CONQUERING THE DEMONS WITHIN: MEN IN RECOVERY

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HOW MEN IN RECOVERY CONCEPTUALIZE CHALLENGES AND USE THEIR INHERENT STRENGTHS TO NAVIGATE THEM

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ABSTRACT

The aim of this thesis is to explore how men in recovery from substance use conceptualize challenges and use their inherent strengths to navigate them. Estimates of substance use prevalence rates in Canada suggest that approximately one-in-five Canadians will meet the diagnostic criteria for substance use disorder throughout their lifetime (Pearson, Janz & Ali, 2013). These prevalence estimates represent a significant cause for concern as addiction is a significant phenomenon in contemporary Canadian society.

A scoping literature review was conducted on nineteen research studies to investigate the state of current research. Although there is a wealth of studies on addiction, research frequently utilizes pathologizing approaches. These approaches are commonly focused on addiction in the context of a social or individual issue ripe with problematizing discourses. Six qualitative semi-structured interviews were conducted on men living in recovery-based supportive housing for this research to explore their experiences from the onset of substance use into substance use and recovery efforts. A strength-based perspective was adopted for analysis purposes in order to more accurately reflect on the inherent strengths of the participants. The men provided in-depth accounts of their experiences, conceptualized challenges to their recovery and contrary to many contemporary research discourses, demonstrated an affluence of strengths while articulating challenge navigation. The men were also proactive in their ability to anticipate future challenges and conceive methods of effective challenge navigation.

Findings of this study are analyzed and discussed in the context of recognizing the magnitude of the challenges facing the men in recovery and the incredible strengths that they demonstrate in challenge navigation. The implications for current social work practice are outlined and several suggestions are tabled with the goal of improving current practice methods. Finally, suggestions for future strength-based addiction research are offered with the intention of

seeking overall improvements to the research field and addressing existing gaps within the literature.

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This work is dedicated to all lives affected by substance use

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Chapter 1: Introduction

The Diagnostic and Statistical Manual of Mental Health Disorders 5 (DSM5) is considered the standard manual for medical professionals across North America. DSM5 refers to addiction as "substance use disorder" and classifies it as a diagnosable mental health disorder (American Psychiatric Association, 2013). Substance use disorder and addiction related discourses among the medical community, psychology and the addiction community have debated this classification for years. The root of this debate involves conceptualizing addiction through a disease-based model (Kalivas & Volkow, 2005; Wallace, 1993). This model views addiction as a maladaptive coping mechanism that originates through conscious, albeit poor decision making, elements of personal choice, a lack of self-control, and assumption of personal responsibility by the individual (Banks & Negus, 2017; Heyman, 2009).

Although each paradigm is not without advantages and disadvantages, both paradigms employ a pathologizing view of addiction that can result in perpetuating a re-victimization of the addiction community by incorporating a labeling strategy. For example, referring to someone as a "junkie" or as living with substance use disorder alters the way they are treated socially often resulting in further stigmatizing discourses and subsequent subpar treatment. Labelling will often contribute to the embodiment of the addiction as the single most prominent identifying and salient characteristic of the individual. The addiction takes on an identity in and of itself, essentially "becoming" the individual. This contributes to 'scarlet letter' connotations and possibly the adoption of self-fulfilling shame-based prophecies centred on weakness and a failure to adapt to societal expectations. I do not mean to imply that addiction should be observed as a solely positive entity as there are indeed challenges associated with addiction, but there is an

opportunity here to positively alter discourses and pursue healthy change in the way addiction and recovery are conceptualized.

Addiction often negatively impacts micro, mezzo and macro levels of society taking lives, tearing families apart and resulting in billions of dollars spent annually (Canadian Centre on Substance Use and Addiction and University of Victoria Canadian Institute for Substance Use Research, 2018; Spiehs & Conner, 2018). This considered, there is an opportunity for an exploration of a strengths-based theoretical lens that incorporates the recognition of strength, resilience, proactive change, empowerment and the development of a positive recovery based social support network throughout this unique community.

Addiction is rampant in Canada. Addiction prevalence rates indicate that approximately 21% or more than six million Canadian's meet the criteria for substance use disorder throughout the course of their lifetime (Pearson, Janz & Ali, 2013). This prevalence considered, stigma riddled discourses surrounding the community are still incredibly common. In this thesis, I intend to draw attention to this unique community while highlighting the magnitude of strength they possess in overcoming obstacles. It is my position that although we can never truly fully understand the journey of another person, we can adopt an empathetic approach to their struggles and appreciate how difficult it may be to persevere. We can commit to the notion that we should by no means cast judgement upon the choices and experiences of others, while respecting the autonomous nature of free will and the uniqueness of the individual paths chosen by our peers.

In conceptualizing this research, I turned to participants that are addiction survivors. They have battled addiction related issues and continue to do so daily. I ask that they share their expertise on the subject so that we may appreciate their wealth of knowledge. In doing this, I hope that I am accurately able to capture their stories in a way that not only makes them proud but pushes the envelope for further strength-based research in this incredible field. I remain

hopeful that the findings of this study will help me answer: How do men in recovery conceptualize challenges and use their inherent strengths to navigate them?

Chapter one introduces the thesis topic, explores prevalence rates of addiction in Canada and presents the dominant albeit pathologizing paradigms on addiction. Chapter one also summarizes my place in the research while demonstrating my passion for this subject material. Chapter two provides inquiry into the existing literature on recovery using a scoping literature review method. The literature further conceptualizes recovery, explores the experiences of men in treatment, articulates addiction related stigma and unpacks recovery capital. Chapter three presents the strength based theoretical lens for analysis and further outlines the methods used in this research. Chapter four thematically presents the findings of the research. Chapter five includes a reconceptualization of addiction and recovery and offers a discussion on findings covering all themes present in chapter four. Chapter five also discusses the role of social work while presenting limitations of this study and offering suggestions for further research inquiries. Chapter six concludes the thesis.

1.1 My Place in the Research

I first got involved with addiction work through employment in withdrawal management services nearly 15 years ago. Withdrawal management or "Detox" as it is more commonly known is widely considered no man's land in the war on drugs. In referencing the war on drugs, I do not intend to imply the 1980's Regan administration "just say no" war on drugs that was ultimately a catastrophe of a social policy. The Regan era 'War on Drugs' is responsible for inflicting countless atrocities on an already vulnerable population and further marginalizing the community through the elicitation of moral judgements, public smear campaigns and in many instances further victimizing the victims of their own unique life tragedy (Maté, 2008). The only thing Regan's war gave us, was memorable albeit ridiculous commercials featuring the infamous egg

and frying pan routine (Partnership for a Drug Free America, 2010) that to this day elicits humorous recollections of watching Saturday morning cartoons during my childhood. The war on drugs that I am referring to is war that aspires to save humanity from itself.

Following detox, I landed a position in residential addictions treatment and spent many years working in this capacity before moving back into the pursuit of further academic endeavors. As I reflect on this, I see several similarities between myself and the people I was going to war in support of. Like them, I also had a dark past with heartbreaking stories of trauma to tell. Perhaps it was my struggle with depression or the chronic suicidal ideation that plagued my adolescence. Maybe it was my own experience with mind-altering substances during my teens and early 20's that brought me here. There is one thing I am certain of: during those days I felt more like I was surrounded by my peers, by people that really were not any different than me. I was in a place that I felt comfortable, a place that I belonged. Perhaps for the first time in my life I felt like I was not alone.

Looking back, I am not sure that I ever really was addicted, at least not in the conventional sense. I most definitely knew my way around a variety of mind-altering substances and frequently used them for my own self-medicating purposes. I struggled with the pain of a reality that I wanted no part of. I found some comfort, at least initially, in numbing myself from the harshness of my own reality. One thing I am confident of is that I fell in love with the field in those early days and saw a little of myself in every single one of the faces I tried to support. I overcame the charade of hiding behind someone I was not, which I had been employing for many years to avoid suspicion. I allowed the uniqueness of my idiosyncrasies to enter my workspace and was rewarded through the richness of my experiences with the lads I was entrusted with supporting.

Each passing day on the job allowed for the beginning of a new adventure. I never found myself tiring of the challenges that came with it. Addiction work provided me the rare opportunity to glare at my reflection in a mirror from a critical distance and ask how I could be better. These people I worked with lived, felt pain and yearned for its resolution perhaps through the same perpetual numbness as I did. They had endured the burdens of a world riddled with disappointing outcomes hell bent on its dog eat dog philosophies and lived to tell about it. They had been rejected by a society that made judgements before asking questions and cast labels before hearing the answers but refused to submit. They had been effectively written off and discarded by everyone and everything in their lives, yet they were somehow in the process of dusting themselves off and getting back up to have another go at life. They were not going to accept the defeat, complacency or mediocrity that I had allowed to creep into my own existence. Instead, they came to pursue a change so monumental that it left me memorized, inspired and hopeful for the resolution of my own issues.

That I am sitting here writing the introduction to what will become my Master of Social Work thesis is a testament to the relationships, trust and respect that I shared with the clients all those years ago in the psychoeducational group therapy rooms. I got the idea to pursue a higher level of education following what I can only describe as a heavily emotional group therapy session. A couple of the lads suggested that I go further with concepts related to our collaborative discussions on revolutionizing treatment methods and the state of the addiction field in general. Following my sarcastic response that I did not have enough letters after my name to go any further, I was subsequently challenged by the group to go and get the letters that I spoke of. They believed in me, definitely more than I believed in myself and just as I believed in them. Within the next six months I found myself enrolled in the Bachelor of Social Work program at McMaster University wondering how the hell I had gotten there.

Recalling my journey personally, professionally and academically I see a great deal of fortune in my experiences. I was fortunate enough to endure the personal torments that I encountered if for no other reason than it altered my life course. I was gifted with the opportunity to work alongside the most amazing, selfless, compassionate and empathetic human beings that would have easily taken a bullet in order to spare my life and given me the shirt off their backs. Though many of them had nothing in a material context, they were richer than most of the people I had met across all aspects of my life in so many diverse and invigorating ways. I admire them and procured inspiration through their unimaginable displays of courage. With every new day comes the arrival of another uncertain future, another barrier to traverse and another challenge to overcome yet here they stand defiant and refusing to give in.

Chapter 2: Literature Review

Though there is a wealth of addiction-based research and many areas of inquiry such as social processes, recovery measures and prevention have seen substantial interest by scholars (Bathish et al., 2017; Morton, O'Reilly & O'Brien, 2016; Neale et al., 2015; Russell, Gillis & Heppner, 2016), research on strengths within addiction is limited (Andersen, 2015; Haroosh & Freedman, 2017; Spiehs &Conner, 2018). Some scholars suggest that research on addiction is preoccupied with pathologizing and identifying and examining deficiencies and weaknesses which further perpetuates stigma and oppression (Rudzinski, McDonough, Gartner & Strike, 2017; Spiehs &Conner, 2018). There is even suggestion that substance use recovery can yield benefits while providing opportunities for growth and development (Haroosh & Freedman, 2017; Timpson, Eckley, Sumnall, Pendlebury & Hay, 2016). It is my intent to situate my research within this niche and draw attention to strengths held by persons living in recovery from substance use related issues.

2.1 Literature Review Method

A scoping method was loosely used to define how I conducted a review of the literature for this research project. I selected a scoping review method as it is effective in reviewing complex material and would help to provide insight into areas of inquiry where there has not seen an extensive amount of previous research (Arksey & O'Malley, 2005; Mays, Roberts, & Popay, 2001). The scoping style review contributes to the identification of gaps within the research and creates a platform for discourses involving more in-depth inquires within the identified field of study (Colquhoun et al., 2014; Grant & Booth, 2009). In addition to exploring research on what is known in relation to addiction and strengths exhibited by men in recovery, a scoping literature

review is effective in covering a broad range of methodologies and establishes parameters for a more thorough analysis.

I consulted three data bases for the literature review. These databases included: EBSCOhost, ProQuest and Web of Science. A cross-referencing of search terminology was conducted and featured: “male, males, man, men, masculinity, manly and manliness”, with “substance use disorder, substance use, addiction, drug abuse, alcoholism, recovery, rehabilitation and treatment” and “challenges, obstacles, barriers, issues, problems and limitations”. Inclusion criteria for the literature review are as follows: (1) Studies involving male participants. Studies involving male and female participants are also included; (2) Qualitative and quantitative Studies; (3) Studies including substance use addictions including alcohol and drugs; and (4) Primary and secondary sources. Exclusion criteria for the literature review are as follows: (1) Studies exclusively involving female participants; (2) Studies not published in English; (3) Studies published prior to the year 2000; and (4) Studies involving non-substance based and/or behavioral addictions.

During the initial literature review phase 357 article abstracts were reviewed and after applying inclusion/exclusion criteria, 19 articles were deemed appropriate based on content and selected for review. Articles were read once for context and then reread to clarify content and for analysis purposes. Articles were summarized using a chart consisting of (1) title; (2) author; (3) DOI; (4) abstract; (5) research question(s); (6) methodology; (7) method; (8) recruitment data; (9) findings; (10) strengths and weaknesses; and (11) my impressions (Arksey & O’Malley, 2005; Cronin, Ryan & Coughlan, 2008; Colquhoun et al., 2014). Using thematic analysis techniques described in Attride-Stirling, (2001), Fereday & Muir-Cochrane (2006) and Vaismoradi, Turunen & Bondas, (2013), codes were generated analyzed for clarity, grouped and categorized into themes. Themes were reviewed and theme content was revised accordingly. The charts were read

multiple times to ensure nothing was missed in the analysis. Article summaries were cross referenced with the original journals for common outcomes and discrepancies.

2.2 Findings

Common themes emerging from the literature include: (1) Conceptualizing recovery; (2) Men and the treatment of addiction; and (3) Addiction-related stigma. Recovery capital is another concept that frequents the literature and as discussed in Cloud & Granfield (2008), can be broken down into: (a) Social Capital; (b) Physical Capital; (c) Human Capital; and (d) Cultural Capital.

2.21 Conceptualizing Recovery

The worst part about anything, that's self destructive is that it's so intimate. You become so close with your addictions and illnesses that leaving them behind is like killing the part of yourself that taught you how to survive—Samantha Gluck (2013)

Recovery from substance use as a concept is extremely difficult to define. Though the literature does not provide a universally accepted definition for recovery several "working definitions" are available (Timpson, Eckley, Sumnall, Pendlebury & Hay, 2016). It is important to note that within these working definitions, the term "recovery" does not exclusively refer to the complete abstinence of substance use and its related behaviours but encompasses a much broader phenomenon that involves varying approaches to substance use reduction (Timpson, Eckley, Sumnall, Pendlebury & Hay, 2016). Approaches range from abstinent-based or zero tolerance to the incorporation of harm reduction principals that include moderated substance use strategies in the recovery process.

Establishing a working definition for the recovery-based framework incorporated within this research design is important. Incorporating a holistic approach to defining recovery, as suggested by various scholars (ACMD, 2013, Burns & MacKeith, 2012; Neale, Nettleton & Pickering 2012; Timpson, Eckley, Sumnall, Pendlebury & Hay, 2016), is a process in which individuals are able to experience improvements to their lives across a diverse range of areas.

These areas include but not limited to: mental health and the enhancement of personal wellbeing; self-autonomy; self-esteem; self-concept; self-image; self-care; the development and repairing of interpersonal relationships; housing; socio economic status; community inclusion; employment; education; general productivity and spirituality (as cited in Neale et al., 2015). Along with these improvements, the individual can often see a reduction in maladaptive coping mechanisms, substance seeking thoughts and behaviours, escapism mentality, toxic relationships and legal issues upon entering a personalized recovery program (Neale et al., 2015).

2.22 Men and Treatment of Addiction

Exploring the experience of men and addiction, and its overarching effects on substance use treatment and recovery initiatives poses several challenges. Pearson, Janz & Ali (2013) reports that 6.4% of males in Canada reported symptoms aligned with a clinical substance use disorder diagnosis compared with a rate of 2.5% for females. Rates of substance use dependence prevalence specifically by substance of abuse yields an alcohol ratio of 4.7% to 1.9%, cannabis 1.7% to 0.7% and other substances 0.9% to 0.5% with males being more prevalent in all categories (Pearson, Janz & Ali, 2013). Males are alarmingly over two and a half times more likely than females to receive substance use disorder diagnosis in reported cases. Men are also reported as more likely to enter substance use treatment. Males comprised 62.7% of the population accessing publicly funded withdrawal management services in 2015/2016 compared with 36.9% of female accesses and 0.4% accesses for those that identify as “other” (McQuaid, Di Gioacchino & National Treatment Indicators Working Group, 2017). These statistics indicate that although not exclusively a male problem, substance use is a significantly more prominent issue among the male population.

Considering the prevalence of substance use disorder and treatment access among males, issues around masculinity and maleness are ever present in the literature (Enos, 2017; Rodriguez

& Smith, 2014; Williams, 2014). Men are significantly more represented in treatment, yet women represent approximately 70-80% of the service provider population (Enos, 2017). Though men often benefit from working with female addiction counsellors, there can be challenges in addressing male psychosocial development, and in conceptualizing masculinity and internalized values and beliefs around masculinity and gender role expectations and their place in recovery (Enos, 2017; Williams, 2014).

Part of the addiction treatment process typically includes psychoeducational, self-help and therapy-based group sessions. These group sessions are seen to be essential to the treatment process and critically shape the treatment experience (Pooler, Qualls, Rogers & Johnston, 2014). Naturally, the ability to strongly identify with a group of peers in treatment not only enhances the therapeutic relationship among group members but also contributes to the overall cohesion of the group itself. Group cohesion is not only highly correlated with more beneficial treatment outcomes and yielding of better overall recovery results but also plays a role in the enhancement of sustainable change (Pooler, Qualls, Rogers & Johnston, 2014; Rodriguez & Smith, 2014).

Scholars noted that an expectation in group treatment sessions is the disclosure of intimate and often traumatic experiences and the accompaniment of the difficult feelings they invoke. This can pose a substantial barrier to men in recovery due to established gender roles and the socialization of men to adopt a “hard as nails” and a “suck it up” attitude (Pooler, Qualls, Rogers & Johnston, 2014; Rodriguez & Smith, 2014). Any expression of weakness or emotional output that does not convey strength and “manliness” is ridiculed. As such, the formation of concrete male to male bonds in treatment can act as a monumental challenge to men in recovery. A reluctance to engage in, or a withdrawal from, the collaborative group therapy process along with the expression of certain negatively perceived emotions such as anger and rage are usually deemed inappropriate for these environments and often addressed punitively which may result in

a reduction of privileges or further isolation from the group (Enos, 2017). These "punitive" management techniques are still widely employed in treatment even though research indicates that they are counterproductive to the overall recovery process and the adoption of a more trauma-informed approach is highly recommended (Enos, 2017).

The multiple identities and social roles experienced by men are intertwined and can include; partner, parent, employee, son, grandfather, uncle, friend, person in recovery, addict, junkie, hustler, breadwinner, dealer, criminal etc. and can often be conflicting in nature. For example, it can be difficult to adopt a positive view of and individual's role as a responsible or good parent when they also view themselves as a criminal or hustler. These roles and internalized beliefs about what's required to be a man present challenges in recovery and are often not effectively addressed or ignored altogether in treatment (Williams, 2014). Incorporating meaningful discussions focused on masculinity and gender roles, while tailoring treatment experiences to provide educational and family-based programming designed to address challenges and expectations can contribute to successful navigation of these issues (Williams, 2014). This type of intervention would not only offer continued support for men in recovery and their families, but enhance the confidence, self-concept and self-efficacy of the men involved further enhancing their motivation and self-belief for recovery potential (McMahon, Winkel & Rounsaville, 2008; Williams, 2014).

2.23 Addiction-related Stigma

The stigmatized individual is asked to act so as to imply neither that his burden is heavy nor that bearing it has made him different from us; at the same time he must keep himself at that remove from us which assures our painlessly being able to confirm this belief about him. Put differently, he is advised to reciprocate naturally with an acceptance of himself and us, an acceptance of him that we have not quite extended to him in the first place. A PHANTOM ACCEPTANCE is thus allowed to provide the base for a PHANTOM NORMALCY—Erving Goffman (1963)

Weiss, Ramakrishna & Somma (2006) suggests that stigma is a socio-cultural phenomenon in which specific persons and or groups are targeted based on their identification within a subgrouping of society, and as a result, can experience prejudice, devaluation, rejection and exclusion because of this identity. Stigma, as it relates to individuals living with substance use, is present in active substance use and recovery discourses and can be a significantly debilitating. Addiction-related stigma, for example, is rampant and has potentially devastating consequences for persons in recovery. According to Earnshaw, Smith & Copenhaver (2013), stigma affects recovery success rates, mental health well-being and treatment seeking behaviour. Stigma can also contribute to a reluctance of investment in resources, death among substance users, and the perpetuation of oppression (Mattoo et al, 2015). Building off the work of Irving Goffman's seminal work relating to stigma, Roy (2010) suggests that stigma present a massive challenge for those in recovery from substance use due to the internalized struggle with how the individual conceptualizes themselves and their personal narratives. Working to shed stigma can quickly become the focal point of an otherwise healthy recovery and can contribute to internal conflicts in morals, values and belief structures which can have a crippling effect on recovery navigation and the overcoming of personal obstacles (Robb, Chou, Johnson, Liao & Tan, 2018).

Stigmatic labelling and prejudicial social practices towards persons living with substance use related issues not only negatively impact interpersonal relationships with family, friends and other societal entities, but can also affect self-esteem and self-perceptions on the ability to act autonomously while increasing the internalization of shame and guilt based self-discourses (Neale et al, 2015; Timpson, Eckley, Sumnall, Pendlebury & Hay, 2016; Weston, Honor & Best, 2018). Stigmatic labelling, prejudice and judgement is not exclusive to social institutions outside of the recovery community realm, but also occurs within the established social networks of

recovery supports and invokes anxiety, fear and reluctance among persons in recovery as discussed in Rodriguez & Smith, (2014).

Stigma negatively impacts individuals in active recovery and can create barriers to progress by impairing the establishment and strengthening of support networks. Weston, Honor & Best, (2018) maintains that fear of stigmatizing attitudes in communities that recovering persons identify with produce feelings of isolation, marginalization, non-acceptance, judgment and rejection. These stigmatizing attitudes are also seen to damage self-belief, motivation and hope. Some scholars argue that stigma is a contributing factor to relapse not only as in terms of a return to active substance use but in other related thoughts and behaviours, and can contribute to a re-identification with substance using persons to establish a sense of connectedness (Rodriguez & Smith, 2014; Stevens, Jason, Ram & Light, 2015; Weston, Honor & Best, 2018; Witbrodt, Borkman, Stunz & Subbaraman, 2014).

2.24 Recovery Capital

Recovery capital is a concept that dominates the literature (Betkowska-Korpala & Olszewska, 2016; McTavish, Chih, Shah & Gustafson, 2012; Morton, O'Reilly & O'Brien, 2016; Neale et al., 2015; Timpson, Eckley, Sumnall, Pendlebury & Hay, 2016; Weston, Honor & Best, 2018; Witbrodt, Borkman, Stunz & Subbaraman, 2014). Recovery capital is a concept coined by Cloud & Granfield (2008) and refers to the total resources available for mobilization to the recovering person to combat their addiction and overcome barriers. Recovery capitol includes internal and external resources and can be helpful or harmful to recovery efforts. Two examples of this are (1) having more financial resources can open more treatment options yet can also provide increased access to substances should the individual resume active addiction; and (2) having a broader range of people in a recovery network can enhance support but perhaps not all of these individuals are supportive and may do more harm than good. Recovery capital is divided into

four subsections each focused on a different type of resource. These subsections include social capital, physical capital, human capital and cultural capital (Cloud & Granfield, 2008), and are discussed in more detail below.

2.24.1 Social Capital

The most valuable of all capital is that invested in human beings—Alfred Marshall (2009)

2.24.1.1 Family, Friends and the Establishment of Support Networks—The saying 'it takes a village' could not provide a more accurate description of the role social capital plays in addressing challenges in recovery and supporting change efforts. Bathish et al. (2017), Haroosh & Freedman (2017), McTavish, Chih, Shah & Gustafson (2012), Pooler, Qualls, Rogers & Johnston (2014), Rodriguez & Smith (2014), Timpson, Eckley, Sumnall, Pendlebury & Hay (2016) and Witbrodt, Borkman, Stunz & Subbaraman (2014) all suggest that social networks are comprised of family, friends, self-help groups and community. Each grouping is thought to be essential components in the initiation and maintenance of the recovery process. Cloud and Granfield (2008) maintains that possessing increasing amounts of social capital in recovery provides more options, resources and opportunities for maintaining recovery when compared with deficiencies in this area. As they state:

> Be it emotional support or access to opportunities that aid in a cessation effort, persons who have social capital are in a much better position to initiate and maintain a successful recovery effort than individuals who do not have these kinds of acquaintances and friendships (p. 1973).

Supportive networks comprised of family, friends, self-help group members and other community institutions are important for several reasons. First, they provide access to various resources such as financial aid, childcare and employment options, and because of the reciprocal nature of the interpersonal relationship create opportunities for resource sharing (Cloud and Granfield, 2008). Second, these support networks not only combat the negative effects of social

isolation but provide emotional support and a sense of interconnectedness that can encourage a sense of belonging and improvements to self-worth, self-esteem, self-confidence and self-image (Timpson, Eckley, Sumnall, Pendlebury & Hay, 2016). Improvements in these areas provide the recovering person with a greater sense of self-efficacy and improve overall quality of life (Bathish et al, 2017). Finally, support networks are viewed by many recovering persons as a substantial source of motivation for positive changes and in sustaining their recovery efforts (Bathish et al., 2017; Brunelle et al., 2015; Morton, O'Reilly & O'Brien, 2016; Timpson, Eckley, Sumnall, Pendlebury & Hay, 2016; Williams, 2014).

While social capital is widely viewed as critical in the navigation of challenges and overall recovery sustenance, it is not always uniquely positive. Depending on the makeup of an individual's social network, social capital can possess negative connotations towards recovery efforts. Relationships, whether pre-dating or developing during recovery efforts, can be toxic in nature and contribute to emotional fluctuations, the development of stress and even codependency (Weston, Honor & Best, 2018). As these scholars note, "Some of the data presented confirm that social networks drawn upon by people who use drugs can reinforce and even facilitate drug use, and act as barriers to transition to groups that support recovery" (Weston, Honor & Best, p. 497). However, restructuring social networks to better align persons in recovery with likeminded and supportive entities is a complex process. It can be a stress inducing and a potentially isolating endeavor due to the sheer magnitude of change and time required to form connections with new people (Bathish et al, 2017).

Membership in various self-help organizations can be intimidating and appear exclusive to the person in recovery. Research done by Rodriguez & Smith (2014), articulated a reluctance for persons new in recovery to identify with A/A and N/A group members. There are also often conflicting expectations for membership and overall group direction that may scare off potential

membership (Witbrodt, Borkman, Stunz & Subbaraman, 2014). Weston, Honor & Best (2018) suggests that even when admittance to self-help groups is not an issue, members can suffer from an internal exclusivity complex that can dangerously alienate members from other support networks and social institutions creating a similar "social isolation" problem experienced by individuals engulfed in active addiction (p. 491). This "social isolation" problem can contribute to a reluctance for persons in recovery to engage with people and institutions outside of their recovery network leading to feelings of insecurity and other social anxiety related issues (Rodriguez & Smith, 2014; Weston, Honor & Best, 2018). In addition to this, individuals tightly connected to self-help groups that incorporate behavioural expectations for membership can alienate members that do not abide by expectations even temporarily, leaving the person in recovery socially isolated from both groups (Weston, Honor & Best, 2018).

