. I want my daughter to strive for something. I don't want her to strive to be a drug addict. When I was young my goal in life was to make drugs and sell drugs, and be Doctor Death...cooking drugs, you know.

Social learning theory emphasizes that behavior is acquired by observing others, as it employs the principles of operant and classical conditioning (Sands & Gellis, 2012). The theory is directed by the rule of reciprocal determinism which supports the notion that psychological functioning is defined by a combination of interpersonal factors, environmental factors, and behavior (Boyle, Hull, Mather, Smith, & Farley). According to Martin, MacKinnon, Johnson, & Rohsenow, "within the social learning theory, purpose in life may help define a set of reinforcers that are alternatives to the drug use an individual is seeking. Alternative reinforcers may prevent reliance on the use of drugs and alcohol" (p. 183). Another tenet of the theory is that learning is influenced by many factors. In this respect, people are more apt to follow a model when that model has characteristics that are personally similar to the observer or is perceived by the observer to be of high status (Boyle, Hull, Mather, Smith, & Farley).

Beverly spoke more on how her childhood environment further influenced her behavior:

Well I started having, you know, bad consequences .... I was at a friend's house and I was being a little too ... acting up. I was high and causing issues going on. So the cops were called on me and I was taken on disorderly conduct. And I had paraphernalia on me. I didn't even know I had it on me. So that put me in jail for a few days. ...That was the first time I had really gone to jail. It made me think Oh my God, I don't want to be here. There was a woman in the room with me, and she says, Oh, I was in this room last time I was here, and I was in here with my daughter. And I said, oh no, you know. I don't want that.

Interview data acquired from the sample reflect conceptualizations related to factors that contribute to long-term sobriety that extend beyond the average cultural interpretations common to the literature.

### **Effects of Relapse on Sobriety**

A primary objective of this study involved reviewing the interview data to identify factors that contribute to relapse. See, Fuchs, Ledford, and McLaughlin (2014) defines relapse in terms related to drug dependence and drug use as, "the return to drug-seeking behavior after a prolonged period of abstinence" (p. 294). The incidence of relapse occurs after the person has acknowledged the presence of an addiction and enlists assistance from a recovery program as a part of making a conscious effort to remain sober (Voss, 2009). Research shows that 75% of AA members surveyed have an incidence of relapse within the first year of their recovery. The relapse rate drops to 7%

for those who have been sober for five years. Relapse is considered a process, rather than an event. Relapse commonly appears in the early stages of recovery when individuals are just beginning to come to grips with being sober and understanding the havoc they have reeked in the lives of themselves and others, and are learning about the changes they must make in order to live a substance-free life (Voss). When it manifests itself many years after an individual has been effectively enjoying sobriety and appears to have triumphed over their addiction, the act of relapse illustrates that there is some element that has been absent from the recovery plan all along. Also, when relapse occurs after years of recovery from alcohol and drug use, many times the person in recovery has become comfortable in their recovery and their style of life, and there are no longer putting forth the same effort they initially were in order to stay clean. Relapse can also occur in times of intense emotional distress related to personal and professional difficulty (Voss). Preventing relapse is a lifelong process and is dependent on the recovering individual changing their relationship with high-risk behaviors that may spearhead relapse. Learning useful tools to avert relapse is an important part of sustaining recovery and increasing self-efficacy (Roberts & Greene, 2002). From the interviews performed, study participants revealed significant opinions on the reasons people in recovery experience relapse and how it factors into recovery. Respondents were also queried on their thoughts concerning relapse being part of the Twelve-Step recovery model. The following subsection describes the consequential factors of relapse on sobriety discovered within the data.

