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Sarah Elizabeth Goss

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ASSESSING THE MARKERS OF AGENCY IN SUCCESSFUL RECOVERY
JOURNEYS: A CONSTRUCTIONIST NARRATIVE OF PARTICIPANTS
IN AN ASSERTIVE COMMUNITY ENGAGEMENT MODALITY

A Thesis
Presented to
the Graduate School of
Clemson University

In Partial Fulfillment
of the Requirements for the Degree
Master of Science
Social Science

by
Sarah E. Goss
December 2020

Committee:
Bryan Miller, Ph.D., Committee Chair
Melissa Vogel, Ph.D.
Alain Litwin, M.D.
Irene Pericot-Valverde, PhD

ABSTRACT

The Faces and Voices of Recovery program in Greenville, South Carolina is part of a national recovery advocacy movement utilizing a harm-reduction framework. This study aims to identify how individual agency is accounted for in this harm reduction-based recovery group and by extension, the recovery process. Spanning a four-month discourse collection process, and incorporating partial and complete observations of participants this study identifies four tiers of participation and engagement (1) high engagement successful recovery (2) low engagement successful recovery (3) high engagement struggling recovery and (4) low engagement struggling recovery/disengaged.

KEY WORDS

Recovery · Substance Abuse · Agency · Recovery Coach · Harm Reduction

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LIST OF ABBREVIATIONS

AIR	Active in Recovery
BNDD	Bureau of Narcotics and Dangerous Drugs Complete
CPO	Participant Observation
DSM	Diagnostic and Statistical Manual of Mental
FAVOR	Disorders Faces and Voices of Recovery
FDA	Federal Drug Administration
IRB	Institutional Review Board
MAT	Medication Assisted Treatment
OUD	Opioid Use Disorder
PPO	Partial Participant Observation

DEFINITION OF TERMS

Agency. Defined as goal-oriented energy by Mathis et al. (2009), agency refers to the individual's ability to take responsibility for their behavior and actions in pursuit of a positive life path towards recovery.

Engagement. A combination of Drobets' et al. (2019) interpretation of "elevated attention to stimuli with enhanced saliency or relevance for certain individuals or groups" in conjunction with how individual agency relates to attentional bias and threatening or sensitive subject matter presents itself as speaking participation, but also non-verbal active listening, observed disinterest in the meeting, degrees of participation and level of discussion to create a working definition of engagement that can be applied to agency in individuals recovery paths.

FAVOR Greenville. FAVOR Greenville is a Recovery Community Organization (RCO) and serves as the Upstate's "Welcome Center to Recovery." A charter member of the Association of Recovery Community Organizations (ARCO), FAVOR is one of nine RCOs accredited by the Council on Accreditation of Peer Recovery Support Services (CAPRSS).

A recovery-oriented sanctuary, FAVOR exists: to put a "face on recovery" to reduce stigma and discrimination; to support individuals and families in sustaining a personal path to recovery; and to create innovative ways to address addiction - our nation's # 1 public health problem whose is to promote long-term recovery from substance use disorders through education, advocacy and recovery support services, resulting in healthier individuals, families, and communities.

Harm Reduction. Rather than use a narrow and rigid definition, Lenton & Single's (1998) socio-empirical definition of harm-reduction comprising of three parts: *(1) the primary goal is the reduction of drug related harm rather than drug use per se (2) where abstinence-oriented strategies are included, strategies are also included to reduce the harm for those who continue to use drugs; and (3) strategies are included which aim to demonstrate that, on the balance of probabilities, it is likely to result in a net reduction in drug-related harm.* Serves as the applied definition of harm-reduction referred to in this thesis.

Opioid use disorder. The maladaptive use of opioids prescribed or illicit resulting in two or more criteria that reflect impaired health of function of a 12-month period (American Psychiatric Association, 2013). As established by the DSM-V, opioid use disorder incorporates the previous definitions of opioid dependence and opioid abuse (American Psychiatric Association, 2013).

CHAPTER ONE

INTRODUCTION

I never considered myself an alcoholic. Even now typing this, the dissonance between my understanding of myself and that word cause an anxious friction. I am young, in graduate school, for a short time I was even engaged. These are all markers of success, not anything I would associate with an alcoholic. I grew up in a stable, nuclear, upper-middle class suburban home, the oldest of three children. I was never un-loved, but I was not the favorite either. I graduated in the top of my class in high school and later with honors in college. I never drank until I moved to South Carolina for graduate school.

When the opportunity to do research with an organization called Favor in nearby Greenville County, I leapt at the opportunity. To my cohort's dismay I was practically handed a thesis topic and committee. The program, which utilizes an assertive engagement modality of treatment and a harm reduction perspective on recovery was to be the basis of my study. I never in a million years imagined myself a part of the program or to have an alcohol problem in general. After all, no one grows up wanting to be an alcoholic.

Disclaimer

Unintentional to the start of my research and this study, which began as a narrative means to identify the motivating factors behind participant engagement morphed into an ethnographic approach to constant comparative analysis in which I found myself just as much a participant in recovery as the individuals I was studying. The perspective I gained by slowly integrating into the recovery community granted me access to subjective narratives and rich dialogue to understand the experience of those in recovery and allowed me to both observe and experience

how participants used the resources available to them and in doing so took agency in their own recovery. My role as a researcher was strengthened in this aspect as I gained entrance into a community, I would have otherwise been an outsider to. The process of integrating myself into this community was not smooth, rather rocky as I came to terms with and reshaped my own identity. This should not however, be viewed as a limitation or weakness in the study rather a strength. My ability to truly understand and share in the lived experiences of the individuals yielded a richer discourse than I could have initially imagined possible.

Purpose of Document

The purpose of this thesis is to understand how individual agency is accounted for in harm reduction-based recovery groups and by extension, the recovery process. This study aims at identifying the factors of agency presented by participants in all-recovery meetings spanning a four-month discourse collection process. Discourse analysis will be discussed further in this document and includes discourse from meetings, conversations, observations and one on one interviews.

Background of Study

In a previous study conducted by a team of researchers from Prisma Health-Upstate, University of South Carolina School of Medicine and Clemson University, drug use that resulted in emergency room intervention and hospitalization was studied in conjunction with recovery coach intervention in what was called the Force team (Parrish, 2019). Results concluded that recovery coaches were significant in motivating individuals to be active in recovery and pursue treatment options when necessary as compared to traditional standards of care where recovery coaches are not present (Parrish, 2019). In this foundational step to active recovery, recovery

coaches were found to fill a void that emergency care providers had previously not addressed. As one recovery coach stated,

“Recovery coaches in the ER have changed the dynamic --the mindset of clinicians. I can absolutely 100% attest to that. Yes. When we came in 2018 on January 8th for six months it was like that. That’s what I heard “oh that’s the drug addict thank god y’all are here to deal with it because we don’t know what to do with it. They’re just a bunch of drug addicts and they suck’ that kind of thing. Us being there and working and treating the patients like real patients that have a health care issue, I swear it has changed the mentality of healthcare professionals –meaning doctors and clinicians in the ER.” -Henry

Additionally, this signified the role of recovery coaches in early recovery with latent conclusions positing that introduction into recovery support groups amongst other treatment settings was consistent with individuals taking agency in recovery. Absent are the long-term results of this intervention and measures to qualify participants as active agents in their own recovery.

Introduction to Favor

The Faces and Voices of Recovery program in Greenville, South Carolina is part of a national recovery advocacy movement whose vision “embraces and celebrates recovery from substance use disorders as a positive, healing force” (Favor, 2019). Self-defined as a movement, center and family, the organization was incorporated in 2004, with its Greenville location opening in July 2013 (Favor, 2019).

Unique to Favor is a new methodology of treatment; an assertive community engagement modality of treatment that advocates for all pathways to recovery and network access to non-clinical recovery support programs “offering immediate intervention and access to intervention services and recovery support” (Favor, 2019).

Harm reduction makes up the philosophical framework of the organization, in which decreased use extending to abstinence of the abused substance(s) are the goals and ultimate

identifiers of success in, and persistence on recovery journeys. In this framework, the vision and mission of Favor posit a “healing force” in the Upstate region of South Carolina, in which the core beliefs are; addiction recovery as a reality in the lives of millions, a multiplicity of pathways to recovery, the success of recovery in supportive communities, recovery as a voluntary process, recovery as a retrieve for addiction related loss and recovering and recovered people as a part of the solution (Favor, 2019).

As such, recovery support is offered by the organization at no cost in the forms of individual, family, and community support outlets. Resources of which can be found online or in person at the Greenville locality and are published monthly in a public calendar of events.

Need for Study

While previous research has been done with Favor and on the intervention of recovery coaches in the emergency room setting, there is a lack of research on harm-reduction and generic recovery groups; definitions of which can be found in the definition of terms portion of this paper. Evidence to support the success of early intervention and crossover from emergency room overdose instances with projected success in recovery was found by the team of researchers from Prisma Health Upstate, University of South Carolina School of Medicine, and Clemson University in a previous study however, the cross-sectional pilot-study lacked sufficient evidence on how harm-reduction based recovery groups evidenced participant agency in successful recovery or indicators thereof. This study aims to identify markers of agency and additionally edify successful agency in participants to increase intervention in when there is a lack thereof.

Purpose of Study

The purpose of this study is to explore how participants engage with harm reduction approaches to recovery specifically in respect to Favor Greenville and the agency of individuals

in their recovery journey. The intended effect of this study is to determine ways to intervene in situations where agency is not present and to determine what factors impact agency in successful recovery pathways.

Additionally, this serves to highlight areas where Favor as an organization can increase intervention for successful recovery outcomes. It is important for organizations to understand how participants utilize the resources available to them and to view the use of these resources as indicators of agency thus allowing for a greater allocation of these resources.

CHAPTER TWO

LITERATURE REVIEW

Background

First considered a “wonder drug” in 1898, heroin was commercially available as a cough suppressant following clinical trials under Bayer Co. (Moghe, 2014). The addictive properties of heroin became apparent when legislature was passed in 1914 under the Harrison Narcotic Act in which heroin became a federally controlled substance (Terry, 1915). Common perceptions of heroin changed in the 1960’s, as increases in opioids as a result of the Vietnam war spurred a “social condition” around opioid use which paralleled that of infectious diseases (Mold, 2007; Mund & Stith, 2018). Under the Controlled Substance Act of 1970, heroin was officially recognized as a schedule I drug, rendering it highly addictive and with no medicinal value. It wasn’t until the 1970’s under President Ford that the Bureau of Narcotics and Dangerous Drugs (BNDD) partnered with local law enforcement in a pilot task force to address the nonmedical use of heroin (DEA, n.d.). A formal task force was later instituted in 1973, the Drug Enforcement Administration (DEA), which incorporated the BNDD and Custom’s drug agents to enforce federal drug law (DEA, n.d.).