2.24.2 Physical Capital

2.24.2.1 Financial Security and Access to Material Resources—The ability to mobilize monetary assets and achieve financial security provide significant advantages to the person in recovery. According to Cloud & Granfield (2008), physical capital can provide several options for enhancing recovery outcomes by improving the availability of treatment options, providing access to better health care, physical relocation, and increased professional helping options such as access to insurance, leaves of absence and vacations. Morton, O'Reilly & O'Brien (2016) suggests that health management and physical exercise may also support relapse prevention and the overall maintenance of recovery efforts by positively effecting social inclusion, self-esteem, emotional and stress management, communication and confidence. Brunelle et al. (2015) found that physical and psychological health and overall quality of life were important factors in motivating participants to seek positive changes through reducing or eliminating substance use altogether. Timpson, Eckley, Sumnall, Pendlebury & Hay (2016) also

reported that its advantages considered; physical capital was viewed as slightly less important than the other forms of recovery capital by participants. This was due to its perception as an indirect recovery resource where its primary function is to facilitate access to other forms of capital to benefit recovery efforts.

2.24.3 Human Capital

Every person intuitively seeks personal independence, the ability to exercise autonomy over the course that his or her life takes—Kilroy J. Oldster (2015)

2.24.3.1 The Role of Self-Determination, Autonomy and Motivation—

Acknowledging the substance dependent person's right to self-determination while seeking to provide motivation for change is a nearly impossible balancing act employed by loved ones and treatment providers alike. Assumptions are dangerous, especially when they involve the desired behavioral outcome of others. This can sometimes create a winless situation for men in recovery as they are not only constantly held in comparison to behaviours exhibited by their "addicted self" but also measured against societal expectations on how a "normal person" should behave. Carrying unrealistic expectations around how a person in recovery should behave leads to others establishing unattainable goals and works against the self-determination of the individual while driving them further away (Betkowska-Korpala & Olszewska, 2016). Conversely, should expectations and goal establishment be insufficient, successes in the change process fizzles out and the recovering person runs the risk of falling back into old habits. Neale et al (2015) outlines this balancing act in stating:

> If we set expectations too high, we risk further excluding those who are already marginalized; if we set expectations too low, there will likely be little satisfaction in making progress (p. 32).

The very perception of what a recovering person needs in order to be successful is a point of contention between service providers and service users. According to research completed by

Neale et al (2015) service users report that service providers carry a "superhuman" level of expectations around recovery outcomes and measures. Service users suggest that these anticipated outcomes and measures far exceed the expectations and responsibilities attributed to those that do not identify as "in recovery" (Neale et al, 2015). This in and of itself not only hampers clients' autonomy, expertise and self-confidence, but also measures clients against unattainable goals in relation to the speed and magnitude of their change process. Self-determination and self-efficacy need to remain the focus of any treatment model as they are fundamental predictors of recovery success that not only increase motivation but also support the overall change process (Turpin & Shier, 2017).

Observing the substance dependent person's capacity to successfully navigate their recovery and effectively demonstrate autonomous decision making even while experiencing intra-personal incongruences, represents both a challenge and a solution. Motivation for change is unique to each individual and while it can be learned it is not something that can be taught (Brunelle et al, 2015). This is problematic as treatment providers almost exclusively offer a "one size fits all" approach to service delivery and in doing so, remove much of the autonomy of the client to self-regulate and assume responsibility for self-motivating sustainable change (Betkowska-Korpala & Olszewska, 2016; McTavish, Chih, Shah & Gustafson, 2012; Neal et al., 2015; Pooler, Qualls, Rogers & Johnston, 2014; Witbrodt, Borkman, Stunz & Subbaraman, 2014).

Incorporating a 'cookie cutter' approach to service provision effectively ignores a more collaborative client-centred model that tailors service delivery to the uniqueness of the person seeking care, treatment and support for substance use. This method of service provision assumes the professional knows best and the clients will fit into a framework rather than contouring service provision to wrap around the diverse needs of the individual and extrapolate his strengths.

Although widely employed in contemporary practice, this model is not seen as the most successful approach (Timpson, Eckley, Sumnall, Pendlebury & Hay, 2015). It is difficult to ask anyone to buy into a "top down" service provider knows best approach, that attempts to dictate a life course using measures of success that those attempting change are not even sure that they agree with in the first place. Neale and colleagues (2015) conducted a study exploring the drastic differences between how service user's measure recovery compared with perceptions of service providers. Neale and colleagues (2015) suggested that clinical recovery measures are flawed and incongruent with what service users might perceive as important in recovery and further suggested that they would benefit from a more collaborative approach. This collaborative approach would better incorporate the perspectives of service users rather than ignoring them (Neale et al., 2015). Finally, Brunelle et al. (2015) argues that observing the client as their own expert and forming a therapeutic alliance while promoting self-efficacy and responsibility present opportunity for sustainable change and navigation of this challenge.

***2.24.3.2 Education and Skill Development*—**The literature maintains that creating opportunities for education while establishing a platform for nurturing existing skill sets and developing new ones is critical to navigating challenges in recovery. Recovery based programming typically employs psychoeducational and group therapy sessions centred on providing education for the recovering person while working on skill development. Many scholars argue that this education and skill development piece is one of the most important aspects of successfully navigating challenges in recovery and should be the foundation of any model (Morton, O'Reilly & O'Brien, 2016; Russell, Gillis & Heppner, 2015; Timpson, Eckley, Sumnall, Pendlebury & Hay, 2016; Witbrodt, Borkman, Stunz & Subbaraman, 2014).

In any attempt at recovery, education and skill development contributes to measurable improvements in both intrapersonal and interpersonal relationships. Turpin and Shier (2017) discusses the intrapersonal effects of education in recovery:

> Changed perspectives about addictions occurred in many ways for respondents. Work on self-reflective exercises and drug awareness would surface new ideas and develop a holistic and informed approach to substance use. As well, educative components of treatment helped respondents learn about substances and patterns of use. The result of this work often changed perspectives about addictions as they relate to the interpersonal realm (p. 139).

Furthermore, education and skill development support: self-awareness and the understanding of core issues within the addiction, emotional management and self-care habits, improvements to communication and problem solving, healthy stress management and coping techniques, and improvements to interpersonal relationships (Morton, O'Reilly & O'Brien, 2016).

2.24.4 Cultural Capital

There is nothing like returning to a place that remains unchanged to find the ways in which you yourself have altered—Nelson Mandela (2009)

2.24.4.1 Changes in Beliefs and Identity—Changing behaviours associated with substance use into those consistent with recovery ideals is no simple task. It requires a shift in values, beliefs and overall transformation in identity from an individual entrenched in substance use to someone that is immersed in a recovery-based lifestyle (Bathish et al, 2017; Betkowska-Korpala & Olszewska, 2016; Neale et al., 2015; Rodriguez & Smith, 2014; Timpson, Eckley, Sumnall, Pendlebury & Hay, 2015). This transformation of identity is consistently discussed across the literature and often viewed as the single most difficult challenge facing persons in recovery. Rodriguez & Smith (2014) suggests "As they depart from an identity that has failed them, they are challenged with the creation of an identity that is congruent with their new social world" (p. 486). Cloud and Granfield (2008) maintains: "Indeed, constructing new systems of

meaning that are consistent with sobriety and/or nonproblematic substance misuse is commonly the most difficult component of any substance misuse recovery effort" (p. 1974).

Persons in recovery are required to shift previously accepted social norms of substance using culture, and transition from identifying as "the addict" to a "person in recovery". Along with this shift in identity, a recovering person must also successfully navigate multiple lifestyle changes including changes to thoughts, behaviours, beliefs, values and social environment. According to Haroosh & Freedman (2017), "From this perspective, recovery is seen as requiring the adoption of a new way of life that is meant to sustain the recovery, manifested in changes in lifestyle, habits, values and gradual spiritual growth" (p. 2).

A shift in identity poses substantial challenges to the recovery person's perception on what is now defined as "normal behaviour" and is managed by a distancing of substance use related values and decrease in social identification with those actively using substance (Bathish et al., 2017). In order to effectively manage the identity transformation required of the recovering individual, a reconstruction of the social environment and self-imposed shedding of previous peer groups, people, places and things is often seen to assist the process (Rodriguez & Smith, 2014; Weston, Honor & Best, 2018). This can help in relapse prevention and avoid a re-normalization of substance misuse ideals.

Turpin & Shier (2017) suggests that a thorough intrapersonal self-assessment with attention to raising self-awareness is required to facilitate the shift from an active addiction-based lifestyle into recovery. It is helpful for an individual in recovery to conduct a thorough evaluation of their own self-esteem, self-worth and self-efficacy. Such potentially develop an increased sense of self-awareness in these areas and sets up the opportunity for enhancing these concepts (Bathish et al., 2017; Pooler, Qualls, Rogers, Johnston, 2014; Turpin & Shier, 2017). The literature does however maintain that caution must be exercised when dealing with self-

awareness and intrapersonal analysis. Neale and colleagues (2015) report that while service users are primarily in agreement with the importance of self-reflection, they suggest that constantly self-reflecting may inhibit the attainment of "closure" in certain emotionally charged situations and potentially lead to relapse. Service users also cautioned that maintaining perceivably negative traits and emotions such as self-doubt, anxiety, guilt and shame can keep recovering persons aware of the challenges they face and avoid being blindsided by over-confidence and dangerously unrealistic perceptions of success (Neale et al, 2015).

Finally, while working on changes in self-identification, self-awareness, support circles and social environments, it is important to pursue changes in emotional and stress management, coping mechanisms and the administration of self-care initiatives (Bathish et al., 2017; Betkowska-Korpala & Olszewska, 2016; Pooler, Qualls, Rogers, Johnston, 2014; Russell, Gillis & Heppner, 2016; Turpin & Shier, 2017; Witbrodt, Borkman, Stunz & Subbaraman, 2014). Coping strategies and skills improve the daily management of emotions and stress while helping the recovering person in the effective management of triggers and cravings for substance misuse (Turpin & Shier, 2017). Service users also report that self-care is critical for managing stress and emotional ups and downs, and in promoting a shift from maladaptive coping mechanisms into ones that maintain a recovery-based lifestyle (Rodriguez & Smith, 2014, p. 484).

***2.24.4.2 Finding Meaning and Purpose in Recovery*—**Finding meaning, establishing purpose, deriving belonging, and attaining a sense of productivity are considered key elements in the recovery journey made by service users. Timpson and colleagues (2015) state, "Developing a sense of belonging and purpose in life was a key part of people's recovery discourse" (p. 34). Setting goals and developing interests capable of evoking passion contribute to the growth of the recovering person while invoking hope and providing a potentially positive outlook on future endeavors (Turpin & Shier, 2017). Goal establishment and the subsequent

attainment of these goals provides a sense of accomplishment that contributes to increased perceptions of self-efficacy and overall recovery maintenance (Betkowska-Korpala & Olszewska, 2016).

Many recovering persons experience a sense of loss and difficulty taking the next steps towards their recovery, and life in general. Reconnecting to the community and attaining a sense of belonging and importance promotes a strong sense of responsibility in recovery and is seen to combat the isolating forces of addiction (Morton, O'Reilly & O'Brien, 2016; Weston, Honor & Best, 2018). Attaining a stronger connection to supportive social networks and community institutions is also seen to represent growth in overall wellbeing (Bathish et al., 2017).

Finally, the seeking of education and employment opportunities and "giving back" to the community, be it recovery based or in general terms was widely reported as important to service users, and helps avoid stagnation through the progression of the recovery process (Timpson, Eckley, Sumnall, Pendlebury & Hay, 2015) and (Weston, Honor & Best, 2018). Improvements to education and employment also assist with overall goal attainment initiatives (Turpin & Shier, 2017). While generally seen as positive, Neale et al (2015) warns that managing employment and other recovery commitments can be strenuous on recovering persons and pose challenges to their recovery due to long hours, access to more financial capital and increasing responsibilities that can be counterproductive to self-care measures.

2.3 Discussion

The literature provides a wealth of knowledge on men in recovery and the challenges they face. There is a diverse myriad of subject material to explore, yet much of the research is focused on the examination and critique or praise of various treatment methods. The literature frequently discusses successes, failures and innovative concepts aimed at improving recovery rates while streamlining service provision to incorporate best practice ideals. Though both qualitative and

quantitative research methods are represented, there is a distinct emphasis on quantitatively seeking improvements to existing treatment methods. Key concepts and areas of discussion derived from the literature include; defining recovery, how socialized concepts of masculinity impact recovery, stigmatizing attitudes towards substance use disorder and the attainment and deployment of positive recovery capital to combat challenges faced in recovery while subsequently limiting and addressing negative recovery capital.

Challenges that men in recovery face are identified and discussed. These challenges, however, are often conceptualized within the confines of a paradigm that pathologizes substance use disorder related issues and provides a problematizing framework for analysis. These issues considered, there is some encouraging research that incorporates a strengths-based perspective. Research completed by Spiehs & Conner (2018) challenges stigma and suggests a complete shift in the conceptualization of persons in recovery to adopt an approach focused on strength and prosperity. Haroosh & Freedman (2017) highlights the posttraumatic growth of persons living in recovery, expressing their value as people and ability to persevere through the difficulties that they face. Similarly, Timpson and colleagues (2016) focuses on resilience and looks at experiences of substance use recovery and the benefits associated with these changes. Andersen (2015) and Neale and colleagues (2015) utilize a person-centred approach to their research that strongly advocates for participant incorporation into changing recovery standards and protocol. Bathish and colleagues (2017) and McTavish and colleagues (2012) explore recovery as a collaborative process rich with potential for social networking and community support while outlining the strength and courage of the participants. Utilizing a strength-based approach to substance use recovery research could represent a significant change for the field and start finally shifting recovery-based discourses into a more positive and empowering direction.

Chapter 3: Theoretical Perspective and Methods

A research study exploring how men in recovery conceptualize challenges and use inherent strengths to navigate them can be conducted using many diverse theoretical perspectives. Each of these perspectives would provide unique lenses for data analysis and could quite conceivable result in vastly different outcomes using similar data. Research methods must also be considered as similarly, different methods may alter a research study's findings regardless of the theoretical perspective used. This chapter will discuss the use of strength-based theory in this study and outline all methods used in the research design.

3.1 Theoretical Perspective: Strength Based Theory

Few men during their lifetime come anywhere near exhausting the resources dwelling within them. There are deep wells of strength that are never used—Richard E. Byrd (1996)

Strengths based theory provides a unique and contemporary lens to critically analyze substance use and addiction related issues. Strengths Based Theory was first adapted for social work practice in the late 1980's and early 1990's at the University of Kansas in the Department of Social Welfare. At this time, strengths-based theory was observed to be a revolutionary approach to support case management work with clients experiencing severe mental health related issues by Charles Rapp and Ronna Chamberlain (Saleebey, 2008). Theory and practical application procedures of a strengths-based perspective were discussed at a 1988 University of Kansas seminar attended by several social work professionals, researchers and educators from across the country. Following the success of this seminar, the initial framework for the theory "The Strengths Perspective in Social Work Practice" was published by Denis Saleebey in 1992 and went on to establish itself as a well-respected and frequently utilized theory (Saleebey, 2008).

Strengths-based theory was incorporated within addictions work during the early to mid-1990's and was immediately accepted as an innovative and effective method to address the issues

faced within the community (Miller & Berg, 1995; Rapp, Siegal & Fisher, 1993; Saleebey, 1996; Siegal, Rapp, Kelliher, Fisher, Wagner & Cole, 1995; Weick, Rapp, Sullivan, Kisthardt, 1989). Strengths-based theory continued its evolution and became one of the most widely employed frameworks within addictions work by social work researchers and practitioners throughout the early 21st century and into contemporary practice. It's ability to successfully and consistently yield positive results in the treatment of addiction related issues was seen as revolutionary and a welcome change to typical problematizing approaches (Bellamy, Rowe, Benedict & Davidson, 2012; Davidson, Andres-Hyman, Bedregal, Tondora, Frey & Kirk Jr, 2008; Davidson & White, 2007; Matto, 2004; Harris, Brazeau, Clarkson, Brownlee & Rawana, 2012; Okundaye, Smith & Lawrence-Webb, 2001; Rapp, 2002; Redko, Rapp, Elms, Snyder & Carlson, 2007).

Inquiries into how individuals in recovery overcome challenges and continue to demonstrate persevering qualities while trying to navigate their daily lives may benefit strongly from the following core Strengths-based theory principals: (1) Recognition that all persons possess potential, value, diversity and the unique strengths that persons already possess regardless of the challenges they experience. This is contrary to discourses that prioritize problem solving and lack inquiry into intrinsic strengths that can be mobilized to overcome adversity. For example, substance users are often viewed as weak in nature because of their chronic substance use. This approach, however, does not consider the intricacies of what it takes to maintain an addiction. Obtaining the financial means for substance use and managing the physical and social consequences requires significant dedication, creativity and strength; (2) Belief in a person's ability to demonstrate resilience as a response to challenges, and experiences of trauma and adversity. Resilience in this setting can also be conceptualized as a stubborn reluctance to observe a return to substance using behaviours as a viable option when confronted with challenges in recovery. For example, substance use often becomes a default 'go to' almost dispositional in

nature response to trauma, adversity, challenges and just about anything else (Maté, 2008). Learning to combat these intense desires and almost automatic responses demonstrates an intense resilience by the recovering person; (3) Observation that change is a constant and unavoidable entity ever-present in the life course. Change is dynamic and may take on positive or negative connotations depending on the perception of the recovering person. Changes in recovery from substance use are many and occur frequently throughout the recovery process. Change in recovery is seen as an evolutionary and necessary process that constantly reshapes the recovering person (Gorski, 2011). For example, early recovery challenges may be overcome or considered irrelevant during middle and even later recovery (Gorski, 2011); (4) Acceptance in the concept of a person-centred reality and in the notion that the individual is the expert in their own journey. Many theoretical approaches and clinical interventions establish the position that the researcher, clinician, service provider etc. knows best due to their experience and education. Strength-based theory maintains that the individual is the central component more than capable of not only developing solutions and altering their life-course but as having the autonomy and capacity to employ these amendments; and (5) The importance of collaborative initiatives and the establishment of supportive structures and networking while developing a sense of community and belonging. Here, the environmental makeup of the individual is viewed as having the potential for becoming a rich resource that can be utilized accordingly. Mobilizing recovery capital and developing strong community-based bonds and supports are a key feature of this principal. (Hammond, 2010; Saleebey, 1996; Weick, Rapp, Sullivan, Kisthardt, 1989).

3.2 Strength-Based Theory and this Study

The aim of this research design is to thoroughly explore the experiences of men that self-identify as living in “recovery” from addiction related issues using the uniqueness and empowering nature of a Strength Based approach for analysis. Using a strengths-based approach will ensure that the

participant experience remains the focal point of the research process, and the client directed discourses will dominate the interview procedure and overall participant experience. This strength-based lens will ensure the integrity of the information provided while promoting data extrapolation in ways that is culturally relevant to the participants and central to their recovery efforts. This strength-based lens will also present the participants as catalysts and experts in their own change process in a uniquely positive manner that is committed to highlighting strength perseverance, competence and cooperation. This lens will also maximize human potential and nurture autonomous driven sustainable change while eliminating discouraging self-discourses. Finally, adopting a positive, strength-based approach will ensure that participants' issues are not further pathologized or negatively emphasized during the interview process (Reason & Bradbury, 2001).

The questions used in the interview process are intended to highlight participant strength. Participants will be asked to identify personal qualities they possess that may help them manage self-identified challenges during their interview. Participants will also be asked to anticipate future challenges and articulate how they may navigate these. In employing this line of questioning, it is my intent to emphasize the strengths presented and focus on participants potential to successfully navigate challenges in accordance with the strength-based model.

By casting inquiry into how participants conceptualize and navigate challenges I intend to capture the resilience, resistance and perseverance demonstrated throughout their stories. I aim to emphasize how these measures have contributed to their successes in recovery and overall lives in general. Interview questions were designed to encourage participants to explore ways in which they were able to use these qualities to overcome adversity throughout their recovery. Recovery as a process can be conceptualized as the ultimate form of resilience, resistance and perseverance

(Rudzinski et al., 2017) and an integral component of a strength-based analysis (Hammond, 2010; Weick, Rapp, Sullivan, Kisthardt, 1989).

The interview questioning is broken down into five sub-sections of inquiry. The first four of these sub-sections were designed with the intent of capturing the participants' addiction and recovery journeys. Questions were designed to flow chronologically, and accent change consistent with the strength-based approach (Reason & Bradbury, 2001). The four subsections include: (1) History; the onset and progression of addiction; (2) Treatment; addictions treatment trajectory and experiences; (3) Recovery; trajectory including the conceptualization and navigation of challenges; (4) Future; goal setting and challenge navigation.

In encouraging the conceptualization of challenges by the participants during the interview process rather than incorporating researcher hypothesized challenges, I intend to retain participant autonomy. In accordance with a strength-based perspective, this approach ensures that participants are central to all processes and able to dictate the course of the interview through how much they chose to share. Capturing the essence of each participant's story and using inductive coding maintains that participant experience remains the focal point of research findings.

Collaboration and support networks are key components of the strength-based perspective (Saleebey, 1996; Weick, Rapp, Sullivan, Kisthardt, 1989). Considering the importance of these structures, questions involving treatment experiences and the supportive networking of the participants were woven into the interview process. Participants were also asked to conceptualize future challenges and how they may use supports and resources to overcome these.

3.3 Weakness Versus Strength: A War of Semantics or Unrecognized Potential?

Just as weakness can be considered the absence of strength it can also be conceptualized as the reluctance to observe aspects of fortitude within one's life. As such, incorporating a strengths-

based approach allows for the acknowledgement of personal strengths within experiences. This acknowledgement and continued deployment of these strengths, along with the normalization of past experiences contributes to the further enhancement of confidence, self-esteem and self-efficacy (Weick, Rapp, Sullivan, Kisthardt, 1989). Varying strengths can be mobilized and deployed in ways that benefit the individual and assists them in goal attainment and the resolution of their challenges. Saleebey (1996) suggests:

> People learn from the world around them, through formal education or through the distilling of their day-to-day experience. Clients can often surprise practitioners (and themselves) with the talents they have (or once had but let fall into disuse or out of memory). Such talents, whether juggling, cooking, baking bread, or tending to the needs of the ill, may become tools for helping build a better life (p. 299).

A reluctance or inability to observe strengths is often a byproduct of a pathologizing view of addiction. Under this lens, addiction is interpreted as a weakness or severely problematic behaviour that inhibits the individual from living a fulfilling life, attaining their potential or contributing to the richness of the communities in which they reside (Saleebey, 1996). An over-insistence on identifying individuals as "having a problem" or even "being the problem" contributes to ideologies centred on problems as dispositional traits within individuals. These ideologies are based on perceptions of morality and incorrectly assume that they can provide accurate insight into the articulation of who the persons experiencing the problem are as people (Weick, Rapp, Sullivan, Kisthardt, 1989). Strengths within the individual are overlooked in place of the presence of problems. Okundaye, Smith & Lawrence-Webb (2001) compares the difference in approaches:

> Where the medically oriented practice models focus on dysfunction, deficits and limitations, the strength orientated writers move to the opposite end of the continuum emphasizing health, functionality, opportunities and capabilities (p. 70).

The Strengths Based perspective presents an opportunity to alter discourse to take a more positive stance, esteem-building, experience and supports challenging internalized shame-based

ideologies while striving to use emotional guilt as a healthy motivating source for change (Merritt, 1997). It is in this alteration of contextual meaning that an opportunity develops for a paradigm shift from individuals that are so beaten down by pathologies, shame and stigma, into persons not only worthy of change but also capable of unearthing incredible internal resources to become the driving force in their own successes thereby yielding phenomenal results in the process. Drawing on strengths rather than weaknesses allows the research design to embrace the participant's perseverance and encourage self-identification of their ability to overcome adversity.

3.4 Resilience, Resistance and Perseverance: It's Not All Pushing and Shoving

My scars remind me that I did indeed survive my deepest wounds. That in itself is an accomplishment. And they bring to mind something else, too. They remind me that the damage life has inflicted on me has, in many places, left me stronger and more resilient. What hurt me in the past has actually made me better equipped to face the present—Steve Goodier (1999)

Addiction is a complex issue that yields substantial difficulties, recurring stresses and traumatic experiences within an individual's life. Stresses and trauma can not only contribute to the onset of addiction (McCormick, Taber & Kruedelbach, 1989; Maté, 2008) but are also ever-present throughout, sustaining substance use related cravings and behaviours. These stresses and traumas usually affect the individual in all areas of their lives on a biopsychosocial continuum. Grief and loss based emotional responses are ever present in addiction and often contribute to further spiraling the individual into substance use by strengthening escape cues and perpetuating the cycle of their addiction (Cadet, 2016; Dayton, 2000; Koob, 2008).

Just as stresses and traumatic experiences have the potential to inflict monumental damage and life-long distress in people, they also have the potential to create a platform for healing, learning, personal growth and development. It is essentially down to the response elicited from the individual and their ability to effectively heal from their stresses and traumas.

Will the individual give into their addiction? Or will they progress with a stronger sense of self and new skills to combat future challenges? This phenomenon has been labelled as Post-Traumatic Growth and involves the extraction of positive and strength generating results from the experiencing of negatively perceived events (Joseph, Murphy & Regal, 2012; O'Leary & Ickovics, 1995; Linley & Joseph, 2004). It is a "what doesn't kill me makes me stronger" type approach.

Post-traumatic growth is considered by many researchers to be a critical opportunity to build resilience, strengthen emotional management, develop new skills, establish positive coping mechanisms and provide substantial overall improvements to one's quality of life (Iacoviello & Charney, 2014; Jayawickreme & Blackie, 2014; O'leary, Alday & Ickovics, 1998). Furthermore, Peterson, Park, Pole, D'Andrea & Seligman (2008) suggests: "Terrible events are all too common in people's lives, but the effects of these events are not uniformly negative and may include increased strengths of character" (p. 217). The importance of strengthening character and resiliency in addiction recovery work is critical to successfully navigating challenges faced by the community and can be the foundation for prosperity in recovery (Arpawong et al, 2015; Harris, Smock, Tabor-Wilkes, 2011; Hewitt, 2007; Stump & Smith, 2008).

Resilience is not the denial of trauma, stress or pain, but the ability to manage and potentially persevere through these challenges employing a method that works for the individual. A resistance to capitulation or refusing to surrender in the face of adversity is the catalyst for change and the development of positive coping mechanisms (Saleebey, 1996). Acknowledging the relevance of positive responses to coping with experiences of trauma, stress and emotional management, while celebrating the development of new coping mechanisms within the interview process of this research could contribute to nourishing the change process and helping support the positive growth in self-esteem, self-image and self-concept among the participants.

3.5 Change: The Unavoidable Paradox

Change is observed as an ever-present phenomenon within a strengths-based approach and although surprising to some, is viewed as having every potential to be positive in nature (Hammond, 2010; Weick, Rapp, Sullivan, Kisthardt, 1989). The transition from active addiction into recovery is a monumental task that produces changes in almost all areas of an individual's life. The "Transtheoreticial Model" is a therapeutic tool focused on several processes of change and is widely used in addiction treatment. This model is made up of smaller change models, change scales and change-based skill development sets, and aims to explain the change process while offering therapeutic suggestions for clinical practitioners and skill development support (DiClemente, Schlundt & Gemmell, 2004; Migneault et al, 2005; Petrocelli, 2002). Successful transition into a life in recovery is dependent upon the addicted individual's multifaceted alteration of their lifestyle through biopsychosocial changes. These changes include behaviours of a substance seeking or maladaptive nature, shifting to recovery-based identification thoughts and emotional navigation and the social environment (Gorski, 2011).