### **Motivator to Remain Sober**

Recovery is generally typified by a person having continual control over their issues with substance abuse, and is evidenced by increased health and wellness, and effectual social functioning. A person realizing that state has managed to draw upon extant resources to affect a positive outcome (Duffy & Baldwin, 2013). According to Manejwala (2014), an eight -year study involving approximately 1,200 addicts in recovery found: 1) only one third of the people who are sober less than one year will remain sober; 2) of those who attain one year of sobriety, less than one half will experience relapse; and 3) there is fifteen percent or less chance of relapse for a person who has been sober for a period of five years. A familiar theme that emerged from the interview data involved relapse acting as a motivator for maintaining sobriety. Four participants responded to the interview item reporting the motivating effect of relapse on sobriety. Historically regarded as an emblem of failure to a person in recovery, relapse is now seen as a normal part of the process of recovery and serves as a vehicle of learning for the individual in recovery (Stevens & Smith, 2001). Expressing his opinion about relapse, Reid stated:

It plays a big role. You either relapse or you don't. I've heard people say that relapse is part of staying sober .... If you're sober you don't need to relapse. The relapse is always a part of addiction. It's something that it motivates people to stay clean because they don't want to relapse. ... I relapse, I die. I'm doomed. For me that's a very realistic possibility. If I decide to take a drink I will die because that's what almost happened last

time .... That always scared me. Relapse is part of my story.... That motivates me to stay sober.

There are many definitions associated with relapse. Relapse is often defined as a setback or collapse in an individual's capacity to produce change or effect a modification of target behavior. Simply put, relapse can be regarded as the return to a mode of compulsively dysfunctional behavior, and as a return to substance use (Stevens & Smith, year??). While many Twelve-Step recovery organizations may view relapse as a devastating blow to the recovering individual's attempt at sobriety, it is the belief of many mental health practitioners that relapse can serve as a learning experience to the person in recovery. It can teach the individual about recognizing the factors that led to the relapse, strengthen their resolve for change, and serve as inspiration to develop a plan to prevent a recurrence of the event (Stevens & Smith). Nancy's viewpoint on relapse was consistent with the research data. She stated:

Relapse can be a learning experience so that it can tell the person that this is the last place I want to be. For some people relapse is a death sentence and unfortunately some people never come back. For the ones that do, they can learn what it was like being out there and make it part of their story and find support.

The risk of relapsing is generally present when a person's coping skills are inadequate to withstand a situation where the person's propensity to use is elevated and enhanced (Martin, MacKinnon, Johnson, & Rohsenow, 2011). Glenn claimed a perceived advantage to relapsing and stated, "... relapsing... can act as a negative enforcer or a

positive enforcer... You know, sometimes a person relapses for a minute just to cope, you know, and if they survive it, maybe they come out better”. Early research has identified the decrease in relapsing behavior with the introduction of positive coping skills in situations of intense distress (Gossip, Stewart, Browne, & Marsden, 2002). Coping skills are identified as a group of overt or cognitive behavior patterns designed to effectively address actions and conduct when faced with challenging situations (Goldfried, 1980). Coping behavioral skills fulfill a major role in the treatment of substance use. Multiple studies have shown that individuals who are able to rapidly respond to highly stressful situations using effective coping skills, were less likely to experience relapse at the end of treatment. Moreover, if relapse did occur, the episode would be of shorter intensity and duration than it would be if no useful coping skills were available to the person in recovery (Gossip, Stewart, Browne, & Marsden). Joyce also reported recognizing the benefit to be gained from experiencing a relapse event. She stated, “The relapse contributes to staying clean...you might relapse again but you can learn something from those couple days that you were clean and... learn something from those days that you relapse... you can learn from those mistakes.” Other participants in the study cited ego-thinking and grandiosity, living in the past, and not doing what it takes to stay sober as factors effecting relapse on sobriety.

### **Gaining Control Over Addiction**

Analysis of the interview data derived from the sample of participants revealed significant factors understood to be associated with gaining control over addiction. The impulsive urge to use that is associated with drug addiction can be seen as a loss of