The production of Percocet and Vicodin in the mid to late 1970’s and later oxycontin in 1996 increased the available opioids in the medical market (Moghe, 2014). The number of prescriptions for opioids skyrocketed, with 8 million more prescribed in 1996 than the year prior (Moghe, 2014). By the early 2000’s medical standards for prescription opioids were backed by pharmaceutical companies, predominantly Purdue Pharma, whose tactics included publishing literature for doctors on prescribing opioids (Moghe, 2014). The information was later removed in 2009.

The widespread non-medical use of both heroin and other opioids has since doubled from 1999-2013 (Mund & Stith, 2018), with roughly 11.5 million Americans effected in 2016 (Ahrnsbrak et al., 2016) and current estimates topping some 2-million Americans suffering from opioid use disorder (OUD) following the inclusion of the disorder in 2013 to the DSM-V (Wakeman et al., 2018).

Treatment for OUD largely centers on medicated assisted treatment, covered later in this paper. The effect of OUD on Americans is evidenced in the amount of prescriptions used in MAT based programs, with 12.5 million prescriptions filled in a given year for Buprenorphine alone (Wakeman et al., 2018). Current risk populations vary, with evidence of drug-related problems (DRP) in elderly populations commonly linked to the number of drugs and drug interactions within pharmacotherapy for chronic disease (Ahmad et al., 2014). Whereas evidence of non-medical opioid use in adolescent populations centers on environmental and social factors (Stumbo et al., 2017). New synthetic variations of opioids have amounted to increases in opioid related deaths across risk populations, setting the stage for research on effective treatment for opioid use disorder (Frank & Pollack, 2017).

Theoretical Orientations within the Literature

It is not uncommon for agency to be utilized under social constructionism or contextual action theory (McCullough & Anderson, 2013; Cain, 1991). The approaches similarly attest to joint agency of the individual but differ in the way agency is formed and presented.

In a social constructionist approach, knowledge is viewed as constructed as opposed to created (Andrews, 2012). Therefore, “society is viewed as existing both as a subjective and an objective reality” with a joint, or shared understanding of knowledge (Andrews, 2012 pg.40). In

this more basic orientation, participant narratives are seen as the individuals' truth whereas there are multiple understandings of a shared ultimate reality.

In the case of contextual action theory, agency is defined as 'joint goal related action' comprised of three parts:

“(1) Human action and agency are freely exerted within the bounds of our physical, biological, social and cultural contexts (Martin et al., 2003). (2) Agency is conditionally defined as the biologically and socio-culturally mediated capacity to act (Ahearn, 2001); and (3) all human action has a reciprocal relationship in shaping, enacting and responding to our biological substrates and socio-cultural context (Zidjaly, 2009).” -(McCullough & Anderson, 2013).

Regarding treatment, this theory builds on the social, historical and culturally constructed ideologies as evident in narrative therapy, solution focused therapy and collaborative language systems (McCullough & Anderson, 2013). This works in conjunction with the understood norms of society, i.e. substance misuse and abuse as deviant behavior.

A critique of these traditional applications of theoretical application comes from the perspective of embodied knowledge from Ellingston, in which she denounces the classic passive voice of the researcher, opting instead for an active voice and reflexive perspective on race, ethnicity, age, and experience as inherently influential to the discourses and data collection processes (2006). In this critique, the researcher's body and voice are the forefront of data collection as this in turn relates to how the researcher is perceived in the field and as such the discourses. This perspective can be dually applied to the participant, who's narrative is intrinsically linked to his or her embodied self.

Opioid use disorder (OUD)

For the purpose of clarification, opioid use disorder, rather than opioid abuse or opioid addiction will be the working definition used to define non-medical opioid use in the participant population. Defined by the Diagnostic and Statistical Manual of Mental Disorders, (fifth

addition), opioid use disorder is the maladaptive use of opioids, prescribed or illicit resulting in two or more criteria that reflect impaired health or function of a 12-month period (American Psychiatric Association, 2013). Diagnostic criteria for OUD centers of the following:

“(1) use of an opioid in increased amounts or longer than intended, (2) persistent wish or unsuccessful effort to cut down or control opioid use, (3) excessive time spent to obtain, use, or recover from opioid use, (4) strong desire to use an opioid, (5) interference of opioid use with important obligations, (6) continued opioid use with important obligations, continues opioid use despite resulting interpersonal problems, social problems or both, (7) elimination or reduction of important activities because of opioid use, (8) use of an opioid in physically hazardous situations, (9) continued opioid use despite resulting physical problems, psychological problems or both, (10) need for increased doses of an opioid for effects, diminished effect per dose, or both, and (11) withdrawal when dose of an opioid is decreased, use of drug to relieve withdrawal or both” (American Psychiatric Association, 2013).

It is only recently in the fifth edition of the DSM-V that OUD was included, combining two previous disorders; opioid dependence and opioid abuse (American Psychiatric Association, 2013). It is estimated that more than 2 million Americans suffer from an OUD (Wakeman et al., 2018).

Literature on Addiction

While literature on medication assisted treatment (MAT) is extensive, there is lack of literature surrounding experimental, or non-traditional psychosocial modes of treatment. Similarly, modes of treatment that were not exclusively centered on MATs appeared as vague or listed merely as mental health centers where non-medical opioid use was secondary to social or environmental stressors linked to mental health. That said, included in the review of the literature is a brief background on opioid use disorder, as well as an overview of literature on psychosocial modes of treatment, MATs, and barriers to access, a theme that emerged in the literature, but had no distinct solution. The purpose of including barriers to access, centers on FAVOR’s assertive community engagement modality, of which is a possible future solution to access.

Treatment Modalities in the Literature:

Psychosocial Modes of Treatment

Psychosocial methods target situational and developmental stress through emphasis on “prevention and the interface between the individual and the individual’s environment” (Healthy Start Coalition, 2015). This treatment modality incorporates not only the individual, but a group, family or community to target and address specific emotional and social problems. In the example of the Community Reinforcement and Family Training for Treatment Retention (CRAFT-T) study, multiple modes of engagement from family and community members in comparison to standard psychosocial-individual treatment resulted in significant results for adults with families who participated in the study (Brigham et al., 2014).

Medication-Assisted Treatment (MAT)

Defined as an evidence-based practice that combines pharmacological interventions with substance abuse counseling and social support, MATs account for almost all research on opioid specific treatment modalities (Mund & Stith, 2018). In primary care settings four key components: (1) pharmacotherapy with buprenorphine or naltrexone (2) provider and community educational interventions (3) activity within the community and (4) integration and coordination of OUD treatment with other medical and psychological needs and psychosocial services provide (Korthuis, 2016).

Literature on drug-related programs and treatment modalities overwhelmingly focus on Medication Assisted Treatments (MATs; Yarborough et al., 2016; Mund & Stith, 2018). Defined by the American Addiction Centers Resource, Recovery.org as “the use of medications and behavioral therapy to treat people who have substance use disorders,” MATs often target the acute withdrawal process (Hatfield, 2018). The minimization of withdrawal symptoms is

principally treated by three medications approved by the Food and Drug Administration (FDA): buprenorphine, naltrexone and methadone (Connery, 2015). All three medications function similarly as ligands that bind to mu-opioid receptors, acting as partial agonists or full agonists in the case of methadone (Connery, 2015). Both naltrexone and methadone are classified as schedule II drugs, whereas buprenorphine is classified as a schedule III drug (Connery, 2015). All three drugs interact with opioid receptors on nerve cells in the brain, to block both cravings, sedating effect, and euphoria associated with opioid misuse to alleviate or partially alleviate withdrawal symptoms (ASAM, 2016; Korthuis, 2017). Treatment with opioid agonists may also be referred to as opioid agonist therapy (OAT) in the literature (Wakeman et al., 2018).

The incorporation of buprenorphine; a schedule III drug under the Controlled Substances Act, in lieu of Methadone; a schedule II drug, has been a central topic of discussion in MAT related literature (Mund, & Stith, 2018). Patient preference for methadone or buprenorphine is common in current literature, as are variants and coalescence of buprenorphine: suboxone; containing buprenorphine and naloxone and Subutex; containing buprenorphine (Drugrehab.org, 2018; Connery, 2015). Subutex is classified as a partial agonist-antagonist whereas suboxone is a partial agonist, however both are schedule III drugs (Connery, 2015).

Barriers to Access

In researching treatment modalities, the concept of barriers to treatment is common, even identified in the example of Becker et. al, as central in areas with high rates of unemployment, lack of insurance, and low rates of treatment (Becker et al., 2008). In a survey from the National Survey on Drug Use and Health (NSDUH) 2002-2004, it was found that new policy strategies surrounding vulnerable populations would expand treatment to otherwise marginalized populations (Becker et al., 2008). The annual survey aims at collecting data on ‘the prevalence of

substance use and its correlates, including employment, insurance, and treatment status' through the following questions:

“(1) what demographic and clinical factors are associated with opioid use disorder? (2) What proportion of patients with opioid use disorder receives treatment? (3) Among patients with opioid use disorder, does receipt of treatment vary by insurance status (e.g., uninsured vs. insured) or type (e.g., public vs. private)? (4) What demographic and insurance factors are associated with receipt of addiction treatment, and (5) who finances this treatment and where is it received?” (Becker et al., 2008 pp. 10).

Literature in support of Becker and colleagues' argument emphasizes the importance of employment either in temporary, informal work or in the form of formal job training and job attainment, and the availability of treatment as it relates to insurance afforded therein (Richardson et al., 2012).

However, Richardson introduces a dichotomy to groups facing barriers that is absent in Becker's argument. Movement into a formal job, while understood as a positive measure of success by Becker, can inhibit or even stop treatment for individual's receiving social assistance (Richardson et al., 2012). The barrier is thus two-fold, in that there is not only a barrier to treatment but also the social mobility and capital afforded by having a formal job.

The purpose of this literature is to identify the ways in which current standards of recovery are limiting the overall reach of these treatment modes. By extension this literature highlights the accessibility of Favor as a harm-reduction group therapy approach to recovery which acts as a remedy to the gaps and barriers of traditional and clinically based treatment options.

CHAPTER THREE

RESEARCH DESIGN AND METHODS

General methodological assumptions

Scholarship on qualitative research methods posits that “scholars regularly debate about what qualitative research is, how and why it should be conducted, how it should be analyzed, and in what form it should be presented” causing a myriad of questions regarding the substance, accuracy and worth of qualitative research as it pertains to the field (Guest, Namey & Mitchell, 2013). As such, the assumptions and limitations of the study are imperative and lend to a degree of transparency required.

Assumptions of ontology, epistemology, axiology, generalizations, causality and logic are all present in qualitative, ethnography-based research (Capella University, 2013). Addiction is not a singular phenomenon and therefore cannot be treated as such. Rather, is socially constructed and differed from person to person. This assumption coincides with a constructionist narrative perspective to the multitude of factors influencing social behavior and agency. That said, the application of embodied knowledge fills the void that social constructionism leaves in regard to ontological linkages and assumptions and as such should be noted (Ellingston, 2006; Andrews, 2012).