Changes to the way the individual behaves are essential to transition from an individual in active addiction into an individual in recovery. The very nature of "substance taking behaviour" is what the individual is attempting to alter and any changes to this behaviour are aimed at supporting a recovery-based lifestyle. Included herein are the rejection of physical substance use and all related substance seeking behaviours. Also included within these behavioral changes are alterations to eating habits, physical exercise routines and medication protocols when deemed appropriate (Gorski, 2011).

Thoughts and feelings are also affected by the change process. Transitioning into a recovery-based lifestyle requires the redevelopment of personal identity, and management of maladaptive thoughts and emotions such as altering catastrophic and all or nothing thought

patterns. Identifying as a person in recovery and aligning with similar thought processes creates new schemas for introspective reflection. The individual in recovery will often have trouble rejecting their previous substance using identity. A further rejection of social labeling may also contribute to successes in recovery (Best et al., 2016). Overcoming the changes in identity is essential to experiencing successes in recovery (Rodriguez & Smith, 2014). Spiehs & Conner (2018) maintains that this change process can be strongly supported through the alteration of language used to describe persons in recovery by clinicians, researchers and other practitioners. Changing the term "person in recovery" to "persons who thrive" will better capture the nature of their "human capacity" "strengths" and "potential" (p. 375).

Finally, alterations to the social environment are also important. Avoiding the presence of unnecessary triggers in the form of persons, places and things that were associated with substance use where possible, while learning to manage unavoidable situations, in conjunction with utilizing coping mechanisms to manage cravings are associated with improving recovery successes and avoiding situations in which relapses may occur (Gorski, 2011). These changes are not easy and often require adjustments as the individual continues to evolve in their recovery lifestyle.

3.6 Person-Centred: A New Perspective on the "Expert"

Strength Based Theory not only exerts that reality is concept uniquely individualized to the person that it centres around, but celebrates that principle allowing the individual to carve out their own conceptualization of how their reality is contoured (Weick, Rapp, Sullivan, & Kisthardt (1989). This fundamental principal of Strength Based Theory is similar to a client centred perspective and draws from postmodern and social constructionism discourses (Oko, 2006). This approach acknowledges a client's perspective and their capacity to create meaning from the world around them through a lens that works for them. Weick, Rapp, Sullivan, & Kisthardt

(1989) suggest that eliciting change and achieving a desired future is not a fluid or universally consistent concept but dependent upon the experiences of the individual and subsequent shaping of their reality: "Even though the systems of social rules suggest that there is an objectively correct way to proceed in human life, most people experience a different reality" (p. 353).

In support of the individually constructed reality principal, Strengths Based Theory also maintains that the individual is the expert of their established reality capable of eliciting personal change by drawing on internal strength-based resources (Hammond, 2010; Saleebey, 1996). In doing this, Strengths Based Theory suggests that the client's shaping of their reality allows the individual to effectively take control of their world and start to bring about change in the desired direction. Strength Based Theory encourages the empowerment and the development of self-efficacy while aiming to provide hopeful discourses for the future (Rapp, Saleebey & Sullivan, 2005). The "self-constructed reality" concept aligns itself well with the other core Strengths Based perspectives and aims to validate the client perspective while providing a sense of control and belief at the individual's capacity to engage in positive change processes.

3.7 Collaboration: It Takes a Village

The Strengths Based Theory concept of supportive structures, networking and community, challenges archaic discourses surrounding male gender roles and suggests that strength and success in the change process are derived through the establishment of not only a new social support structure, but also strengths existing social support communities. This framework for success is contrary to many all-powerful and conquering stereotypical male gender roles that have only recently begun to be deconstructed and challenged for their farcical nature and unrealistic expectations (Enos, 2017; Williams, 2014). Deriving a sense of belonging from a community can enhance resilience, encouragement, support, problem solving and motivation while nurturing skill development and forming destigmatizing connections (Saleebey, 1996).

Community support and interpersonal networking are also viewed as a critical component to goal attainment and overall successes in recovery programming by many addiction studies and therefore a natural fit for Strength Based Theory (Bathish et al., 2017; Brunelle et al., 2015; McTavish, Chih, Shah & Gustafson, 2012; Pooler, Qualls, Rogers & Johnston, 2014; Weston, Honor & Best, 2018). A Strength Based lens provides an opportunity to encourage the development of these community-based relationships while creating a platform for sustainable change, skill enhancement and providing a sense of responsibility to make contributions to the betterment of the community while attaining a citizenship standing (Saleebey, 1996). The establishment of a sense of belonging and community connection can create purpose and a sense that the community is depending on the individual and nourishing this sentiment while supporting the growth of the individual combats the very nature of addiction (Maté, 2008).

3.8 Methods

3.81 Recruitment

During the recruitment phase of this study I enlisted the support of a residential treatment agency for substance use recovery located in Hamilton Ontario. I met with the Chief Executive Officer and Program Manager of the treatment facility and discussed the specifics of the research design as well as my intent to engage with clients residing in the supportive housing program for participation in the study. I was issued a letter of support by the treatment facility (Appendix E). I conducted a short verbal presentation (Appendix N) to the attendees of the treatment centre's weekly aftercare meeting. The presentation was approximately ten minutes in duration, and I answered questions on the study directly following the presentation. I left several copies of a recruitment poster (see Appendix A) at the residential treatment facility outlining the study and providing my contact information for interested parties to follow up at their convenience via telephone or email.

3.82 Participants

Following the verbal presentation, five clients expressed interest in the study, signed a "consent to record eligibility" document (Appendix C) and were invited to complete a short eligibility screening (Appendix B). All five clients were deemed eligible to participate in the study in accordance with the study's eligibility criteria. In order to participate, individuals were required to be: (1) Male; (2) Aged 18 or over; (3) Able to understand English; (4) Currently identify as in "recovery" from substance use; and (5) Have completed residential treatment within the past two years. The clients were invited to contact me via telephone to further discuss the study. A sixth individual contacted me by telephone, issued verbal consent and completed the eligibility screening requirements for participation in the study.

3.83 Interview Establishment

The five individuals that expressed interest in participation following the presentation contacted me by telephone and further expressed interest in participating. I explained that I was conducting a strength-based study on men in recovery and how they conceptualize and overcome challenges. I discussed the study procedures and highlighted potential risks and benefits of the study. Finally, I asked if there were any questions and established interview times with five of the six participants. This process was completed using an oral phone script (Appendix D). The sixth individual was presented the oral phone script and had his interview time arranged at his request during his initial telephone inquiry.

3.84 The Semi Structured Interview Process

Qualitative semi-structured interviews were conducted in Hamilton Ontario at a location of each participants choosing. Five of six individuals asked for the interview to be conducted in a private interview room at the residential treatment centre while the remaining participant asked that the interview take place in his supportive housing unit of residence. Participants were each given

instructions (Appendix F), the letter of information and consent document (Appendix G), a short demographic questionnaire (Appendix H) and an interview question guide (Appendix I). I reviewed every document with each participant prior to the commencement of the interview process and answered their questions. Participants completed the consent document and the demographic questionnaire. I obtained verbal permission to start the audio recording device and commence the interview.

Upon completion of the interview process, I asked each participant how they were feeling and what the interview process was like for them. There were no issues expressed by any of the participants at this time and feedback on the interview experience was extremely positive. I also provided each participant with a list of support services in the Hamilton area (Appendix L). Finally, participants were issued a letter of appreciation for sharing their expertise (Appendix K). Participants were also given a $25 gift card for Walmart as a small token of appreciation. Compensation receipt was tracked using a compensation log (appendix J). Participants email addresses were obtained to provide a completed research document following a successful thesis defense.

3.85 Data Analysis

The semi-structured interviews were audio recorded and transcribed verbatim in their entirety by me into Microsoft Word to ensure clarity and accuracy, and to support the data analysis process. As discussed in Braun & Clarke (2006), verbatim transcription conducted by the researcher during data analysis is the first step in learning the depth of data present and is the initial platform for establishing meaning from the data. Pseudonyms were used to protect the identity of the participants. I also altered potentially identifying information including; names of family members, friends, colleagues, addiction counsellors and places of employment where necessary during the transcription process to further protect against participant identification and to ensure

the integrity of the confidentiality agreement. Other than this, the data remained unaltered. Following the verbatim transcriptions, the audio recordings of the semi-structured interviews were deleted from the recording device May 19, 2019 in accordance with the study's confidentiality parameters.

After the completion of the verbatim transcriptions, I reread the transcriptions in their entirety to further familiarize myself with the data and ensure accuracy prior to the commencement of a thematic analysis. The flexible nature of a thematic analysis allows for a thorough account of the participants' experience and highlight similarities and differences between each participant while effectively summarizing an extensive range of data (Nowell, Norris, White & Moules, 2017). The thematic analysis was conducted using several steps to ensure consistency (Aronson, 1995; Attride-Stirling, 2001; Braun & Clarke, 2006; Fereday & Muir-Cochrane, 2006; Maguire & Delahunt, 2017; Vaismoradi, Turunen & Bondas, 2013). The following measures were used in the thematic analysis process; (1) Verbal transcriptions were read thoroughly and reread in order to familiarize myself with the raw interviews in their entirety following suggestions by Braun & Clarke (2006); (2) Interviews were then reread critically and analytically with attention paid to the emergence of salient and recurring issues within the data set in accordance with a process outlined in Attride-Stirling (2001); (3) Initial codes were then established using an inductive open coding process described in Vaismoradi, Turunen & Bondas (2013). An inductive coding approach was chosen for the research design to incorporate a participant driven "bottom up" design in order to fully capture the richness of the participants' interviews. A highlighter pen was used to reduce potions of the data into more manageable pieces. Ink pen was then used on the data to summarize these codes into one- or two-word descriptions based on the key content of the text. These codes included descriptions such as; secrecy, sadness, guilt, fitting in, help seeking, social isolation, employment, trauma, anger, and

miss-treatment in accordance with suggestions on data driven code generation in Braun & Clarke (2006) and Vaismoradi, Turunen & Bondas (2013); (4) Data was then re-read and codes were grouped into clusters based on the emergence of similarities as outlined in Attride-Stirling (2001) and Braun & Clarke (2006). Cluster included topics such as mental health, emotional conveyance, motivation, productivity, hope and relationship issues; (5) Clusters were grouped together into similarly emerging concepts. These concepts were re-evaluated and compared with one another. During this process clusters were reviewed, revised, re-named and re-grouped accordingly with other clusters based on similarity and rebranded as latent sub-themes (Braun & Clarke, 2006; Fereday & Muir-Cochrane, 2006; Vaismoradi, Turunen & Bondas, 2013). For example, emotional conveyance and feelings became emotional management. Sub-theme categories included concepts such as health, intrapersonal relationships and systemic issues; (6) Themes were then reviewed, reorganized and renamed accordingly to better reflect content and then used in the final analysis (Braun & Clarke, 2006). A strength-based analysis perspective was utilized throughout the coding and theme development processes. Verbatim transcriptions from the face to face interviews were retained for data analysis purposes and will be destroyed by shredding following a successful defense of the thesis no later than October 1, 2019.

3.86 Ethics Review

Ethical approval for this research study was sought by the researcher from the McMaster University Research Ethics Board (MREB). In accordance with the University's ethical considerations the researcher used the following methods to ensure confidentiality and minimize risks of harm to the participants: (1) Participant names and identifying information such as the treatment centre's name were altered to protect confidentiality; (2) I signed an oath of confidentiality while seeking ethics approval; (3) Participants were informed of my intent to protect data and provided with a description of my methods of storing data including password

protection and securing data in a locked home office drawer. Participants were also given guidelines on how and when data would be destroyed in accordance with the study's confidentiality policy; (4) Participants were able to withdrawal from the study at any time and in doing so withdrawal any information provided including the audio recording of the interview and subsequent interview transcription; (5) Participants were given written copies of study procedures and interview questions to review prior to the commencement of the interview process. Participants were also informed that they did not have to answer any questions that they did not feel comfortable answering; (6) Participants were provided a list of supportive counselling resources in the Hamilton area in the event they desired counselling.

For more information on the ethical considerations for this study, please see the ethics application submitted to MREB for review on February 20, 2019 (Appendix O).

Chapter 4: Findings

4.1 Participants

During the interview process the researcher interviewed six men that identified as being in recovery from substance use. As previously discussed in the methods section, the names of the participants were altered to ensure their anonymity. This considered, the men expressed their consent for the sharing of their personal stories and use of transcription quotes as required for the purpose of this thesis and were keen to offer the fullest extent of their support to the researcher. The interviews ranged in length from 52 minutes to one hour 19 minutes with an average time of one hour six minutes and a median time of one hour four minutes. The corresponding demographic information is as follows: (1) The participants ages ranged from 36 to 76 years with a mean age of 51.3 years and a median age of 48.5 years; (2) In terms of ethnicity, five of the men identified as Caucasian, two of which further identified as European and one man identified as Indigenous; (3) With respect to sexuality, all six participants identified as heterosexual; (4) Five men identified their relationship status as single and one man identified as divorced; (5) With respect to employment, one man identified as employed full time. Two men identified as employed part time and are also currently students. One man identified as employed part time. One man identified as unemployed and one man identified as retired; (6) As expected, educational attainment corresponded to personal income level. Three men identified as making less than $25,000 per year. Three men identified as making between $25,000 and $40,000 per year; (7) In terms of income attainment, three men identified attending college two men identified attending university and one man identified attending college and university; (8) All six men identified living in the Hamilton area; (9) Only one of the participants identified having issues with a single substance while the remaining five participants identified issues with polysubstance

use. Polysubstance use refers to the using of multiple substances. At the heart of this study, concerned with men in recovery, (10) In terms of previous substances used, the following was reported. Five men reported alcohol use, three identified cannabis use, four reported cocaine or crack-cocaine use, three reported opiate use, one reported methamphetamine use and two acknowledged use of prescription medicines beyond it's medically prescribed intended use; (11) The men's ages of initial substance use ranged from 14 years to 18 years with a mean age of 15.3 years and a median age of 15 years; (12) The men's age at which they identified problematic substance use onset ranged from 22 years to 47 years with a mean age of 28.8 years and a median age of 25.5 years; and finally, (13) The men's ages of first attempt at recovery ranged from 27 years to 55 years with a mean age of 35 years and a median age of 32.5 years.

As discussed previously, data was transcribed verbatim, reviewed thoroughly by the researcher and analyzed thematically. The challenges that emerged for male participants in active recovery from substance use were coded using an inductive approach. Generated codes were linked together into themes. Themes were reviewed and framed through the emergence of recovery-based challenges. At the heart of this thesis—to document strengths of men in recovery attention is also given to participants attempts at incorporating successful challenge management strategies to preserve recovery initiatives and goal attainment. The five major themes present in the interview data include: (1) Physical and Mental Health, (2) Importance of Relationships, (3) Attaining Purpose and Belonging in Recovery, and (4) Systemic Issues that Negatively Affect Recovery.

4.2 Physical and Mental Health

Health emerged as an overarching theme throughout the data analysis process. Both physical and mental health concerns were identified as a significant challenge to recovery requiring substantial navigation efforts by all six participants during the interview process. Physical health was

discussed in the context of (1) The evolution of physical health challenges and the effects on participants; (2) The effects of physical health challenges; and (3) Responses to physical health challenges in ways that emphasize recovery. Mental health concerns were discussed as (1) Mental health contributes to substance use; (2) Mental health as a catalyst for change; and (3) successfully managing mental health in recovery.

4.21 The Evolution of Physical Health Challenges

Participants described physical health as a concern during the interview process. Physical health was often reported as minimized or neglected altogether by four of six participants while in active substance use. This disregard for physical health was thought by participants to be a direct consequence of substance use. Participants reported engaging in avoidance type behaviours and suggested it was easier not to think about health consequences and potential ailments while in active addiction. Three of the men reported developing a lack of faith or mistrust in the health care system. This lack of faith in the system was due to prejudicial treatment by health care providers and repeated unsuccessful attempts at managing symptoms.

> My health deteriorated so bad because of neglect and my uh, uh, somewhat jaded view of the system. You know, not wanting to interact with the them cause they weren't helping me anyways. I had such a bad attitude towards them you know what I mean. I would just stay away from them (Dan).

4.22 The Effects of Physical Health Challenges

Challenges with physical health were consistently identified as impacting the overall functionality of the participants. These physical health challenges were viewed by participants as compromising their ability to perform recovery-based activities and general daily functioning. Physical health ranged in severity from permanent breathing issues, diabetes and the potential onset of cancer, to issues with weight, reoccurring illnesses and general physical issues. The

impacts of these ailments were identified as being moderate to severe in nature and successful management of the issues critical to attaining a sustainable recovery effort.

Three of the six participants disclosed that they have been diagnosed with chronic physical health issues including Chronic Obstructive Pulmonary Disease (COPD), diabetes and sleep apnea following medical consultations. The men observe their respective diagnoses as a direct consequence of using substances and suggest that these physical health ailments interfere with their overall functioning and completion of daily tasks. The men also suggest that difficulty with their physical health has previously impacted or continues to impact their ability to navigate the supports of their recovery community including attendance at self-help meetings and appointments, and participation in recovery-based events such as gatherings and special outings. Two of the men reflect on the difficulty of their experiences living with COPD:

> I am dealing with something that I would not wish anyone to have and that's COPD. It's changed my lifestyle intensely. I have to deal with this and that has really drained me from the way I used to feel. I miss the way I used to feel. I mean I used to hop skip and jump no problem. Now, if I jump, I'll just fall over. There are things that I just can't do anymore (Jeff).

> My health got to the point where I've got COPD now, which I have to take care of and a lot of physical stuff that now I have to address cause if I addressed it 20 years ago I wouldn't be in the shape I'm in. (Dan).

One participant describes his experiences in early recovery as "hell" physically and suggested that he lamented being chronically and physically ill due to the deterioration of his immune system from active substance use but had to learn how to manage this. These constant physical ailments made it difficult to maintain employment and achieve his goals. This participant suggested that the general expectation is that following substance use cessation the individual should be able to recover physically from their active substance use ailments as they are no longer using substances but cautioned that "it doesn't work that way". He maintained that because the body has become accustom to accounting for the chronic chemical presence of

substance within it this has become a "baseline" and the body then has to "relearn" how to function without that presence and experiences constant issues with its functionality.

> I was sick a lot. My immune system was so messed up. I wouldn't know if I was sick or still somehow detoxing or whatever. Now I look back and my immune system was so messed up, so compromised I was sick a lot when I first got sober. People don't realize it too, but it takes a while for your immune system to catch back up cause it's so used to having substances running through it. And you see it now to with the new guys too. Like I notice that being around the house (Albert).

4.23 Responses to Physical Health Challenges in Ways that Emphasize Recovery

The significance of physical health issues and their impacts on daily living grew in importance throughout the recovery process as participants sought to improve all areas of their lives and pursue healthier living. Participants considered their physical health to be a critical component of a substance use cessation program and therefore integral to attaining success in recovery. Participants were also keen to suggest that alleviating concerns on their physical health was seen to be a contributing factor to overall reductions in stress and anxiety. This noted, participants exhibited a powerful desire towards the identification and subsequent management of these issues as they entered a recovery-based lifestyle. The men were keen to effectively address physical health issues early in recovery to provide themselves clarity, peace of mind, and to circumvent the effects of anxiety. Greg discusses his experience:

> I figured I'd get all the medical health stuff first. Let's not worry about what's going on with your body, let's get everything checked out. Okay so I'm type 2 diabetic, I've got sleep apnea and uh I've got this, and I've got that. Let's go see the doctors and get it all checked out so that's not lingering around in my mind. You know so I'm not worried about oh was that something I felt inside or not. You know, just go and see the doctor and get all that stuff checked out so I can move forward. (Greg)

Participants conveyed several strategies in trying to combat their physical health challenges. The cessation of substance use was first and foremost to the participants who suggested that consumption of unhealthy substances is a hinderance to the management of physical health issues and only exasperates this challenge. The men disclosed that they are slowly

learning to trust in medical professionals once again through their newfound commitment to managing health issues and the support they are currently receiving through the treatment facility. The men articulated that they have slowly begun to see the benefits of working within the medical system and considering this, they have formulated diverse support networks to support their management of physical health. Jeff shares his experience

> Well, I've got a lot of doctors you know a lot of good doctors and a lot of good medical staff that are looking after me. My family physician is great and if he doesn't know something but feels that something should be looked at then he sends me to a specialist right away. He looks at me quite frequently. And there is a thoracic surgeon, I have a pulmonary specialist, a respirologist and an optometrist and they're all great. (Jeff)

Participants were cautiously optimistic about their ability to connect with the system and work within it to address their issues but were sometimes hesitant to disclose that they were in recovery from substance use for fear of receiving negative treatment.

Scheduled for an operation in the few months, one of these participants has expressed anxiety regarding the physical pain that he will no doubt experience. Although nervous about the operation, he does not shy away from the realization that conventional pain management medications will pose a significant relapse risk to his recovery. This considered, this participant has decided to strategize with his addictions counsellor and medical supports to incorporate a non-narcotic based pain management strategy that he is hoping will be effective in managing his pain without posing risk to his recovery. He's willing to do whatever it takes to preserve his recovery even if that results in substantial discomfort.

> All this stuff is coming in the next month or so. I've been in a lot of pain for a while now and I've got this throat operation coming. So, I'm going to be out of action. I'm going to be in a lot of pain and how am I going to take care of that pain? I can't do it the old way no more (Dan).

Four of six participants also expressed the importance of battling through their physical ailments to preserve their recovery commitments. The men stated that this is sometimes

excruciating and exhausting but critical to their recovery. Participants maintain that even though attendance at various functions such as self-help meetings can be compromised due to their physical health ailments, they navigate these challenges by utilizing multiple avenues of support. These avenues of support include: connection with housemates, treatment centre staff and other recovery-based supports to assist with transportation and ensure participation wherever possible. In some cases when transportation is unavailable the men walk great distances to ensure that they can attend their meetings and adhere to other recovery responsibilities.

> I work my ass off in the program even though I'm going through all kinds of crap medically. I did all these modules and programs. I follow the model and work at it. I've got a good doctor now and I'm working on my physical health, my mental health and my addiction (Dan).

Finally, participants discussed the importance of doing everything possible to support their physical health. Trying to eat right, getting exercise as often as possible and seeing the house doctor when they are ill or concerned were described as instrumental to improving their immune systems and general physical health. One of the four men has even decided to quit smoking:

> So, then you see this getting into play uh quitting smoking for example. I want to be around for a while so quitting smoking there's a big thing. Doing things like that, crating a better quality of life for myself. (Greg)

Another participant describes the improvements in his physical health, applauds his efforts and takes pride in his work attendance over the past year:

> I take pride in it. Like, I didn't miss a day of work this year um and I am trying to take care of myself, so I'm not sick all the time" (Albert).

Participants remain committed to maintaining good physical health and continue to utilize strategies and supportive social networks aimed at maintaining their endeavours.

4.24 Mental Health Contributes to Substance Use

All participants identified mental health as a concern during the interviews. Mental health had a broad sphere of significance and manifested across the substance use and recovery continuums of the participants in several ways. Mental health was referenced by the men as a large contributing factor to the onset of substance use. All six of the men disclosed that they had used substances as a coping mechanism for experiences of childhood trauma, to manage anxiety and depression and to confront lingering fears of 'fitting in' with their peers.

Experiences of childhood trauma were discussed by two participants as being a significant source of their substance seeking behaviour. Participants did not go into extensive detail on the traumas they experienced but saw this as impacting their mental health negatively and leading them to seek substance as a way of coping with the emotional response.

> My father, the man who raised me. He died when I was 14. Alright so whether I look back on that and whether that directly had anything to do with my alcoholism I don't know. I'm not really going to go to much into that, but the onset of my substance use was in high school. (Chris)

> I had a lot of, well childhood trauma too. I knew it then and then I was trying to make myself feel better. So, if you know, you told me it would get me high, I would take it. Like the more the better. Like my friends would use recreationally. I would use constantly. I was getting to the point where I was high 24 hours a day at that point. Pretty well from the day I started I was actually high on something at one point of the day or another but then it would be all the time and it continuously progressed. I was looking for more and more. (Dan)

Four participants described their initial substance use as occurring during their adolescence primarily to cope with feelings of depression and anxiety, as an escape from the confines of their daily lives or just to connect with their peers and feel like they were a part of something. Participants expressed that during adolescence they lacked confidence and often engaged in substance use to improve their social standing. 'Fitting in' was extremely important to

the five men and they shared that they often did not feel comfortable socially or even in their own skin when not using substances.

> Um, I was young. Grade nine probably when it really got going. [Using substances] was a way to connect. A way to feel a part of. You know I could fit in with any group as long as I had that with me, right? (Frank)

> God, I was just partying you know like I thought I was having a grand old time. I didn't have a care in the world but inside, um I was not too good. I was uncomfortable all the time. That's why I drank because I was uncomfortable. I didn't like being me. You know, I was nervous all the time and I had severe anxiety, …social anxiety. I didn't fit in at all. That's what I was like and so I drank to cope with it (Chris).

All participants were swift to indicate that using substances was a way of coping with their mental health. The men met suggested that they were met with years of positive reinforcement through the attainment of friends and diverse social groups and helped the men improve their self-esteem, self image and self worth at least temporarily. Substance use was observed to be a solution to participants' problems, a way to self-medicate and escape their pain. A way to become someone completely different from who they were. A way to make all their depression, anxiety, stress and discomfort dissipate by numbing themselves from feeling altogether:

> It's my comfort zone. I know I can make everything go away with that needle or that bottle. It will all go away and I won't care about any of it. It won't matter (Frank)

Long-term struggles with depression and anxiety have continued to challenge recovery efforts and all five participants openly discussed the challenges associated with daily living. The men disclosed that these struggles significantly alter the way they live and make it difficult to do just about everything, including getting out of bed some days. Greg discusses his experience with anxiety:

> So, when I was in the psych ward for the first few weeks it was great. You know, they were feeding me Diazepam and for the first time in a long time I did not have the fear or the dread or the crippling anxiety. Prior to that, at one point the anxiety was lasting for weeks at a time. I was hiding in shadows. (Greg).

4.25 Mental Health as a Catalyst for Change

Four of the six participants expressed attempting suicide on at least one occasion. Suicide attempts were viewed by the men as their only way out and the result of intolerable mental health, substance use related issues and the impacts of these on their social environment. Suicide attempts were observed as the last straw and an excellent catalyst for change by three of the men. Ultimately, these mental health challenges helped identify that something was drastically wrong in their lives and needed alteration.

> I tried to commit suicide and then I woke up and that's when I first decided I've got to do something. I was like, I'm going to try and get sober. So yeah, that's how it went down. (Albert)

> Well it was the second time that I tried to commit suicide. I had a really good job at the time. My addiction had progressed, and I was having problems with my girlfriend and stuff like that. Then one day I don't know it was like a wall and I got in my car and drove back to Hamilton and I took, over the course of about six hours, I took about 250 pills and booze and I tried to kill myself. I ended up in intensive care and in the psych ward and that was when I realized, well, I have a problem. I lost my job, I had just lost my girlfriend, I tried to kill myself and that didn't work um and here I am. Yeah, that's when I realized that I've got a problem and I've got to do something about it. (Dan)

Though participants attributed their mental health issues as a contributing factor to their substance use during active addiction none of the men cast the blame solely in this direction and they were keen to take responsibility for what they described as their "choice".

