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**THE EXPERIENCE OF RELAPSE AFTER LONG-TERM SOBRIETY AND
SUBSEQUENT RETURN TO SOBRIETY**

A dissertation presented to the faculty of

ANTIOCH UNIVERSITY SANTA BARBARA

in partial fulfillment of
the requirements for the
degree of

DOCTOR OF PSYCHOLOGY

in

CLINICAL PSYCHOLOGY

By

BAHRAM EDWARD KAIKHOSROW SHAHROKH

JUNE 2019

THE EXPERIENCE OF RELAPSE AFTER LONG-TERM SOBRIETY AND
SUBSEQUENT RETURN TO SOBRIETY

This dissertation, by Bahram Edward Kaikhosrow Shahrokh, has been approved by the committee members signed below who recommend that it be accepted by the faculty of Antioch University Santa Barbara in partial fulfillment of requirements for the degree of

DOCTOR OF PSYCHOLOGY

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Abstract

While psychiatric medications have been categorized as the same as substances of abuse in Alcoholics Anonymous (AA), medications for common medical disorders were not affected by this disapproval of medication. It may be time for a new dialogue (Woody, 2015). According to Gjersing and Bretteville (2018), there has been a concerning increase in overdose deaths in the last decade. This includes a threefold increase in overdose deaths from prescription narcotics and six-fold increase in overdose deaths from heroin in the United States. When prescription opioid users find difficulty in obtaining pills, they may move on to heroin, which is much more readily available on the streets, in an effort to avoid painful opioid withdrawal. For this study, individuals who had previously achieved long-term abstinence from alcohol or substance use but relapsed after a significant amount of time sober were interviewed in order to better understand their experience with relapse as well as their experience returning to at least partial remission. Thematic analysis was conducted on interview data. The results from this phenomenological analysis of interviews with eight participants identified several themes regarding the experience of being a long-timer, relapsing after a substantial amount of time abstinent, and challenges to as well as factors in returning to AA. These themes are organized as long-term recovery, relapse, and a new beginning. Long-term recovery is further explored as acute treatment only, treatment did not utilize evidence-based interventions, treatment did not address emotional issues, contact with mental health, long-timer, and complacency and drifting. Relapse is further explored as medical issues, new trauma, and justification of the use of medication or marijuana. A new beginning is further explored as recovery challenges such as feelings of ostracism, age-related issues, and shame as well as recovery factors such as finding acceptance and love within the fellowship, cognitive reframing, and re-engaging the program with enthusiasm. This Dissertation

is available on Open Access at AURA: Antioch University Repository and Archive,
<http://aura.antioch.edu> and OhioLink ETD Center, <http://www.ohiolink.edu/etd>.

Acknowledgements

The purpose of this project is to honor long-timers who have lost their time and have returned to sobriety, are struggling, and have passed on. This project is dedicated to all recovering individuals who are thriving or suffering in and out of the rooms.

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Chapter I: Introduction

In the United States, addiction or substance dependency is a problem that has received much attention through media and research. For individuals who are addicted, the disorder wreaks havoc in social, psychological, medical and economic domains. The majority of research regarding addiction appears to be concerned with psychological and pharmacological interventions that address the issue in individuals first coming to treatment or for those who have been struggling with treatment. Some studies (Chi, Parthasarathy, Mertens & Weisner, 2011) and articles (White & Kelly, 2011) have been concerned with a necessary paradigm shift in the conceptualization of treatment from an acute care model to one of long-term recovery management. The basis for this shift is in the consideration that addiction is a chronic disease that remains in remission but is never fully cured (White & Kelly, 2011).

Additionally, recovering persons who have been able to maintain abstinence for a long period of time, such as 15 to 20 years and then relapse are given less attention by researchers, clinicians and social support systems (Milliard, 2007; Strawbridge, 2007; Milani, 2013). It would seem if an individual has been able to achieve the behavioral, cognitive, attitudinal, and mood changes (Delay, 1985) required to get sober and maintain their sobriety for many years they would have surpassed the threshold for relapse. However, limited research indicates this is a growing phenomenon (Milani, 2013). The problem is compounded by the focus of other recovering persons in self-help 12-step fellowships on the “newcomer” who is starting their journey rather than the “old-timer” who had a slip. “Old-timer” is a term used within the 12-step community referring to a recovering person who has remained abstinent from drug and alcohol use for 15 years or more. Due to the ageist nature of this term, an individual with long-term sobriety will be referred to as a “long-timer.”

While there is not substantial literature on this phenomenon, it is becoming a prevalent issue. One source of information is popular culture. A recent case is the accidental drug overdose of Phillip Seymour Hoffman. Hoffman stopped using drugs and alcohol at the age of 22 and recently returned to substance use a few years ago following 23 years of abstinence. Hoffman attempted to get clean and sober again and completed a successful treatment episode. Sadly, he took a lethal dose of heroin and cocaine and died February 2nd, 2014 (Weber, 2014).

Another recent tragic death is the suicide of Robin Williams at the age of 63. Although Williams' widow maintains he had maintained his sobriety at the time of suicide, Williams checked into a drug and alcohol rehabilitation center the previous month. Williams had also relapsed in 2006 following 20 years of sobriety. While it is known Williams' suicide was directly related to his knowledge of the detection of early Parkinson's disease, what is less known is the impact his struggle with relapse and returning to recovery played on his ability to cope with the stress of this newly discovered medical condition (Rottenberg & Brown, 2014; Siezckowski, 2014).