Fundamental to the design of this study are axiological assumptions as to meaning making and value assessments. This is apparent in the coding process as words such as consequence carry inherently different meaning and application to individuals despite being frequently used by both recovery coaches and participants within harm reduction recovery groups. More relevance to axiology will be discussed in the results and discussion portion of this paper.

Similarly, the epistemological relationship between myself as the researcher and participants in the study as co-creators of discourse; with emphasis on the participant as the ultimate author of their experience being their truth. (Ruhl, 2014; Capella University, 2013).

Furthermore, the inability to generalize conclusions from sample discourse to larger populations is a limitation of this research design. The shared and lived experiences that comprise the data collected are intrinsic to the individual participants and while there are undoubtedly idiosyncrasies within anecdotes, each experience cannot be generalized and holds relevance. This is not to negate the value of information provided from these discourses rather, edify the lack of generalizability.

Additionally, this is not a design in which causality is determined or searched for. Inferences into causality are not present. That said, this design contributes to a better understanding of the processes in meaning making and co-construction of reality by participants and immediate actors (McCullough & Anderson, 2013).

This design as such is ethnographic in nature. It encompasses in-depth interviews and observations as primary means of discourse collection and allows for a shifting perspective to gain rich and embodied knowledge.

Delimitations

As this study is primarily focused on the markers of agency in harm reduction-based recovery and the accompanying levels of engagement this signifies, only harm-reduction support groups were studied as opposed to various other recovery group settings. This included purposefully avoiding observations with abstinence-based recovery groups where engagement in programs is gauged on any substance use or the abstinence thereof.

Access to the Field

The Faces and Voices of Recovery program in Greenville, South Carolina is part of a national recovery advocacy movement whose vision “embraces and celebrates recovery from substance use disorders as a positive, healing force” (FAVOR, 2019). Before beginning research, access to the field, including introduction to and the formal permission of use therein must be obtained. Favor’s Greenville location acts as the specific locality where in-person meetings are held and acts as the immediate locality to observe the interaction and engagement of participants in the program. Thus, this location is the starting point for conducting observations and in-depth interviews. Due to the nature of ethnographic fieldwork the field is not limited to this locality, rather it is a stepping point to “multi-local” or “trans-local” fieldwork allowing the researcher to follow people, objects, a specific symbol, a metaphor or story (Marcus, 1995; Ciesielska et al., 2018). My introduction to the field was presented as a student, and it was often that staff referred to my presence as “the intern.”

Defining the Field

In defining the field further, context is explored to understand the inter-workings of the setting research is to take place. This is to understand how the setting is utilized, and to prepare for sampling. Included in defining the field is identifying the roles of participants within the organization. For example, the recovery coaches who act in a formal sense, however, are likely to act as informal gatekeepers and act as informal sponsors (Hammerly & Atkinson, 2007). In doing so, this allowed myself as the researcher to maintain a reflexivity where I understand how participants may perceive my role as a researcher. This also acts to identify additional settings where research may be conducted. In this study additional settings include that of “Active in Recovery” or AIR events which maintain the ideals of Favor but occur outside of the initial setting and as such require adaptation on the part of the researcher.

Ethnographic Research Design

The choice to employ an ethnographic design for observational research stemmed from the work of Madden (2010) in which the social context of study is complex, and not necessarily definitive. This suited the nature of my project where saliency to drug use and the mechanisms of active agency in recovery were the basis of my research interests. The role of the researcher in this sense is not fixed, rather renegotiated throughout the duration of the study and likely to shift between partial to complete participant observation (Ciesielska, Bostrom, & Ohlander, 2018). Because, ethnographic studies “privilege the context and participants’ point of view allowing for thoughtful understanding of their subjective experience and the meaning they attach therein” (p.21) it made sense to employ a research design nested in face to face research and shared social spaces (Ruhl, 2014).

The benefit of ethnographic research includes the prolonged physical presence of the researcher and the ability to reestablish oneself to access a changing field and adapt accordingly to maintain a reflexivity throughout the duration of study (Ciesielska, et al., 2018). I repeatedly reestablished myself through the course of my research as a student-researcher and maintained my physical presence on a weekly basis as I become familiar to participants to conduct partial participant observation as defined by Ciesielska and colleagues as taking part in the interactions, but not the type of activity that is specific to the group” (2018).

This research design lends itself to observations, interviews, conversations and shared experiences with participants. That said, planning discourse collection in the form of in-depth interviews in conjunction with questionnaires based on the Treatment Options Study (TOP), in which adults with opioid dependence were interviewed on prior experiences with treatment for opioid dependence in addition to a short questionnaire (Yarborough et al., 2016) were used as the

primary discourse to be analyzed and coded for emergent themes. In preparation pilot interviews were conducted prior to the start of the study and served as framework included in the interview protocol.

Interviews with recovery coaches focused on the perceptions of recovery, agency and their personal interactions with participants in harm-reduction based recovery. By contrast, interviews with participants focused on their initial experience with Favor and harm reduction, including but not required to include interactions with recovery coaches or experiences that highlighted harm-reduction.

Observations in conjunction with interviews granted yet another perspective and one from which I was able to compare, contrast and ultimately cross-analyze my discourse. Observations were not limited to all-recovery meetings but included conversations, shared experiences, and observations of events outside of; but still sponsored by the Favor Greenville locality. This fundamentally strengthened my research and aided in my analysis and findings.

Additionally, analysis of brochures, pamphlets, Favor's website, and Facebook group were included as they prove relevant to a constructionist narrative approach to understanding how experiences of participants exist both within and out of the physical bounds of the locality (Ciesielska et al., 2018; Miller, Stogner, & Miller, 2016).

Population and Sampling

The population of interest in this study includes all participants of Favor, including but not limiting to paid staff, volunteer recovery coaches, guest speakers, and participants in any of the meetings held at the Favor Greenville location.

The sample of this study is a convenience sample of both paid staff and volunteer recovery coaches as well as participants in *All Recovery* meetings. Divided into two sub-groups

(1) recovery coaches at Favor Greenville, and (2) Favor participants in harm reduction-based recovery meetings; this expands to All Recovery, Smart recovery, and generic recovery groups. Participants were recruited through CEO and COO of Favor, Rich Jones.

A comprehensive, although non-exhaustive list of recovery coach candidates was provided by Rich Jones, under the criteria that individuals had completed recovery coach training through Favor. Length of time utilizing programs in Favor will not be a criterion as to include individuals who may have either recently began participation, as well as individuals who may have left and later returned. For consistency, participants interviewed were present in at least three recovery meetings a week.

Recovery coach participants were approached via email if a working email was provided or by phone if email was not available. A total of five recovery coaches were interviewed via a convenience sample of the first five respondents. A copy of this email is available in the appendix. Participant candidates were also approached in person at Favor, amassing to twenty participants. Samples were collected via convenience sampling; the first five recovery coach respondents and the first twenty participants were interviewed for a total of twenty-five participants in the two demographics.

Demographic data was additionally obtained through a brief demographic survey. Participants were asked at the beginning of the interview process to complete a short demographic survey. Participant data illustrated in Table 1. Illustrates the assigned pseudonym, age, gender, ethnicity, income, religious affiliation, stable living arrangement, employment status and typology. The same demographic data for recovery coaches is present in Table 2.

Table 1. Demographic Data of Participants

Pseudonym	Age	Gender	Ethnicity	Income	Religious Affiliation	SLA*	ES**	P/RC***	Category****
Amanda	38	F	White	\$50,000-\$74,999	Other, Christian Baptist	Yes	Not Employed	Participant	Active Successful
Ashlin	24	F	White	\$25,000-\$49,999	Spiritual	Yes	Yes, Full Time	Participant	Active Successful
Beau	52	M	White	\$175,000 and Over	Christian-Protestant	Yes	Not Employed	Participant	Active Successful
Brandon	42	M	White	\$10,000-\$24,999	Christian-Protestant	Yes	Yes, Part Time	Participant	Active Successful
Chris	63	M	Unspecified	\$25,000-\$49,999	Spiritual	Yes	Not Employed	Participant	Active Successful
Daniel	71	M	White	\$50,000-\$74,999	Christian-Protestant	Yes	Retired	Participant	Active Successful
Devin	30	M	Asian/Indian	\$75,000-\$99,999	Other, Sikhism	Yes	Yes, Full Time	Participant	Active Struggling
George	64	M	White	\$10,000-\$24,000	Christian-Protestant	Yes	Not Employed	Participant	Disengaged
Haley	37	F	White	\$10,000-\$24,999	Christian-Protestant	Yes	Unemployed	Participant	Active Successful
Harry	64	M	White	\$10,000-\$24,999	Other, Deist	Yes	Unspecified	Participant	Active Successful
Jared	27	M	White	\$10,000-\$24,000	Spiritual	No	Yes, Part Time	Participant	Active Struggling
Kathy	34	F	White	\$10,000 or Under	Christian-Protestant	Yes	Unspecified	Participant	Active Successful
Paul	40	M	Unspecified	\$175,000 or Over	Spiritual	Yes	Unspecified	Participant	Active Struggling
Perry	32	M	White	\$25,000-\$49,999	Spiritual	Yes	Yes, Full Time	Participant	Active Successful
Roger	60	M	White	\$75,000-\$99,999	Christian-Protestant	Yes	Retired	Participant	Active Successful
Ryan	39	M	White	\$100,000-\$124,999	Christian-Protestant	Yes	Yes, Full Time	Participant	Active Successful
Thomas	34	M	White	\$50,000-\$74,999	Not Religious	Yes	Yes, Part Time	Participant	Active Successful
Tommy	39	M	White	\$50,000-\$74,999	Spiritual	Yes	Yes, Part Time	Participant	Active Successful
Travis	35	M	White	\$25,000-\$49,999	Spiritual	Yes	Yes, FullTime	Participant	Active Successful
Zach	57	M	White	\$175,000 and Over	Not Religious	Yes	Not Employed	Participant	Active Successful
*Stable Living Arrangement									
**Employment Status									
***Recovery Coach/Participant									
****Active Successful/Active Struggling/Disengaged									

Table 2. Demographic Data of Recovery Coaches

Pseudonym	Age	Gender	Ethnicity	Income	Religious Affiliation	SLA*	ES**	P/RC***	Category****
Henry	49	M	White	\$175,000 and Over	Christian-Protestant	Yes	Yes, Full Time	Recovery Coach	Active Successful
Jacob	32	M	White	\$25,000-\$49,999	Christian-Protestant	Yes	Yes, Full Time	Recovery Coach	Active Successful
Marilyn	57	F	White	\$50,000-\$74,999	Other, Religious Science	Yes	Yes, Part Time	Recovery Coach	Active Successful
Margaret	60	F	White	\$50,000-\$74,999	Christian-Protestant	Yes	Yes, Part Time	Recovery Coach	Active Successful
Trina	67	F	White	\$10,000 or Under	Spiritual	Yes	Yes, Part Time	Recovery Coach	Active Successful
*Stable Living Arrangement									
**Employment Status									
***Recovery Coach/Participant									
****Active Successful/Active Struggling/Disengaged									

Sampling for Observations

The who, what, when and where of research design is grounded in identifying potential participants while “attempting not to influence the course of events and exert minimal influence of the environments” (Ciesielka et al., 2018). This includes a well-researched literature review on the part of the researcher as well as an understanding of the physical space of study. I made copious notes on how participants utilized and managed their time and the physical space of the Greenville location. This included how the overarching themes “All Recovery” were present in the various meetings and organizations that used the space as well as how participants used time within the All Recovery meeting.