control over actions that leads the individual to engage in drug-seeking behavior (Belin, Belin-Rauscent, Murray, & Everett, 2013). Consequences associated with addiction and substance use are extremely complex and involve many factors. They often have acute somatic and psychosocial repercussions (Nordfjaern, Rundmo, & Hole, 2009). The physical effects of drug abuse on the brain lead to cognitive impairment, and impede the brain's capacity for responding to new experiences (Kleiner, 2003). Alcohol and drug use alters the chemistry of the brain regardless of the age of the user and does so permanently. Discontinuing the use does not restore the brain to its level of functionality prior to the start of the use. However, with treatment and guidance individuals are able to learn how to manage the symptoms resulting from the substance abuse (Inaba & Cohen, 2000). This can be accomplished through attending Twelve-Step recovery programs, managing distress through meditation and prayer, rebuilding relationships, and turning to others for support (Stevens & Smith, 2001). A primary objective of the study involved examining the interview data for conceptualization of gaining control over addiction. The following subsection describes factors related to gaining control over addiction located within the data in greater detail.

### **Practicing**

Interviews with the sample of study participants revealed that attaining control over addiction commands a significant effort from the addict in recovery. Establishing that habits are directly triggered through the process of conditioning they become difficult to control, particularly in the face of drug associated motivations and inducements (Belin, Belin-Rauscent, Murray, & Everett). Two participants reported that

practicing sobriety was essential to gaining control over addiction. In response to the interview item regarding how people gain control over addiction. Reid stated, “Practice, practice, practice. Go to meetings...have a relationship with God. These aren’t the things that happen overnight. Practicing it day after day...that saying "one day at a time"... it’s true”. One focus of Alcoholics Anonymous (A.A.) is that of keeping the members engaged in activity centered on their sobriety. Members are involved in life-long activity referred to as “twelve- stepping”. This entails members actively engaging in services geared toward aiding others who are suffering from addiction, and therefore benefiting themselves through their selfless actions. To work the “steps” in A.A. calls for the member in recovery to accept each new day as it comes and to diligently practice their recovery- supporting “step” efforts each day. Members are encouraged to actively and committedly engage in positive endeavors for themselves and others in recovery that promotes their wellness and sobriety (Alcoholics Anonymous, 2001). Cheryl supported the concept of the individual in recovery putting forth the effort to maintain sobriety. She stated:

First of all, having a set mind and the ability to know that you are not going nowhere, you know ... you’re in an addiction ... if you think that you’re going to continue ...and be prosperous, you’re not. So you have to make up your mind. Because you know how you can lead a horse to water but you can’t make him drink? You’ve got to be willing to drink.

## **Commitment**

The interview data evidenced another significant factor correlated with gaining control over addiction. Commitment is the act of pledging or vowing to do or accomplish something (Webster's II, 1988). The act of commitment is linked to a person's willingness to do what they can to support a group or organization without expectations of remuneration, and signifies the seriousness of the individual's intent (Rudy & Greil, 1987). Commitment is a process that surfaces as the person forges a connection between their own beliefs and the demands of an organization. The process is one in which the rewards of accomplishment are supremely fulfilling and override the desire to pursue actions in other less rewarding directions (Rudy & Greil). Nancy said about gaining control over addiction, "...when I quit using meth I was just done... I committed to it right away...self- talk is one of the biggest things that strengthens your ability and your commitment for recovery... strengthens your resolve and your commitment...". Gwen addressed the query and stated,

"I think that once people realize that they have lost control of their lives due to using drugs or alcohol that they make a commitment to deciding that they want to quit. The next step is to figure out a program that will work for them where they can learn the tools ... they will need to make their lives match the values that they want for themselves. Overcoming addiction is not something people can do by themselves ... And it takes a commitment to the fact that they are going to stay away from those people and things that can create triggers."