4.26 Successfully Managing Mental Health in Recovery

All six participants viewed mental health as one of the primary catalysts for transitioning into a recovery-based lifestyle and viewed successful mental health management as crucial to successfully maintaining their lifestyle change. The men disclosed that mental health continues to affect their daily activities but expressed that they attempt to manage it in 'better' ways than by using substances. All six men expressed hope, determination and a subtle confidence at managing their mental health issues. All six participants were keen to identify that mental health is a

particularly difficult challenge to overcome because of their previous coping methods of alcohol and drug use not being an option but suggested that they will continue to fight. The men disclosed that they no longer burry their mental health issues or numb them with substance use. The men reported that they confront mental health issues head on, and continuously strive to improve the ways in which they manage these issues. Using the support of medical mental health professionals, addiction counsellors, self-help groups, peers and family when needed were reported by the participants as strategies that they use to combat mental health challenges. The men emphasized the importance of relaying information on how they are feeling to their mental health supports.

> I use my supports, if I don't it's not going to work. I'll call my counsellor or Canadian Mental Health, talk to my peers in supportive housing or come in and talk to the guys in the house. I let it out, I don't bury it anymore. I don't sit on it and that is a huge part of my recovery that I talk now (Dan).

Participants also relayed that they needed to take care of themselves appropriately and include the practice various self-care activities into their recovery programs and cautioned the risks to their mental health and relapse potential should they not adhere to these practices.

> If I don't take care of myself and keep at the forefront of my sobriety than it can very quickly turn and go the other way so it's a lot of self-care and being aware of my motivations (Albert).

Like physical health, ensuring dietary needs are met, engaging in exercise and obtaining necessary sleep requirements are seen to be critical to supporting mental health management initiatives by the men. Engaging in spirituality, meditation, mindfulness, cognitive behavioural therapy and dialectical behavioural therapy techniques and practicing humility and gratitude were other effective mental health management strategies as described by the men.

> Nothing beats anxiety like action. For an hour each morning when I go to class, I am not in my head. I'm trying to breathe and not die. I am sweating profusely and loving it. Most importantly, I'm not thinking about the other stuff that creeps into my head (Greg).

Challenging oneself to become "comfortable being uncomfortable" is no easy task and requires a consistent tremendous effort throughout recovery but has helped participants discover positive self-belief and learn to value themselves as people and like who they are.

> I challenge myself on a daily basis. I put myself out there and I realized with the anxiety thing I'm comfortable. The greatest thing is I'm comfortable in my own skin. I really am" (Chris).

Still, the men maintained that it is important to sometimes take a step back and regroup during difficult times. Being cognizant of mood fluctuations and emotional extremes were also seen to be necessary in preserving recovery efforts and employed by the participants to manage their mental health.

> I went through a few issues with school in this past year. Uh my blood pressure was high, stress was high, and my anxiety was high, so I had my depression meds changed. A couple of the guys I knew really well had died and then I start to worry about that and then a bunch of these other things were going on and I said okay well let's just put it all on the table and talk to all the supports across the board and let them know what's going on with you and then how can I utilize these supports to start eating away at this big ball of wax I let build up? (Greg)

4.3 The Importance of Relationships in Recovery

All six participants disclosed that relationships were significant in their lives both in the context of their recovery and overall life satisfaction. The men discussed relationships in two unique contexts: (1) Intrapersonal relationships as the relationship that exists within them. This is how the men make sense of their internal dialogue and self-regulate; and (2) Interpersonal relationships as the relationships that the men build externally. These relationships are formed socially with other people. Participants suggested that successful navigation of both types of relationship was essential to maintaining continued success in recovery.

4.31 Intrapersonal Relationships

The men viewed the relationship that they built with themselves as crucial to attaining success in recovery and suggested that internal change was a necessary occurrence to navigating their

recovery. Alterations to intrapersonal relationships were identified as a concern by all participants and viewed to be the most one of the most intimidating challenges to their recovery efforts. The men discussed intrapersonal relationships in the context of (1) The significance of experiencing emotion and emotional authenticity; (2) The loss of peers in recovery hurts and contributes to fear of relapse; (3) Learning to manage 'difficult' emotions; (4) Being cognizant of Emotional Extremes; (5) Shedding the culture of addiction; (6) Harm reduction was unsuccessful; and (7) Embracing a new recovery-based identity.

4.31.1 The Significance of Experiencing Emotion and Emotional Authenticity—

Many of the participants disclosed that emotion felt like a completely new experience following the cessation of substance use as they were no longer "numbing" themselves. The men explained that they often struggled with the vivid nature of their emotions and expressed that they had a lack of insight into appropriate conveyance and intensity of their emotions. Participants struggled with questioning emotional authenticity and expressed relief when their emotional congruence matched up with what they thought was "normal" in a given situation. Coming to terms with these "unaltered emotions" often required the seeking of validation by the men.

> Uh, it took a long time for my emotions to settle down and kind of regulate themselves and now I think they're as regulated as then can get so I try and face them head on. It sounds weird and I hope not too sadistic but um there is this joy in knowing it's real and not synthetic or not because I'm inebriated. (Albert)

One of the men became emotional during the interview while discussing his experiences of "feeling again" as he had legitimate concerns about his ability to experience emotion following substance use cessation.

> I'm still working on dealing with emotions cause for a lot of years I didn't have any and I've said that numerous times here. I've cried for the first time in I don't know how long recently and learned to laugh again. It's becoming more natural. At first it was forced because I buried my emotions for so many years and none of it was natural right? But it's coming back. It feels good when it happens naturally. It doesn't feel so good when I gotta

> force it, but I realize too that I gotta force it too sometimes and eventually it will become natural again right? So, it's hard. Emotions are hard for me to deal with. (Dan)

4.31.2 The Loss of Peers in Recovery Contributes to Fear of Relapse—

Relapse was articulated as a perceived consequence of not appropriately navigating emotion by participants and a genuine fear towards this process was expressed. Participants could not envision the process of having to rebuild their recovery from the ground up. Three of the men reflected on the recent loss of two of their close peers in the treatment program who had tragically lost their lives. This reminded the men of their own mortality and forced further self-analysis of their feelings about their loss.

> A couple of the guys I knew really well here died. What did that mean to me about those guys dying? You know. Am I supposed to feel a certain way? Do I not know how to grieve? I mean these are men I broke bread with, how is that affecting me? (Greg)

> I've had a few friends die. Guys that I've known. Yeah, I feel sad, but I realize that's part of this. I've never had people close to me die before. I've never been in this sort of world before. It's a whole different world where guys die. People die and that's a big, that was kind of a big thing for me at first. It was that the finality of this is really right there in your face. (Chris)

In conceptualizing such dire consequences, participants universally articulated that they did not want to die and that they had come too far in recovery to fail. Instead of allowing this fear to inhibit progress or restrict growth, participants were swift to suggest that they were keeping a healthy fear of relapse to ensure that they maintained a steady progression, refraining from stagnation, and making choices that align with their recovery goals.

> I see my friends going, dropping, like and I see all that happening. I'm one bad choice away from that and I don't wanna die I'd like to be around for a lot of things. I gotta stop. I know the end result and I don't have another one of those in me. (Frank)

> It was a learning point, like a painful lesson but that's one of those things where a lot of people don't get to survive to learn that lesson and that's why I feel sort of blessed to have the opportunity. (Albert)

***4.31.3 Learning to Manage 'Difficult' Emotions*—**Managing difficult emotions such as guilt, shame remorse and fear weighed heavily on the participants. Although the men expressed the trouble, they experienced in dealing with these types of emotion, a return to substance use behaviour to cope was not seen as a viable option by anyone. The participants conveyed that they struggled with some of the things that they did during active addiction. One of the men said that he had "robbed, cheated and stolen" from strangers, friends and loved ones alike to maintain his substance use and that the guilt and shame of hurting the people he "care for most" was still raw.

> That was one of the hardest things I had to do. I literally chose that lifestyle over raising a daughter. I dropped my daughter off. I chose that over my own daughter. Like, fuck. But I see uh the benefits of making that choice now. At the time I was very shameful, very guilty, very all those negative things and that kept me out there. I'm uh, I can't do this. I'm a piece of shit, blah blah blah. Today I can see that she's like I said, she's 13 and we get a long pretty well and I can see the benefits of that hard decision. I wasn't able to do it. I wasn't able to give her those things, but my parents were (Frank).

Avoiding difficult emotions such as anger and sadness was not observed to be a solution for navigating recovery and the men suggested that it was their responsibility to learn how to mange these emotions no matter how uncomfortable they were. Working through these emotions by confronting, unpacking and learning to deal with them through seeking positive outlets for their release was suggested as a strategy for managing this challenge by four of the participants.

> I'm a big choice person. I have the choice whether to get angry. I used to get angry a lot and then I avoided that, those situations. Now, I'm accountable for my actions. You really have to learn and pick your battles. I have to ask myself, is this something that needs addressed? Or are you just being a dick in your own head with your ego because someone else is not living up to my standards. Bottom line, that's bullshit. I challenge myself. Do it all the time. What am I working on now? Unconditional love, it's brutal, impossible. I tried it one day when I went into work, first 30 minutes, out the window but I've committed to it and to challenging myself" (Chris)

> I had an experience the other day where I was very angry. I was on the phone with a co-worker and I did express that I was upset at the situation, but I decided to not do anything at that time you know. I thought, end the phone call and finish doing what you're doing. I was shopping at the time and shouldn't be on the phone getting mad at people. So, get

> done what you're doing and then go talk to someone about the situation when you're not so hot. So heated. So emotionally charged. Ask yourself, is this something that you need to engage in? Is this something that needs more fuel on it? I just had to talk about it and go to the gym and that helps with it. (Greg)

***4.31.4 Being Cognizant of Emotional Fluctuations*—**Though emotional experiences were viewed as positive by the men, they were approached cautiously as participants were keen to identify that their emotional highs and lows were warning signs that could threaten recovery. Participants were also quick to outline that it is not just the negatively perceived emotions that they needed to reflect on and be wary about, but that they also needed to observe the positive emotions so that they did not get too comfortable in their recovery that they are not paying attention to triggers, warning signs and risks of relapse. Positive emotions were seen to be more of a threat to maintaining recovery than negative ones in several instances.

> When I left here, that was huge for me. That's what I tell all the other guys. Avoid the highs and lows. Don't get too down, too contemplative and especially avoid the "you get up in the morning and go oh fuck this is the best fucking day ever" (Chris).

Clinging to hope and welcoming the possibility of attaining the life they desired, enabled the men to not only contemplate a better future for themselves. Experiencing raw emotion both good and bad, and learning how to live with this kept the men striving for further successes in recovery and discussing the possibility of learning to embrace living in an unaltered reality.

> The only way to get through it is to keep going through it and then eventually it's weird but now I crave escape from my own reality very little. Which at first, you're like "that really happens?" I remember guys would be like "no I really don't feel like having a drink' and I didn't buy it and then it happens to you and then you're that guy. It does go away. (Albert)

Aspirations towards achieving something more was reported to provide a healthy confidence and perceptions of a future endless in possibilities. Maintaining hope towards a better future enabled the men to come to terms with their pasts while helping them believe in themselves.

> The biggest goal I have is to justify my existence. Justify every day and make a difference. Nothing will faze me due to the hard life I've had. It's put things in

> perspective. I have a completely new perspective now; nothing in this world can shake me" (Dan).

4.31.5 Shedding the Culture of Addiction—All six men suggested that they had become immersed in the culture of addiction and that this was more difficult to break than the addiction itself. Participants conveyed that their very identities were entrenched deep within substance using culture and their thoughts, feelings and behaviours were conditioned to accept this as their new state of "normalcy". The men reported their social networks throughout secondary school, post-secondary school and employment strongly influenced their justifying that their substance using behaviour was the standard way of living.

> I was in my 20's working at a brewery. I got all the free beer and wine I wanted to drink. I would drink eight bottles of wine sometimes even on a Sunday and from there it went to vodka and then in the height of it all because of where I worked and being in my 20's it all seemed normal to me right? It did seem normal. Everyone else partied and the guys I worked with drank a lot. (Chris)

> I was high functioning. I had good jobs and I had a crowd of friends. We were all high functioning. We had good jobs, we had money, we had cars, we had everything. So, we didn't think that we had a problem, right? We were doing everything work wise during the day but at night and on the weekends, we were like the wild bunch. (Dan)

All six men disclosed that they had to come to terms with the notion that they are "addicts" and can not safely play with substances of any kind. Though this process, participants found it extremely difficult to alter their identity from viewing themselves as "addicts" in a negative context to persons in recovery and shedding all the preconceived notions of how they should behave, think and feel. Participants suggested that they were often their own worst enemies and had to work hard to redefine their new "normal".

> I do what's going to work and what's going to keep me sober and it's been difficult. It's been really hard cause it's so unnatural for me to do what I'm doing now. I was a big procrastinator and I could coast but I decided that that's not how I want to live. I want to get better and do everything I can. (Dan)

4.31.6 Harm Reduction was Unsuccessful—Four of the men discussed struggling with harm reduction strategies for years, trying to convince themselves that they could regulate their substance use by implementing self-control techniques. The men likened this experience to an internal wrestling match involving two conflicting desires. The men also suggested that at times it was seemingly impossible to conceptualize triumphing over the desire to use substances and cautioned that 'nine times out of ten' engaging in this internal dialogue resulted in substance use. Frank discusses his internal struggle:

> I don't know it's almost like there's two of me. It's like there are two different people up there and one of them is going "fuck them, fuck them man you're good" and the other one is not talking anymore. He almost disappeared right? And then off you go. So, this one guy burns it all down and that's when you get to that bottom and then all of a sudden that other dude has his voice back again. I mean I don't want to come across as sounding crazy but that's what it's like, almost (Frank).

Three of the participants reported initially experiencing minimal success in their substance use regulation attempts. The men suggested that this 'success' mistakenly enhanced their belief that they could self-regulate substance use. The three men suggested that this internal dialogue merely prolonged their "denial" and that their substance use always ended up spiralling out of control. Rationalizing these control strategies were working through maintaining employment and relationships sporadically through this period kept the men using substance until they became immersed in what they described as a new bottom again and again. The three participants recall unsuccessful attempts at substance use moderation:

> There are people who can do that, that can just have a couple of drinks. I was holding that hope that someday I was gonna be able to drink again. I was going to be able to smoke pot, I'm not really big on pot but, take some kind of mind-altering substance like a normal person (Chris).

> I really didn't believe that treatment could help me. I just couldn't see not using. And so, I just played the game so to speak. You know, I went on with it fully and correctly. I didn't

> cheat or anything like that, but I kept thinking that in six months' time I would use again. And so, I did. (Jeff)

> I came to this conclusion based on the simple fact that I was trying to eliminate alcohol and drugs from my life, and I couldn't do it until I started making all these other changes. And this is the weird thing is that I said, "you need to drink and stop using all these drugs" and then I was like "all of them?" I started using over the counter medication and it wasn't working so I'd be like okay and then go back to drinking and using illegal drugs again. (Albert)

***4.31.7 Embracing a New Recovery-Based Identity*—**Changes in the participants identity from an active substance user to an individual in recovery, and the subsequent disregarding of moderated substance use strategies was discussed as a turning point by all six participants. These men maintained that they sometimes struggled with accepting their recovery as a constant presence requiring their full attention and absolute commitment to maintain. All six men suggested that their viewed recovery as a lifelong process, a 'journey not a destination'. The men discussed the significance of a shift in view on recovery from an unattainable or undesirable ball and chain type entity to something that they willingly embraced once they were able to experience the richness of recovery. The men emphasized that although it took a long time to accept recovery as their only option, once they were able to let go and embrace the transition into a recovery based identity they started to appreciate who they really were as people and discover what is really important in life. Self-belief, acceptance and the realization that recovery can be an amazing experience was relayed by the men as important in the change process. Believing things can get better and setting out a healthy recovery routine were also reported as crucial to the process while challenging themselves to "be better people" was working well for the men.

> My new moral compass should be, I'm going to be honest and truthful to the best of my ability every day. That's something I can take for the rest of my life. So those things changed for me. Um, my recovery is awesome" (Chris).

> Harm reduction and things like that wouldn't work for me. I would try anything to be that weekend guy and it didn't work. Now that's one of my favourite aspects of this, I don't have that bartering system in my head. (Albert)

One participant had to engage with self-inflicted tough love yet demonstrated tremendous insight and self-awareness in addressing his employer for support and subsequently preparing himself to move forward into recovery.

> I was uh working a job at the time and my boss kept taking me back no matter how many times I screwed up. I had gone to detox I don't even know how many times. I think I had gone 11 times over 11 months and uh you know I finally said "could you please not take me back again. I am trying to make some decisions over my future and you're not helping. I love you and appreciate what you are trying to do for me, but I need some tough love right now". So, he said "okay, you're fired now get your stuff and get the fuck outta here" and I said, "thank you" (Greg).

Participants recognized that they will continue to face challenges in this area and suggested that they need to remain cognizant that complacency does not creep back into the fold while ensuring that they absolutely cannot re-entertain thoughts of "playing" with substance using ideals.

> I can't use for any period safely and I'm okay with that today. I do still have that, like I was explaining the two guys. They are, he's still there but they both have their voice now. I gotta maintain those things. So, when I start thinking that way again, when that guy starts talking again, I need to question that now. I've put together this new view on it through learning it the hard way. That's what I did, and I can't, I don't have another one of those in me anymore. I'm quite happy where I'm at today (Frank).

Ultimately, the men remained confident that they were "better off" embracing their recovery identities and that this is how they would like to live life.

4.32 Interpersonal Relationships

Social interactions have altered for the participants as they move through their recovery due to intrapersonal changes and alterations to their general social environment and its makeup. Participants discussed the importance of maintaining healthy interpersonal relationships in their recovery. Participants articulated concerns around: (1) Substance use damages relationships; (2) Learning to socialize again; (3) Repairing existing relationships; (4) Forming new relationships;

(5) Establishing boundaries in relationships; and (6) Establishing boundaries in the physical environment.

4.32.1 Substance Use Damages Relationships—Participants discussed the significance of interpersonal relationships in their lives and expressed regret at damaging these relationships throughout their addiction. Participants assumed responsibility for their role in their personal relationships and acknowledge the role their substance use played. Five of the six men expressed remorse but also conveyed acceptance at the deterioration of some meaningful interpersonal relationships.

> I lost everything. My relationship, a genuine relationship, gone. Your girlfriend leaves and you get cut off from family. I did that to my girlfriend. I did it to my parents. I did it to everyone. (Frank)

> I couldn't go home. I've lived in Hamilton all my life and my family. My mom lives in Hamilton but yeah, there's no Christmas' for me. Not at all. Lost family, lost friends. It was huge. (Chris)

> My mother moved to B.C. She moved there to be a nanny to my brother and sister-in-law's kids as they didn't have money for childcare at the time. But I think I was also scaring her away with my drinking behaviour. We lived together, shared an apartment. (Greg)

> I wasn't at home much. And when I was at home, I was wasted most of the time. I was able to get away with it for a while and then it all fell apart. Just before it ended, I went to treatment a second time. It was a super program and they had top notch professionals. I beat the booze and chemicals in there. I got clean and that changed my life again, but it didn't save my marriage. (Dan)

> I have a lot of regrets. Like my wife, we ended up getting a legal separation. She just couldn't take it anymore. I can't believe how she doesn't, well she actually does hate me to some degree I know, and I can understand that's for sure because I put her through so much stress. (Jeff)

4.32.2 Learning to Socialize Again—Two of the participants suggested that their addiction was extremely isolating and that they spent years removed from social situations. The men said they deliberately used to isolate for a fear and general dislike for social environments. The men described their experiences in early recovery as overwhelming especially when

confronted by the and said they were exhausted in merely entertaining the thought of being in the presence of other people.

> Addiction is isolating. The only time you'd see me out is if I ran out of booze or I had to get drugs and if you'd seen me I was hating being out. I mean the only time I was happy was when I was by myself. It took me years to feel comfortable navigating the rooms of A/A and N/A. (Albert)

> When I came here, I had the wickedest social anxiety. I hated being out there around people. It was very social. I was basically put in the exact situation that made me drink in the first place. Dealing with social situations and how I was going to fit in. I know this was just based on my ego, right? It's all about me and how I feel (laughs) It was a situation I didn't like and felt uncomfortable in. It was awkward for me. (Chris)

Surprisingly both men eventually enjoyed the social aspect of treatment and maintain that it is one of the most important components of their recoveries today. The men report that they are learning to trust others and enjoy socializing in recovery groups and related activities. As Albert shares:

> You've got to get used to socializing again. Like I hadn't sat down and ate dinner with other people in like over a decade and then I did, and I really enjoyed that, and I still do. (Albert)

***4.32.3 Repairing Existing Relationships*—**Participants articulated a strong desire to work towards improving familial relationships and seeking a deeper connection with people where possible. The men suggested that this is a big part of their future goals and external motivation to stay the course on their current recovery journeys. The men expressed gratitude towards family and friends that have stuck by them through their lengthy battle with addiction and continue to support their recovery. Participants relayed their intent to continue working on strengthening bonds with their close friends and family and remain optimistic about their ability to improve relationships. The men report having observed significant improvements in interpersonal relationships since embracing recovery.

> My son doesn't have a lot of time cause he's working and doing university at the same time and doing well. We've never really been able to match on something that both of us

> really like together and I'd really like to make more of a connection with him. And also, too, I'd like to see if someday my wife, well if she'd ever have me back. There are still issues that she will not forget, and I don't blame her. She's a wonderful lady and she's my best friend and I'm thankful for that. (Jeff)

> That's the other thing I've done in recovery too. I've reconnected with my children and my grandchildren too cause they didn't know me. I was a stranger. Cause at my one son's house I'd walk right through. I'd walk right past the kids and they didn't know me when I was high. I'd walk out back and get high. Now, when I walk into the house, I sit right down with them and they are like "grandpa" and now, I have my kids over to my house all the time (Dan).

> I'm quite happy where I'm at today. I'm quite happy with my relationship with my daughter, with my relationship with my parents today" (Frank).

4.32.4 Forming New Relationships—The formation of new relationships with people supportive of participants recovery-based lifestyle was viewed as important to maintaining a healthy social environment capable of providing avenues for support and continued success in goal attainment and overall recovery maintenance. Participants universally articulated that they were extremely fortunate to have the support of their housemates, others in the treatment program and the recovery community in general and saw this support as crucial to their overall success.

> It's amazing. I've gotten used to trusting and living with a great bunch of guys. You know and I feel empowered. I've never had that before. (Jeff)

> I have the support of the guys in the house, the other guys in recovery and the supports of other groups of people through public speaking. (Dan)

> Most of my friends are sober or attempting to get sober. Everyone that is close to me knows that this is what I am doing. I have a lot of supports in sober housing and that gives me access to the treatment centre here and the counselling and it plugs me into a sober minded community. (Albert)

> Peers are number one. I am currently living in supportive housing. I keep the guys I live with in the house as number one. I talk to them every day. Number two would be the treatment centre here cause I can come back in here if I need to. (Frank)

Participants suggested that establishing new relationships and supports outside of what is traditionally considered "the recovery community" with a diverse makeup is also important. While the men observed the importance of establishing new connections within the recovery

community, they maintained that they do not want to close themselves off from experiencing relationships outside of their recovery and familial circles. The men indicated that this helps them learn about their recovery in a different context and grow as individuals. Finally, the men suggested that having diverse social circles comprised of various people and groups of people helps enhance their sense of community and provides them with multiple unique avenues for support.

> My doctor, my boss is one of those guys that I can confide in about anything. There is this girl that I go to the gym with, same thing. I am able to talk to her and say I am struggling with some things in my life. (Greg)

> I just know that if ever there's something that I need to talk about I know who I can call. I have about six or seven people that know what's going on with me. I have a couple of friends that I talk to every single week that aren't in the program. They aren't or weren't alcoholics. (Chris)

***4.32.5 Establishing Boundaries in Relationships*—**Part of the interpersonal relationship navigation required the participants to set boundaries around what they will and what they will not accept in their relationships to preserve their respective recoveries. Boundaries consisted of navigating people, places and things that pose a threat to recovery. Participants discussed the importance of placing limits on existing relationships, or eliminating relationships altogether, to preserve recovery efforts and safeguard from potential relapse. Participants expressed concerns around boundary establishment and terminating relationships as this was often uncomfortable yet maintained a strong pledge to their recovery and articulated their committed to doing what is necessary to preserve their recovery having learnt from things that did not work for them in the past.

> The first time I got sober, I was living in a house that was full of drugs. I lived with my best friend and so I was still in the place where I had done my worst and I mean trying to recover in that house while it was still going on was challenging. Then when I met my wife, she was still using, and I wasn't. It was precarious. It was a minute by minute thing and I was fighting it. I started drinking occasionally and then one day she was smoking a joint and said, "if you loved me, you'd smoke with me" and that was the end of it (Dan)

> And then It's the company I keep too. That's something I've learned on my 20-year journey. When it's around me all the time, I can't. That's my default. (Frank)

> I went back to work and everything was great and then for like three and a half years and then a buddy of mine and I started doing coke because if I'm not drinking then that's okay right? I can't lose a job doing coke. I'm not drinking. (Chris)

Close relationships with family members and friends were identified as sometimes challenging by all participants. This was due to several factors such as the nature of the relationship, expectations, stress, emotions and finally, concerns around family members and friends that use. Interpersonal relationships were discussed candidly by participants and they expressed the importance of not altering boundaries regardless of the significance of the relationship in question. The men discussed having to sever ties or limit interactions with important persons due to their ongoing substance use or the general toxic nature of the relationship. Though there were some mixed emotions on this, participants said they would make the necessary decisions to preserve their recovery. As two participants shared:

> Like my brother. I have a brother that's, well I can say it, he's an alcoholic. I still talk with him and see him at family stuff, but I don't go out of my way to see him as much as I used to because of what we've done together, because of how we carried on for 10 years. It's hard to see him, where he's at too. I know in my experience with him, he's a drinker. (Frank)

> I have a brother. I have two brothers who maintain substance use. I have to be careful. I have to surround myself with the right people cause my life went to shit so quick when I didn't. (Albert)

Participants expressed that most their social network is comprised of people that identify as in recovery and that are supportive of sober living. The men articulated that over many years living between recovery and active addiction they sometimes ended up near people from the recovery community that they used with. The men expressed that although they could support recovery ideals, it was difficult to see people traverse between recovery and active addiction. Further to this, the men said that though they expressed a genuine desire to support others in their

recovery efforts, they often had to moderate or even terminate these relationships when they felt they posed a risk to their own sobriety. Maintaining relationships with people in active use, or not firmly establishing boundaries, has previously become a road to relapse for many of the participants and because of this, they are cautious to surround themselves with people that support their recovery goals. Though the men report being able to not sever ties where necessary to protect themselves, they are quick to express that they hold no judgment. As Albert shares:

> The company I keep is a big part of my recovery today. In my past experiences, I go back to those same guys that are using and I go to work for them, I go back to that same situation. I've changed everything. There is a lot I've cut out of my life. A lot of people I've cut out for good reasons. A lot of people that, you know, don't mean any harm but are on their own journey too. Today I realize that I can't be a part of that (Frank).
> Just recently I've had to learn to say no in certain areas of my life because if I get too far away from the sober community, I end up not sober and then it all goes away anyways. I've learned from trial and error. (Albert)

***4.32.6 Establishing Boundaries in the Physical Environment*—**Participants also relayed concerns about their physical environments. Being adjacent to environments that they used to use substances in such as a residence or local bar can be difficult and triggering. The men suggested that living near substance using environments where many of them had used previously, often made it hard to navigate the city safely. The men suggested that it is often difficult walking to aftercare, Alcoholics Anonymous and Narcotics Anonymous meetings due to their neighbourhoods and passing numerous bars, houses and other places where they had regularly used substances.