Similarly, this included notes on social actors and objects such as the incorporation of an open kitchen where participants could make coffee, get snacks and how they interacted in these settings before, after and during meetings. The routines and rituals of participants, as well the diversity and age of participants was also noted in observations and later collected as demographic data in in-depth interviews for a select group of participants. Additionally, the agency of participants was observed in how they presented themselves both during the meeting and outside of the meeting. These specific observations are rooted in the dissonance in discourse between individual participation in the meeting and their actions outside of meetings as told themselves.

Sampling for In-Depth Interviews

Sampling for in-depth interviews differed in that a non-exhaustive list of recovery coaches was provided in part by Hubert Yarborough and Rich Jones of Favor. An introductory email was sent to the coaches in this list and a convenience sample was taken from the coaches that responded. Additionally, a convenience sample of participants from All Recovery meetings

was utilized. Informal sponsors interested in the study and the progression thereof would introduce myself as the researcher and invite participants to schedule a time to interview. Once scheduled, participants would engage in the semi-structured interview, and adjoining materials including a demographic survey, letter of informed consent and a signed receipt of incentive. As a token of appreciation, participants were gifted a twenty-dollar Walmart gift card.

Procedures

Consent and Confidentiality

Working closely with the Clemson Institutional Review Board, Dr. Bryan Miller, Dr. Melissa Vogel, Dr. Alain Litwin, and Dr. Pericot-Valverde to adhere to the ethical standards and guidelines for research, the inclusion of a letter of confidentiality was incorporated to limit the risks associated with participation in the study. Additionally, I avoided salient questions in the interview allowing for participants to engage at a degree they felt most comfortable with. Interviews were conducted at Favor's Greenville location to further decrease the risk of participation and to have counseling services and recovery coaches on site and available to participants if the need arose.

In accordance with Clemson University's institutional review board, the protocol qualified as exempt under category 2 in accordance with regulations 45 CFR 46. 104(d) of Clemson University's compliance standards. Under this determination, participants are at minimal risk of harm. This includes the permission of Favor Greenville to utilize their facility to carry out interviews and observations in a familiar yet private space.

Participants involved in this research study were willing participants and were incentivized to participate. Participants who completed the in-depth interview and a brief

demographic survey were given a \$20 gift card to Walmart as a token of appreciation for their participation in this research study.

Additionally, participants were made aware that at any point within the data collection process they would like to no longer participate, their interview and survey data would be dropped from the research study and consequently destroyed.

To protect participant's identity and further decrease the risk of participation no identifying names or features from participants were retained and pseudonyms were assigned to each participant to differentiate transcribed interviews and protect participant privacy. All names voiced by participants in the interview process were removed to further protect the identity of participants. A copy of the IRB submission is included in the appendix.

Discourse and Data Collection

Discourse and data were collected via partial participant observation, complete participant observation and in-depth interviews with both recovery coaches and participants at Favor Greenville. In using an ethnographic research design, I was able to form connections with participants to gain insight into their respective lives, discover how agency presents itself in a harm reduction based method of treatment and observe how and to what degree participants engaged in the program.

Research Questions

The original research interests aimed at (1) identifying factors that prompted participation in Favor's Greenville's all-recovery meetings and (2) researching the degree if any that recovery coaches had on impacting participation shifted to (1) an interest in identifying themes of active agency in recovery and (2) identifying the *degree* of engagement in *successful* recovery. Measures of success in recovery, as well as identifiers of agency within recovery have been

discussed in the literature review as well as a brief differentiation of agency markers in traditional modalities for active recovery, including but not limited to abstinence from alcohol, pharmacologically, cognitive behavioral therapy, self-help group attendance, family therapy, individual interventions, and combined behavioral interventions (Ciesielska et al., 2018). Both observations and interview methods were utilized to explore these questions. Semi-structured interviews in adherence to an interview guide were conducted with both partial and complete observations acting as auxiliary and confirmatory research (Jamshed, 2014).

Partial Participant Observation

Partial Participant Observation (PPO) was conducted three times a week during noon to one “All Recovery” meetings, as well as six thirty to seven thirty meetings Tuesday evenings if there was a time conflict with a noon meeting throughout the week. PPO was the dominant form of observation in this study and was used to identify what participants were repeatedly engaging in the program, as well as to identify topics, emotions and repeating discourse through the course of the meetings. Forty-six meetings were observed, as well as a ten to fifteen-minute time period before and after the meeting. I continually attempted to make note of the relationships I observed and the fellowship of participants who regularly attended. Additionally, I immersed myself in the setting, to understand how participants utilized both the physical landscape of Favor before, during and after meetings as well as the degree of participation.

Complete Participant Observation

Complete Participant Observation (CPO) as defined by Ciesielska and colleagues refers to researchers attempts to “blend into the studied environment and to appropriate the group’s lifestyle, customs, and even the way they perceive reality” (2018). This method of observation allows for a richer context, however, risks the researcher’s ability to maintain reflexivity. In my

own experience, I found myself becoming a CPO as the study progressed. While I was unaware of my own addictive tendencies and habits, I found that when I aligned myself with participants, I was able to better understand their experiences and in doing so built stronger rapport and gained access to embodied knowledge. It was not until I shared my own experience with alcohol abuse that I was accepted into the group. Important to note is that it was not my intention nor coercive measure to gain entrance into the participant group, but reflexivity on my behalf to realize the degree to which I related to those I was studying. I was no longer a partial participant, rather became completely emerged. This ethnographic method of observation shed light on how “the concrete stuff of our world influences people’s behaviors in obvious and subtle ways” (Madden, 2010, p.103) while simultaneously juxtaposing quantitative studies on attentional bias that served as a focal point in relational readings (Drobes, Oliver, Correa, & Evans, 2019).

In-Depth Interviews

It is not uncommon in ethnography to utilize a range of interview structures "from formally structured accounts to informal conversations" used in conjunction with ethnographic methods (Ruhl, 2014). In-depth interviews were the primary means of collecting data and were comprised of twenty-five one-on-one semi-structured interviews with recovery coaches and participants of Favor Greenville.

Two semi-structured interview guides followed themes within the field and highlighted emotions consistent with participation in and at Favor. One guide was consistent with coaching behaviors and the relationships developed in the coaching process whereas a second guide was used for participants to evaluate participation and engagement with Favor. Both interview guides as well as transcriptions of the interviews are available in the appendix. Under the direction and supervision of Dr. Bryan Miller, Dr. Mellissa Vogel, Dr. Alain Litwin and Dr. Pericot-Valverde,

in-depth-interviews were audio recorded and transcribed. Once transcribed the audio recordings were destroyed to maintain confidentiality.

Participants were able to engage at whatever degree they felt most comfortable. To reduce the risk of harm to participants no questions about specific substance use, length of use, or consequence was incorporated in the interview guide. Participants were encouraged to speak for as little or long as they would like on their life experience and experiences with Favor Greenville. Interviews were audio-recorded and lasted an average of twenty-eight minutes, with the shortest recorded interview lasting approximately nine minutes and the longest lasting approximately seventy-two minutes in length.

Data for in-depth interviews took form in three organizational phases, (1) identifying categories, (2) determining themes from categories, and (3) applying theory to emergent themes to reach a conclusion (Silverman, 1993).

Breaking down this coding process, the first category identified was participation; (1) those who were active in discourse during all-recovery meetings and (2) those who took passive or struggling roles in participation. Participants falling in the actively engaged, or successful participation category were more likely to participate in socialization pre- and post- All Recovery meetings

Discourse Analysis

Discourses collected included in-depth interviews, discourse from All Recovery meetings, conversation and observations. During this process, participants were aware of their participation and asked to elaborate on their experiences, perspectives and feelings throughout research collection. A constructionist narrative approach from within socially oriented narrative research was implemented to account for the broader social contexts of the personal experiences

shared for the purpose of this study (Cigdem, Fathi & Squire, 2013). This important differentiation from individual oriented forms to a narrative constructionist approach accounts for the individual's "states produced socially by their narratives" in which "the narratives themselves are social phenomena" (Cigdem et al., 2013 pp.3). The efforts in this approach are specific to the meaning-making process and furthermore the context of which those meanings are made (Cigdem et al., 2013).

The analysis process was not succinct rather, occurred throughout the duration of discourse collection and a brief summary period post-collection. Constant comparative analysis of discourse allowed me to be 'within the research process' as explained by Charmaz, and dually lent itself to narrative ethnography (Gubrium & Holstein, 2006, p.185; Ruhl, 2104).

Member Checking

Member checking in the form of follow-up conversations and a continued presence at Favor was incorporated into the ethnographic design of this study. Informal conversations often offered an easy transition into continued dialogues where the personal experiences of participants were shared and reflected on where it was common for participants to say "I didn't think of that during the interview." My continued presence allowed access to myself if any questions about the research arose, or if any train of thought was provoked during a meeting or experience outside of the meeting. This kept an open avenue for communication throughout the study.

Summary

The focus of my research shifted early in discourse collection from understanding the motivating factors behind treatment to identifying the ways in which participants utilized the resources available to them. In doing so, this highlighted the agency of participants to be present in their own recovery.

CHAPTER FOUR

RESULTS

Interview and observational analysis were conducted in addition to a brief demographic survey. Demographic survey results of which are presented in Table 1 and Table 2. This data was collected to further analyze the sample, however, held little to no relevance on the discourse collected other than indicating that a majority of participants are older than thirty-five with few participants aged younger and that participants overwhelmingly identified as male. Sexual orientation was included in the survey however, held no significance and for the purpose of protecting participant identity has been omitted from the demographic data. A copy of both guides is included in the appendix in addition to the demographic survey used.

Interviews

Two interview guides were utilized: one for recovery coaches and one for participants, each guide elicited different responses. Recovery coaches were asked about their life experience, role as a recovery coach, their motivations for occupying this role, interactions with participants and resources available to manage this role. All but one recovery coach noted a history with substance use and abuse. Three recovery coaches specifically referenced “consequence” and indirectly, constructed meaning-making processes.

Comparatively, participants were asked about their experiences, if they utilized a recovery coach and if so, what that interaction looks like, their role as a participant at Favor and feelings surrounding their recovery journey. All but one participant had an overall positive experience with Favor.

Both guides yielded similar responses as to feeling a sense of belonging when physically present either on site or at Active in Recovery events. A select few participants noted specific

moments that acted as catalysts for their recovery journey or named other participants are being central to their sobriety. Every interview at one point or another had something positive to say about the program, its participants or affiliated programs. Every individual interviewed viewed themselves in active recovery based on their participation in the program, use of the facility, or resources therein.