Research supports the notion that addiction is a chronic brain disease that has no bearing on the addicted person's lack of willpower. People suffering to overcome addiction begin to heal and get better when they begin to take steps to improve their lives and take responsibility for maintaining their sobriety (Sack, 2012). According to Inaba & Cohen (2000), the addictive disease theory, or medical model, "maintains that the disease of addiction is a chronic, progressive, relapsing, incurable, and potentially fatal condition that is mostly a consequence of genetic irregularities in brain chemistry and anatomy that may be activated by the particular drugs that are abused" (p, 67). It also supports the claim that addiction is ignited by experimentation with an agent or drug that is welcomed into a vulnerable environment (Inaba & Cohen). As the brain is the hub of human activity, its complexities and connections to all other systems within the body have posed decades of challenges to researchers determined to find causes and treatment for issues related to substance abuse and addiction (Stevens & Smith, 2001). Research scientists have determined that the pleasure sensation is the foremost emotion linked to human survival. This feeling of pleasure is generated in an area of the brain known as the nucleus acumens which is a portion of the limbic structure of the brain. Neurons containing dopamine carry pleasure signals throughout this part of the brain, and travel through the cerebral cortex, limbic system, and brain stem (National Institutes of Health, 1996). Researchers have determined that the pleasurable feeling of reward is an enormously potent biological drive. This is the same reward system that is illuminated when a person derives pleasure from food, sex, or power. It is known that if an agent is identified as being responsible for promoting feelings of satisfaction within the brain, a

person will learn behaviors that continue the use of that agent to reinforce the gratifying feelings. Researchers realize that people quickly discover how to reproduce the actions that bring them satisfaction, and having access to these rewards becomes a very powerful tool of the brain. Because of this fact, the unabated pursuit of the state of intoxication is a tremendously powerful drive present in the biological makeup of all human beings (Steven & Smith). Jan agreed that commitment was important to gaining control over addiction and stated:

Well first they stop using whatever it is they're addicted to, and then there has to be some sort of a program of improvement .... There has to be a deep-down commitment that no matter what, you're not going to get involved in using; whatever the addiction might be.

Other participants in the study cited self-control and environment, educating themselves about their disease, and having a support mechanism as factors for gaining control over addiction. The sample of men and women experiencing successful long-term sobriety provided multiple illustrations of factors responsible for their continuing success in overcoming drug and alcohol addiction.

### **Summary**

In this chapter, the data from the study was analyzed and discussed. Chapter four described conceptualizations and facilitating factors that contribute to successful long term alcohol and drug recovery. The following chapter presents a description of the conclusions and recommendations. The limitations of the study and the implications for social work practice and policy are also considered.

## **Chapter 5**

### **CONCLUSIONS AND RECCOMENATIONS**

This chapter will provide a summary of the study and a discussion highlighting the major findings and the conclusions that were reached in this study. Next, the limitations of the study and recommendations for future research will be presented. Lastly, implications for social work practice and policy will be addressed.

#### **Conclusions**

This study focused on the ways that people who were suffering from addiction achieved long term recovery and what role relapse plays in recovery. All participants were self-reporting to have at least five years in recovery. Recovery was defined by the participant, as either abstinent or not using the drug(s) that they had been addicted to. There were nine participants who were all over 35 years old and from the Sacramento County Area. Qualitative data was drawn from the ten interview questions.

This research study asked the questions: what factors contribute to successful long term alcohol and drug recovery, and what factors contribute to relapse? The study was guided by several main questions: how do you think people gain control over their addiction, what role does relapsing itself contribute to people eventually staying or not staying clean, what do you think is the reason people relapse, why do you think people attend 12- step meetings, how do you feel about a person in recovery or recovered being labeled an addict, and what factors do you think contribute to long term sobriety?

Given the study's guiding research questions, these researchers had hypothesized that people who had suffered from addiction who were recovered or still participating in

recovery, would talk about diet, exercise, family and spirituality as a contributing factor to long term success. Researchers speculated that most people can learn to have control over their addiction if they make decision to change. Lastly, researchers conjectured there would be both negative and positive connections between relapse and recovery.

Through the study's qualitative analysis emerged three main themes in the context of how recovery is achieved. The three main themes, spirituality or a personal relationship with a God of their understanding, the importance of setting goals and having a purpose, and relapsing as a motivator to staying in recovery were partially what researchers thought they would find. The data suggests that most people who have had long term recovery have a spiritual connection. This is congruent with Dr. Kaskutas (2015) research with 78% of the participants agreeing that feeling connected to a spiritual being or force that helps them deal with difficulties is part of what recovery means. These researchers found it surprising that only one of the participants talked about family and none referred to diet or exercise as factors that are a part of long term success for alcohol and drug addictions. A majority of people suffering from alcohol and/or drug use disorders also suffer from of the biochemical, metabolic, and nutritional disorders (Finnegan, 1989). There is evidence to suggest that exercise and diet can significantly reduce the symptoms of depression that can go along with withdrawal.