The research question for this study is, "What is the lived experience of a long-timer who relapsed after many years of abstinence and was then able to return to sobriety?". Along with this question come many sub-questions: What were the factors that contributed to the relapse (medical issues, psychosocial issues, etc.)? What was the process of the "pre-lapse" or behavioral and cognitive changes leading up to the actual substance use? Did the long-timer notice he or she was heading toward use or were there factors preventing him or her from noticing the gradual or acute shift toward use? What did the relapse consist of? How did it impact his or her life? How did it become apparent to the long-timer he or she had to return to abstinence and what factors helped him or her get sober again? What factors made it more difficult for a previous long-timer

to return to and maintain early recovery? Is the experience of this sobriety different from his or her previous sobriety?

Chapter II: Literature Review

While there is a large literature on relapse (Gjersing & Bretteville, 2018; Gossop, Stewart, Browne, & Marsdon, 2002; Gullo, Loxton, & Dawe, 2014; Krenek & Maisto, 2013; Liebschutz et al., 2013; Lijffijt, Hu & Swann, 2014; Pilowsky et al., 2013; Snelleman, Schoenmakers, & van de Mheen, 2014) and relapse prevention (Chiesa & Serretti, 2014; Daley, 1987; Dalsbø et al., 2010; Day & Mitcheson, 2017; Galanter, 2018; Kelly, Stout, Zywiak & Schneider, 2016; Larimer, Palmer, & Marlatt, 1999) in general, there is a dearth of literature addressing the population that is the focus of this dissertation, that being people who relapsed after 15 years of sobriety. Although the literature concerning this populations is very scarce, there is substantial literature regarding a conceptual shift in approaching alcohol and substance use disorder treatments, types of evidence-based treatment, models of addiction and recovery, factors for relapse and factors for recovery. Historically, drug addiction treatment protocols have overwhelmingly focused on treating patients and clients with interventions that conceptualize addiction as an acute disorder as opposed to a chronic disease. As the research regarding effective evidence-based treatment models grow, data points to the need for recovering persons to continue engaging with health care and social support. Besides, literature regarding substance abuse treatment focuses on personality traits, cognitive deficits and social influences that increase the risk of relapse for individuals who are in early and ongoing recovery while other researchers focus on factors that increase treatment retention, ability to cope with difficult affect, and protective factors. The following literature review will explore current studies, reviews, and meta-analyses regarding the above as well as some recent qualitative studies that have also begun looking at older adults in recovery.

Introduction

Before examining the most recent research on substance use disorders and treatment, a brief introduction to the diagnostic criteria of alcohol and substance use disorders will be provided along with recent statistics regarding prevalence. It is useful to note that previous research focuses on the DSM-IV-TR diagnostic criteria which designated substance use disorders into separate abuse and dependence categories. The current DSM-5 has eliminated these categories and condensed them into a single continuum diagnosis ranging from mild to severe; therefore although both diagnostic criteria have been included, the current study will utilize the most recent diagnostic criteria when describing the results as relevant.

Diagnostic Criteria in DSM-IV-TR. The DSM-IV-TR delineates alcohol use disorders (AUD) and substance use disorders (SUD) by specifying drug name and level of severity. Problematic AUD and SUD are labeled as abuse whereas more severe pathology is labelled as dependence. A combination of criteria for dependence on three or more substance where none of the substances predominated is considered Polysubstance Dependence (American Psychiatric Association, 2000).

Abuse. According to the American Psychiatric Association (2000), the criteria for substance abuse was the following:

“A. A maladaptive pattern of substance use leading to clinically significant impairment or distress or distress, as manifested by one (or more) of the following, occurring within a 12-month period:

1. recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home (e.g., repeated absences or poor work performance related to substance use; substance-related absences, suspensions, or expulsions from high school; neglect of children or household)

2. recurrent substance use in situations in which it is physically hazardous (e.g., driving an automobile or operating a machine when impaired by substance use)
3. recurrent substance-related legal problems (e.g., arrests for substance related disorderly conduct)
4. continued substance use despite having persistent or recurrent social and interpersonal problems caused or exacerbated by the effects of the substance (e.g., arguments with spouse about consequences of intoxication, physical fights)

B. The symptoms have never met the criteria for Substance Dependence for this class of substance.”

Dependence. According to the American Psychiatric Association (2000), the criteria for substance dependence was the following:

“A maladaptive pattern of substance use, leading to clinically significant impairment or distress, as manifested by three (or more) of the following, occurring at any time in the same 12-month period:

1. tolerance, as defined by either of the following:
 - (a) a need for markedly increased amounts of the substance to achieve intoxication or desired effect
 - (b) markedly diminished effect with continued use of the same amount of the substance
2. withdrawal, as manifested by either of the following:
 - (a) the characteristic withdrawal syndrome for the substance (refer to Criteria A and B of the criteria sets for Withdrawal from the specific substances)
 - (b) the same (or closely related) substance is taken to relieve or avoid withdrawal symptoms
3. the substance is often taken in larger amounts or over a longer period than was intended

4. there is a persistent desire or unsuccessful efforts to cut down or control substance use
5. a great deal of time is spent in activities necessary to obtain substances (e.g., visiting multiple doctors or driving long distances), use of the substance (e.g., chain smoking), or recovery from its effects
6. important social, occupational, or recreational activities are given up or reduced because of substance use
7. the substance is used despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance (e.g., current cocaine use despite recognition of cocaine-induced depression, or continued drinking despite recognition that an ulcer was made worse by alcohol consumption).

Remission. According to the American Psychiatric Association (2000), the criteria for remission (e.g. recovery) was the following:

Early (one to twelve months) or Sustained (over twelve months) full remission: These specifiers are used when for the noted time none of the criteria for dependence or abuse have been met.

Early (one to twelve months) or Sustained (over twelve months) partial remission: These specifiers are used when for the noted time one or more of the criteria for dependence or abuse have been met, but the full criteria for dependence has not been met.

Diagnostic Criteria in DSM-5. In the most recent revision of the DSM, the distinction of abuse and dependence are no longer used and instead each specific substance is labeled as a substance use disorder with severity specific from mild to severe (American Psychiatric Association, 2013b). The DSM-IV-TR criteria are presented because much of the existing literature refers to these previous criteria.