One point of interest centered on how recovery coaches and participants alike utilized the space and resources available to them. Only ten participants (50%) noted having a recovery coach, and of those, only six, (30%) spoke to actively utilizing their recovery coach. The four (20%) participants who did not, specifically stated that they chose to end relationships with their coach. Seven, (35%) chose deliberately not to have a recovery coach at all. It is important to note that four of the six participants actively utilizing coaches were individuals earlier into their recovery, whereas the remaining two participants had accumulated longer lengths of sobriety. The remainder of participants noted the physical space of Favor both in aesthetic nature and as a central locality to build fellowship in recovery.

Of most importance was the number of interviewed participants who utilized a recovery coach and the capacity to which they did. This will be discussed further in the results.

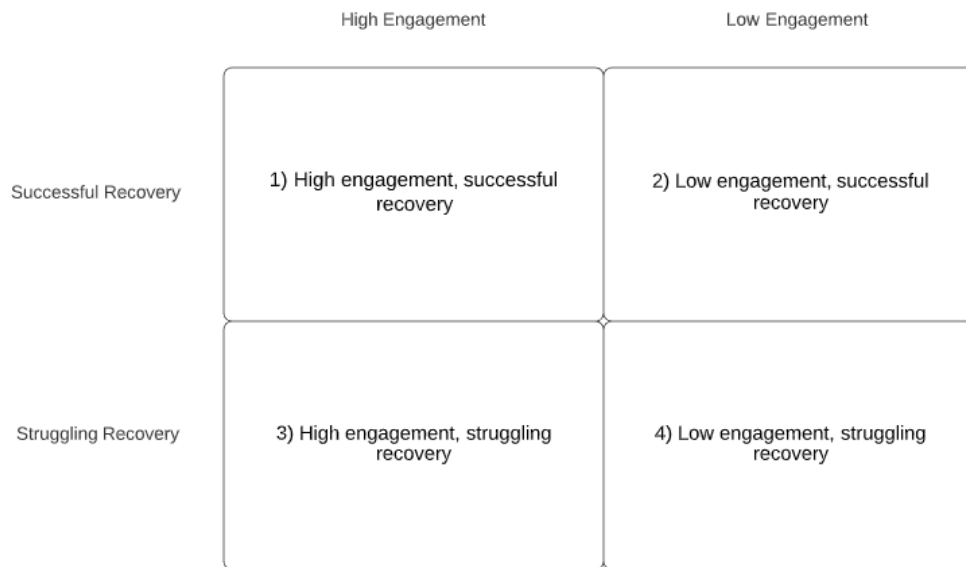
Observations

PPO stemming four months contradicted findings from the 2001-2002 National Epidemiologic Survey on Alcohol and Related Conditions in which gender differences on prospective tendency to alcoholism indicate decreases (Smrekar et al., 2018). The length of time since completion of the survey posits that individuals pursuing active recovery should parallel this trend. Yet, the ratio of men to women at All Recovery meetings showed a different dynamic. Men comprised most of the participants in meetings, whereas women were the minority. This

was less consistent with recovery coaches. Important to note is that All Women Recovery meetings did occur on Saturdays which lent itself to less female participants in the general All Recovery meetings due to the conflicting times of meetings.

Additionally, this observation held true in the interview portion of discourse collection. As evident in the demographic table, more men than women were interviewed. In part, this gender disparity is a result of convenience sampling at meetings. As more males were present than females, more males were interviewed. This will be touched on further in the limitations portion of this paper. This does not however, change observed differences in participation levels in the group during observations.

Figure 1. Breakdown of Engagement Level: Active and Struggling Engagement



Levels of engagement varied in participants, lending this observation to a typology of recovery orientations. This ranged from high engagement, successful recovery; low engagement, successful recovery; high engagement, struggling recovery; to disengaged, struggling recovery. A Breakdown of these typologies can be seen in Figure 1. Differences in participation levels and

participant's progress in recovery as observed during and through interviews placed participants into each of these typologies.

To further break down Figure 1, each typology was constructed by identifying the following characteristics within the four distinct groups: 1) high engagement, successful recovery refers to continued physical presence at meetings, contributing constructively to meeting topic and discussion, actively listening to discussion (not distracted) and socializing pre/post-meeting; 2) Low engagement, successful recovery refers to periodic presence at meeting, minimal constructive contributions to meeting topic and discussion, actively listening to discussion and casual participation in pre/post-meeting socializing; 3) high engagement, struggling recovery refers to continued physical presence at meetings, contributing in unconstructive ways to meeting topic and discussion, passive listening or observed disinterest in the meeting and lack of socializing pre/post-meeting; and 4) low engagement, struggling recovery refers to periodic presence or discontinued presence at meetings, minimal or unconstructive contribution to meeting topic or discussion, passive listening, observed disinterest in the meeting and lack of socializing in pre/post-meeting socializing.

Engagement

Determining the *degree of engagement* then became the objective, positive engagement, and the inverse. Attentional bias understood in Drobles' et al. (2019) interpretation as "elevated attention to stimuli with enhanced saliency or relevance for certain individuals or groups" similarly looked at factors mitigating addictive tendencies however, did so via a modified form of Ridley's (1930), Stroop test. While this instrument was not utilized in this study, the relevance from Drobles' et al., conclusion is (2019).

As such, this formed the threshold of thought surrounding how individual agency related to the attentional bias of threatening or sensitive subject matter. This by extension would mitigate a change in action by the individual and how they engage in the present situation. This is not limited to speaking participation, but also non-verbal active listening, observed disinterest in the meeting, degrees of participation and level of discussion. For example, participant Daniel noted early childhood in the deaths of first his sister, then mother, and finally father. Daniel's aversion to topics about familial loss would not illustrate disinterest, rather discomfort.

To reach the third organizational phase of axial coding, semantic usage as demonstrated by Van Staden and Fulford (2004), in addition to understandings of meaning and value-based meaning making were identified as markers of active agency in participants. To further explain, the role of meaning-making as a measure of agency, Herrnstein's 1970 "matching law" coincides with the reoccurring idea of 'consequence' present in two of the eight staffed recovery coach interviews (Field et al., 2020). Consequence is defined as *a result or effect of an action or condition*, yet there is no indication of a positive or negative result or effect (Drobes et al, 2019).

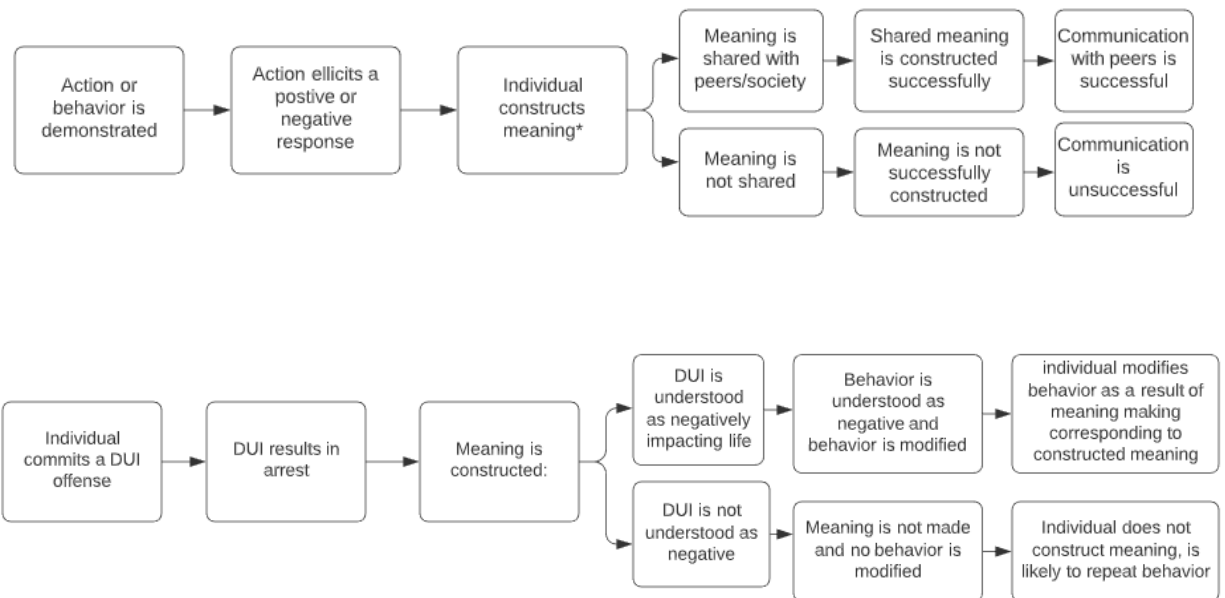
As evidenced by recovery coach Jacob in his interview, consequence was continually and an innately negative result of substance use and as such held a negative connotation in his meaning making process.

"I would say that we don't start... I didn't get high cause' it sucked, you know what I mean like I used substances because it made me feel good. There was many years of my life that was were just perfect. Um, and drugs not only made them that way but they increased it. Consequences is when people like us are faced with the, you know the, I guess just the obvious nature of what we're doing. And the fact that ok yeah I know I just smoked a little bit of weed, but it is illegal and if you get caught you go to jail. You know what I mean. Or, I'm just drinking a lot but okay you get in a car, you're gonna' get arrested for drinking. When the consequences pile up, it's kind of hard to stop, you stop having fun and then I guess you realize at that point there are people who just stop because there are consequences to what they do and there are people like myself who although

the consequences are there and I want to stop for some reason.” -Jacob, Recovery Coach

The same pattern of meaning making can be seen in recovery coach Henry’s interview where “serious consequences started to kind of happened as a result of drinking. Namely, a DUI and then a second DUI about a year and a half later. But it just progressively, just bad decision making.” Both interviews demonstrate the use of consequences, both utilize and shape its meaning in a negative way, and both were able to communicate effectively with one another because they both hold the same understanding of what consequence means. In other words, their meanings match. While this specific example illustrates how consequence is used and understood, the same theory can be applied to other words and phrases in recovery as further discussed in the discussion portion of this paper. The following figure serves as a visual representation of this process.

Figure 2. Diagram of meaning making as demonstrated in the example of a DUI



Meaning is constructed based on individual's experience and a constructed meaning of the world. Shared meaning is achieved when the individuals meaning matches the meaning as understood by those around them, or society at large (Van Staden & Fulford, 2004).

High Engagement Successful Recovery

As previously touched on, meaning making as a marker of agency was the largest finding in this study. How participants and recovery coaches alike created meaning was a constructive process. When meaning was shared, communication was effective and these individuals tended to more actively engage in discussion both in and surrounding meetings. Overwhelmingly, participants interviewed reported positive feelings and words associated with Favor and their experiences with the program. This, in accordance with matching law, was reiterated in their actions.