This research showed that people believed it was important to have a purpose and goals which aligns with the 95.1% of over 9,000 participants that state that "living a life that contributes to society, to your family, or to your betterment" (Kaskutas, 2015, p. 89), is in their definition of recovery.

The major findings under the theme of the effects of relapse on sobriety were supported by this research. There were both positive outcomes and negative outcomes to relapse. Six out of the nine participants talked about relapse as being a motivating factor to recovery. Two agree that if you follow whatever sobriety plan that you have committed following, then relapse is not part of recovery. The stigma associated with relapse can sometimes keep a person from coming back into treatment after a “fall” (Curley, 2001). Some of the participants mentioned that they had lost close friends or family who relapsed and died because they never stopped using. While these were terrible tragedies, many people learned from what they saw happen and it motivated them to recommit to their recovery.

Looking at the third major qualitative analysis findings, researchers in this study hypothesized that people would be able to gain control over their addiction once they made the decision to change their lives was partly correct. Seven of the nine participants identified in some way that making the decision to end people’s addiction is at the core of recovery. One-third stated that the commitment to staying in recovery is a key factor, and two participants replied that the way through recovery is to practice.

According to Alcoholics Anonymous (2014), the 12-step is: “Having had a spiritual awakening as a result of these steps, we tried to carry this message to alcoholics, and to practice these principles in all our affairs” (p. 5-8). The 12-step is what guides many people in recovery to continue practicing what they have learned. This is reinforced in California’s System of Care treatment programs that have adapted evidenced-based models. These programs equip the client different skills, coping



mechanisms, mindfulness exercises and tools they can learn how to practice. They do this by learning the new skill, trying it out in the community, coming back to work out the bugs, and then practice it repeatedly until they have mastered the technique (Whitter, Hillman, & Powers, 2010)

### **Recommendations**

There is a continuing need for the development of new treatment technologies. With more people seeking help for substance use disorders, providers need ways to better outcomes for their clients. From the research findings, recommendations can be made for future researchers to explore relapse and recovery, and for professionals in the field of substance use disorder treatment to broaden their treatment plans and goals.

### **Future Research**

The findings of this research study can potentially be both quantitative and qualitative in design. A larger sample size would be required in order to be generalizable. Participants could be placed into different categories of long term recovery, five, ten, fifteen or more years. Specific demographics relating to the exact number of years the person been recovered or in recovery, the path they took that led them to become recovered or recovering, and their drug(s) of choice could be included.

For this research project, the questionnaire was created to evoke thoughtful participation and answer the research questions. For future research, the questions should be updated to further explore what the is person's history, and how their health, and family life, and other specific factors that might contribute to successful long term recovery. Since these questions were not asked directly, they might have been overlooked

as possible factors in this study. Having the person give their definition of recovery would also be helpful. A quantitative study is suggested to find correlations between relapse, recovery, spirituality, exercise, family, treatment, and diet.

Another recommendation for any further studies would be to give the participant a copy of the questions before the interview. This gives the interviewee an opportunity to process the questions and deliver a thoughtful response. It could also provide a chance for clearing up any definitions or areas where the participant might need clarification. This process can help the participant to feel more comfortable discussing private and possibly sensitive subjects.

### **Practitioners and Professionals in the Field**

One of the recommendations proposed by this research is for professionals in the field of recovery. When a person first goes into treatment they might not have a full understanding or internalized definition of what recovery looks like for them. This ambivalence can lead to relapse in early recovery. According to Dr. Kuskutas's study findings, people in early recovery can grasp the definition of recovery. This revolutionary finding can redefine how providers work with their clients. In the past it has been thought that people in early recovery are not equipped and unprepared to understand what recovery is. Based on the findings in this research study, long term recovery is defined early on and then practiced in perpetuity. The specific components of recovery could be used for topics in process groups (Kaskutas, 2015).