Substance use disorder. According to the American Psychiatric Association (2013a), the criteria for a substance abuse order was the following:

“A. A problematic pattern of [substance] use leading to clinically significant impairment or distress, as manifested by at least two of the following, occurring within a 12-month period:

1. [Substance] is taken in larger amounts or over a longer period than was intended
2. There is persistent desire or unsuccessful efforts to cut down or control [substance] use.
3. A great deal of time is spent in activities necessary to obtain [substance], use [substance], or recover from its effects.
4. Craving, or a strong desire or urge to use [substance]
5. Recurrent [substance] use resulting in a failure to fulfill major role obligations at work, school or home.
6. Continued [substance] use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of [substance].
7. Important social, occupational, or recreational activities are given up or reduced because of [substance].
8. Recurrent [substance] use in situations in which it is physically hazardous.
9. [Substance] use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by [substance].
10. Tolerance, as defined by either of the following:
 - a. A need for markedly increasing amounts of alcohol to achieve intoxication or desired effect.
 - b. A markedly diminished effect with continued use of the same amount of [substance].
11. Withdrawal, as manifested by either of the following:

- a. The characteristic withdrawal syndrome for [substance]
- b. [Substance] (or closely related substance) is taken to relieve or avoid withdrawal symptoms.”

Prevalence. According to the 2014 National Survey on Drug Use and Health, approximately 21.6 million individuals aged 12 or older met the criteria for a substance use disorder in 2013. This translates into 8.2% of the population aged 12 or older. Additionally, an estimated 22.7 million individuals aged 12 or older needed treatment for an illicit drug or alcohol use problem in 2013 while only 2.5 million received treatment at a specialty facility for an illicit drug or alcohol problem (Substance Abuse and Mental Health Services, 2014).

Prevalence in Older Population. As of 2014, it is estimated 2.8 million older adults (aged 50 and older) meet the criteria for a substance use disorder (Ellin, 2014). Han, Gfroerer, Colliver, and Penne (2009) estimate this number will increase to 5.7 million older adults meeting the criteria for a substance use disorder by 2020; therefore treatment and intervention are relevant issues among older adults with a substance use disorder regardless of the status of the individual as relapsed or currently using. Older adults who have a substance use disorder have an enhanced risk of mortality (Scott, Dennis, Laudet, Funk & Simeone, 2011)

Quality of life. Health, as defined by the World Health Organization (2006) is “a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity.” According to Ugochukwu et al. (2013), the primary target of health care interventions, therefore, must be the restoration of health in order to be successful. The authors further define the restoration of health as “attaining a state of overall well-being or quality of life (QoL).” Volk, Cantor, Steinbauer, and Cass (1997) found higher use of alcohol translates to poorest QoL (as measured by the SF-36) in a cohort of primary care patients. In the same study,

patients who met the criteria for alcohol dependence additionally had significantly lower role functioning and mental health subscale scores whereas patients meeting criteria for alcohol abuse did not show this decrease in QoL. Stein, Mulvey, Plough, and Samet (1998) found that both substance use disorders and alcohol use disorders were associated with lower QoL in the areas of social function, health perception, mental health, and pain. Miller and Miller (2009) state individuals entering substance abuse treatment have a wide variety of other problems which may be a higher priority than the cessation of substance use. Therefore, regardless of the substance of abuse, individuals in active addiction have a lower QoL than non-addicted individuals.

Not only is QoL impacted by meeting the criteria of a substance use disorder, but mortality is also affected. Neumark, Van Ettan, and Anthony (2000) found individuals that meet the criteria for a dependency diagnosis on average die 22.5 years earlier than those who do not. In a study in which experts reviewed and scored the physical harm and societal cost of chronic substance use in the Netherlands, Amersterdam, Pennings, Brunt, and van den Brink (2013) reported alcohol and tobacco carried a high score due to the societal disease burden of somatic disease. Additionally, amphetamines and cocaine received a high score while benzodiazepines, ecstasy, and cannabis received intermediate scores (Amersterdam, Pennings, Brunt & van den Brink, 2013)

Scott et al. (2011) found older age, health problems, and substance use were associated with an increased risk of mortality. However, Scott et al. (2011) also found that a higher percentage of time abstinent and longer durations of continuous abstinence were associated with reduced risk of mortality. A review of the treatment response of over 100 randomized controlled studies of addiction treatment by McLellan, Lewis, O'Brien, and Kleber (2000) found most of the studies showed significant reductions in drug use, improved personal health, and reduced

social pathology. Although these studies did not indicate a cure, they did indicate there is a correlation between treatment, abstinence or remission and improved QoL.

Theories of addiction. A brief discussion of the various theories of addiction are presented in order to inform the reader regarding predominating thinking of the basis of a substance use disorder

Medical model. The medical model or disease model of addiction is characterized as a brain disease with biological, neurological, genetic, and environmental sources of origin. The continued use of drugs and alcohol has altered brain neurochemistry and produced an imbalance of neurotransmitters. It may also be influenced by other biological, psychological, or sociological entities (Clark, 2011; McLellan, Lewis, O'Brien & Kleber, 2000).

Psychodynamic model. The psychodynamic model of addiction views the disorder of one in which the individual is self-medicating. Drug abuse is the symptom of underlying psychological problems. The use of drugs is a maladaptive coping strategy. Patients will no longer require the use of drugs when they have resolved internal conflict (Goodman, 2015).

Social model. The social model of addiction views drug use as a learned behavior. An individual becomes addicted after using drugs due to peer pressure and modeling by others. Additional environmental factors also contribute to drug use. Drug use is a maladaptive relationship negotiation strategy that serves to mitigate relational and social stressors (Kaskutas, 1999).