“One of the, absolutely one of the hardest things for me was to become involved in my own recovery and recovery in general” spoke participant Chris; a perfect example of taking agency in recovery. Chris exemplified harm reduction, often making a point to say “any pathway to sobriety is the right pathway.” Chris perfectly emulated Favor's mission. So much so, that as participant Amanda details,

“I'm getting ready to move right off [local street]. And so I'll be able to come to more stuff, I'll be closer. So I won't have to drive, as far... I want to be at least five miles within Favor because I pretty much feel like I live here. Which is not a bad thing.”

Similarly, two of the participants interviewed, both Amanda and Beau became volunteer recovery coaches after having positive and engaging experience with Favor. Beau, who now oversees and plans Active in Recovery events became a coach after forming a friendship with his own recovery coach. Both the interviews and observations of Amanda and Beau matched to a

positive experience and positive meaning making, and both identify themselves as in active recovery. As such, both Amanda and Beau can be categorized in a high engagement success group. This by far was the largest group observed.

Some participants like Brandon and Roger were in regular attendance and in active recovery. Roger heard about Favor through outreach at the Phoenix Center while completing Alcohol Drug Safety Action Program (ADSAP). He can tell you the exact day he started to coming to Favor, “I got my driver’s license back. I left the highway department and I immediately came here. So I remember that day because that was where I got my driver’s license back. So I started coming here October 18th, 2014. And it’s been great.” -Roger, Favor Participant

Roger was personable, recognizable, and often gave advice or presented topics at meetings and on one occasion led a meeting in lieu of a recovery coach. Brandon, like Roger was also a regular attendee at meetings and contributed to varying degrees every meeting.

When interviewed, Brandon stood out. He was one of two participants who expressed dissatisfaction with Favor, however, was active in meetings and participated in outreach for the program. When asked to elaborate on his dissatisfaction, Brandon only offered vague explanation and generalized discontent with leadership in the program. A follow-up was requested, but Brandon did not respond. Still, his active role within, and physical presence in meetings placed him in this typology.

Similarly, participants who identified as recovery coaches were all within this group. Recovery coaches, all but one of whom are in recovery took on active roles during meetings either by leading discussions or presenting topics, or by contributing throughout the meeting. Recovery coaches were also present in pre/post-meeting settings both for casual socialization

with participants but also to make themselves available to participants for private check-ins or one-on-one guidance if needed.

Low Engagement Successful Recovery

Kathy was one of the first participants interviewed and I had never seen her at a meeting in my preliminary research. She was referred by a coach to participate in this study and happily agreed. Kathy seldom came to meetings due to the distance from her home to the site but insisted that Favor “saved her life” after fifteen years of drug and alcohol abuse. Kathy’s participation with Favor was solely based on her relationship with her recovery coach.

“I try to text or call her at least every other day to let her know, because if, like I said if I go a day without it, she'll either call or text me. Nine times out of ten It's a text because it's just a lot easier when I'm busy and she's busy. But we try to get together at least once a week. But if we need more, we do. I just check in with her. I say hey, it's Kathy I just want to let you know I'm still clean and sober” -Kathy, Favor Participant

While she was aware of the various programs offered on, and in the case of AIR events - offsite, she had never participated in them due to distance and being without a license or vehicle. Despite this, Kathy was active in her recovery and took steps in the form of continued communication with her coach to stay on a path to recovery. While Kathy’s story epitomizes Favor’s assertive engagement community modality of treatment, it was only an isolated case.

Interesting, was the number of participants within this group who have not or hold no interest in having a recovery coach. Rationale behind this stemmed largely from length of time sober or cross-over from abstinence-based groups where a sponsor was already present. In the case of participant Tommy, his network was comprised almost exclusively of family and friends -predominantly his mom. While he noted signing up for a coach initially when he started participating with Favor, he quickly decided a coach was not for him, “it's a group of people. Like

my mom is one of my big supporters. And she just happens to live in Greenville and she happens to be retired and she happens to have a lot of time on my on her hands.” -Tommy, Favor Participant

Tommy came to meetings daily and prior to this study served as a guest speaker on occasion, sharing his path to recovery. However, did not participate in discussions and even exhibited disinterest with meeting topics and discussion observed and even voiced in his interview, “In meetings I get tired of hearing the same things. I’ll pick up my phone and check ESPN.com.” Tommy was well known and even helped host AIR events on occasion but again, seldom spoke in meetings.

High Engagement Struggling Recovery

“Connection is the opposite of addiction” stated participant Beau; it was an anecdote I often overheard from coaches and participants in high engagement successful recovery and something I began to witness firsthand with participants in the high engagement successful recovery typology. However, not all participants were connecting with their peers or coaches. As it was, two participants stood out as not connecting and these were Jared and Devin. Despite high engagement with the group, both individuals were struggling in recovery, categorizing them in a high engagement struggling group. Both of these participants had recovery coaches, were newer in recovery and when interviewed had inconsistencies with their dialogue and observed action.

Jared liked the harm-reduction model of treatment, as opposed to abstinence. He smoked marijuana and would openly discuss drinking; his drug of choice was heroin. Jared struggled the most with meaning making and held on to the notion of *slip ups*. Slip ups referred to relapses in recovery. In this case, opioid use. In his words,

“I was doing this exact same shit a year ago today” “That’s one of the big things about Favor is like, slip ups might happen and they’re okay with it as long as you f**ing realize that and start doing the next right thing.”

Each relapse was just a slip up. It was forgiven and rather than “the next right thing” as Jared would say, the relapse would play out and when consequence reached him, Jared would come back to Favor. There was a break in the meaning making process. His words did not match his actions, nor did his words match the understood meaning of those around him. Where recovery coaches understood a slip up to mean unintentional relapse and negative in connotation, Jared viewed slip up as okay. When asked specifically about relapse, Jared stated “I’m not gonna be shunned [from Favor], you know, if anything, I’m welcomed back even more.” There was a difference in value-based meaning making that was not being communicated. This was also the case with Devin.

Most striking about Devin was how different the interview was from the observed actions, in this quote Devin expresses his sobriety as a priority, and later acknowledges his alcohol use as a negative factor in his life and categorized himself as active in recovery later in the interview.

“When I first got out of rehab the first thing I thought was I need money, I need a place a place to live, and this and this and this and this, I need a relationship, I need to be cool with my parents... all this shit I needed to be cool with right? I knew money wasn’t going to solve it, but that’s still what I was like ‘okay I’m going to make some money and everything will be okay’ and getting sober was on the list, but it just wasn’t number one. What’s changed is now it’s number one. I’ve screwed up three or four times this year and I realized if I had just been sober I wouldn’t have screwed up”

However, in meetings Devin would repeatedly exit and enter the room, cause disruptions and distractions and even showed up to an Active in Recovery event visibly intoxicated. Devin was a complete participant at the beginning of my research but later became a passive participant. The meaning-making process was not complete and as per the example of consequence, there was none. Despite this, Devin would continue to come to meetings and

considered himself active in recovery by doing so. The problem thus being a mistaken case of agency. Coincidentally, Devin spoke to this in his interview stating,

“It’s crazy because like, I actually took this program like not seriously for the first eight months. So I wa actually drinking, driving, doing stupid shit like, just doing things I used to do back in the day. Got away with it, never got in trouble.” -Devin, Favor Participant

Interestingly, Devin acknowledged his recovery coach before this, and both recognized his lack of agency while simultaneously acknowledging behaviors indicative of recovery and then concluding that he was in active addiction.

This is not to negate attentional bias to topics presented and after cross-referencing the topic of discussion with Devin’s interview, was not seen as aversion to a threatening or sensitive topic. In this same aspect it was noted that both Jared and Devin would consistently sit towards the outer edges of the room interpreted as passively sitting in on meetings as opposed to taking a more active seat towards the center of the room.

Low Engagement Struggling Recovery or Disengaged

Similarly, this brings about an additional categorization and grouping disengaged. Those who active chose to not participate or who have ceased participation all together at Favor. This group had one participant in my interviews: George. George was present in the beginning of my research, attending groups daily until he interviewed and ceased participation with the all-recovery group for reasons unknown. George’s interview focused primarily on his mental health and dissociative feelings with Favor.

Contrary to most participants feeling welcomed and apart of favor, George felt very isolated; so much he “refrained from coming for about a year and a half”.

I was unable to follow up with George and he did not make mention of leaving the group in his interview, nor offered any specific ways in which Favor could alter their approach to recovery however, asked that mental health, depression and anxiety be a larger focus at Favor.

As previously stated in the limitations portion of this paper, the research design was unable to retain individuals who became disengaged. That said, it is impossible to know if George deferred to active substance abuse, if he found a different support group, or if he physically left the area. George indicated that he was not from Greenville, nor did he want to stay in Greenville however stated he was in graduate school in the area. He offered no mention of plans to leave during his interview.

CHAPTER FIVE

CONCLUSIONS AND DISCUSSION

Answering the Research Questions

The purpose of this study was to understand how individual agency is accounted for in a harm reduction-based recovery group setting and furthermore, the recovery process of substance use and abuse. This served to identify the markers of agency and by extension increase intervention for successful recovery outcomes via Favors harm-reduction, assertive community engagement modal of treatment. The results imply the need both for future studies and best practices. In utilizing a narrative approach to discourse collection and analysis, interviews formed the skeletal structure of the data collected, adjoined using first partial participant observation then complete participant observation. This allowed for a holistic and constructionist perspective of the discourse and as such created rich dialogues to gather data.

Limitations

Before delving too deeply into discussion it is important to note the limitations of this research given the time, cost, and limited capacity of a single researcher to both conduct discourse collection and to then analyze, code and reach conclusions thereof. Additionally, those who chose to participate were not new to Favor, meaning they had been coming for some time to meetings and therefore should be noted. Even newer participants had established relationships with either a recovery coach or other participants prior to the beginning of my research. Similarly, while observations indicated partial or active struggling participation, limited numbers of these participants took part in interviews despite observations indicating a larger presence of these participants.

Furthermore, my role as a researcher and dually my role as an alcoholic granted me a unique perspective where I was privy to a deeper understanding of the life experiences of recovery coaches and participants. I did not divulge this information to the group until after the completion of interviews however, I was also not fully self-aware of my own abusive tendencies with alcohol until late into discourse collection.

Also, important to discuss is how my research plan did not account for participants who became disengaged from the program, or in that same stream of thought, actively avoided engagement in the program. This was in part due to the design of the study as I did not have additional time, finances, or assistance in obtaining information from this group. Therefore, this group requires future research, and no conclusion can be reached. This same stream of thought can be applied to the gender disparity noted in the demographic table. The research design relied on a convenience sample, of which was comprised primarily of male-identifying participants.

Lastly, due to restrictions imposed by the spread of Covid-19 and the temporary closure of the facility I was not able to reach some participants for follow-up questions.