### **Limitations**

One of the limitations of this study is that it utilizes qualitative methods and does not incorporate quantitative methodology. The most apparent limitation was the number of participants and the non-probability-sampling procedure that was utilized in this research project. There were nine subjects, who self-reported, based on their definition of recovery, with a minimum of five years in recovery. With these constrictions the study is not generalizable to the public.

Other than the initial screening questions regarding the minimum of five years in recovery, participants were not asked specifically how long they had been recovered or in recovery. For the purpose of keeping the risk factors to the subjects low, researchers of the study designed the questions to revolve around what they thought about recovery and relapse generally, and not necessarily specific to their own recovery. Many of the participants did share their personal views and individual relapse and recovery journeys. The scope of the research was constricted by both the demographic questions and the research questions.

### **Implications for Social Work Practice and Policy**

This research study offers an understanding of the significance social workers play in the arena of alcohol and other drug recovery at the micro, mezzo, and macro level. The micro level involves the individual and the family. At this level the social work profession plays a big part in providing direct services to people suffering from addiction, and providing support for family and friends of people in recovery. By equipping social workers with relevant evidence-based treatments, they can provide

optimum treatment plans and recovery goals for their clients. The implications of this research provides a way to help the individual formulate their personal definition of recovery, with a clinician who can help them with their values and goals. By starting early in recovery with a commitment to their individualized meaning of what recovery means for them, they are likely to remain in recovery long term.

At a mezzo level, the findings in this study can educate counselors, social workers, and other professionals in the field to the factors that contribute to relapse and how to provide meaningful definitions of recovery. These can be turned into new curriculum that can help people overcome the barriers and stop using practices that do not work.

At a macro level, policy makers could use this research to be aware of the recovery rates with people who suffer from addiction who only attend 12-step meetings. Many of these people cannot afford to go to treatment facilities, so their only source of help comes from mutual aid meetings because they are free to all. They can change policy, create new ones and give proper funding to the agencies that would provide services to the people who need them. Evidence-based practices would require more money to operate, however relapse rates would significantly go down, and repeat consumers would not take up funding. All of the recommendations and implications are congruent with the core values of the National Association of Social Workers. These include service, social justice, dignity and worth of the person, importance of human relationships, integrity, and competence (NASW, 1999)

## Conclusion

In recent years there has become disagreement between some models of treatment and the 12-step community as to the definition of recovery. If we look at drug and alcohol addiction from a medical model, then a person could be clean in recovery from heroin, and be on an opiate substitution such as methadone or buprenorphine. From a pharmacological perspective these drugs are similar. More and more recovery houses are accepting new clients who are on high doses of methadone. Many alcohol and drug counselors, working in treatment centers have a bias and believe that substance use disorders should not be treated with another addictive long term drug.

The word “addict” generally has a negative connotation related to it. Often in American society what comes to mind when we hear the word addict is a person in an abandoned house, with a needle sticking in their arm getting ready to go rob the local gas station at gunpoint in order to get their next fix. This negative stigma is a barrier that has prevented many people suffering with alcohol and substance use disorders from seeking treatment (Rainsky, 2003). In fact, 80 to 90 percent of the people in North America drink a brain altering substances caffeine, the stimulant found in coffee (Bernstein, Clarke-Stewart, Penner, & Roy, 2008). This seemingly harmless beverage actually has addictive qualities, including physical withdrawal symptom (DSM-V 2013). It is unlikely most people would like to label themselves as an addict because they spend hours during the week, and possibly thousands of dollars a year at Starbucks.

Changing how society views people suffering from substance use disorders is something that starts with the language that we use. So much of the nomenclature that

professionals use carries heavy negative stigma. They use term such as “drug abusers”, “substance abuser” and “addicts.” By labeling people suffering with addictions, as abusers of drugs, or alcohol, it discounts the environment, genes and the substances themselves play on addiction (Curley, 2001). Policy makers need to start making the changes at the federal level. SAMHSA, Substance *Abuse* and Mental Health Services National Institute on Drug *Abuse*, the National Institute on Alcohol *Abuse* and Alcoholism, the Center for Substance *Abuse* Treatment (CSAT), the Center for Substance *Abuse* Prevention all unintentionally define what a person suffering from addiction might feel about themselves as an abuser (Curley). In social work practice, it is important to empower people and one way to achieve this to change the negative thoughts into positive ones.