Moral model. The moral model or criminal justice model of addiction views addiction as a consequence immoral character and weak self-will. Addicts have the willpower to overcome the compulsion to use but choose not to; therefore drug abusers are anti-social and should be punished. Drugs in and of themselves are undesirable (Clark, 2011).

Bio-psycho-social model. The bio-psycho-social model of addiction is a combination of features from the above models to some greater or lesser degree. Each person uses drugs as a result of some or all aspects of the other models. Treatment and recovery will need to address the physical, mental, and spiritual health of the individual as well as the social environment (Buchman, Skinner & Illes, 2010).

Treatment Protocols

Acute vs. Long Term. White and Kelly (2011) provided historical reasoning for the use of treatment measures which address addiction as an acute disorder and provide a case for the treatment of addiction as a chronic disease. The authors additionally compared the two approaches and provided a detailed framework for a possible long-term treatment protocol that is aimed at providing sustainable recovery assets and tools to individuals who suffer from substance use disorder. The differences are important to examine for the following reasons: if a recovering person relapsed after a considerable amount of time abstinent from drug and alcohol use, it would be pertinent to examine and explore whether the relapse occurred due to deficits from having been treated with the acute framework. It would also be pertinent to get feedback on whether treatment from a chronic disease framework could have either prevented the relapse or served to moderate the relapse to minimize any harm done. White and Kelly (2011) described eight changes in service practices regarding “(1) attraction/access to treatment, (2) assessment and level of care placement, (3) composition of the service team, (4) service relationship/roles, (5) service dose, scope and duration, (6) locus of service delivery, (7) linkage to communities of recovery, and (8) post-treatment monitoring, support and early re-intervention.”

McLellan et al. (2000) conducted a literature review of chronic medical illness and drug dependency. The authors presented an argument by analogy whereby drug dependency is

compared to well-studied chronic medical illnesses such as type 2 diabetes mellitus, hypertension, and asthma. Although drug dependence does not require the presence of physical symptoms, it does affect the neurocognitive structure and functioning of the brain (i.e. ventral tegmental area connecting the limbic cortex through the midbrain to the nucleus accumbens) and produces enduring and possibly permanent pathophysiological changes in reward circuitry, levels of specific neurochemicals, and the stress response system. Twin studies show there is a genetic heritability for the disposition toward drug dependence to a similar degree of type 1 diabetes and adult-onset asthma. Although personal responsibility plays a role in the onset of drug dependence, personal responsibility also plays a role in the onset of hypertension. In addition to behavioral, cognitive, and emotional intervention, individuals in treatment for drug dependency may also benefit from various medications that have shown to accentuate long-term admission similar to other chronic medical illnesses. Treatment and medication adherence rates are similar for drug dependency and other chronic illnesses (McLellan et al., 2000). Despite these similarities, drug dependency is still treated as an acute disorder. Long-timers treated with an acute care model may suffer consequences of relapse due to a lack of long-term contact with healthcare professionals.

Scott et al. (2011) reviewed data from a stratified sample of 1,326 patients from 222 addiction treatment programs on the West Side of Chicago to determine the effect of number of treatment episodes, abstinence and time spent using on mortality. They determined baseline factors of older age, preexisting chronic illness, and engagement in illegal activity enhanced mortality whereas abstinence was associated with lower risk of mortality. The duration of sustained abstinence achieved had direct and indirect effects on the relationship between long-term treatment and mortality. The authors found that participating in more treatment episodes in

the early years of use decreased risk of mortality while participating in treatment later in life and spending a greater percentage of one's lifetime in treatment did not. According to Scott et al. (2011), the findings do not support acute care and augment the chronic disease model.

Chi, Parthasarathy, Mertens, and Weisner (2011) reviewed results from a meta-analysis of two longitudinal studies conducted by Kaiser Permanente Northern California. The results from these studies provided quantitative support for some of the proposed service changes by White and Kelly (2011). Chi et al. (2011) followed remission or readmission of a sample of 1,953 participants at one, five, seven, and nine years. Among other factors, Chi et al. (2011) studied the likelihood of participants who were at risk of returning to active use when attending yearly follow-ups with primary care physicians versed in substance abuse treatment. According to Chi et al. (2011), "This study found that having yearly primary care and specialty care (substance use treatment and psychiatric services) when needed was associated with remission over nine years for substance use patients in a private, nonprofit, integrated managed care health plan" (p. 1197). This provides evidence for the expansion of the treatment team suggested by White and Kelly (2011) as well as the need for post-treatment monitoring, support and early intervention. The current study may provide additional evidence if participants felt this was a factor in leading to relapse or may have been a protective factor.

An additional study by DuPont and Humpreys (2011) reviewed three new highly effective treatment models that support long-term recovery for drug and alcohol dependence as opposed to treatment as usual which is typically a few weeks of outpatient counseling with no biological testing, no use of contingency management and no medication. Physician Health Programs, Hope Probation, and South Dakota's 24/7 Sobriety Project were reviewed.

Physician Health Programs are intensive treatment approaches that require physicians who have substance use disorders to complete a rigorous five-year treatment in order to maintain their medical licenses and ability to practice. Initially, physicians will attend a 30-90 day residential inpatient or 90-day outpatient program depending on the case and are randomly screened for drug and alcohol use one to two times per week. After a period of abstinence, these physicians are tested approximately one to two times per month. Physicians are also required to attend 12-step meetings (DuPont & Humpreys, 2011). One study showed that 64% completed their contract, 16% extended their contracts or signed new contracts, and 28% had not completed their contract or were no longer monitored indicating a high success rate (DuPont & Humpreys, 2011) over the national average of outpatient treatment success of 40% (National Institute of Drug Abuse, 2013). Of the physicians who completed their contracts, 81% had no relapse and 45% had one or two positive tests (DuPont & Humpreys, 2011). Critics of the program contend the higher SES and education of physicians indicate a higher prognosis. Therefore DuPont & Humpreys (2011) reviewed two programs that involved participants involved in the criminal justice system in order to provide additional evidence for their argument for the benefits of long-term care models.