Discussion

Literature on harm reduction-based modes of recovery focus largely on the differences between abstinence-based modes of recovery and barriers to conventional and clinical based treatment modalities. Similarly, literature on addiction narratives largely focus on the types of narrative and linear progression of addiction as a disease than the individual narratives themselves. What is lost in these approaches are the intimate and personal moments where everyone's sense of self and the world is misconstrued. By looking at how meaning is constructed both interpersonally and in relation to interactions with other participants and recovery coaches, it is evident that meaning is not always shared. The result being fractured

ability to make meaning and by extension modify behavior and ultimately learn from experiences.

In this sense, recovery coaches shared a remarkable trend of understanding one another both in their interviews and their observations. Perhaps this was due to their training, check-ins, or prolonged presence at Favor however, neither factor was spoken to during the interviews. Whereas participants in high engagement successful recovery exhibited this in a less obvious manner. Where coaches would use the same semantics, participants exhibited shared meaning in their actions. The value they placed on sobriety and fellowship was seen in pre- and post-meeting interactions. Most of the participants in this category were longer into their recoveries and did not utilize Favor for more than All Recovery meetings. The actions of this group matched their interviews and more so emulated abstinence than harm reduction. Similarly, individuals in this group characteristically had a recovery coach when they initially entered into Favor, later deciding that a recovery coach didn't work for them or indicated a friendship rather than a mentorship. This is not to negate the role of recovery coaches in early intervention but is a phenomenon that requires future studies to better understand the changing role of recovery coaches through the recovery journey.

On that same token, the role of recovery coaches is highlighted in the consequence of disengagement and the increased risk for relapse or continued substance abuse in disengaged groups as well as questions of how and by what means to reach them.

Currently, participants who sign up for a recovery coach and provide contact information can be reached at a provided phone number. Participants who do not sign up, or do not provide contact information are then only able to be contacted if they are on site, highlighting the importance of engagement while physically present at Favor.

Additionally, this lends itself to understanding meaning making and was of implementing strategies to increase shared meaning. This is best exemplified in high engagement struggling participants; what can be taken away from this group can be applied to increase and implement ways to increase shared meaning. The disconnect between the interviews and observed actions demonstrated a fractured understanding of agency. Participants in this category were self-aware to the degree of passive engagement but could not construct meaning to achieve active participation. The generalized notion that they were active in recovery due to limited participation hindered their ability to become actively engaged and take agency for their actions and behaviors.

Future Research

It is important to note as well that research on harm-reduction treatment modalities is still new and warrants research in and of itself. When applied to Favor specifically, research on recovery coaches within this framework should also be pursued.

Research on measuring and mitigating agency should also be discussed. Given the highly individualized nature of recovery and difficulties obtaining data, there is not an easy solution, nor is there a framework to implement that could variably alter the course of recovery to avoid instances like this rather, there needs to be more research on ways to mitigate agency. The consequence of this in a harm-reduction model of treatment is continued active addiction and the presence of actively addicted individuals amongst individuals in recovery.

Additionally, the gender disparity noted in participant interviews warrants future research on all-recovery and women's recovery groups. The overwhelmingly male sample interviewed may have skewed the results of this study and as such should be noted. Further research on sex-specific or co-ed groups could potentially show a difference in results.

Similarly, research on age-specific demographics would benefit the field. The largely homogenous age of the sample did not account for younger populations. Observations of younger participants were noted however, their presence was few and far between when compared with the majority.

Conclusion

While there are undeniable benefits to harm reduction-based models of recovery there is also evidence to warrant future studies to mitigate when participants lose agency in their recovery. This by no means negates the benefits of harm-reduction but illuminates where resources can be used to help participants continue in their recovery.

This study evidenced the ability participants have within their individual recovery path and highlights how literature lacks research on agency in recovery. The largely homogenous sample illustrates the difference in outcome and perspective from participants utilizing the same resources at the same locality. The strength of the sample is thus seen in the result of the study.

The strength of the approach is evidenced in the analysis of in-depth interviews and observations. One without the other only yields only a fraction of the information to be gained from combining the two. When used concurrently a different and more complete conclusion can be reached. In this case, interviews across the board indicated success and agency whereas observations indicated a disconnect in some participants despite their perception of self-agency.

Recommendations from participants included adding additional groups for individuals in longer-term recovery and a group for newcomers. However, there is no perfect solution. In this instance, newcomers could likely relate better to other individuals newly in recovery but would lack advice from individuals in successful and longer recovery. Additionally, finding the time for

additional meetings, staff to be present at these meetings, and having an appropriate number of participants are all factors that influence the ability to hold these meetings.

APPENDICES

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INTERVIEW GUIDES

Interview protocol: Participant

Motivating factors of engagement and participation in non-traditional and experiential treatment settings

Interview Protocol

PIs: (To be determined)

Student Investigator: Sarah Goss

Operational Definitions

Prisma Health-Upstate. As of January 16, 2019, Greenville Health System merged with Palmetto Health and is now known as Prisma Health. GHS is Prisma Health-Upstate and Palmetto is Prisma Health-Midlands. This study is only focused on the Upstate affiliate, formerly GHS.

FAVOR Greenville. FAVOR Greenville is a Recovery Community Organization (RCO) and serves as the Upstate's "Welcome Center to Recovery." A charter member of the Association of Recovery Community Organizations (ARCO), FAVOR is one of nine RCOs accredited by the Council on Accreditation of Peer Recovery Support Services (CAPRSS)

A recovery-oriented sanctuary, FAVOR exists: to put a "face on recovery" to reduce stigma and discrimination; to support individuals and families in sustaining a personal path to recovery; and to create innovative ways to address addiction - our nation's # 1 public health problem whose is to promote long-term recovery from substance use disorders through education, advocacy and recovery support services, resulting in healthier individuals, families, and communities.

Opioid use disorder. The maladaptive use of opioids prescribed or illicit resulting in two or more criteria that reflect impaired health of function of a 12-month period (American Psychiatric Association, 2013). As established by the DSM-V, opioid use disorder incorporates the previous definitions of opioid dependence and opioid abuse (American Psychiatric Association, 2013).

Recovery Coach. Trained recovery coaches are the heart of FAVOR Greenville. Coaches assist participants with developing and following a recovery plan and solving problems directly related to recovery. The relationship of a coach to a participant is strengths-based and highly supportive, rather than directive. It differs from the role of a 12 Step sponsor or professional clinical counselor: coaches do not diagnose, provide therapy, or help a participant work the 12 Steps

Interview Questions

1. To start, tell me about your experiences that led you to FAVOR Greenville
2. **INSERT FAVOR GREENVILLE DEFINITION.** When you reflect on your experience at FAVOR Greenville, what are three adjectives that best describe your experience.
3. Are there any experiences or interactions that come to mind specifically?
 - a. PROMPT if participant is struggling with answers:
 - i. Ideal for:
 1. Events

2. Interactions with recovery coaches? Staff?
3. Specific skills learned
4. FAVOR Greenville culture
4. I'm interested in your **interactions with your recovery coach** specifically your initial interaction
 - a. Tell me about the day/night you met with a recovery coach. *Please note: No names necessary.*
 - b. How often did you interact with them and what was it like? *Both positives and negatives.*
 - c. Do you feel your recovery coach provided opportunities for you to learn and grow? *Elaborate.*
5. Next I'm interested in your **participation with FAVOR.**
 - a. What did you find as the most challenging aspect of participating in FAVOR Greenville's program? Why? What resources did you feel that you/your recovery coach had to manage that challenge?
 - b. What motivations did you have to continue participating in FAVOR Greenville's program?
6. After your FAVOR Greenville experience, do you plan to continue in FAVOR's program? Why /why not?
7. Do you feel a sense of belonging at FAVOR Greenville? Why/why not.
8. As we continue to evolve as a community outreach program, what do you wish Recovery Coaches knew about what matters most to participants?
9. Lastly, is there anything I haven't asked or covered that is important to understanding your experience with FAVOR Greenville?

Data Points to be gathered

General impression of FAVOR Greenville

Three adjectives that describe FAVOR Greenville.

An individual's journey through FAVOR Greenville.

Clear understanding of participant's experience with recovery coaches in terms of:

- a. Point of Contact
- b. Quality of interactions
- c. Trust and encouragement for growth/ continues engagement

Clear understanding of participant's experience with FAVOR Greenville

- d. Challenges faced
- e. Areas of growth/skills and knowledge gained

Participant perception of ER/FAVOR environment where they interacted with recovery coaches

Continued interest in FAVOR Greenville as a participant

Degree by which one feels a sense of belonging at FAVOR/w recovery coaches

Suggestions for future improvements; a deeper understanding of what FAVOR Greenville participants value in treatment

Additional thoughts/comments on FAVOR Greenville

Interview protocol Recovery Coaches

Motivating factors of engagement and participation in non-traditional and experiential treatment settings

Interview Protocol

PIs: (To be determined)

Student Investigator: Sarah Goss

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2. **INSERT FAVOR GREENVILLE DEFINITION.** When you reflect on your experience at FAVOR Greenville, what are three adjectives that best describe your experience.
3. Are there any experiences or interactions that come to mind specifically?
 - a. PROMPT if participant is struggling with answers:
 - i. Ideal for:
 1. Events
 2. Interactions with recovery coaches? Staff?
 3. Specific skills learned

4. FAVOR Greenville culture

4. I'm interested in your **interactions with participants** specifically the participants you work with in your role as a recovery coach
 - a. Tell me about the day/night of being a recovery coach. *Please note: No names necessary.*
 - b. How often do you interact with participants and what was it like? *Both positives and negatives.*
5. Next I'm interested in your **participation with FAVOR.**
 - a. What did you find as the most challenging aspect of participating in FAVOR Greenville's program? Why? What resources do you feel that you/your recovery coach had to manage that challenge?
 - b. What motivations do you have to continue participating in FAVOR Greenville's program?
6. After your FAVOR Greenville experience, do you plan to continue in FAVOR's program? Why /why not?
7. Do you feel a sense of belonging at FAVOR Greenville? Why/why not.
8. As we continue to evolve what if anything would you do differently?
9. Lastly, is there anything I haven't asked or covered that is important to understanding your experience with FAVOR Greenville?

Data Points to be gathered

General impression of FAVOR Greenville

Three adjectives that describe FAVOR Greenville.

An individual's journey through FAVOR Greenville.