> It's a challenge staying clean. The thoughts are always there and it's everywhere. Using as long as I have in this city, I'm given a guided tour everyday. I used to go here, I used to go there. There were so many places that I used. (Dan)

All six participants suggested that keeping an open dialogue and working with their housemates was crucial to keep each other accountable. The men also reported that travelling with

housemates or other recovery supportive persons and taking extensive detours was deemed supportive of their recovery efforts.

Three participants discussed challenges with substances being ever-present throughout their work environment. These three men identified as being close to substance use daily. Every day they go to work they endure the struggle of being in the presence of substance using environments surrounded by coworkers and customers that consume substance and normalize their use. Though this was viewed as a challenge, it was also described as a positive as this can ensure that they are monitoring their recovery and be a healthy reminder.

> My work. I'm a carpenter. A framer. In the workplace I was constantly around it. These are challenges. (Frank)

> I work with and get to help a lot of people who don't know that they have a problem with drugs and alcohol, and I get to help a lot of people who do know that they have a problem with drugs and alcohol. I find it keeps me fresh in the forefront of what's important to me in recovery and that's continuously moving forward. (Greg)

Participants discussed being proactive in addressing any issues around substance exposure with their employer and collaboratively devising strategies such as limiting interactions with using persons where appropriate and not attending employment related functions where alcohol is consumed to mitigate risks.

4.4 Attaining Purpose and Belonging

Striving for purpose and belonging was also viewed as important by all participants. The men expressed that they felt the need to derive meaning from their recovery and achieve a sense of purpose within their community and in a societal context. Participants discussed attaining purpose and belonging in recovery in the following contexts: (1) Being productive in recovery; (2) Productivity through employment and education; (3) Productivity through remaining active in the recovery community; (4) Avoiding burnout; (5) Giving back to communities and society; and (6) Changing values and motives.

4.41 Being Productive in Recovery

Participants reported deriving a strong source of self-esteem, self-belief, a sense of purpose from being productive and achieving a balance in recovery and life. The men reported that early in recovery it was difficult not to feel productive having felt unproductive for so long. The men also suggested and that this impacted their self-esteem and overall sense of daily accomplishment. Productivity was viewed as a strong source of hope and motivation among participants and provided them with a sense of accomplishment and feelings of social responsibility. Productivity as a concept was subjective in its interpretation to the participants, but regardless it was highly valued. Productivity was universally recognized by the men as a vivid contrast to what participants described as the chaos and selfish nature of their addiction and provided them with a sense of daily purpose.

> I need to be of use, I need to have a purpose again because I didn't. Now I have something that makes me feel better about myself. I think having a schedule makes me wanna take care of myself and be a productive member of society again" (Frank).

4.42 Productivity Through Employment and Education

Four of the six participants identified as currently employed. The men disclosed that there are conflicting ideals in the recovery community about work especially in the first few months of substance use cessation. Participants explained that working is often the focal point of men living in early recovery as they want to get back to what is considered a "normal" living environment as soon as possible. The men cautioned that there may be issues with trying to do too much too soon, the stress induced through employment, and energy depletion can be difficult for men to manage in early recovery. Participants also suggested that working too much can throw off the work-life and work-recovery balance and cautioned that the extra access to financial means that may be used to purchase substance.

> One of my major challenges is stress. When I first got out of treatment, boy I got stressed with this job (Chris)

> I started working right away. I got right into management I was making a lot of money and so immediately I got right back into the hardcore addiction and I was using constantly like 24 hours a day. We had the money, right? And I was working 7 days a week. (Dan)

> So, I'm heading back home from treatment. I get home. What do I do? Oh, I should go right back to work. All of a sudden everyone is happy for you. Okay you are doing well. This is good, you're working. You get a place a car. You know I build all this shit back up again. I do all these things and I dive right back into life again and I hold it together for a bit and then I grab that drink. (Frank)

Similarly, participants found that education also provided them with a sense of productivity and a platform for improving their current level of employment and achieving the overall sense of learning and accomplishment. Two of the men disclosed that they were currently pursuing academic advancement and employed simultaneously. Three other men suggested that they were strongly considering further education opportunities.

> What's important to me in recovery? Continually moving forward, there are short term and long-term goals and the completion of those is compelling me to move forward. So now I am a university student and when I went to college or even before that I went to academic upgrading and I was class valedictorian. I mean if you saw my high school grades, I remember when I told my dad I was going to be the class valedictorian and I thought he was going to have a heart attack (Greg).

> I jokingly said to my mom, I'm shooting for 90. So, when I finished the course, I ended up with a 95.5% so I guess I can do school. Take away the alcohol and drugs and 'ya' know? (Chris)

Participants however, warned that like employment, education could be troublesome because of the commitment and challenge it poses to maintaining balance and expressed that they had to learn to sometimes slow down.

> I literally have 130 pages of reading to do this month for my course and I have my co-op which is 70 hours of placement plus about 40 hours of work and filling out my 30-page thing. Add one more unit to finish and then next month I have my assignment which will take me 40/50 hours plus my final. So, I should be pulling my hair out. And I get stressed but I just do the best I can. (Chris)

4.43 Productivity through Remaining Active in the Recovery Community

Participants were also keen to identify that their participation in the self-help and recovery communities was a strong source of productivity. The men felt that this kept them focused on their overall recovery program and helped avoid overextending themselves and potentially losing sight of recovery as their number one priority. The men also suggested that maintaining a solid routine also helped them feel productive, like they are accomplishing something and fully immersed in their recovery efforts. Routine was viewed as contributing to overall life-balance which were observed to be in direct conflict with the sporadic and unpredictable nature of addiction.

> I go to A/A and I go to N/A and I have a sponsor as well as a lot of peers. (Albert)

> I still follow the routine I went through in treatment. I get up and make my bed and do my laundry now. I go to my appointments. I have a twelve-step program. I am aware of what I need to do, and I take care of that need. (Dan)

> Getting up and making my bed in the morning. That's super important it really is. I didn't realize that until I came to treatment. That was never on my radar. I was like "beds made?" who gives a shit. But yeah, I make it every single day since I left treatment. (Chris)

4.44 Avoiding Burnout

Participants were able to derive a sense of belonging and achievement from feeling productive and reported that having learned from past experiences they were cautious to avoid trying to take on too much especially early on in their recovery. The men explained that they need to ensure that they remain cognizant of their situation and reflect on this constantly to avoid "burning the candle at both ends". Participants explained that solid communication with their support network to relay concerns and support burnout identification

> I witnessed people who went too far and then they burn out and become resentful and they cut off their supports and that's one of those things that I've maintained. That whatever supports you have you have to maintain them. You don't want option reduction. You don't want to limit the hands that you have to reach out for. (Greg)

The men reflected on the magnitude of their accomplishments while also discussing future goals while committing to staying on track with their recovery efforts.

> I've got some decisions to make but also, I've done it before where I get too far away from sobriety and I end up not sober so like I'm very aware that I'm not in a position where I can just do whatever I want. I've got to do certain things to have these opportunities, so I think the important word her is just slow. (Albert)

4.45 Giving Back to Communities and Society

All six participants expressed fervent desires to give back to other people. Though this was typically expressed in the context of the recovery community, it was not exclusively discussed in this manner. The men were also interested in the overall betterment of the communities that they belong to such as their geographical neighbourhood, place of employment and school(s) attended by their children. All participants viewed it important to ensure the general prosperity of society wherever possible. The men expressed gratitude profoundly and suggested that they were fortunate to be where they are today. Participants viewed giving back as a personal responsibility, yet this was conveyed without negative or burdensome connotations. The men were genuinely invested in supporting newcomers to recovery and their communities in general and felt that this helped them derive purpose in recovery.

The participants conceptualized "giving back" in different ways yet sometimes ran into difficulty with this as they were keen on giving as much of themselves as they possibly could. Giving back sometimes created issues around the participants overall sense of moral responsibility and potentially retraumatized them through the repeated sharing of their stories. One participant suggested that he sometimes struggled with managing his own expectations on what he felt was appropriate to give of himself to his recovery community. The participant suggested that while he remained committed to helping wherever possible, he ran into issues managing his time accordingly.

Like for me, right now, I'm involved with the se speaking arrangements and starting to plug myself into this community a little bit differently. I'd love to just take over and be like 'okay, here we go' but I've tried these things before. I need to maintain this, which means I need to be here. I need to be connected. I am a twelve-step(er) and I need to be connected to that group. I came through here [treatment centre] and this is a big part too. Sometimes these are challenges too. Like you know, you get kinda pulled in different directions. I've learned that you've gotta be, where I've gotta be, I have to give it a voice. I've got to say 'no' and be okay with that. That's something new for me (Frank)

4.46 Changing Values and Motives

Participants described a transformation in their values and motives while engaged in recovery and said that they could strengthen their own endeavours through giving what they have learned away to others. Two of the men are currently acting as peers supports to the recovery program for new admissions and program clients. The other four are actively engaged in house activities and supporting clients where possible. This support includes things such as providing someone to talk to, life skills support and transportation assistance for getting to appointments.

> Maintaining my connection with the treatment centre and living in supportive housing and being a peer support for a lot of guys in recovery. I want to invest myself in it and it's really helping with my own recovery. (Greg)

> I know there are 22 guys in the house right now that are just starting out on this journey. I can be here. I can show them that this can work. That helps me. (Frank)

Developing a positive reputation in the recovery community was viewed as important to the participants as they were keen to be viewed as trustworthy by their peers and provide a solid sounding board for other recovering persons. Participants were hopeful that in creating this perception of themselves and through sharing of their mistakes and successes, others could benefit from their experiences and perhaps engage in healthier decision making. All six participants are involved in the recovery support program through the treatment centre. The Recovery Support Program brings program graduates back to the house to share their stories with current residents in the hope that it will provide them with inspiration, motivation and an opportunity to further network with recovery-based peers.

> Pleasure is a big motivating factor but um it's mostly me trying to give back and help others. It's weird but it's completely changed. Before it was all substance, substance, substance. My friend recently asked me why I go to AA and I was like cause I know there's going to be a guy that comes in there and he has a drug or alcohol problem and he comes in and somebody fucking rams God down his throat and um it's going to scare him. I was like I'm going to be there to say hey man, you can still get sober. When you come in, you're just so lost and you can have people steer you the right way or steer you the wrong way (Albert).

Two of the participants are actively involved in community-based programming and discussion groups with addiction related helping professionals and are using the intimacy of their personal stories and experience navigating the recovery system to help educate addiction and mental health professionals, policy makers and newcomers to recovery. The men expressed that they want to give back to them and support furthering addiction research, education and best practice initiatives for service providers in whatever capacity that they can.

> The need to share and help other people it's a gift. I want to leave a legacy not just for my kids but for other people in addictions and mental health. You know that you're not too old and it doesn't matter what you've gone through. You can become better and become part of society again and give back to society. I want to get up every day and have a purpose, cause I didn't have a purpose for so long (Dan).

4.5 Systemic Issues that Negatively Affect Recovery

Issues facing the participants on a systemic level were viewed as challenging because of the overarching structural impact on their recoveries and the deep-rooted sense of helplessness they often felt regarding their ability on influencing macro level changes. Participants discussed systemic issues in the following context: (1) Stigma and its effects on recovery; (2) Substance use treatment is massively underfunded; (3) Issues with treatment approaches; and (4) A desire to be part of the change.

4.51 *Stigma and its Effects on Recovery*

Four participants expressed discontent with stigma towards the addiction community. These men discussed the effects of social norms and expectations on shaping their social environment and how this further perpetuated inequality. Stigma was viewed as the oppressive and debilitating

towards recovery efforts. Stigma was also suggested to severely restrict access to the resources necessary to succeed in recovering from substance use such as employment, access to equitable health care and the funding of addictions treatment. Participants discussed the relevance of stigma in their lives and how it presented a challenge to their recovery.

> Dealing with others and the world at large, me as an alcoholic and addict. I'm living in a world that maybe wasn't set up for me, you know. I have a chronic brain illness. So, it's the same way that maybe the world isn't set up for a really short person, you know. It's hard to step up to the curb because the curb is made for someone who is five foot seven inches tall right? (Greg)

All the men openly shared experiences of being treated unfairly because of their addiction, and the lingering effects that this had on their overall self-esteem and the carrying of existence-based shame. They suggested that stigma results in a self-critical culture where persons in recovery are unattainably trying to live up to the expectations of others. This unjust treatment contributed to a mistrust of the system and professional institutions as a whole and acted as a barrier to the participants' recovery seeking initiatives. Participants relayed experiences with health care providers.

> I had a psychiatric doctor tell me 'your problem is, you want to tell the world to go fuck itself' I said no that's not it and then walked away from the system. I believed that for a long time and that's why I never faced my addiction. (Dan)

> There were these different tables. Methadone clinic staff, doctors, shelter workers. It's easy for someone in their shoes to view a person as an alcoholic or an addict. They are viewing that person and that's what they are labelling them as. I look at that person and see a person. I don't see an addict. I see a person going through the same fucking thing that I did and now I'm over here and they're still there. How can I make that journey easier for this person, so they don't have to go through what I went through? At the end of the day it's degrading. You're not looking at a person you're looking at a label, a number, you're not looking. There is a person sitting there. There are beautiful people that I've met here that are gone now that should be here and we'll meet a hundred more of those guys if nothing changes. They are very good people, very productive people once they get the help they need. (Frank)

Participants suggested that the combination of moral judgment type attitudes towards addiction and monumental deficiencies in education by health care professionals is costing lives.

The men warned that the judgments and misinformation that many medical professionals convey is a travesty and can also seriously damage people's perceptions on addiction. The men argued that they are tired of being viewed as second-class citizens and deserve to be treated with dignity and the same respect as any other human being regardless of whether people agree with their choices.

> Last week we spoke to several professionals and a year and a half ago, that wouldn't have been possible. Now, I'm able to get up there and change people's perceptions about addiction. I've got addiction and I've got mental illness and I've suffered but I'm no different from you. I'm just as articulate as you are. I've sat at your tables, I've worn a suit and tie, I'm open to your views, be open to mine as well and give me the same level of respect. (Dan)

Two participants articulated that addiction related stigma in the workplace restricts equitable treatment for persons living with addiction issues. The men suggested that they received discriminatory treatment at their places of employment and sometimes had issues gaining employment due to legal issues involving substance use. The men argued that people can make mistakes and still be good employees, but this is often why people do not ask for help. Participants also suggested that people are sometimes left with little alternative but to stay immersed in substance using culture and often must resort to selling substances or other illegal activity to make a living.

> When I lost my job in 2012, they didn't give me anything. No warning, no support. They just said, "you're gone, you're done." I was an executive chef and they don't put up with that shit. I was brand new cause another company bought us out and came in and it was so much pressure and I wasn't ready for it. (Chris).

> I think being branded a criminal like with my past, it's hard to find work sometimes. People do a background check or anything like that. There are barriers to that. I think that's a stigma thing. I mean some of the most trustworthy people I've ever met have made some bad choices and are paying the price and over-paying that price. For me to be self-employed right now its easier for me to get work like that, on my own as opposed to applying for a job. So, I could apply for a job at a high-end carpentry place and they see the background check and say, "maybe this isn't for you". But I could go get that same job if the person that hired that company would just hire me directly. So those are the barriers but I'm learning to navigate them. (Frank)

4.52 Substance Use Treatment is Underfunded

All six participants also recalled the challenges they experienced with substance use treatment being underfunded. The men regarded funding as the primary catalyst's in making treatment and system navigation significant challenges to their recovery efforts. Participants were swift to suggest that the lack of funding or investment in treatment and making the system easier to navigate is due to social ignorance regarding addiction and recovery, and overall addiction related stigma.

> They are so complacent, the powers that be, with way uh the status quo about addiction and mental health. There is not a great urgency to change things. There is a lot of talk. That's the problem and it's not going to get any better. It's going to get worse. We need action now to change things. There is a lot of talk, a lot of round table stuff and discussion on strategies and this and that but you know, we need immediate action cause people are dying. (Dan)

Three participants reported that a serious lack of funding for addictions support severely hindered their residential treatment and post-treatment experiences. The men suggested that substance use treatment programming is run on a "shoe-string" budget and not having access to the resources required to effectively navigate treatment and post-treatment supports posed a significant challenge for them. The men cautioned that a reluctancy to invest in treatment supports contributes to relapse rates and costs lives.

> The counsellors went home with the administration at the end of the day. I mean no one is there and it was ten men trying to deal with everything, their problems completely by themselves. On weekends there was no staff on the whole weekend. There was a "head of the house" or house leader and everyone had a tenure for two-weeks. They're responsible to call someone if there is a problem. (Jeff)

> I completed this program and I'm feeling great. I'm 28 days clean now. So, I have all this support there, kind of like a little thumb on you so to speak, then I left and there was nothing all of a sudden. (Frank)

> After the treatment ended, I went back to that same shelter. I wasn't able to attend aftercare through treatment cause they wanted another two-thousand dollars. And, obviously very few people who went through that treatment centre went to aftercare. We were on OHIP beds and had no money for treatment let alone to afford the aftercare. That

> was not a component that we were eligible for, for the average person anyways. The treatment itself was great but I think because aftercare was out of the picture it left a sour taste in my mouth. You do the 21 days. You make this choice and then you can't connect with this place anymore. It was almost like a spin cycle. You did your 21 days and then you get spit out on the other end and it was kind of like a closed door. Aftercare was strictly pay to play and in retrospect I look at continuing care or aftercare and the role it plays in my recovery today and I look back at that experience and go wow! You really missed out on a big opportunity. (Greg)

Wait times to access treatment options were a point of contention for all participants. The men expressed their discontent with current wait times for both residential and out-patient treatment options and suggested that this is a product of a critically underfunded system that is in desperate need of revitalization. The men found this particularly upsetting due to the intense nature of making the initial decision of asking for help with addiction and expressed that there is a limited window in which an individual will look to alter their substance using behaviour. Participants argued that a lack of beds in residential treatment sees many people in need forced to wait for treatment without having a safe place to stay sober. The men suggested that waiting unreasonably long periods to access treatment often contributes to an increase in substance using behaviour with many individuals entering treatment in worse shape or not making it at all.

> I spent like six months in a mental hospital. It was a long time like a crazy long time, but they could see I was trying to get sober and had to wait a long time to get into treatment. (Albert)

> I was there in the shelter waiting to get into treatment. I was there for a month before I got my intake date, so I had to stay in the shelter and try to maintain my sobriety goals. (Greg)

> I walked through the doors at MASH and that was last year. I spent 47 days in MASH waiting to get into treatment. (Dan)

4.53 Issues with Treatment Approaches

Participants also reflected on the issues that they experienced while trying to successfully navigate substance use treatment and the addictions support system. Participants articulated concerns around substance use treatment assimilative "one size fits all" approach to programming

and insisted on a more personally contoured treatment absent of punitive-based responses to diversion as this made them feel "less than" and like they were children being scolded for misbehaving.

> I found their program kind of basic and I didn't drink but it really didn't do much for me. The times you weren't in class it was basically a co-ed party kind of thing. It was very regimented, very punitive. Basically, you got in trouble if you weren't like at the gym on time. It sort of didn't click for me. It wasn't a very comfortable thing. I felt like I was even more lost. Like I was even further away from recovery. (Chris)

> I've been to treatment centres where things were pulled away and you had to claw back a lot of the freedoms and stuff and they had a very different feeling to it, and it was co ed which wasn't good for me either. (Greg)

4.54 Desire to Be a Part of the Change

Participants relayed a strong desire in becoming part of the system to invoke changes from within. Two of the participants are actively engaged with education and system navigation discussions sharing their lived experience alongside addiction and mental health treatment providers throughout the Hamilton community in the hopes that their stories and insight may break down barriers and yield significant improvements for others in recovery. They remain hopeful that through these collaborative education efforts, they can become strong advocates for change and positively alter the way in which addiction survivors are perceived throughout society. The men expressed the desire to hold a respected voice and engage in change-related discourse with the overall goal being a system overhaul.

> I was dealing with my son's addiction at the time. It was the final meeting we had about his situation before I took him out of the system. We sat at a table in Toronto with oh probably a couple million dollars worth of talent. The head of psychiatry in Toronto and all these agencies and stuff and they told us that there was nothing more that they could do for my son. Then I walked out. It's unfortunate. I knew what he needed. I brought the voice of experience. (Dan)

> I'm part of the community as well. I'm doing all these engagements with the harm reduction team. I'm working with these people to inform them and to share my experience with the system. That in turn is supporting me with my recovery. So, you go there and share your experience with them, and they are just floored. Like holy shit. (Frank)

Chapter 5: Discussion

The transition from active substance use into a recovery-based lifestyle represents a massive undertaking of a complicated and lengthy change process. Recovery efforts require courage of an unquantifiable magnitude and the attainment of success can only be described as the most colossal of challenges deserving of our respect and recognition. The purpose of this study was to cast inquiry into how men in recovery from substance use conceptualize challenges and use their inherent strengths to navigate them. Participants shared their recovery stories openly and discussed experiences, challenges to recovery and the navigation of these challenges. Through the intimate disclosure of their experiences, the men personified strength and an incredible depth of detail. Participants were also able to envision the potential for future recovery challenges and held a reserved confidence towards successfully managing these issues.

A strength-based lens was employed in contrast to typical pathologizing approaches to this subject material. These approaches often negate the positive and resilient qualities of the participants while emphasizing deficiencies and adopting problematizing discourses. Through the incorporation of a strength-based perspective, it was my intent to explore this community in a manner that draws attention to the enormity of the changes they are implementing. I aimed to capture the diversity, strength, perseverance, resilience and autonomy of the participants which is atypical of addiction research (Andersen, 2015; Haroosh & Freedman, 2017; Spiehs & Conner, 2018). The qualitative interview process was designed to seek perspective directly from the participants, thus maintaining consistency with the research question in that challenges were conceptualized by the men rather than myself. I sought to capture the depth of detail presented to me by the men during the interviews while accurately conveying the self-awareness, insight and creativity expressed as they conceptualized the successful navigation of their issues.

Data extracted from the interview process was thematically analyzed for the presence of recurring themes. As previously discussed in my findings, four key themes emerged from this study due to their significance to the participants and their consistent presence throughout the interview transcriptions. These themes will be further analyzed below and include: (1) Physical and mental health; (2) The importance of relationships; (3) Attaining Purpose and Belonging; and (4) Systemic issues.

5.1 Recovery Challenges Further Explored

5.11 Physical and Mental Health

As a recovery challenge, physical health and mental health discourses were both prominent throughout the interview process and it became apparent that to participants, these are significant issue requiring attention. When compared with the literature consulted for the literature review contrasting health paradigms emerged. While mental health was well represented in the literature and considered important to service users (Haroosh & Freedman, 2017; McTavish, Chih, Shah & Gustafson, 2012; Morton, O'Reilly & O'Brien, 2016; Russell, Gillis & Heppner, 2016), the importance of physical health in successful recovery was not given equal attention. Brunelle and colleagues (2015) suggested that physical health was an important motivating factor in substance use cessation, but arguably was not as heavily weighted as other motivating factors such as psychological and social health. Measuring service users' views on important recovery concepts, Neale and colleagues (2015) concluded that physical health importance was not deemed as important in recovery as other factors such as client autonomy, relationship prosperity and improved mental health.

Unlike Timpson, Eckley, Sumnall, Pendlebury & Hay (2016), who highlight physical health as a by-product rather than an integral component of recovery, participants of this study viewed their physical health as a more integral component of their overall holistic recovery

approach. Participants of this study maintained that experiencing physical health issues interfered with their ability to perform general tasks and participate in recovery-based programming. These men also suggested that issues with physical health inhibited their overall enjoyment of life in recovery. Furthermore, the participants reported that physical health issues also negatively affected their mental health by inducing stress and anxiety related responses. Feelings of stress and anxiety emerged through fears around discovering the severity of longstanding medical issues and mediating pain management strategies. Participants were swift in highlighting that pain management medication would forever be a trigger for relapse and regardless of the situation they would need to be cognizant of what this could mean moving forward. In asserting that this is the future that they are faced with, the men adopted a proactive approach to challenge navigation and were able to engage in discussions around managing future challenges in this area.

In this study, mental health was viewed as a contributing factor for the initial onset of substance use and the continued use of substances despite further experiencing negative consequences. Substance use was reported as being a previously unsuccessful coping mechanism to manage depression, anxiety and help participants experience a sense of 'fitting in'. Although substance use as a coping mechanism was observed to have initially managed mental health symptoms, participants reported that they felt using substance further exasperated mental health symptoms over time. Successful management of existing mental health symptoms was given priority in recovery to minimize risks to relapse and maximize overall life enjoyment by all men. These men indicated that they would continue to try and manage their mental health issues with the help of their diverse support network.

All six participants were able to not only able to identify a wide range of issues relating to their physical and mental health challenges but showed a genuine desire to face these challenges head on. The men recited experiences of effective health management initiatives throughout their

recovery endeavours while conceptualizing strategies to manage outstanding health issues. Participants were effectively able to anticipate future challenges to their health while discussing mitigating risks to their overall recovery efforts. All of those interviewed employed the establishment of diverse support networks including medical professionals, counsellors and peer support in overcoming challenges to their health. Diet and exercise were also utilized along with tobacco cessation strategies. Participants reported being open to taking psychotropic medications to help manage mental health related issues should they be prescribed but were also keen to suggest other methods of management including, counselling, self-help, daily reflection, meditation, and fitness routines. Participants also sought to "normalize" help seeking behaviour and become "comfortable" reaching out for support when needed. Finally, stress management techniques were discussed and prioritized in trying to combat health issues.

5.12 The Importance of Relationships

***5.12.1 Intrapersonal Relationships*—**Intrapersonal relationship management was presented as a sizable challenge by participants in my study. Similar to the literature, as discussed in Bathish and colleagues (2017), Neale and colleagues (2015), Timpson, Eckley, Sumnall, Pendlebury & Hay (2016) and Turpin & Shier (2017), participants in my study conceptualized their transformation from a substance user into someone that identifies as in recovery was one of the most difficult challenges they faced but likely the most important.

Similar to research done by Turpin & Shier (2017), Bathish and colleagues (2017), Russell, Gillis & Heppner (2016) and Witbrodt, Borkman, Stunz & Subbaraman (2014), participants of this study conveyed the importance of improving self-awareness and traversing emotional extremes while coming to terms with guilt, shame and remorse through the implementation of self-care practices. Participants of this study held similar sentiments as in Haroosh & Freedman (2017) and Rodriguez & Smith (2014), in that success in recovery requires

a completely new way of living. This "new way of living" includes; embracing a new way of thinking, feeling and behaving, challenging beliefs and values and altering the social environment. This way of living is continuous and without end, in that efforts must be sustained on an ongoing basis to avoid complacency, stagnation and any possibility for a return to substance using behaviour.