Hawaii's Opportunity Probation with Enforcement (HOPE) and South Dakota's 24/7 Sobriety Project are similar programs requiring treatment of individuals in the criminal justice system. HOPE participants are convicted felons who are likely to violate the terms of the parole. South Dakota's 24/7 Sobriety Project participants are individuals convicted of multiple Driving While Intoxicated charges (DuPont & Humpreys, 2011). Both treatment protocols involve heavy random testing and mandatory short-term incarceration for violations and substance abuse. Twelve-step meetings are encouraged but not required (DuPont & Humpreys, 2011). Studies

have shown that 85% of HOPE participants and 66% of Sobriety Project participants complete the program. The main limitation of these studies is the mandatory nature of treatment. These participants may have had a higher motivation to complete and succeed with treatment.

However, due to the bottom-up processing and impulsivity characteristics of individuals in recovery from a substance use disorder, consequences are not viewed as the primary factor in rehabilitation (Davis, Patte, Tweed & Curtis, 2007; Evans, Li & Hser, 2009; Staiger et al., 2014).

The above studies and literature reviews indicate there is a need for a shift of treatment of substance use disorder from an acute treatment model to a long-term treatment model. Substance use disorders or drug dependency demonstrate similar characteristics as other chronic medical illness in which current treatment approaches are based on a long-term model. Additionally, it has been demonstrated by abstinence and remission rates that treatment success is enhanced by models embracing a spirit of long-term recovery approach.

Treatment Stages

According to the National Institute on Drug Abuse (2013), the intention of drug addiction treatment is “to help addicted individuals to stop compulsive drug seeking and use. Treatment can occur in a variety of settings, take many different forms, and last for different lengths of time. Because drug addiction is typically a chronic disorder characterized by occasional relapses, a short-term, one-time treatment is usually not sufficient” (pg. 8). Laudet, Becker and White (2009) additionally state treatment goals include the strengthening of personal resources (self-confidence, coping skills, self-efficacy), helping clients acquire “alternative rewards” (valued assets increasing the price of returning to active use), connecting them to protective activities (social support), and strengthening supportive relationships with family and friends. The predominant forms of drug addiction treatment are detoxification or medically managed

withdrawal, short and long-term residential, and outpatient treatment (National Institute on Drug Abuse, 2013). These formats are discussed briefly in order to provide the reader with the most recent developments in addiction treatment. Current study participants may refer to one or more treatment modalities or interventions or more interestingly not refer at all to these protocols.

Detoxification. Although there are a variety of modalities and treatment centers, often treatment begins with some form of detoxification. Detoxification in and of itself is the body clearing of toxins, which in this case are drugs and alcohol. Depending on the severity of use and physical dependency, medically managed withdrawal may be required in order to address unpleasant and potentially fatal side effects from the cessation of use. Drugs of abuse that necessitate medical detoxification are alcohol, benzodiazepines, opioids, barbiturates, and other sedatives. Detoxification alone does not provide relief to the distress caused by psychological, behavioral, and social problems. Without further assessment and additional treatment interventions, it is likely an individual will relapse and return to active addiction (National Institute on Drug Abuse, 2013).

Long-term residential. Long-term residential treatment is a highly structured model providing 24-hour care via therapeutic community. It is generally held in a nonhospital setting. The typical length of stay is between 6-12 months. Treatment focuses on increasing the ability of individuals to lead a socially productive lives through activities designed to help residents examine damaging personal beliefs, self-concepts, and destructive patterns and adopt new positive ways to interact with others. Comprehensive services may be offered that address legal, financial and psychiatric issues. The goal is to “resocialize” the individual through the program’s entire community (residents, staff, and social context) (National Institute on Drug Abuse, 2013).

Short-term residential. Short-term residential treatment is a comparatively more brief intensive form of residential treatment than long-term residential treatment. These programs were designed initially for alcohol dependence; however, they have expanded to include other drugs following the stimulant epidemic in the 1980s. The typical length of stay is 3-6 weeks and may be held in a hospital setting. Most short-term residential programs are based on a modified 12-step approach (Twelve Step Facilitation – discussed below) and group and individual therapy. It is recommended clients completing a short-term residential stay follow up treatment with engagement in an outpatient program in order to promote continuity of services and maintain a recovery structure (National Institute on Drug Abuse, 2013).

Outpatient treatment programs. Outpatient treatment programs are the most common form of treatment in the United States (SAMSHA Treatment Episode Data Set, 2005, 2008). Although the intensity and level of services of outpatient treatment vary, group counseling is the major component. Outpatient treatment is preferable due to reduced cost and because they allow the client to continue working and engaging in outside social support. Outpatient treatment may also address additional medical or other mental health problems (National Institute on Drug Abuse, 2013).

Treatment retention and drop-out. A well-documented problem in the delivery of addiction treatment services is treatment retention (Mattson et al., 1998; Stark, 1992). In 2005, the completion rate for publicly funded programs was 44% and for outpatient programs 36% (SAMSHA Treatment Episode Data Set, 2005, 2008). The completion rate for Prop 36, a California court-mandated outpatient modality, was 32% (UCLA ISAP, 2006). The completion rate for two publicly funded, state licensed intensive outpatient programs in New York City in 2003-2004 was 40% (Laudet, Stanick, & Sands, 2009).