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- c. Trust and encouragement for growth/ continues engagement

Clear understanding of participant's experience with FAVOR Greenville

- d. Challenges faced
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Continued interest in FAVOR Greenville as a participant

Degree by which one feels a sense of belonging at FAVOR/w recovery coaches

Suggestions for future improvements; a deeper understanding of what FAVOR

Greenville participants value in treatment

Additional thoughts/comments on FAVOR Greenville

CODING MANUAL

Themes were coded using words or phrases within interviews in accordance with the observed actions in All-Recovery Meetings. The following demonstrates

Theme 1: Success in Recovery → Individual is in long-term recovery and evidence this in interview

Category 1 Agency:

- Taking responsibility for actions or behaviors while in active addiction
- Detailing events chronologically and demonstrating positive change over time
- Demonstrating or exhibiting a sense of shared semantic meaning

Category 2: Positive Engagement:

- Referring to continued presence at meetings
- Referring to use of resources available at Favor

Theme 2: Struggling in Recovery → Individual references active substance use, limited time in recovery, difficulty relating to treatment

Category 3: Negative Engagement:

- Difficulty contributing in meeting settings
- Decrease in participation/attendance in meetings
- Exhibiting disinterest/negatively contributing
- Referring to active substance use, relapse, or “slip ups”
- Inability to create shared meaning or adhere to meeting rules

Resulting Typology

1) high engagement, successful recovery refers to continued physical presence at meetings, contributing constructively to meeting topic and discussion, actively listening to discussion (not distracted) and socializing pre/post-meeting

2) Low engagement, successful recovery refers to periodic presence at meeting, minimal constructive contributions to meeting topic and discussion, actively listening to discussion and casual participation in pre/post-meeting socializing

3) high engagement, struggling recovery refers to continued physical presence at meetings, contributing in unconstructive ways to meeting topic and discussion, passive listening or observed disinterest in the meeting and lack of socializing pre/post-meeting

4) low engagement, struggling recovery refers to periodic presence or discontinued presence at meetings, minimal or unconstructive contribution to meeting topic or discussion, passive listening, observed disinterest in the meeting and lack of socializing in pre/post-meeting socializing.

IRB SUBMISSION AND APPROVAL

LETTER OF PERMISSION

November 11th, 2019

Re: Clemson Institutional Review Board

Dear Sir/Madam,

I write on behalf of FAVOR Greenville in support of the research study “Motivation for treatment: A look at an assertive engagement community modality of treatment.” This study will be overseen by Dr. Alain Litwin, MD, Dr. Irene Pericot Valverde, PhD, Dr. Melissa Vogel, PhD, Dr. Bryan Miller, PhD, and Sarah Goss, second year graduate student in the M.S. applied sociology program. Sarah will be conducting this research under the supervision of Dr. Bryan Miller, Dr. Alain Litwin, and Dr. Melissa Vogel, will be conducting the qualitative student interviews.

FAVOR Greenville will allow Sarah Goss access to their facility in Greenville, at 355 Woodruff Road #303, Greenville SC 2960. Additionally, FAVOR will assist in recruiting participants for this study by providing names and contact information of recovery coaches and FAVOR participants.

Sincerely,

A handwritten signature in black ink, appearing to be the initials 'MG' followed by a flourish.

FAVOR Greenville

Information about Being in a Research Study

Clemson University

“Motivation for treatment: A look at an assertive engagement community modality of treatment”

KEY INFORMATION ABOUT THE RESEARCH STUDY

Voluntary Consent: Dr. Bryan Miller is inviting you to volunteer for a research study. Dr. Bryan Miller is an associate professor at Clemson University conducting the study with Dr. Melissa Vogel, Dr. Alain Litwin, Dr. Irene Pericot-Valverde, and second year graduate student Sarah Goss.

You may choose not to take part and you may choose to stop taking part at any time. You will not be punished in any way if you decide not to be in the study or to stop taking part in the study.

Alternative to Participation: Participation is voluntary; therefore the alternative is to not participate in the study.

Study Purpose: The purpose of this research is to understand the motivations behind pursuing and continuing addiction treatment and how an assertive community engagement modality of treatment impacts personal motivations.

Activities and Procedures: Your part in the study will be to participate in in-person or skype/zoom internet interviews. In-person interviews will be recorded via voice recorder. Skype/zoom calls will be recorded for the purpose of recording audio only. All data will be stored in a secure file and will only be accessible to the interviewer. Interviews are to begin in November and end in December. Only when a participant is unable to meet in person/requests to interview via skype/zoom, will sessions be recorded.

Participation Time: It will take you about an hour to an hour and a half to be in this study.

Risks and Discomforts: Potential risks include loss of confidentiality if a participant is at risk of harming his/her self or others. Participants are advised to not use any identifying names or descriptions.

Possible Benefits: There are no direct benefits from this study, however a potential benefit of this study would be to expand this treatment modality beyond Greenville.

EXCLUSION/INCLUSION REQUIREMENTS:

Criteria for participation include either being an active recovery coach or a participant at FAVOR Greenville.

INCENTIVES

Participants that complete an interview, either in person or via Skype/ZOOM and fill out a brief demographic survey will receive an incentive of a \$20 Walmart gift card to compensate for their time.

AUDIO/VIDEO RECORDING AND PHOTOGRAPHS

In-person interviews will be recorded via an audio recording device and stored until transcription is completed. If requested by participant, Skype/Zoom internet calls will be conducted. Technology for the purpose of these calls requires the use of a smartphone or computer/laptop/device with audio connection. Calls will be recorded and later destroyed after transcription.

EQUIPMENT AND DEVICES THAT WILL BE USED IN RESEARCH STUDY

In-person interviews will be recorded via an electronic audio recording device. If requested by participant, Skype/Zoom internet calls will be conducted. Technology for

the purpose of these calls requires the use of a smartphone or computer/laptop/device with audio connection.

PROTECTION OF PRIVACY AND CONFIDENTIALITY

The results of this study may be published in scientific journals, professional publications, or educational presentations.

A quiet and private area for data collection will be utilized to maintain participant privacy. Data collected will be kept confidential in a locked and secure file. Anonymity is difficult to maintain and cannot be promised, however participants are advised not to use any identifying names or descriptions during the data collection process. Identifiable information collected during the study will be removed and the de-identified information could be used for future research studies or distributed to another investigator for future research studies without additional informed consent from the participants or legally authorized representative.

COUNSELING INFORMATION

Resources to participants are available through FAVOR Greenville at 355 Woodruff Road #303, Greenville SC 29607 or via FAVOR Greenville's website favorgreenville.org

In the event that you experience a negative reaction from participating in this study, notify the research team immediately. Should you need to connect with someone, consider the following confidential resources

- Clemson University students may access psychological care through Counseling and Psychological Services at Redfern Health Center, call (864) 656-2451.
- Mental Health America of Greenville County's CRISIS line: 864) 271-8888. Free, 24/7 crisis phone line.
- Crisis Chat: <http://www.crisischat.org/>, free chat line available 2PM to 2AM, 7 days/week.
- Crisis Text Line: Text "START" to 741-741, service is free through most major phone service carriers and available 24/7.
- National Sexual Assault Online Hotline: <http://apps.rainn.org/ohl-bridge/>, free, 24/7 online chat service.

- Contact a mental health professional of your choice, at your own expense.

CONTACT INFORMATION

If you have any questions or concerns about your rights in this research study, please contact the Clemson University Office of Research Compliance (ORC) at 864-656-0636 or irb@clemson.edu. If you are outside of the Upstate South Carolina area, please use the ORC's toll-free number, 866-297-3071. The Clemson IRB will not be able to answer some study-specific questions. However, you may contact the Clemson IRB if the research staff cannot be reached or if you wish to speak with someone other than the research staff.

If you have any study related questions or if any problems arise, please contact Sarah Goss at Clemson University at 717-430-9109 and/or segoss@g.clemson.edu.

CONSENT

By participating in the study, you indicate that you have read the information written above, been allowed to ask any questions, and you are voluntarily choosing to take part in this research. You do not give up any legal rights by taking part in this research study.

A copy of this form will be given to you.

**CONSENT TO PARTICIPATE IN A
RESEARCH STUDY**

“Motivating factors of engagement and participation in non-traditional and experiential treatment settings”

You are being asked to participate in a research study **“Motivating factors of engagement and participation in non-traditional and experiential treatment settings.”** The purpose of this study is to determine what aspects of non-traditional treatment settings aid in the recovery of substance use disorders. Additionally, this study seeks to understand how participants engage in positive behaviors post treatment as a result of the techniques learned in the program. The study will be comprised of interviews at FAVOR Greenville, lasting approximately one hour in to one and a half hours in length. **Please read the information carefully. At the end, you will be asked to sign this document if you agree to participate in the study.**

We are asking for you to participate in an interview lasting approximate one to one and a half hours where you will be asked about your experience during and after involvement with FAVOR. Additionally, you will be asked about your time and experiences in non-traditional or experiential treatment settings. Questions about your experience in treatment and continued involvement with the program will be addressed. The interview will be audio recorded. The audio recordings will be transcribed by Sarah Goss. Your input will be confidential however, it is advisable not to include any identifiable information.

It is possible that talking about your experience could make you feel uncomfortable. You are welcome to skip any questions that make you feel uncomfortable, and you may also stop the interview at any time. A decision to stop participation will not impact you, and you will still receive your incentive for participation if you choose to stop mid-interview.

Some people find talking about their experiences with FAVOR to be helpful. A possible benefit of this study is that the results may help other people seek participation in non-traditional or experiential settings.

To reiterate, the research team will make every effort to protect your privacy. All your responses to the interview questions will be kept confidential. And names will not be taken or used in recordings

The digital audio recording files will be kept on a password protected computer in a password protected folder and will not be stored on a public network folder. After the audio recording is analyzed, it will be destroyed. The transcriptions will contain no identifying information. When the results of this study are published, participants will be referred to by code numbers, not names. However, because your voice

will be potentially identifiable by anyone who hears the tape/digital recording, your confidentiality for things you say on the tape cannot be guaranteed in the unlikely event that the above data protection plan is breached.

The decision to participate in this study is completely up to you. You will not be treated any differently if you decide not to be in this study. If you decide to be in the study, you have the right to withdraw from the study at any time.

Clemson University wants to make sure that all research participants are treated in a fair and respectful manner. Contact the Office of Research Compliance at (864) 455-8997, or IRB administrator Nalinee Patin at 864-656-0636 or you have questions about your rights as a study participant. If you have any questions about the purpose, procedures, and outcome of this project, contact Sarah Goss at (717) 430-9109, segoss@g.clemson.edu

I have read the information in this consent form. I have had the chance to ask questions about this study, and those questions have been answered to my satisfaction. I am at least 18 years of age, and I agree to participate in this research project. I understand that I will receive a copy of this form after it has been signed by me and the principal investigator of this research study.

Printed Name of Participant

Signature of Participant

Date

Signature of Researcher

Date

Demographic Survey Information

Directions: Please fill in the blank or mark the box with an “x” that is appropriate for you or complete the short answer sections to the best of your ability.

1. Age _____

2. Which gender do you identify with? Male Female Other _____

3. How would you describe your race and ethnicity? Please be detailed: _____

6. What do you identify as? Straight Gay Lesbian Bisexual
 Transgender Other _____

7. What was the approximate annual income of your household during last year?

- Under \$10,000 \$50,000-\$74,999 \$125,000-\$149,999
 \$10,000-\$24,999 \$75,000-\$99,999 \$150,000-\$174,999
 \$25,000-\$49,999 \$100,000-\$124,999 \$175,000 and over

8. Do you identify as a member of any of the following religions?

- Christian-Protestant Christian-Catholic Jewish Muslim
 Spiritual Not Religious Other (please specify) _____

9. Do you have stable living arrangements?

Yes

No

10. Do you work? If yes, part-time or full time?

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