The men in this study were keen to take ownership of their own recovery, and while they were swift to maintain that harm reduction strategies might work for others. Harm reduction strategies were viewed by all participants non-sustainable in their previous experiences and not conducive to established recovery goals. The men acknowledged that they needed to accept that they could not use substances in any circumstance or quantity in order to overcome complacency and stagnation in recovery efforts and adopt proactive measures in identifying relapse warning signs.

Participants universally suggested that although they were not beyond succumbing to future temptation or falling back into old habits, that they had obtained a strong sense of comfort from acceptance of their new recovery identity. Surrounding themselves by peers and remaining in proximity to newcomers in recovery through attendance at self-help meetings acted as a cautious reminder of their hard work and enormity of their change efforts.

Participants remained generally optimistic about their ability to maintain their recovery regardless of their recognition that obstacles would be ever-present throughout their efforts. Allowing emotions to naturally exist in their raw form and avoiding the constant searching for validation or forcing authenticity were discussed as methods of managing concerns. Remaining aware of emotional fluctuations and vigilantly managing them throughout their recovery journeys was viewed as essential to overcoming challenges by participants.

Engaging in regular self-forgiveness practices through using positive affirmations to combat guilt, shame and remorse were also seen as crucial to success. Maintaining hope and striving towards a better future while learning from the past were further strategies employed to successful emotional management. Participants relayed that as difficult as it may be, they felt that learning to become comfortable being uncomfortable was ultimately what they needed to achieve in managing some of their more difficult emotions. Finally, participants suggested that they were committed to self-discovery and allowing the rawness of their emotional experience to redefine how they saw themselves as people while continuing to serve as motivation for future changes.

During the interview process, three of the men became visibly emotional when disclosing that two of the treatment centres former residents had recently passed away. As a researcher, social worker and human being this was difficult for me as their pain was evident and the interview room was a particularly intimate setting. I could sense how much these men were affected by the loss of their peers and how much they genuinely cared for the greater recovery community. This was not surprising to me given the extent of experience working within the addictions field, but it was refreshing nonetheless to witness the raw presentation of emotion by the participants. That these men could express such empathy and compassion towards men who were complete strangers prior to residential substance use treatment, has reinvigorated my belief in humanity while reminding me of the harsh reality they face.

5.12.2 Interpersonal Relationships—Interpersonal relationships were articulated as a challenge and seen as a substantial motivator to sustain recovery efforts by the participants. Bathish and colleagues (2017), Brunelle and colleagues (2015), Haroosh & Freedman (2017), and Stevens, Jason, Ram & Light (2015) suggest that although motivation for recovery comes from diverse internal and external sources, interpersonal relationships were found to be one of the most significant motivators for substance use cessation. This was consistently demonstrated

throughout the interview process by the participant's discussion on their recovery trajectory and conceptualizations of recovery maintenance motivators. The participants also discussed the importance of establishing a positive recovery community and building relationships designed to support and motivate each other. This is consistent with research discussing the critical nature of interpersonal relationships and social networking in recovery completed by Bathish and colleagues (2017), McTavish, Chih, Shah & Gustafson (2012) and Pooler, Qualls, Rogers, Johnston (2014).

Participant's recognition of the significance their interpersonal relationships had on their recovery contributed to considerable regulation efforts of their social environment. Pre-existing relationships were assessed and initiatives towards repairing and maintaining these relationships were discussed. In instances where existing relationships were not readily available for improvement, due to their termination or a reluctance to explore reconciliation, the men expressed hopeful sentiments towards indulging in future efforts where possible. The men also disclosed recognition of responsibility in their role within the demise of these relationships and an overall acceptance of the situation. In some instances, as discussed in the findings, this acted as a motivator to drive participants to want to do better and provided them with future goal establishment opportunities.

As discussed in the literature review, Cloud and Granfield (2008) conceptualized involvement in social relationships, support networks and belonging to community institutions in recovery as 'social capital'. Timpson, Eckley, Sumnall, Pendlebury & Hay (2016) and Weston, Honor & Best (2018) present social capital as arguably the most important component of a successful recovery. Though social capital can be positive or negative depending on the social makeup of the individuals support network and how they interact with it, individuals that are able to circumvent negative social capital while strengthening positive social capital are better

equipped to succeed in recovery. Participants echoed this throughout the interviews in discussing the roles their social network played in their recovery and how they reinforced positive social capital while limiting or avoiding negative social capital. This was accomplished through the maintenance of existing healthy relationships and the formation of new ones. The establishment of boundaries around difficult relationships and terminating relationships that threatened recovery efforts helped participants navigate recovery successfully while minimizing triggers and risks of relapse. This finding was consistent with Weston, Honor and Best (2018) in that the regulation of social capital networks based on their composition and contents were crucial to attaining success in recovery.

In circumstances where relationships were severed or moderated to preserve recovery efforts, participants universally expressed an absence of judgment towards individuals in active substance use. Participants were swift to express that although but measures towards sustaining their recovery took precedence over the maintenance of recovery threatening relationships, they were mindful of being respectful and demonstrating empathy. Boundary establishment was viewed as an evolutionary process impacted by previous recovery maintenance attempts and relapses, and reflective of a constantly changing social environment. Participants also discussed limiting other physical, psychological and social triggers as in Rodriguez & Smith (2014).

5.13 Attaining Purpose and Belonging

Participants expressed the need to experience a sense of belonging within their established communities. Addiction was considered the absence of a purpose and an isolating entity by participants, who felt that this pushed them into the periphery of society. This invoked feelings of being “irrelevant” and like they did not belong in any social setting. Participants suggested that they often compensated for their lack of belonging by seeking it in substance using environments. This left them feeling even further disconnected because of physiological substance use effects,

difficulty trusting in that environment and their inability to develop much more than surface connections.

Much attention was given to feeling a part of society and contributing to its betterment through work and education initiatives and in doing so participants were able to derive a sense of purpose and belonging. Consistent with the findings of Morton, O'Reilly & O'Brien (2016) and Weston, Honor & Best (2018), employment, education, skill development and daily routine provided participants of this study with a sense of accomplishment and productivity and helped distance them from the chaos of substance use. This experience of feeling productive contributed to a greater sense of connection to the community and society. These endeavors provided the men with what they considered to be a direction in life, when reflecting on their past accomplishments and prospects of future goal attainment.

Productivity and its ability to provide purpose and belonging for participants contributed to their self-worth, self-esteem, self-belief, self-determination and self-efficacy while perpetuating positive recovery outcomes as consistent with findings discussed in Turpin and Shier (2017). This experience of belonging also further supports the changing sense of self and further aligns the participants with a recovery-based self-image while shedding previously held conceptions of the addicted self (Rodriguez & Smith, 2014; Timpson, Eckley, Sumnall, Pendlebury & Hay, 2016). Participants of this study echoed these findings by identifying as employees, students and members of their recovery community. The men also suggested that they felt connected in their productive roles and could further develop support networking opportunities and new hobbies that pushed them further away from feeling isolated. Participants in this study were cognizant of the potential challenges associated with productivity such as money, time and stress management issues as similarly reported in Neale and colleagues (2015), but in contrast, welcomed the responsibility and saw it as becoming accountable.

Consistent with findings reported in Timpson, Eckley, Sumnall, Pendlebury & Hay (2016) participants saw cultural capital as a more fulfilling component of their recovery when compared with physical capital and even went as far as suggesting that physical capital would "look after itself". Participants conveyed the desire to assist and provide ongoing support to others who may be experiencing similar addition related issues. Though this was present in the literature (Brunelle et al., 2015; McTavish, Chih, Shah & Gustafson, 2012; Pooler, Qualls, Rogers, Johnston (2014), more attention was given to the benefits received by those in recovery and did not necessarily convey the altruistic intent of the participants. In this study, participants received the positive results of giving back such as building support networks and deriving motivation through experiencing past reminders but also did so for the betterment of their community. Participants valued their lived experience and saw this as a unique opportunity to provide insight to others in the hopes that they may repeat successes and learn from mistakes. Giving back was emphasized as fundamentally important to the participants during the interview process and they expressed no desire for monetary compensation or personal gain as a result of their desire to help. For the participants, doing what they perceived as their part to help along with the feelings of connectedness, purpose and belonging that this provided was more than enough and they were able to justify expending the time required and making other sacrifices to do so.

5.14 Systemic Issues

Participants shared their experiences with systemic issues including stigma, treatment concerns and general addiction support related issues. Participants suggested that unlike the other challenges to their recovery efforts, systemic issues were challenging to navigate due to their inability to directly influence change. Similar to research done by Earnshaw, Smith & Copenhaver (2013), participants conveyed that systemic issues severely altered treatment success rates and acted as a barrier to individuals in all areas of their recovery.

Consistent with academic literature on stigma (Neale et al., 2015; Timpson, Eckley, Sumnall, Pendlebury & Hay, 2016; Weston, Honor & Best, 2018), participants reported that the effects of stigma on their self-esteem and belief in their capacity to recover were cataclysmic and contributed to holding on to warped self-perceptions including existence and autonomy shame. Participants reported that stigma prevented progress in recovery by limiting their opportunities such as employment and education, while restricting their overall access to resources including equitable health care support and the judicial system.

Participant's position that there was little that they could change at a structural level on an individual level did not prevent them from envisioning change for future generations of recovering persons. Participants emphasized that the system had come a long way over the past 20 years and would continue to be reimagined through continued evolutionary addiction science and further advocacy efforts. Participants maintained hope in initiating change through repeatedly challenging the system and engaging in advocacy work around the eradication of stigma.

Participants also voiced their desire to try and work alongside treatment providers and addiction related support workers to collaboratively shift treatment methods. The findings of this study are similar to (Betkowska-Korpala & Olszewska, 2016; Brunelle et al., 2015; McTavish, Chih, Shah & Gustafson, 2012; Witbrodt, Borkman, Stunz & Subbaraman, 2014), in that recovering persons find various unique methods to success and therefore cannot be funnelled into a singular treatment system. Participants of this study suggested that although they were respectful towards various treatment models, and they recognized that clinical expertise was imperative to their recovery efforts, they requested a greater sense of self-determination in the process. Finally, participants were keen to suggest that treatment methods must better reflect the individual needs of the participant in contrast to an overall singular best practice model. This is

consistent with the findings of Rodriguez & Smith (2014), Timpson, Eckley, Sumnall, Pendlebury & Hay (2015) and Turpin & Shier (2017).

Participants relayed a strong desire to improve relationships with policy developers, treatment providers and other medical professions in the hopes that this will create a platform for a mutually beneficial discourse on how to support and engage persons in recovery in a manner that promotes autonomy, respect and diversity. Participants verbalized that they are open to engaging in whatever capacity that they can to work towards helping others eradicating stigma and improving the system but insisted that they required a larger role to achieve this. Participants were able to achieve some success at overcoming their systemic challenges, but this was due to their own persevering qualities rather than the result of systemic changes.

5.2 Addiction and Recovery Paradigms Re-Conceptualized

It is also important to revisit conceptualizations of addiction as a biologically-based medical disease as in Kalivas & Volkow (2005) and Wallace (1993) or as a maladaptive choice based coping mechanism as in Banks & Negus (2017) and Heyman (2009), the experience of addiction or substance use is a significant issue. While these models contribute to our overall understanding of addiction, it is important to recognize that they primarily adopt a deficiency-based analysis of the phenomenon. Although these models provide insight into the core functions of addiction, they are unable to unequivocally capture all its intricacies and fully explain causality. Both models are also responsible for further pathologizing men in recovery thus subjecting them to stigmatic labels and prejudices. A model capable of providing an absolute causal pathway of addiction may never be established, and for good reason. Addiction in a complex phenomenon and its root causes and effects are unique to the individual and diverse within every scenario. It is therefore imperative to consider that while these models may deepen our understanding of addiction as a phenomenon, exercising caution towards the social consequences of universally labeling people

as ‘addicts’ or living with ‘substance use disorder’ should be more responsibly observed. Perhaps these models would be better served incorporating a more prominent assessment of the intrinsic strengths possessed by individuals living in recovery who spend every day surviving their addiction. Perhaps devoting attention to capturing the phenomenon of addiction from multiple lenses as suggested in Wanigaratne (2006) would result in a more diverse approach to research.

Contemporary discourses often conceptualize addiction as “the problem” and solutions are drafted specifically that attempt to treat the addiction itself rather than the core issues at play. Although over time, addiction becomes its own issue. Its origins are typically that of an attempt at a solution rather than a problem. The men of this study and every individual and group related to addiction recovery that I have worked with over my fourteen-plus years in the field described the onset of their addiction as a result of unsuccessfully trying to circumvent their experience of pain. Maté (2008) also argues that addiction is an attempt to manage pain, whether physical, psychological or sociological. Hari, (2015) argues that the evolution of pain in some individuals can be so overwhelming that they seek an escape from their own reality. Initially, the substance is effective at providing the escape and with the positive reinforcement that the individual seeks. However, as substance use intensifies and the biopsychosocial dependence increases, sacrifices in other areas of an individual’s life are rationalized and other problems manifest. As the cycle of substance use perpetuates, individuals are progressively impacted on a biopsychosocial continuum (Gorski, 2011). Therefore, the War on Drugs and just say no approaches fail because they incorrectly assume that they are dealing with the problem. They are however, merely attempting to treat the symptoms without exploring the underlying motivation of the substance user to alter or escape reality by the individual.

If society became capable of conceptualizing addiction from a strength-based perspective, maybe we could focus on improving the lives of addiction survivors and devoting more research

and financial capital into exploring solutions. This could represent a better use of resources and yield improved results for those living with substance use related issues. Every person living with substance use related issues deserves understanding and support rather that misunderstanding and ridicule. Should the substance user ultimately decide to explore substance use cessation and consider recovery options, it is important that they are able to receive them with open arms in a timely manner and given the opportunity to change rather than being left to fall through the cracks of a chronically inadequate system.

Just as addiction is a complex phenomenon, so is recovery from addiction. Recovery does not have a single universal definition as suggested by ACMD (2013), Burns & MacKeith (2012), Neale, Nettleton & Pickering (2012) and Neale et al. (2015) but encompasses a diverse range of holistic improvements to various areas of an individual's life such as improvements to relationships, mental health and feelings of love and belonging. The physical removal of substance and the behaviors associated with the physical manifestation of substance use is a step in the recovery process however physical cessation only represents the beginning of the transition into a recovery-based lifestyle. Dealing with the cognitive, emotional and social processes required represents a much larger component of the individual's overall recovery trajectory and is a better indicator of successfully reducing or altogether eliminating substance use. Consider that incarcerating a substance user may result in their abstinence from the substance for a lengthy period but employed in isolation, this type of intervention does nothing in the resolution of the issues that led the individual into the addiction in the first place. Throughout my fourteen-years experience working with men in recovery many men that have been incarcerated have shared that the first thing they did when released was engage in substance use.

Recovery might be better conceptualized as occurring along a continuum that can incorporate harm reduction and abstinence-based strategies where appropriate for the individual.

Harm reduction strategies may not be right for everyone as discussed by the men in this study. It is important to consider that while harm-reduction did not work for the men, perhaps it can be viewed as the point in which they recognized a need for change and as a starting point to their chosen abstinence lifestyles. As addiction can deprive people of self-esteem, self-confidence and self-worth among other things, it is important to note that whichever strategies are used, they must be employed in ways that emphasize the inerrant strengths of the individual and work to shed stigma. Therefore, it is important to consider that recovery can be viewed as any state of being whereby a substance user identifies a desire to explore a regulation of substance use. This involves the incorporation of biopsychosocial alterations aimed at genuinely reducing substance use and the behaviours that the substance user has come to identify with it. Along with regulating substance using related thoughts, emotions and behaviours, recovery implies that an alternative method of managing issues contributing to the reluctance of the substance user to desire a presence in their own reality without the use of mind-altering substances. This may involve the process of identifying, and subsequently addressing multiple deep seeded core issues that contributed to the onset or maintenance of associated substance using related behaviours.

5.3 Implications for Social Work Practice

It is important to discuss the role that social work plays within the context of supporting individuals in recovery. Social workers employed directly in addictions work scenarios such as in a treatment or therapeutic capacity are in a unique and difficult, yet rewarding roles due to their capacity to support and positively reinforce the addiction community (Brunelle et al., 2015, Enos, 2017; Pooler, Qualls, Rogers & Johnston, 2014; Rodriguez & Smith, 2014; Spiehs & Conner, 2018; Stevens, Jason, Ram & Light, 2015; Turpin & Shier, 2017). Social workers not employed directly in addictions work will more than likely come across addiction related issues throughout the course of their practice. Examples of this can include situations where addiction support is

referred to externally by the social worker such as in Children's Aid and homeless shelter environments. Regardless of the role the social worker is employed in it is their responsibility to ensure that they implement standards outlined in The Canadian Association of Social Workers (2005).

On a micro level, social workers are directly able to support persons in recovery and their families by listening to their stories and trying to provide support through working within means to remove barriers wherever possible. It is crucial to empathize and recognize the magnitude of the challenge facing these individuals. Maintain that health be managed holistically and include both physical and mental health management strategies. Operate without judgment and understand that the behavioral component of addiction is only a small portion of the change process (Gorski, 2011; Maté, 2008). Supporting individuals towards embracing changes in their identity from active addiction into recovery is crucial but recognize that these changes are often not fluid and can be considered as monumental as altering lifelong religious beliefs or "unlearning" how to tie a shoe.

Be present with recovering persons as they manage emotions as for many this is a difficult and or new experience requiring constant validation. Help normalize the establishment of healthy person-centred boundaries and relationship management, acknowledge expressions of grief and loss over these issues and do not minimize or imply that they merely get over it or move on. Support their need for love and belonging through helping to create connections and become productive. Encourage furthering education, employment and skill development where appropriate and support navigating these ventures while creating opportunities for "giving back" in some capacity. Finally, openly listen to their experiences of stigma and issues involving treatment while working with them to navigate challenges and pursue change initiatives.

On a mezzo level, social workers are responsible for forming linkages to various services and communities. Work to establish vast supportive networks and referral contacts throughout the community that can assist with mental health, childcare, finances and other issues and connect persons in recovery to these supportive resources. Continue to seek personal development through furthering education and seeking training opportunities when available. Work to educate others and encourage sensitivity training to professionals working alongside those in recovery that may hold different values or unrealistic expectations of persons in recovery (Neale et al., 2015; Turpin & Shier, 2017). Assist the recovering person in the navigation of their network and help mitigate issues that arise. Continue to engage in advocacy, outreach and research-based initiatives whenever possible.

On a macro level, social workers must engage in the pursuit of social justice as discussed by Canadian Association of Social Workers (2005). Challenge stigma discourses and work to eradicate them at every level. Continue to shift practice and push boundaries by overtly rejecting policies and practices embracing archaic War on Drugs philosophies and recognize that they do not work. Continue to lobby for equitable and diverse person-centred treatment for persons living with addictions issues. Challenge pathologizing discourses and push for more strength-based analysis and research. Language plays a crucial role in the construction of identity especially as it relates to self-worth and self-esteem (Spiehs & Conner, 2018). Noting this, work to shift discourse from labeling and self-defeating language such as ‘junkie’ into liberating and more strength observant language. Suggest that funding be increased for addictions treatment and research. Challenge the implementation of punitive and judiciary measures as a solution to addiction. Insist on the incorporation of modern research and best practice ideals into substance use treatment curriculums. Embrace diversity in treatment by participants and support their uniqueness wherever possible. Addressing these issues could provide further support in

maintaining recovery initiatives and would represent a worthwhile investment for funders and policy makers alike.

5.4 Limitations

There are limitations with this study and for this reason it is important to exercise caution when inferring conclusions from the results herein. There have been few studies that have incorporated a strength-based analysis of men in recovery and because of the subjective nature of participant conceptualized challenges and methods of challenge navigation these results cannot be generalized with any scientific authenticity beyond the realm of this study. This study utilized convenience sampling methods. The sample size was relatively small with 6 participants and limited to a heterogeneous makeup lacking in diversity. It is therefore important to consider what effects a similar study with a different sample population set in a different part of the world may yield. Another point to consider is that this study was focused on persons in recovery that have completed treatment at one specific treatment centre and may not be reflective of the experiences of persons in recovery who have completed alternative treatments or not engaged with recognized treatment supports and may be employing other methods to recover. Finally, it is important to remember that this study was based on substance use related addictions and cannot be generalized to be representative of other forms including but not limited to behavioral and impulse control related addictions.

5.5 Recommendations for Future Research Inquiries

Future research in this area of inquiry may do well to look at the relationship between the progression of men in recovery and the development or enhancement of their strengths and how they build during the recovery process. Do men's inherent strengths increase during substance use recovery? What affects these strengths and the men's ability to retrieve them? Does substance use treatment enhance this process? Does the amplification of self-esteem and self-worth increase

the men's ability to retrieve their strengths? How might set- backs in recovery affect the men's ability to draw on their strengths? Perhaps broadening the range of sample size and the incorporation of reliable scales as a tool of measurement would benefit future studies. For example, using scales that measure self-esteem, self-efficacy and various collaboratively established recovery measures might provide further insight into the role of inherent strengths in recovery. Interviewing participants over multiple sessions to ascertain how their conceptualization and navigation of challenges alters with the progression of time, may provide a more concrete understanding of the general participant progression and provide researchers and service providers alike with more insight into the evolutionary process of recovery.

Chapter 6: Conclusion

Challenge navigation in recovery from substance use represents an incredibly difficult journey with minimal room for error. With relapse and the potential for a prolonged re-exposure to substance using behaviours articulated as “not an option” for the participants, they must remain vigilant in their recovery management and ensure that they learn from previous experiences while anticipating the presence of future issues. Throughout the course of this study I was gifted with the opportunity to better understand the severity of the challenges facing the participants and consistently reminded why I hold the recovery community in such high regard.

All six participants recalled the use of their inherent strengths when discussing the ways in which they navigated challenges throughout their recovery continuum. The men were resilient in the face of physical and mental health related challenges and refused to compromise their responsibilities and recovery efforts because of these ailments. Participants provided insight into methods they employed to overcome intrapersonal barriers including rapidly changing identities and emotional management and outlined initiatives that they are taking to prevent a re-occurrence of these barriers. The men emotionally discussed their interpersonal relationships and accepted responsibility for their role in difficult and lost relationships. Desire towards repairing relationships wherever possible was expressed and healthy boundary establishment strategies to preserve recovery outlined. Productivity and attaining belonging within communities was of critical importance to participants and they discussed becoming accountable through achieving a purposeful existence within their chosen social circles and society. Finally, aspirations towards initiating systemic change discourses alongside professionals were cautiously conveyed and expressed with a subtle hint of optimism.

Further to these findings, I was treated with such respect by the individuals that I interviewed. They were amazingly warm spirited and welcomed me with open arms. I felt at ease and comfortable almost immediately. The men appeared genuinely excited to speak with me and share their experiences, insights and ideas. We had a few good laughs, shared some tender moments and collaboratively discussed ideas on change during the interviews. The men left me with a lot to think about as someone who works in the addiction field, and I hope that this experience will enable me to improve the service delivery of my practice and inspire me to push boundaries further while staying true to the uniqueness of the communities that I serve. I feel as though the participants gave me their raw and unfiltered selves and were honest with me about their experiences from the opening question. I feel incredibly honored that the men were so candid in the sharing of their experiences with me and relayed such a strong desire for me to use their telling of these stories in a way that would benefit their community.

I designed this study with the participants firmly in mind and approached it wanting to explore the rawness of their stories from a perspective that celebrated their courage and resilience. Having worked in the addiction field in varying capacities for more than fourteen years I aimed to conduct a study able to capture the experiences of men in recovery and provide them with an opportunity to share their voice on the issues facing them. I wanted to present these men to the world in the same positive light that I have been fortunate enough to see them in over the years. Reflecting on this journey that this thesis has been, I am confident that I was able to explore concepts relevant to the participants and present them in a way that draws attention to their importance throughout the recovery process.

If I were to improve the design of this study in any way, I would have inquired further and in more detail about participant experiences specifically around their handling of previous relapses and how that contributed to their conceptualization of challenge navigation. I would also

inquire about how these experiences contributed to where they are at today and further explore the learning process. One of my questions was: "If this is not your first attempt at recovery what worked, what did not work in previous attempts?" This represented a potential entry point into this discussion, but I did not design follow up questioning and due to time constraints, I was reluctant to explore this further. I would also have liked to have asked more in-depth questions about participant's previous treatment experiences and how they compare to their most recent treatment experience as again this seemed like a rushed question and given my subsequent analysis of the interviews I feel like this would have been an important area for further inquiry.

Moving forward, I will be considering options for a PhD social work program. In anticipating further research ideas there are a couple ideas ruminating. I would like to work in collaboration with men in recovery to design a residential addictions treatment program from the ground up. In doing this I would further consider academic recommendations, best practices within the field, my work experience and the recommendations of service users in the hope that I can design an inclusive and holistic treatment experience designed to support the uniqueness of persons in recovery and address their diverse needs.

Another avenue that I would like to investigate was presented to me during the interview process. I had an opportunity to engage in a brief conversation with one participant about his belief that all that he has endured throughout the course of his addiction, has made him a better person. The participant expressed that he felt like he had become a more humble, empathetic, compassionate and determined person because of his addiction and was thankful for having had an addiction. While I have heard this statement a few times in all my years' experience working in the field, it is a rarity and although I was able to engage this concept briefly with the man, I would have liked an opportunity to probe further and unpack ideas around what this concept means and whether it can be used to positively reinforce self-worth.

Recovery from substance use is unique to each individual and by no means linear. Challenges faced are dynamic and constantly evolving throughout recovery in what is best described as an ongoing circular process. The participants of this study can ill afford to become complacent in their recoveries as the jarring reality that a return to substance use is often met with catastrophic and even fatal results. Challenges that these men successfully navigate today will give way to new challenges tomorrow, and this process will continue to repeat itself. That these men remain cognizant that there is no end point to their recovery journey, conveys a tremendous self-awareness on their part and prepares them in ways that embrace the perseverance that comes with successful challenge navigation. The men must continue to ensure diligence and remain engaged in the diverse recovery program that they have established for themselves while utilizing the resources they have at their disposal to ensure long-term sustainable success by whatever means they chose to define it.

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Appendix A
Recruitment Poster

PARTICIPANTS NEEDED FOR
RESEARCH IN RECOVERY AND RESILIENCE

I am looking for male 18+ volunteers living in active recovery to take part in a study entitled:

"How Do Men That Identify As "In Recovery" From Substance Use Related Issues Demonstrate Resilience and Navigate Challenges"

You would be asked to complete a short demographic questionnaire and participate in a semi-structured interview on your experiences in recovery lasting approximately 60-90 minutes in duration.

In appreciation for your time, you will receive a $25 Walmart gift card as a thank you for participating. You can also have access to a summary of study results Information collected will be kept strictly confidential by the researcher. Wayside House staff will not be made aware of your participation in the study and participation will not compromise any services received.

For more information about this study, or to volunteer for this study, please contact:

Jason Palmer
Student Researcher
McMaster School of Social Work
647-200-4282
Email: palmej3@mcmaster.ca

This study has been reviewed by and received ethics clearance from the McMaster University Research Ethics Board.

Appendix B

"How Do Men That Identify As "In Recovery" From Substance Use Related Issues Demonstrate Resilience and Navigate Challenges"

Participant screening form

Thank you for your interest in my research study I would like to invite you to complete this short screening form.