Various studies list a myriad of drop-out factors. In a review of risk factors based on data from international data sets by Brorson, Arnevik, Rand-Hendrikson, and Duckert (2013), the authors report cognitive deficits, low treatment alliance, personality disorder and younger age to be the predominant and consistent risk factors to treatment drop-out. Laudet et al. (2009) identified dislike of some aspect of the program, program interference with other activities, substance use, practical issues, does not want/need help, personal issues, finances, and program not helpful as reasons clients reported for dropping treatment. Evans, Li, and Hser (2009) identified client level and system level reasons for drop-out based on court-mandated client report. Client level reasons were low motivation for treatment, denial of drug problem, desire to use drugs or relapse, and bad environment or friends who are users. System level reasons for drop-out were that the program was too hard or strict, treatment conflicted with work, lack of services, fees cost too much, and dissatisfaction with treatment.

Treatment completion is one of the most consistent factors related to favorable outcomes across all addiction treatment and modalities (Dalsø et al., 2010). According to the American Psychiatric Association (2007), treatment completion is associated with abstinence and lower crime rate. According to Stark (1992), treatment completion is also associated with fewer relapses and higher levels of employment. Therefore, addressing drop-out factors in order to promote treatment retention and completion has been a concern for researchers and clinicians alike. One method of addressing treatment drop-out is to address the concerns of the client. Laudet et al. (2009) state that although 67.2% of clients reported the treatment provider could have done nothing to have kept them in treatment, the remaining third reported they would be more amenable to treatment if their need for social services was addressed, if the program staff were more supportive, and if the program was more flexible regarding schedule. Evans et al.

(2009) stated that negative outcomes of those who did not complete treatment were more severe problems related to drugs, employment, legal matters, medical health, and psychiatric functioning. This indicates addressing these factors specifically during treatment may have promoted better treatment retention, as these factors were likely related to drop-out. In a study identifying protective factors regarding treatment retention for older adults with anxiety in a primary care psychology program, Hundt et al. (2013) identified treatment credibility, treatment expectancies, social support, and improvements in symptoms predicted higher treatment satisfaction. Treatment satisfaction resulted in improved outcomes related to treatment retention and completion.

Recommendations for improving treatment satisfaction and treatment retention additionally vary. However, the predominant view is in promoting client-therapist alliance and identification of high-risk patients. Goodman, McKay, and DePhillippis (2013) made the case for progress monitoring as having the potential for significantly improving treatment outcomes. Progress monitoring has been shown to enhance the treatment of chronic medical disorders and therefore is likely to improve outcomes in substance abuse as treatment for substance use disorders continues to shift to more appropriate long-term treatment paradigm. Laudet et al. (2009) recommend an ongoing dialogue with clients to continually identify reasons for seeking help, needs and expectations, experiences with and attitudes about treatment, perceived likelihood of completion, and to explore and address possible barriers to retention. Brorson et al. (2013) recommend identifying high-risk patients and screening for cognitive deficits and personality disorder at baseline, modifying treatment environment to higher support and lower control, involve clients in decision making, and increasing therapeutic alliance. Hawkins, Baer, and Kivlahan (IVR) as a cost-effective means of obtaining consistent client feedback and

notifying clinicians regarding distress and satisfaction. IVR is a telephone-based system in which clients can call and complete surveys weekly in order to provide treatment providers with valuable data regarding treatment factors such as use, attitude, and so on. The study found that participants who remained in treatment completed more calls, at a 72% compliance rate, than participants who dropped out.

Treatment modalities.

This section will provide a brief summary of current evidence-based substance use treatment modalities. Although there are additionally various medication-based assisted treatments as well as neurofeedback-based treatments, these interventions will not be discussed.

Twelve step facilitation (TSF). As the efficacy of 12-step programs has been established in addiction treatment research (see below), a goal of this mode of therapy is to orient the recovering individual toward as well as prepare them to engage with 12-step fellowships and programs. This form of therapy provides the foundation for a recovering individual to become familiar with concepts of acceptance as well as surrender, and to take action in active involvement. Acceptance involves understanding a substance use disorder as a chronic progressive disease for which willpower is not sufficient to overcome, causing life to become unmanageable, and abstinence is the only solution. Surrender involves understanding abstinence as achieved by turning one's will over to a higher power and the fellowship/support of other recovering addicts. Active involvement refers to the engagement with 12-step meetings, working with a sponsor who provides guidance working through the self-reflective process of each of the 12 steps and related activities following the therapeutic structure of the 12-step program (National Institute on Drug Abuse, 2013).

Cognitive behavioral therapy (CBT). The application of CBT in the treatment of substance use disorders has additionally been shown to be effective. CBT operates from the theoretical frame that learning plays a critical role in the development of maladaptive behavioral patterns like substance abuse; therefore, to counter this learned maladaptive pattern, a recovering person will learn to identify patterns and then to correct them using a variety of different and novel behavioral and cognitive skills. A recovering person will additionally learn to anticipate likely problems and develop positive coping skills to address these as they occur. Techniques associated with CBT as adapted for substance abuse are the exploration of both positive and negative consequences of use, the development of self-monitoring to recognize cravings and relapse justification, the identification of risk situations, and the ability to apply positive coping skills to address craving and avoid identified high-risk situations (National Institute on Drug Abuse, 2013). CBT is most frequently associated with and utilized through Marlatt's Relapse Prevention model when treating substance use disorders (Larimer, Palmer & Marlatt, 1999).

Contingency management (CM). This form of therapy is based on various token-economy systems. Two common CM interventions are Voucher-Based Reinforcement (VBR) and Prize Incentives CM. Treatment providers utilize VBR will provide clients with a voucher that has some monetary value for every negative urine sample. The vouchers may be redeemed for food items, movie passes, etc. Treatment providers utilize Prize Incentives CM will allow clients who are providing drug-free urine samples and attending therapy sessions opportunities to enter into a drawing for cash prizes. If a client has an unexcused absence or positive drug test, then their ability to enter into the drawing is reset. (National Institute on Drug Abuse, 2013).