The primary purpose of this study was to find out what factors contribute to successful long term alcohol and drug recovery and to understand how relapse contributes to recovery. The second purpose of this research study was to increase the amount of research on different definitions of recovery, how we have arrived here as society, and how this applies to people who are suffering from substance use disorders. The findings in this study show that additional research on this topic will be helpful for individuals, practitioners, and policy makers. Future qualitative and quantitative research studies would add to the current research and hopefully find a way to end addiction for good.

## Appendix A

## Interview Questions

## Factors That Contribute to Successful Long Term Alcohol and Drug Recovery

1. What is your gender? ( Male, Female, Transgender, decline to state)
2. What is your age range? ( Under 35 or over 35 years of age)
3. What is your ethnicity? (Caucasian, African-American, Hispanic, Asian, other – Please describe \_\_\_\_\_).
4. How do you think people gain control over addiction?
5. What role does relapsing itself contribute to people eventually staying or not staying clean?
6. What do you think is the reason people relapse?
7. Why do you think people attend 12- step meetings?
8. What is your opinion of relapse being part of recovery in the 12 – step program model?
9. How do you feel about a person in recovery or recovered being labeled an addict?
10. What factors do you think contribute to long term sobriety?
11. Do you know of any other individuals who have been sober for at least 5 years whom you think might be interested in participating in this study? If not, thank you very much for your time. If yes, please give me their name, contact phone number and/or email address.

## Appendix B

### Consent to Participate in Research

#### Factors That Contribute To Successful Long Term Alcohol and Drug Recovery

Our names are Shannon Edmiston and Stephanie Robinson, and we are graduate students at California State University, Sacramento, Division of Social Work. You are invited to participate in a research study which will involve an exploration into the factors that contribute to successful long term alcohol and drug recovery.

Your participation is entirely voluntary and your decision whether or not to participate will involve no penalty or loss of benefits to which you are otherwise entitled. If you decide to participate, you are free to discontinue participation at any time without penalty or loss of benefits to which you are otherwise entitled.

The purpose of this research is to examine the outcomes of people that have lived experience on what has been helpful, and what has been deleterious to their long term sobriety in order to enable treatment providers to create change. If you decide to participate, you will be asked to participate in an audio taped interview utilizing ten pre-selected questions. Your participation in this study will be approximately one hour.

We are appreciative of your time. If you have any questions about the research at any time, please call Shannon Edmiston at (XXX)XXX-XXXX or at [srh232@csus.edu](mailto:srh232@csus.edu) or Stephanie Robinson at (XXX)XXX-XXXX or at [stephaniecarolr@csus.edu](mailto:stephaniecarolr@csus.edu). You may also contact Dr. Maria Dinis, the advisor of this project at (916) 278-7167 or at [dinis@csus.edu](mailto:dinis@csus.edu). If you have any questions about your rights as a participant in a research project please call the Office of Research Affairs, California State University, Sacramento, (916) 278-5674, or email [irb@csus.edu](mailto:irb@csus.edu).

Any information that is obtained in connection with this study and that can be identified with you will remain confidential and will be disclosed only with your permission. Measures to insure your confidentiality are that a pseudonym will be used in the study in lieu of your proper name. The data obtained will be maintained in a safe, locked location and will be destroyed after a period of one year upon completion of the study by August 31, 2016.

Your signature below indicates that you have read and understand the information provided above. You understand that your participation is completely voluntary. By signing below, you are not waiving any legal claims or rights.



I, \_\_\_\_\_, agree to be digitally recorded for interviewing purposes of this study.

Signature: \_\_\_\_\_ Date:  
\_\_\_\_\_

I, \_\_\_\_\_, agree to participate in the research study.

Signature: \_\_\_\_\_ Date:  
\_\_\_\_\_

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