INSTRUCTIONS:

1. I identify as a male…
[ ] Yes
[ ] No
[ ] Prefer not to say

2. I'm 18 years of age or older…
[ ] Yes
[ ] No
[ ] Prefer not to say

3. I am able to understand English…
[ ] Yes
[ ] No
[ ] Prefer not to say

4. I identify as "in recovery" from substance use related issues…
[ ] Yes
[ ] No
[ ] Prefer not to say

5. I have completed treatment for substance use within the past 2 years…
[ ] Yes
[ ] No
[ ] Prefer not to say

Please hand this brief information sheet to the student researcher upon completion. Thanks.

Appendix C

Consent to record participant screening information

Participant Number	Consent Given	Date Received

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Appendix D

"How Do Men That Identify As "In Recovery" From Substance Use Related Issues Demonstrate Resilience and Navigate Challenges"

Student Researcher: Jason Palmer

Oral Participant Study Description Script

Verbal phone script: Introduction: Hello. I'm *Jason Palmer.* I am following up on your interest to participate in a study I am conducting about resilience in the context of substance use recovery. I'm doing this study this as part of research for my Master's Degree Thesis at McMaster University's School of Social Work in Hamilton, Ontario Canada. I'm working under the direction Dr. Randy Jackson of McMaster's School of Social Work.

Study procedures: I will invite you to participate in a one-on-one interview that will take about 60-90 minutes in duration. This interview will take place in the community at a location determined by you, at a place you feel safe and comfortable. I will be asking you to complete a short demographic questionnaire and questions about your experiences in recovery, challenges, goals etc. Some of the sample questions include:

What are some of the challenges you currently face?
How are you managing these challenges?
What supports do you currently have in place?
What goals do you have for the future?

I will use an audio recorder to make sure I don't miss what you say for clarity, accuracy and analysis purposes. We can set up a time and place that works for us both.

Are there any risks to doing this study? It is not my intent to cause any harms, risks or discomforts during the interview process however, when discussing some of the private details of your life such as challenges and history you may feel uncomfortable or anxious. You do not need to answer questions that you do not want to answer or that make you feel uncomfortable and you are free to stop the interview process or take breaks at any point.

Benefits: It is unlikely that there will be direct benefits to you; however, by better understanding your experiences with resilience in recovery I am hopeful that it will encourage further research in the field.

I will keep the information you tell me during the interview confidential. Information I put in my report that could identify you will not be published or shared. Any data from this research which will be shared or published will be the combined data of all participants. That means it will be reported for the whole group not for individual persons. Wayside House staff will not be made aware of your participation in the study and no services will be compromised. It is however

possible that we can be identified through the stories that we share so please keep this in mind when answering interview questions and do not share anything that you do not feel comfortable with.

Voluntary participation:

- Your participation in this study is voluntary.
- You can decide to stop at any time, even part-way through the interview for whatever reason.
- If you decide to stop participating, there will be no consequences to you.
- If you decide to stop we will ask you how you would like us to handle the data collected up to that point. This could include returning it to you, destroying it or using the data collected up to that point.
- If you do not want to answer some of the questions you do not have to, but you can still be in the study.
- If you have any questions about this study or would like more information you can call or email Jason Palmer at **(647) 200-4282** or palmej3@mcmaster.ca

This study has been reviewed and cleared by the McMaster Research Ethics Board. If you have concerns or questions about your rights as a participant or about the way the study is conducted, you may contact:

McMaster Research Ethics Board Secretariat
Telephone: (905) 525-9140 ext. 23142
c/o Research Office for Administration, Development & Support (ROADS)
E-mail: ethicsoffice@mcmaster.ca

I would be pleased to send you a short summary of the study results when I finish going over our results. Please let me know if you would like a summary and what would be the best way to get this to you.

Consent questions:

- Do you have any questions or would like any additional details?
- Can we set up a time for an interview at your earliest convenience?

Appendix F

"How Do Men That Identify As "In Recovery" From Substance Use Related Issues Demonstrate Resilience and Navigate Challenges"

Student Researcher: Jason Palmer

Instructions for participants

Introduction: Thank you for participating in my study on resilience and recovery. I would like to go over the following documents together. Attached, you will find:

1. An study information form for your review
2. A consent form for participation
3. A copy of the demographic questionnaire
4. An interview guide listing the questions I would like to ask
5. A list of local support services if required

Study procedures: The first step will be for us to go over the information form and should you agree to participate complete the consent form. Following this, I will invite you to complete the demographic form and participate in a one-on-one interview that will take approximately 60-90 minutes in duration. I will use an audio recorder to make sure I don't miss what you say for clarity, accuracy and analysis purposes.

Upon completion of the interview we can review how the interview went and you will have an opportunity to add anything you think I may have missed. If you are experiencing any concerns having discussed your personal experiences with me during the interview process we will have an opportunity to debrief and look at next steps as needed.

Questions:

- Do you have any questions before we begin?
- Can we start with the study information and consent forms? (with participant's permission review these documents together)
- Can we complete the participant demographic questionnaire? (With participant's permission researcher and participant to complete the questionnaire)
- Can I start the audio recording process and begin the interview? (With participant's permission, initiate the audio recording and begin the interview).

DATE: _____

APPENDIX G

LETTER OF INFORMATION / CONSENT

A Study about "How Do Men That Identify As "In Recovery" From Substance Use Related Issues Demonstrate Resilience And Navigate Challenges"

Student Investigator: Jason Palmer
School of Social Work
McMaster University
Hamilton, Ontario, Canada
(905) 525-9140 ext. 23795
Cell 647-200-4282
E-mail: palmej3@mcmaster.ca

Purpose of the Study: The purpose of this study is to explore the experiences of men in recovery. The addiction community is undervalued, severely misunderstood and is forced to endure stigma. My research aims to explore recovery in a positive way and discuss the many successes and obstacles experienced within the community. My research will ask questions around how men in recovery establish community, reframe their identities and maintain positive qualities such as perseverance, resiliency, empathy, compassion and caring in the face of such adversity.

What will happen during the study?] You will be asked to answer a short questionnaire involving the disclosure of some background information on your demographics. You will then be asked to participate in a semi structured interview roughly 60-90 minutes in duration. Interviews will take place in the community at a location determined by you, at a place you feel safe and comfortable. I will be asking you questions about your experiences in recovery, challenges, goals etc. Some of the sample questions include:

- What are some of the challenges you currently face?
- How are you managing these challenges?
- What supports do you currently have in place?
- What goals do you have for the future?

With your permission, this interview will be audio recorded for transcription and analysis purposes.

Potential Harms, Risks or Discomforts: It is not my intent to cause any harms, risks or discomforts during the interview process however, when discussing some of the private details of your life such as challenges and history you may feel uncomfortable or anxious.

You do not need to answer questions that you do not want to answer or that make you feel uncomfortable and you are free to stop the interview at any point and take any breaks from the process that you desire.

Potential Benefits: While there are no direct benefits to your participation in this study, findings from this study will contribute to my understanding of resiliency in the context of substance use and may stimulate further research in this area.

Payment or Reimbursement: As a small token of appreciation for your participation in this study I would like to offer you a $25 Walmart gift card.

Confidentiality You are participating in this study confidentially. I will not use your name or any information that would allow you to be identified…No one but I will know whether you were in the study unless you choose to tell them. Wayside House staff will not be made aware of your participation in the study and no services will be compromised. As I will be quoting some of your interview answers directly in my research analysis, it is sometimes possible that we can be identified by the stories that we tell, so please consider this when answering my interview questions and feel free to skip anything that you do not wish to answer or that you feel may jeopardize your anonymity. The information/data you provide will be kept in a locked desk where only I will have access to it. Information kept on a computer will be encrypted and protected by a password. All audio recordings and their transcriptions will be erased/shredded by October 1, 2019.

Participation and Withdrawal: What if I change my mind about being in the study? Your participation in this study is voluntary. If you decide to be part of the study, you can stop (withdraw), from the study at any time for whatever reason. If you decide to withdraw, there will be no consequences to you and you may keep the gift card. In the case of your withdrawal, any data you have provided will be destroyed unless you indicate otherwise. If you do not want to answer some of the questions you do not have to, but you can still be in the study.

Information about the Study Results: I expect to have this study completed by approximately August 2019. If you would like a brief summary of the results, please let me know how you would like it sent to you.

Questions about the Study: If you have questions or need more information about the study itself, please contact me at:

Jason Palmer
Palmej3@mcmaster.ca
647-200-4282

This study has been reviewed by the McMaster University Research Ethics Board and received ethics clearance. If you have concerns or questions about your rights as a participant or about the way the study is conducted, please contact:

McMaster Research Ethics Secretariat
Telephone: (905) 525-9140 ext. 23142
C/o Research Office for Administrative Development and Support
E-mail: ethicsoffice@mcmaster.ca

CONSENT

- I have read the information presented in the information letter about a study being conducted by Jason Palmer of McMaster University.
- I have had the opportunity to ask questions about my involvement in this study and to receive additional details I requested.
- I understand that if I agree to participate in this study, I may withdraw from the study at any time.
- I have been given a copy of this form.
- I agree to participate in the study.

Signature: _____

Date: _____

Name of Participant (Printed) _____

1. I agree that the interview can be audio recorded.
[ ] Yes
[ ] No

2. [ ] Yes, I would like to receive a summary of the study's results.
Please send them to me at this email address
_____
Or to this mailing address:
_____

_____

_____
[ ] No, I do not want to receive a summary of the study's results.

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Appendix H

"How Do Men That Identify As "In Recovery" From Substance Use Related Issues Demonstrate Resilience and Navigate Challenges"

Demographic Information Sheet

Please do not write your name on this sheet

INSTRUCTIONS: Please fill in this that will provide me with some basic background information about you. You do not have to answer any questions you do not feel comfortable answering. I am here to answer any questions you may have.

Date_____

Participant Number:_____ (All participants will be issued a participant number for compensation purposes to ensure the protection of your identity)

1. I identify as a male:
   [ ] Yes
   [ ] No
   [ ] Prefer not to say

2. My age is _____ years old.

3. I identify my ethic background as:_____

4. I identify my sexual orientation as:
   [ ] Heterosexual
   [ ] Gay
   [ ] Bisexual
   [ ] Transgendered
   [ ] Other_____

5. I identify my relationship status as:
   [ ] Single
   [ ] Married/common law
   [ ] Divorced
   [ ] Seperated
   [ ] Widowed
   [ ] Other_____

6. My current employment status is:
   [ ] Employed _____time.
   [ ] Not currently employed
   [ ] Leave of Absence
   [ ] Student
   [ ] Other_____

7. My current approximate annual income is:
   [ ] Less than $25,000
   [ ] $25,000-$40,000
   [ ] $40,000-$55,000
   [ ] $55,000-$70,000
   [ ] $70,000-$85,000
   [ ] $85,000-$100,000
   [ ] More than $100,000

8. My highest level of education attended (but not necessarily completed) is:
   [ ] High school
   [ ] College
   [ ] University
   [ ] Graduate School
   [ ] Trade School
   [ ] Prefer not to say

9. I currently reside in _____ (city)

10. The substance(s) I identify having an issue with is (check all that apply)
    [ ] Alcohol
    [ ] Cannabis
    [ ] Cocaine/ Crack cocaine
    [ ] Opiates (heroin, fentanyl etc.)
    [ ] Methamphetamine
    [ ] Other

11. The age that I started using this substance(s) was:_____

12. The age I identify the substance(s) became problematic was:

    _____

13. The age I first attempted recovery was:_____

Please hand this brief information sheet to the student researcher upon completion. Thank you.

Appendix I

"How Do Men That Identify As "In Recovery" From Substance Use Related Issues Demonstrate Resilience and Navigate Challenges"

Interview Guide

Information about these interview questions: This document is intended to give you an idea as to what I would like to explore during the interview process. Interviews will be one-to-one and will be open-ended. Because of this, the exact wording may change a little. Sometimes I will use other short questions to make sure I understand what you told me or if I need more information when we are talking such as: "So, you are saying that?", to get more information "Please tell me more about?", or to learn what you think or feel about something "Why do you think that is?". If at any point you do not feel like answering a question or would like to stop the interview, please let me know.

History:

1. Can you provide me with a summary of the onset of your substance use?
2. Can you tell me how your substance use progressed from onset to more intense use?
3. What was this time like for you?
4. What were some of the challenges you faced in active addiction?
5. What made you think about treatment?

Treatment:

1. If this is not your first recovery experience can you tell me about your first recovery experience?
2. What challenges did you face?
3. If this is not your first attempt at recovery what worked, what did not work in previous attempts?
4. Thinking about your most current treatment, what brought you into treatment at this time?

Recovery:

1. Can you tell me a little bit about your recovery?
2. What are some of the challenges you currently face in your recovery?
3. How are you managing these challenges?
4. What qualities do you think you possess that are helping you manage these challenges?

5. What supports do you currently have in place?
6. How do you cope with stress?
7. How do you deal with emotions?
8. Is self-care important to you? If so, how do you manage it?

Future:

1. What goals do you have for the future?
2. How confident do you feel in your ability to achieve these goals?
3. What challenges do you anticipate?
4. How might you handle these challenges?

Checking in:

1. Do you have anything else you would like to add or that you think is important for me to know?
2. How was this interview process for you?
3. Would you like a list of supports?

The End

I would like to take this opportunity to thank you for your participation in this research study. Once more, I would like to reassure you that this information will be kept in the strictest of confidence in accordance to the guidelines that I explained during the completion of your consent form.

Jason Palmer

Appendix J

Compensation Log

Participant Number	Gift Card Received	Date Received

Appendix K

Jason Palmer
Research Student
School of Social Work
McMaster University
Hamilton, Ontario, Canada
(905) 525-9140 ext. 23795

January 25, 2019

Dear Participant:

I would like to take this opportunity to offer my sincerest thank you for participating in this study about recovery and resilience. I acknowledge that your participating in this study was time consuming and may have asked a lot of you. I value the time you committed to this research project and your willingness to provide your personal expertise.

I appreciate your honesty and openness in answering the extremely personal nature of my questions and sharing your experiences with me. Your contribution to this research is invaluable in furthering my understanding of resiliency in the context of persons living in recovery. I am hopeful that your contribution to my study will contribute to further research in this field.

I would like to remind you that all information collected is confidential and I will be providing a research summary to all interested participants following the completion of the research study.

Please accept this $25 gift card as a token of my appreciation.

Thank you very much again for your participation and for your contribution to my research.

Sincerely,

Jason Palmer

Appendix L

"How Do Men That Identify As "In Recovery" From Substance Use Related Issues Demonstrate Resilience and Navigate Challenges"

Student Researcher: Jason Palmer

Counselling Services Information Sheet

- ***Here is a list of services where you can find someone to talk to, if you have something on your mind.***
- ***I would also encourage you to touch base with your primary counsellor here at Wayside House as needed.***

HAMILTON:

Distress Centre Hamilton

The Distress Centre Hamilton offers 24-hour telephone support, crisis intervention, and referral to other agencies where appropriate, for people in distress. This Centre is staffed by trained volunteers.
24 Hour Crisis Line: You will speak to a trained volunteer. The line may be busy at times, but this number is in service. 905-522-8611

Catholic Family Services Walk in Counselling:

Address: 460 Main St. E. 4th floor
Tel. 905-527-3823 ex 279
Web: www.cfshw.com
Walk in Hours Tuesday's 12:00pm-6:30pm no appointment necessary

COAST Crisis Line:

Tel. 905-972-8338
Web: www.coasthamilton.ca

Salvation Army 24-Hour Suicide Hotline:

Tel. 905-522-1477
Web: www.hopesalive.ca

Appendix: M

Oath of Confidentiality

I understand that as a:
[X] student researcher
[ ] interpreter
[ ] transcriber
[ ] audio assistant
[ ] photo or video assistant
[ ] research assistant
[ ] other (*Please specify*) _____

I, Jason Palmer of the Department of Social Work at McMaster University under the supervision of Professor Randy Jackson, do maintain that all confidential information such as participant's names, employers, and other identifying information made known to me will be held in the strictest of confidence and not disclosed to any other person.

[X] I agree to keep all information collected during this study confidential and will not reveal by speaking, communicating or transmitting this information in written, photographic, sound, electronic (disks, tapes, transcripts, email) or in any other way to anyone outside the research team.

[X] I will disclose to my thesis supervisor Randy, as soon as I discover that I know any participant either as a family member, friend, or acquaintance or in any other way; so that the researcher can take the appropriate steps to manage or minimize any conflicts of interest that might occur because of any dual roles I may have.

Name: Jason Palmer Signature: Jason Palmer
(Please Print)

Date: January 25, 2019

Witness Name: _____ Witness Signature: _____
(Please Print)

Appendix N

"How Do Men That Identify As "In Recovery" From Substance Use Related Issues Demonstrate Resilience and Navigate Challenges"

Student Researcher: Jason Palmer

Oral Presentation Script

Verbal presentation script introduction: Hello. I'm *Jason Palmer* a Social Work student at McMaster University. I am working on research for my Masters of Social Work thesis. I have decided to design a study about resilience in the context of substance use recovery. I'm working under the direction Dr. Randy Jackson of McMaster's School of Social Work. I have spoken with the Chief Executive Officer about my desire to involve this treatment centre with my research and he has graciously allowed me to engage with you today to inquire as to whether any of you may be interested in participation in my study. With your permission I would like to pass out a handout describing my study, go over this together and answer any questions you may have.

Hand out recruitment poster and review its contents with treatment centre clients:

Questions: I would like to ask if there are any questions about the study, your participation or anything else that you would like to know?

Next Steps: I have included my contact information on the study handout. If you are interested in participating feel free to contact me at your earliest convenience either via email (review email address) or telephone (review telephone number) and we can discuss further details about the study and any questions you may have. I would like to thank you for your time in giving me this opportunity to share my research study with you today and if this is something you are interested in I look forward to hearing from you. Thanks again.

McMaster University

Appendix O

McMaster University Research Ethics Board (MREB)

FACULTY/GRADUATE/UNDERGRADUATE/STAFF

APPLICATION TO INVOLVE HUMAN PARTICIPANTS IN RESEARCH

[Behavioural / Non-Medical]

Date: January 24, 2019	Application Status: New: [X] Change Request: [ ]	Protocol #:

Helpful Hints **Mouse over bold blue hypertext links for help with completing this form.**

- **Use the most recent version of this form.**
- **Refer to the McMaster University < Research Ethics Guidelines and Researcher's Handbook >, prior to completing and submitting this application.**
- **For <help> with completing this form or the ethics review process, contact the Ethics Secretariat at ext. 23142 or ethicsoffice@mcmaster.ca**
- **To change a previously cleared protocol, please submit the "< Change Request >" form.**

PLEASE SUBMIT YOUR APPLICATION PLUS SUPPORTING DOCUMENTS (scanned PDF signed signature page) BY E-MAIL

You can also send the signed signature page to: **Ethics Secretariat, Research Office for Administration, Development and Support (ROADS), Room 305 Gilmour Hall, ext. 23142**, ethicsoffice@mcmaster.ca.

SECTION A – GENERAL INFORMATION

1. Study Titles: (Insert in space below)

Title: "How Do Men That Identify As "In Recovery" From Substance Use Related Issues Demonstrate Resilience And Navigate Challenges"
1a: **Grant Title:** *(Required for funded research. Click this < **link** > to determine your "grant title").*

2. **Investigator Information:** **This form is not to be completed by < Faculty of Health Science researchers > .**

***Faculty and staff information should be inserted above the black bar in this table.**
Student researcher and faculty supervisor information should be inserted below the black bar in the table below.

	Full Name	Department *& or name of university if different from McMaster*	Telephone Number(s) *& Extension(s)*	McMaster E-mail Addresses
Principal Investigator*				
Co-Investigator(s) *(Insert additional rows as required.)*				
Research Assistants or Project Coordinators*				
Student researchers provide contact information below.				
Student Investigator(s)*	Jason Palmer	Social Work MSW Student	647-200-4282	palmej3@mcmaster.ca
Faculty Supervisor(s)*	Randy Jackson	Social Work	416-702-6745	Jacksr3@mcmaster.ca

3. **Study Timelines:** *(Contact the Ethics Secretariat at X 23142 or ethicsoffice@mcmaster.ca for urgent requests.)*

(a) What is the date you plan to begin recruiting participants or obtain their permission to review their private documents (Provide a specific date)? March 1, 2019

(b) What is the estimated last date for data collection with human participants? March 31, 2019

4. **Location of Research**: List the location(s) where research will be conducted. Move your mouse over this **< Helpful Hint >** for more information on foreign country or school board reviews and contact the Ethics Office at X 23142 or 26117 for information on possible additional requirements. ***Click "Tips and Samples"*** to find a guidance sheet entitled "*Research with Human Participants Conducted through School Boards*".

(a) McMaster University **[ ]**
(b) Community **[X]** Specify Site(s) Substance Use treatment Centre supportive housing program.
(c) Hospital **[ ]** Specify Site(s)
(d) Outside of Canada **[ ]** Specify Site(s)
(e) School Boards **[ ]** Specify Site(s)
(f) Other **[ ]** Specify Site(s)

GENERAL INSTRUCTIONS AND HELPFUL TIPS (Please read first):

Please be as **clear** and **concise** as possible and **avoid technical jargon**. Keep in mind: your **application could be read by reviewers who may not be specialists in your field**. Feel free to **use headings, bolding and bullets** to organize your information. **Content boxes expand** on this application form. Supporting documents accompany this form.

5. **Other Research Ethics Board Clearance**

(a) Are researchers from outside McMaster also conducting this research? If **yes**, please provide their information in Section 2 above. **[ ] Yes [X] No**

(b) Has any other institutional Research Ethics Board already cleared this project? **[ ] Yes [X] No**

(c) If **Yes** to (5b), complete this application and provide a copy of the ethics clearance certificate /approval letter.

(d) Please provide the following information:

Title of the project cleared elsewhere: N/A
Name of the other institution:
Name of the other board:
Date of the other ethics review board's decision:
Contact name & phone number for the other board:

(e) Will any other Research Ethics Board(s) or equivalent be asked for clearance? **[ ] Yes [X] No**

If yes, please provide the name and location of board(s).

N/A

6. **Research Involving Canadian Aboriginal Peoples** i.e., First Nations, Inuit and Métis (Check all that apply)

(a) Will the research be conducted on Canadian Aboriginal lands? **[ ] Yes [X] No**

(b) Will recruitment criteria include Canadian Aboriginal identity as either a factor for the entire study or for a subgroup in the study? **[ ] Yes [X] No**

(c) Will the research seek input from participants regarding a Canadian Aboriginal community's cultural heritage, artifacts, traditional knowledge or unique characteristics? **[ ] Yes [X] No**

(d) Will research in which Canadian Aboriginal identity or membership in an Aboriginal community be used as a variable for the purpose of analysis of the research data? **[ ] Yes [X] No**

(e) Will interpretation of research results refer to Canadian Aboriginal communities, peoples, language, history or culture? **[ ] Yes [X] No**

If "Yes" was selected for any questions 6.a-6.e above, please note that the TCPS (Chapter 9) requires that researchers shall offer the option of engagement with Canadian Aboriginal communities involved in the research. http://www.pre.ethics.gc.ca/eng/policy-politique/initiatives/tcps2-eptc2/chapter9-chapitre9/. For advice regarding TCPS guidelines for conducting research with Canadian Aboriginal peoples, please contact Senior Ethics Advisor at extension 26117.

(f) Please describe the nature and extent of your engagement with the Aboriginal community(s) being researched. The nature of community engagement should be appropriate to the unique characteristics of the community(s) and the research. The extent of community engagement should be determined jointly by the researchers and the relevant communities. Include any information/advice received from or about the Aboriginal community under study. ***The TCPS notes; "although researchers shall offer the option of engagement, a community may choose to engage nominally or not at all, despite being willing to allow the research to proceed". If conducted research with several Aboriginal communities or sub-groups, please use headings to organize your information.***
ATTACHMENTS: Provide copies of all documents that indicate how community engagement has been or will be established (e.g., letters of support), where appropriate.

N/A

(g) Has or will a research agreement be created between the researcher and the Aboriginal community? **[ ] Yes [X] No**

If **yes**, please provide details about the agreement below (e.g., written or verbal agreement etc.).
ATTACHMENTS: Submit a copy of any written research agreements, if applicable. See the MREB website for a sample customizable research agreement by clicking Tips and Samples".

N/A

(h) Are you are seeking a waiver of the community engagement requirement? (A waiver may be granted if the REB is satisfied that, Aboriginal participants will not be identified with a community or that the welfare of relevant communities will not be affected by the research.) **[ ] Yes [X] No**

If **yes,** please provide the rationale for this waiver request in the space below.

N/A

7. **Level of the Project** (Check all that apply)

[ ] Faculty Research **[ ]** Post-Doctoral **[ ]** Ph.D. **[ ]** Staff/Administration
[ ] Master's (Major Research Paper - MRP) **[X]** Master's (Thesis)
[ ] Undergraduate (Honour's Thesis) **[ ]** Undergraduate (Independent Research)
[ ] Other (specify)

8. **Funding of the Project**

(a) Is this project currently being funded? **[ ] Yes [X] No**
(b) If **No**, is funding being sought? **[ ] Yes [X] No**
(c) Period of Funding: **From: [ ]** (mm/dd/yyyy) **To: [ ]** (mm/dd/yyyy)

(d) Funding agency (funded or applied to) & agency number (i.e., number assigned by agency), if applicable.
Click this < link > first, to sample notification letters to help determine your "*agency number*".
(This is not your PIN number).

[ ] CIHR & agency #
[ ] NSERC & agency #
[ ] SSHRC & agency #
[ ] ARB (No number req.)
[ ] Health Canada & agency #
[ ] CFI & agency #
[ ] Canada Graduate Scholarship & Agency #
[ ] Post Graduate Scholarship & Agency #
[ ] Other agency (*Specify*) # (if applicable)
[ ] Undergraduate Student Research Award (no number req.)

(e): Are you requesting ethics clearance for a research project that was not originally designed to collect data from human participants or their records (i.e., your research project originally did not involve collecting data from humans or their records) but you now intend to do so?

[ ] Yes [X] No

9. **Conflicts of Interest**

(a) Do any researchers conducting this study, have multiple roles with potential participants (e.g., acting as both researcher and as a therapist, health care provider, family member, caregiver, teacher, advisor, consultant, supervisor, student/student peer, or employer/employee or other dual role) that may create real, potential, or perceived conflicts, undue influences, power imbalances or coercion, that could affect relationships with others and affect decision-making processes such as consent to participate?

[ ] Yes [X] No

(i) If **yes**, please describe the multiple roles between the researcher(s) and any participants.

N/A

(ii) Describe how any conflicts of interest identified above will be avoided, minimized or managed.

N/A

(b) Will the researcher(s), members of the research team, and/or their partners or immediate family members:

(i) receive any personal benefits (for example a financial benefit such as remuneration, intellectual property rights, rights of employment, consultancies, board membership, share ownership, stock options etc.) as a result of or being connected to this study?

[ ] Yes [X] No

(ii) If **yes**, please describe the benefits below. (Do not include conference and travel expense coverage, possible academic promotion, or other benefits which are integral to the conduct of research generally).

N/A

(c) Describe any restrictions regarding access to or disclosure of information (during or at the end of the study) that the sponsor has placed on the investigator(s), if applicable.