Motivational enhancement therapy (MET). MET therapy interventions address the ambivalence clients have regarding cessation of drug use and participating in treatment. MET

focuses on internal change to potentially provide more rapid results than treatment guiding recovering individuals through a stepwise recovery process. MET is a more structured version of Motivational Interviewing (MI) (U.S. Department of Veteran Affairs, 2012). MI techniques are used to enhance motivation and create a client-centered plan for change. Client application of coping strategies for high-risk situations is continually assessed and clients are provided positive feedback for efforts (National Institute on Drug Abuse, 2013). A meta-analysis of 19 studies by Pace et al. (2017) found a significant relationship between MI-Consistent therapist behavior and increased client change talk and provided additional support for MI process outcome relationships. However, McKay (2017) noted that additional research has found that CBT and MI may not be more effective than other active interventions.

Mindfulness-based interventions (MBI). A growing research base indicates mindfulness-based interventions have a number of positive benefits for reducing drug and alcohol use, promoting abstinence, and improving QoL. In a review by Chiesa and Serretti (2014), the authors found that MBI can result in the reduced consumption of alcohol and other drugs to a significantly greater extent than waitlist controls and some specific controls. Grow, Collins, Harrop, and Marlatt (2014) found home enactment of mindfulness practices improved outcomes of MBI and was associated with significantly lower alcohol or drug use as well as craving during the course of treatment. A study by Witkiewitz & Bowen (2010) compared a group of clients who were dual diagnosed with depression and substance dependency treated with mindfulness-based relapse prevention or treatment as usual. The authors found that Mindfulness-Based Relapse Prevention may not only reduce depressive symptoms and craving in substance abusers more than treatment-as-usual, but depressive symptoms and craving that do occur are less likely to result in relapse. MBIs foster change by aiming to reduce distress

associated with negative stimuli by fostering a non-judgmental attitude toward distressing phenomena (Kabat-Zinn, 1982), by developing adaptive changes in thought patterns or one's attitude regarding these thoughts (Teasdale, Segal, & Williams, 1995), and enhancing the ability to accept previously overwhelming experiences in the present in order to eliminate the necessity for substance use as a way to cope with these uncomfortable emotional experiences (Linehan, 1993b). MBIs that rely entirely on mindfulness meditation practice are Mindfulness Based Stress Reduction and Mindfulness Based Cognitive Therapy while MBIs that rely partially on mindfulness meditation are Dialectical Behavioral Therapy and Acceptance and Commitment Therapy (Ciesa & Serratti, 2014). These interventions assume the patient has been able to maintain some period of abstinence.

Factors for Recovery

In addition to treatment time and completion as well as the use of evidence-based treatment protocols, individuals in treatment for alcohol or substance use disorders can benefit from continued utilization of protective strategies following treatment discharge or completion. In the case of mindfulness, Grow et al. (2014) determined positive Mindfulness Based Relapse Prevention treatment effects plateaued at the 4-month follow-up. The authors also reported home practice of mindfulness was not positively maintained following the end of treatment indicating if home enactment were to continue benefits may additionally persist. An emerging self-help recovery format called "Refuge Recovery" utilizes meditation during meetings (Refuge Recovery, 2019). Participation in group meditation may increase the likelihood that participants may also continue their individual practice (Sterling, 1996).

The continued use of coping strategies is also a protective strategy that clients who have completed can utilize. Gossop, Stewart, Browne, and Marsden (2002) interviewed 242 clients

from 23 residential programs in order to quantify what factors are associated with abstinence, lapse, or relapse to heroin use after residential treatment. The authors reported 40% of clients remained abstinent from heroin use six months following treatment and 30% had a brief lapse but did not continue using heroin and 30% relapsed into continued use. The following factors heavily influenced whether a client remained abstinent, lapsed or relapsed. Clients who remained abstinent were least likely to have used drugs other than heroin when compared to the other two groups. Clients who completed their treatment plan tended to remain abstinent even though time spent in treatment was not significant. Abstinent clients also made use of cognitive, avoidance and distraction coping responses after treatment and at follow-up whereas the relapse group tended not to use either. The lapse group used some of these coping responses (Gossop et al., 2002).

According to a review on 12-step self-help groups by Moos (2008), “self-help and mutual support groups are a key component of the system of informal care for individuals with substance use and psychiatric disorders.” The following section will provide a discussion of self-help groups available for individuals recovering from an alcohol or substance use disorder.

Self-help groups. In addition to 12-step based groups, there are a few additional self-help based recovery programs. Two of these, SMART Recovery and Celebrate Recovery, will be discussed briefly prior to examining the current research on the 12-step programs.

SMART Recovery is a self-help group that focuses on self-empowerment while utilizing research-based interventions taught by other recovering individuals. SMART Recovery utilizes a 4-point approach in order to build and maintain motivation, cope with urges, manage thoughts, feelings and behaviors, and live a balanced life (SMART Recovery, 2014). SMART Recovery provides an alternative to 12-steps by not requiring spirituality as part of its program of recovery.

The National Institute of Drug Abuse (2013) endorses SMART Recovery as an alternative to 12-step meetings although NIDA supports 12-step attendance. An interesting feature of SMART Recovery is that it is continually evolving to include new interventions as the research base for these interventions grows (Harvath & Yeterian, 2013).

Celebrate Recovery is an example of a religious-based self-help group that is gaining popularity. According to their website, Celebrate Recovery has helped over 17,000 at its church of origin and is currently utilized in over 20,000 churches worldwide. Celebrate Recovery is a program based on biblical scriptures and not on psychological theory. The program utilizes group support, the Bible and Celebrate Recovery curriculum consisting of related literature in addition to the utilization of the 12-steps (Celebrate Recovery, 2014). Brown, Tonigan, Pavlik, Kosten, and Volk (2013) found participation in Celebrate Recovery led to an increase in spirituality which was associated in increased confidence and self-efficacy in resisting substance abuse although a causal connection was not concluded.