N/A

SECTION B – SUMMARY OF THE PROPOSED RESEARCH

10. **Rationale**

For the proposed research, please describe the *background* and the *purpose* concisely and in lay terms, as well as any overarching research questions or hypotheses to be examined.
***Please do not cut and paste full sections from your research proposal*.**

Background:
Purpose: Substance use related issues represent one of the most understudied and underappreciated areas of social work practice. The addiction community is undervalued, severely misunderstood and is forced to endure stigma. My research aims to explore recovery in a positive way and discuss successes and obstacles with men trying to traverse the many challenges of their lives in "recovery". My research will ask questions around how these individuals establish community, reframe their identities and maintain positive qualities such as perseverance, resiliency, empathy, compassion and caring in the face of such adversity.

11. **Participants**
For each type of study population, please use the space below to describe the:
(a) Approximate number of participants required for this study. Where applicable, please also provide a rationale for your choice in sample size and/or the sample size calculation (e.g., to explain how a low sample size will still provide meaningful results, or to justify the number of participants needed in research that includes significant risks).
(b) Salient participant characteristics (e.g., age, gender, location, affiliation, etc.) and any specific inclusion/exclusion criteria.
If researching several sub-populations, use a heading for each population and provide details for items (a) and (b).

There will be 6-8 participants sought for participation in this study. This sample size was selected due to the in depth nature of the qualitative interviewing and the subsequent transcriptions of the audio recorded interviews. This sample size will allow for a more detailed interview process and thematic data analysis. The researcher also consulted several research studies that involve a similar demographic and area of research and found that this was a frequently used sample size for qualitative research. Participants in this research project must be male, 18 years of age or older and self-identify as being "in recovery from substance use". Participants will also have completed residential treatment for substance use within the past 2 years and able to understand English.

12. **Recruitment**
Please describe in the space below:
(a) how each type of participant will be recruited,
(b) who will recruit each type of participant,
(c) relationships (if any) between the investigator(s) and participant(s) (e.g. instructor-student; manager-employee, family member, student peers, fellow club members, no relationship etc.),
(d) any permissions for your recruitment strategy(s) (if applicable) you have or plan to obtain for each type of participant. This should not be confused with obtaining a participant's consent to take part in your study.
If researching several sub-populations, use a heading for each study population and provide details for items (a) – (d). Click "Tips and Samples" to find the "How to Unpack the Recruitment Details" worksheet and other samples.
ATTACHMENTS: Provide copies of all recruitment posters, advertisements letters, flyers, and/or email scripts etc. and label these as appendices (e.g., Appendix A or 1).

Participants will be recruited through a residential substance use treatment centre's supportive housing program. The researcher will conduct a short verbal presentation using the recruitment poster (see appendix A) on the study prior to the weekly supportive housing meetings held at the treatment centre until 6-8 participants come forward that meet the researcher's inclusion criteria following a short screening questionnaire (see Appendix B). Consent for the researcher to assign a participation number for the compensation log and to protect participant identity will also be signed (see appendix C). Participants, who are interested in the study, will be directed to contact the student researcher directly. At this time, the study will be explained more fully and any questions answered (phone script Appendix D). Semi-structured interviews specifics will be arranged with participants during this contact session. I have consulted with the treatment centre's executive director and program manager regarding the recruitment process. No relationship between the researcher and the participants currently exists. A letter of support from the treatment agency is attached (see appendix E)

13. **Methods**

Describe sequentially, and in detail all data collection procedures in which the research participants will be involved (e.g., paper and pencil tasks, interviews, focus groups, lab experiments, participant observation, surveys, physical assessments etc. —*this is not an exhaustive list*). Include information about who will conduct the research (include tasks done by assistants translators, transcriptionists etc.), how long it will take, where data collection will take place, and the ways in which data will be collected (e.g., computer responses, handwritten notes, audio/video/photo recordings etc**.)**.
If your research will be conducted with several sub-populations or progress in successive phases; use sub-headings to organize your description of methodological techniques.
ATTACHMENTS: Provide copies of all questionnaires, interview questions, test or data collection instruments etc. Label supporting documents as appendices (e.g., Appendix A or 1) and submit them as separate documents - not pasted into this application.
Click "Tips and Samples" to find the "How to Unpack the Methods" worksheet and other samples.
Click < here > to find the MREB recommended, designed and free online survey service to help you protect participant confidentiality.

During the interview process, participants will be provided with instructions (see Appendix F) and an information sheet (see Appendix G). Participants must consent to their participation in the study (see consent form appendix G). Participants will be asked to complete a short participant demographic questionnaire (see Appendix H) and then participate in a semi-structured interview conducted by the student researcher lasting approximately 60-90 minutes in duration (see Appendix I). Interviews will take place in the community at a location determined by the participant, as a place they feel safe and comfortable. With participant's permission, all interviews will be audio recorded and transcribed verbatim by the student researcher for analysis purposes, clarity and accuracy. Participant names will be altered to protect the confidentiality of all participants within the study.

14**. Secondary Use of Identifiable Data** *(e.g. the use of personally identifiable data of participants contained in records that have been collected for a purpose other than your current research project)*:

(a) Do you plan on using identifiable data of participants in your research for which the original purpose that data was collected is different than the purpose of your current research project? **[ ] Yes [X] No**
If **yes**, please answer the next set of questions:
(b) Do you plan to link this identifiable data to other data sets? **[ ] Yes [X] No**
If **yes,** please describe in the space below:

N/A

(c) What type of identifiable data from this data set are you planning to access and use?
[ ] Student records (please specify in the space below)
[ ] Health records/clinic/office files (please specify in the space below)
[ ] Other personal records (please specify in the space below)

N/A

(d) What personally identifiable data (e.g., name, student number, telephone number, date of birth etc.) from this data set do you plan on using in your research? Please explain why you need to collect this identifiable data and justify why each item is required to conduct your research.

N/A

(e) Describe the details of any agreement you have, or will have, in place with the owner of this data to allow you to use this data for your research. ***ATTACHMENTS: Submit a copy of any data access agreements.***

N/A

(f) When participants first contributed their data to this data set, were there any known preferences expressed by participants at that time about how their information would be used in the future? **[ ] Yes [X] No**
If **yes**, please explain in the space below.

N/A

(g) What is the likelihood of adverse effects happening to the participants to whom this secondary use of data relates? Please explain.

N/A

(h) Will participants whose information is stored in this data set (which you plan to use for secondary purposes) consent to your use of this data? **[ ] Yes [X] No**

Please explain in the space below.

N/A

15. **Research Database**

Does your research involve the creation and/or modification of a research database (databank) containing human participant information? A research database is a collection of data maintained for use in ***future*** research. The human participant information stored in the research database can be identifiable or anonymous.

[ ] Yes [X] No

If "Yes" was answered to the above question, you will need to fill out and submit MREB's "Supplementary Form for Creating or Modifying a Research Database Containing Human Participant Information" along with this application.

NOTE: If you intend to collect or store personally-identifying health information, now or at a later stage in your research, your protocol must be cleared by Hamilton Integrated Research Ethics Board (HiREB) rather than MREB. For further advice contact MREB at X 23142 or X 26117 or HIREB x 905 521-2100 X 44574.

16. **Experience**

What is your experience with this kind of research? Include information on the experience of all **individual**(s) who will have contact with the research participants or their data. ***For example, mention your familiarity with (a) the proposed methods, (b) the study population(s) and/or (c) the research topic.***

My experience with this type of research is limited. I have a conceptual understanding of the proposed methods and the guidance and support of my thesis supervisor to ensure that my methods remain intact and in line with the research proposal. I am familiar with the study population as I have previously worked in the addictions field for more than 12 years in various capacities. I am also familiar with the research topic as I have written several papers on various aspects of this topic during my undergraduate degree and in Graduate school.

17. **Compensation**

	Yes	**No**
(a) Will participants receive compensation for participation?	**[X]**	**[ ]**
Financial	**[ ]**	**[ ]**
Other (specify)	**[X]**	**[ ]**

(b) If yes was answered for any of the above choices, please provide details. **See < Helpful Hints > for funded research projects.**

Participants will receive a small token of appreciation for their agreed participation in the research project. This will be a $25 gift card for Tim Horton's/ Walmart Etc. Compensation will be tracked using a compensation log (see appendix J) Participants will also be issued a letter of appreciation from the researcher for sharing their expertise (see appendix K).

(c) If participants choose to withdraw, how will you deal with their compensation?

Participants that withdrawal at any point during the research process will still receive their compensation.

SECTION C – DESCRIPTION OF THE RISKS AND BENEFITS OF THE PROPOSED RESEARCH

18. **Possible Risks**
(a) Indicate if the participants might experience any of the following risks:

i.) Physical risk (including any bodily contact or administration of any substance)? **[ ] Yes [X] No**

ii.) Psychological risks (including feeling demeaned, embarrassed worried or upset)? **[X] Yes [ ] No**

iii.) Social risks (including possible loss of status, privacy and / or reputation as well as economic risks)? **[X] Yes [ ] No**

iv.) Are any possible risks to participants greater than those the participants might encounter in their everyday life? **[ ] Yes [X] No**

(b) If you checked **yes** for any of questions **i – iv** above, please describe the risk(s) in the space below.

Participants may experience psychological and social distresses when discussing the intimate details of their lives. Often times in the addiction field discussing one's personal journey may involve the re-experiencing of trauma, grief and losses associated with their experiences.

(c) Management of Risk: Describe how each of the risks identified above will be managed or minimized. Please, include an explanation regarding why alternative approaches cannot be used.

Participants will be reminded that they are able to withdraw from the study at any time and the researcher will refer participants to their primary counsellor and a list of resources for crisis counselling (see appendix L) if further support is required.

(d) Deception: Is there any deception involved in this research? **[ ] Yes [X] No**

i.) If deception is to be used in your methods, describe the details of the deception (including what information will be withheld from participants) and justify the use of deception.

N/A

ii.) Please describe when participants will be given an explanation about why deception was used and how they will be debriefed about the study (for example, a more complete description of the purpose of the research). ***ATTACHMENTS: Please provide a copy of the written debriefing form or script, if applicable.***

N/A

19. **Possible Benefits**
Discuss any potential benefits to the participants and or scientific community/society that justify involvement of participants in this study. (***Please note: benefits should not be confused with compensation or reimbursement for taking part in the study*).**

Participants will not directly benefit from their participation. However, they will be made aware that findings from this study will contribute to our understanding of resiliency in the context of substance use and that such may stimulate further research.

SECTION D – THE INFORMED CONSENT PROCESS
20. **The Consent Process**
(a) Please describe how consent will be documented. Provide a copy of the Letter of Information / Consent Form (if applicable). If a written consent form will not be used to document consent, please explain why and describe the alternative means that will be used. While oral consent may be acceptable

in certain circumstances, it may still be appropriate to provide participants with a Letter of Information to participants about the study.
Click "Tips and Samples" for the McMaster REB recommended sample "Letter of Information / Consent Form", to be written at the appropriate reading level. The "*Guide to Converting Documents into Plain Language" is also found under *"Tips and Samples".
ATTACHMENTS: Provide a copy of the Letter of Information and Consent form(s) or oral or telephone script(s) to be used in the consent process for each of your study populations, where applicable.

Participants will be reminded of the following: (1) participation is voluntary and informed via the letter of information and the informed consent form; (2) Participants may withdraw at any point in the study or simply refuse to answer any question asked of them during the interview process; (3) that the interview will be audio-recorded and transcribed; (4) that they will receive a gift card of $25 to honour the expertise they provide; and (5) and that, if they desire, will receive a summary of research findings. A copy of the Letter of Information and Informed Consent form are attached as Appendix G

(b): Please describe the process the investigator(s) will use to obtain informed consent, including who will be obtaining informed consent. Describe plans for on-going consent, if applicable.

Following recruitment, when a possible participant makes contact, the student researcher will go over all details of the study (as described in the Letter of Information and the Informed Consent Form) and any question answered. If the participant wishes to attend and provide an interview, the letter of information and the consent form will again be reviewed (by the Student Researcher) and any further questions answered. Prior to the interview, the participant will be asked to agree and sign the consent form in-person.

21. **Consent by an authorized person**
If participants are minors or for other reasons are not competent to consent, describe the proposed alternate consent process. ***ATTACHMENTS: Attach the Letter of Information and Consent form(s) to be provided to the person(s) providing the alternate consent. Click "Tips and Samples" to find samples.***

The researcher does not intend to recruit participants who are minors (i.e., all participants must be at least 18 years of age or older) or who are otherwise not competent to provide informed consent.

22. **Alternatives to prior individual consent**
If obtaining written or oral documentation of an individual participant's consent prior to start of the research project is not appropriate for this research, please explain and provide details for a proposed alternative consent process. ***ATTACHMENTS: Please provide any Letters of Information and or Consent Forms.***

No alternative to prior individual consent is anticipated or planned.

23. **Providing participants with study results**
How will participants be able to learn about the study results (e.g., mailed/emailed brief summary of results in plain language; posting on website or other appropriate means for this population)?

If desired by the participant, a short one-page written summary of findings will be prepared and disseminated via mail/e-mail to participants. Participants will be asked in the "informed consent" form whether they wish to receive summaries and how they wish to receive them (printed and mailed or emailed, etc.)

24. **Participant withdrawal**
a) Describe how the participants will be informed of their right to withdraw from the project. Describe the procedures which will be followed to allow the participants to exercise this right.

Participants will be informed that their participation is voluntary and that they have of their right to withdraw at any point during the study. Finally, participants will be informed that if they decide to withdraw, they will not face any negative consequences and will still receive the gift-card promised to all participants.

b) Indicate what will be done with the participant's data and any consequences which withdrawal might have on the participant, including any effect that withdrawal may have on the participant's compensation or continuation of services (if applicable).

If a participant withdraws from the study at any point in the research process, the data they have provided will be removed from the analysis. All audio-recordings and/or transcripts will be shredded and destroyed. Again, the $25 gift card given as compensation to participants is theirs to keep, regardless of their withdrawal from the study. Continuation of service is not applicable.

c) If the participants will not have the right to withdraw from the research, please explain.

N/A

25**. SECTION E – CONFIDENTIALITY, ANONYMITY AND DATA SECURITY:**

The level of confidentiality and anonymity promised to participants can vary during different stages in the life cycle of the research (i.e., recruitment, consent, data collection, providing compensation or incentives, data preparation and analysis, data transfer/movement) if applicable), data storage, dissemination of research findings and the final disposition of study documents (archiving or secure destruction, as applicable).

Confidentiality concerns the responsibility for the protection, privacy and security of information entrusted to researchers. Consult the Data Security Checklist at http://reo.mcmaster.ca/educational-resources for best practices to secure electronic and hard copy versions of data and study documents.
Anonymity concerns whether participant identities are known or not.

(a) Will the data you collect be kept protected, private and secure from non-research team members?

[X] Yes [ ] No

If **No**, please explain why not, and describe what steps you will put in place to inform participants that their data will not be kept protected, private and secure from non-research team members.

N/A

(b) How long do you intend to retain **(i)** research data and **(ii)** other study-related documents (e.g., signed consent forms, oral consent logs, participant contact information to send study results and/ or to send compensation/incentives etc.)?

i. Research Data: Audio recordings, once transcripts have been cleaned of identifying information, will be immediately destroyed. Clean transcripts will be retained until the defense and then shredded and destroyed.

ii. Other study-related documents that identify participants: Signed consent forms will also be destroyed following the thesis defense and the provision of research summaries to interested participants. No other study-related documents that identify participants will be gathered. The researcher has also completed and signed a confidentiality declaration (see appendix M).

(c) Please explain the rationale for your data retention plan. Keep in mind, the level of the research (e.g., student or faculty researcher), the type of study, standards of your academic field of study, Canada's Tri-Council Policy Statement (TCPS), the McMaster Research Integrity Policy, requirements imposed by funders, conditions specified in research agreements or data access agreements for secondary use of data and legal or other requirements or guidance.

Our data retention plan is the academic standard in Social Work at McMaster University and adheres to the Tri-Council Policy Statement. Data will be kept, and participants will be made aware of this, as long as it is required for the thesis defense and any subsequent modifications that may be required to complete the academic requirements to ensure that the researcher has access to the data for revision purposes.

(d) Describe how you will explain to participants your research data retention plan outlined above. In your description, also identify and submit all documents (e.g., Letters of Consent etc.) where this will be explained to study participants.

This procedure (see above) is described to participants in the Information Letter and in the Informed Consent Form. Participants will be informed of the research data retention plan during the initial attainment of consent portion of the research project by providing an outline on data retention in the initial consent form.

e) Please use the chart below to describe the identifiability of the data and the data security details for each of the stages of the study.

	Who will have access to the research data and other study-related participant information?	**What identifiable information about participants will be known** either directly (name, ID number, other.) or indirectly (date of birth, place of residence, job title, other).	**Procedures used to ensure that study-related information will be kept protected, private, and secure from non-research team members.** This includes research data plus other documents (e.g., signed consent forms, verbal consent logs compensation lists etc.).	**Location where research data and other study-related participant information will be kept?**
Recruitment	Student researcher	The participant's names will be known only to the student researcher. Other demographic information such as place of residence, job title etc. may also be disclosed during the interview process.	All research data and study related materials will be securely stored and only accessible by the researcher. Digital information will be kept on the researcher's password protected computer.	All study materials will be stored on the researcher's computer and in a locked filing cabinet at the researcher's home.
Consent	Student researcher	The participants will sign their names on the consent form.	Once completed, consent documentation will be brought to the researcher's home and secured.	See above
Compensation or incentives *(if applicable*)	Student researcher	No new information will be required for this.	Immediately preceding the interviews compensation will be purchased and ready to provide to the participants following their participation.	See above
Data Collection	Student researcher	Any additional information disclosed during the interview process.	Semi-structured interviews will take place in a private room at the treatment centre.	See above
Data Preparation & Analysis:	Student researcher	Any additional information disclosed during the interview process.	Will be secured on researcher's password protected computer and retrieved only by the researcher and discussed with the thesis supervisor as necessary.	See above
Data Transfer (movement) if applicable	N/A			
Data Storage	Student researcher	No additional information will be known.	Will be secured on researcher's password protected computer and retrieved only by the researcher and discussed with	See above

			the thesis supervisor as necessary.	
Dissemination of Research Findings	Student researcher	No additional information will be known.	Will be secured on researcher's password protected computer and retrieved only by the researcher and discussed with the thesis supervisor as necessary.	See above
Final disposition of study documents (*archiving or secure destruction, as applicable*)	Student researcher	No additional information will be known.	Will be secured on researcher's password protected computer and retrieved only by the researcher and discussed with the thesis supervisor as necessary.	All materials relating to the final thesis draft will be handled accordingly as per the academic requirements of the thesis process. All other materials will be destroyed in accordance with the researcher's data retention timeline.

Tri-Council Policy Statement (TCPS) Advice: "*The easiest way to protect participants is through the collection and use of anonymous or anonymized data, although this is not always possible or desirable. For example, after information is anonymized, it is not possible to link new information to individuals within a dataset, or to return results to participants. A "next best" alternative is to use de-identified data: the data are provided to the researcher in de-identified form and the existing key code is accessible only to a custodian or trusted third party who is independent of the researcher. The last alternative is for researchers to collect data in identifiable form and take measures to de-identify the data as soon as possible. Although these measures are effective ways to protect participants from identification, the use of indirectly identifying, coded, anonymized or anonymous information for research may still present risks of re-identification".*
Consult the Ethics Office for further advice at X 23142 or X 26117.

SECTION F -- MONITORING ONGOING RESEARCH

26. **Adverse Events, Change Requests and Annual Renewal/Project Status Report**

a) **Adverse events** (Unanticipated negative consequences or results affecting participants) must be reported by faculty researcher or supervisor to the REB Secretariat (Ethics Office – Ext. 23142) and the MREB Chair, as soon as possible and in any event, no more than 3 days after they occur. See: https://reo.mcmaster.ca/policies/copy_of_guidelines#12-0-adverse-events

b) **Changes to cleared research**: To obtain clearance for a change to a protocol that has already received ethics clearance, please complete the "**< Change Request >**" form available on the MREB website or by clicking this link. Proposed changes may not begin before they receive ethics clearance.

c) **Annual Renewal/Project Status Report** Ethics clearance is for only one year.
The minimum requirement for renewing clearance is the completion of an "Annual Renewal/Project Status Report" in advance of the (1 year) anniversary of the original ethics clearance date".

PLEASE NOTE:
It is the investigator's responsibility to complete the Annual Project Status Report that is sent each year by email 8 weeks in advance of the anniversary of the original ethics clearance to comply with the McMaster Research Integrity Policy.
If ethics clearance expires the Research Ethics Board is obliged to notify Research Finance who in accordance with university and funding agency regulations will put a hold on funds.

27. **Additional Information:** Use this section or additional page(s) to complete any part of this form, or for any other information relevant to this project which you wish to provide to the Research Ethics Board.

N/A

28. **POSTING OF APPROVED PROTOCOLS ON THE RESEARCH ETHICS WEBSITE**

a) It is the policy of MREB to post a list of cleared protocols on the Research Ethics website. Posted information usually includes: title, names of principal investigators, principal investigator department, type of project (i.e. Faculty; PhD; Masters, Undergraduate etc.)
b) You may request that the title be deleted from the posted information.
c) Do you request that the title be eliminated from the posted information? **[ ] Yes [ ] No**
d) The ethics board will honour your request if you answer **Yes** to the above question **27 c**) but we ask you to provide a reason for making this request for the information of the Board. You may also use the space for any other special requests.
e) < List of MREB Cleared Protocols > < List of Undergraduate SREC Cleared Protocols >

N/A

Supporting Materials Checklist:

Instructions:

Complete this checklist to identify and describe your supporting materials to ensure your application form is complete

- *When supplying supporting materials, ensure that they are properly labeled (e.g., "Appendix C: Interview Guide for Teachers") and referenced in your protocol (e.g., "The interview guide for teachers – see Appendix C – is...").*
- *Do not cut and paste supporting materials directly into the application form; submit each as a separate appendix.*

- *If you have multiple supporting materials of the same type (e.g., multiple letters of information that target different populations), list each supporting material on a separate row in this checklist. Add a new row to the table if necessary.*

Supporting Materials Checklist	**I will use this type of material in my study** ***(Insert X below)***	**I have attached a copy of this material in my protocol** ***(Insert X below)***	**This is how I labeled and titled this material in my protocol** **(e.g., *Appendix A – "Email Recruitment Script for Organizational Workers"*)**
Recruitment Materials			
Study Information Brochure		**N/A**	
Video/audio recording that explains study details		**N/A**	
Participant Screening Form	**X**		Appendix B
Recruitment Advertisements		**N/A**	
Recruitment Poster	**X**		Appendix A
Recruitment Script – Verbal/Telephone			
Recruitment Script – Email (direct to participant)			
Recruitment Script – Email (From holder of participant's contact information)		**N/A**	
Recruitment for follow-up interview		**N/A**	
Snowball Recruitment script		**N/A**	
Reminder/thank you/ card/script/email			
Appreciation Letter/certificate – For Participants			
Other		**N/A**	
Informed Consent Materials			
Consent Log (to record screening form)	**X**		Appendix C
Oral/Telephone Script	**X**		Appendix D
Letter of Information & Consent Form – **Participants**	**X**		Appendix G
Letter of Information & Consent Form – **Parent**		**N/A**	
Letter of Information & Consent Form - **Guardian** or **Substitute Decision Maker**		**N/A**	
Letter of Information & Assent Form – **Minors**		**N/A**	
Online survey brief information/consent and implied consent buttons		**N/A**	
Letter of Support for Study	**X**		Appendix E
Research Agreement		**N/A**	
Other			
Data Collection Materials			
Information Sharing/Data Access/Transfer Agreement (for secondary use of data)		**N/A**	
Demographic Questionnaire - Participant's	**X**		Appendix H
Instructions for participants	**X**		Appendix F
Interview Guide – (Questions for face to face, telephone, Internet/email interview)	**X**		Appendix I
Interview Guide – Questions for Focus Groups		**N/A**	
Questionnaire or Survey questions & instructions (Paper and pencil or online formats)		**N/A**	

Supporting Materials Checklist	**I will use this type of material in my study** *(Insert X below)*	**I have attached a copy of this material in my protocol** *(Insert X below)*	**This is how I labeled and titled this material in my protocol** **(e.g., *Appendix A – "Email Recruitment Script for Organizational Workers"*)**
Rating Scales/inventories/Assessment Instruments		**N/A**	
Role-play/simulation scripts		**N/A**	
Stimuli used to elicit responses		**N/A**	
Images (photos, diagrams etc.) depicting instruments, equipment, exercises etc.		**N/A**	
Other		**N/A**	
Debriefing Materials			
Debriefing Form		**N/A**	
Deception Study - Debriefing Letter & post debriefing consent form		**N/A**	
Deception Study- Debriefing script – verbal		**N/A**	
Other		**N/A**	
Confidentiality Materials			
Confidentiality Oath/ Agreement	**X**		Appendix M
Confidential Study Code Key Log		**N/A**	
Data Management Plan (DMP)		**N/A**	
Other		**N/A**	
Materials for previous review by other REBs			
Application form –Other REBs (Original)		**N/A**	
Application form – Other REBs (Revised)		**N/A**	
Communication between REB & researcher (letters, emails, faxes etc.)		**N/A**	
Clearance Certificate (Other REBs)		**N/A**	
Other		**N/A**	
Other Supporting Materials			
Compensation Log	**X**		Appendix J
List of support services for participants	**X**		Appendix L
Participant Appreciation - letter, script, email or certificate etc.	**X**		Appendix K
Researcher Training Certificates		**N/A**	
Scientific Licenses		**N/A**	
Other		**N/A**	

29. Researcher Assurance: < SECTION G – SIGNATURES >

[X] I confirm that I have read the McMaster University Research Integrity Policy http://www.mcmaster.ca/policy/faculty/Research/ResearchIntegrityPolicy.pdf, and I agree to comply with this and other university policies, guidelines and the Tri-Council Policy Statement (TCPS) and of my profession or discipline regarding the ethical conduct of research involving humans.

[X] *In addition*, I understand that the following *all constitute violations of the McMaster University's Research Integrity Policy*:

- failure to obtain research ethics clearance;
- carrying out research in a manner that was not cleared by one of the university's REBs;
- failure to submit a **Change Request** to obtain ethics clearance prior to implementing changes to a cleared study;
- failure to report an **Adverse Event** (i.e., an unanticipated negative consequence or result affecting participants) by the investigator or faculty supervisor of student research to the MREB secretariat and the MREB chair, as soon as possible and in any event, no more than 3 days after the event occurs;
- failure to submit an **Annual Renewal/Project Status Report** in advance of the 1 year anniversary of the original ethics clearance date.

Jason Palmer	Jason Palmer	February 2, 2019
Signature of Faculty, Student or Staff Researcher *(Add lines for additional researchers.)*	**PLEASE PRINT NAME HERE**	**Date**

Supervisor Assurance for Graduate or Undergraduate Student Research:

[ ] "I am the supervisor for this proposed student research and have read this ethics application and supporting documents and deem the project to be valid and worthwhile, and I will provide the necessary supervision of the student(s) researcher(s) throughout the project including ensuring that the project will be conducted as cleared and to make myself available should problems arise during the course of the research.

Randy Jackson	Randy Jackson	February 2, 2019
Signature of Faculty Supervisor of Student Research *(Add lines for additional supervisors.)*	**PLEASE PRINT NAME HERE**	**Date**

The signature page may also be emailed as a scanned PDF or sent by campus mail to: Ethics Office, Gilmour Hall-305.
See the top of page 1 of this application form for instructions on how to submit.