The most popular self-help intervention is Alcoholics Anonymous (AA) and related 12-step programs. According to Dawson, Grant, Stinson, and Chou (2006), almost 80% of individuals seeking some form of treatment for an alcohol use disorder will participate in AA. Tonigan, Pearson, Magill, and Hagler (2018) noted that adults with alcohol use disorders in the United States are more likely to attend AA than enter treatment. AA referral as one aspect of service delivery is made by 74% of professional treatment providers (Tonigan et al., 2018). Kelly, Greene, and Bergman (2014) found that individuals recovering from drugs other than alcohol would initially attend more NA meetings and would eventually end up attending more AA meetings post-treatment. According to a review by Moos (2008), a variety of factors and

related theories explain the success of AA. Attendance, sustained participation, and involvement were associated with continued abstinence. Moos (2008) found the following:

“Consistent with social control theory”, which identifies strong bonds with family, friends, work, religion and other aspects of an individual’s social structure as motivational factors for engaging in responsible behavior:

[Self-help groups] SHGs provide support, goal direction, and structure by espousing positive social values and the importance of strong bonds with family, friends, work, and religion. Following social learning and stress and coping theories, these groups highlight the importance of identifying with abstinence-oriented role-models and bolstering members’ self-efficacy and coping skills. Consistent with behavioral economics, they focus on engagement in rewarding pursuits, such as substance-free social activities and helping others overcome substance use problems. (p. 398-9)

Many studies have found that 12-step attendance and participation is associated with better treatment outcomes. Witbrodt et al. (2014) found a relationship between greater 12-step attendance during treatment and post-treatment and increases in 5-year abstinence as well as 7-year abstinence. Furthermore, Witbrodt et al. (2014) concluded participants who reported low or no attendance patterns reported the lowest average rates of abstinence at these follow-up points. Magura, Cleland, and Tonigan (2013) reported the amount of AA attendance during any previous three months strongly predicted the amount of AA attendance in the following three months. Magura et al. (2013) also reported the percentage of days abstinent during a previous three-month period also predicted the percentage of days abstinent in the following three months. Finally, Magura et al. (2013) found higher AA attendance also predicted a greater percentage of days abstinent. Kendra, Weingardt, Cucciare, and Timko (2014) found when satisfaction with

outpatient treatment and 12-step groups was high, there was a mild positive relationship to less subsequent alcohol use severity in addition to a higher likelihood of abstinence from both alcohol and drugs. In addition, 12-step group satisfaction was also associated with less subsequent psychiatric severity (Kendra et al., 2014). Timko, Sutkowi, and Moos (2010) compared baseline and one-year symptoms, and treatment and 12-step group participation over the year in dual diagnosis outpatients and substance abuse-only patients. Timko et al. (2010) found greater 12-step meetings attendance, as well as having a sponsor and greater number of steps worked predicted better alcohol and drug use related outcomes.

Factors for Relapse

Impulsivity. One contributing factor for relapse is the personality trait of impulsivity (Gullo, Loxton & Dawe, 2014). Individuals with an alcohol or substance use disorder tend to choose actions that bring immediate reward, even when this leads to adverse outcomes at some later time (Davis, Patte, Tweed & Curtis, 2007). Various impulsivity-related models have been developed and applied to understand how this personality factor increases vulnerability to addiction, however, the exact number of facets of impulsivity required to provide the most explanatory power is to be determined (Gullo et al., 2014).

Davis et al. (2007) studied the poor decision-making (impulsivity) in individuals by examining the performance on two versions of the Iowa Gambling Task. Participants were additionally assessed for levels of impulsivity, sensitivity to reward and punishment and addictive personality using previously validated measures. Participants who performed well were classified as “learners” and those who did not perform well were classified as “non-learners.” Non-learners were significantly more impulsive, more sensitive to reward, more sensitive to

punishment, and had more addictive personality traits (Davis et al., 2007). This study links addictive personality traits to impulsivity.

Bechara, Dolan, and Hindes (2002) studied the performance of drug abusers and patients with ventromedial prefrontal cortical lesions on the Iowa Gambling Task. Bechara et al. (2002) found that both groups displayed similar deficits in performance. The impairment of ventromedial prefrontal cortex leads to the inability to weigh pros and cons and postpone immediate gratification leading to impulsivity in present behavior. Bechara et al. (2002) and Bechara et al. (2001) concluded individuals with a substance use disorder exhibit similar poor decision-making as a result of neurochemical adaptations associated with chronic drug abuse or due to some prior risk factor.

A review by Stevens et al. (2014) examined neurocognitive aspects of impulsivity in individuals with a substance use disorder and how these aspects affect addiction treatment outcomes, drop-out rates, and difficulty achieving and maintain abstinence. These aspects are cognitive and motor disinhibition, delay discounting, and impulsive decision-making. Impulsivity is linked to bottom-up processing which involves subcortical brain areas such as the amygdala and midbrain. The executive system is the neural system that provides individuals with measures of self-control to counteract impulsivity. This system is based on top-down processing. (Stevens et al., 2014). The authors found:

In particular, the reviewed studies suggest higher levels of cognitive disinhibition, delay discounting and impulsive/risky decision-making may substantially hamper the ability to achieve and maintain abstinence during and following addiction treatment. Whereas the relationship between impulsivity and treatment retention or drop-out needs to be examined more extensively, preliminary evidence suggests that impulsive/risky decision

making is unrelated to premature treatment drop-out among individuals with a SUD. (pg 69).

Gullo et al. (2014) utilized factor analysis to determine the explanatory power and utility of various impulsivity models in regards to the treatment of individuals with a substance use disorder. Gullo et al. (2014) argue no domain of impulsivity should be studied in isolation and that the bottom-up processes of reward sensitive and disinhibition show “remarkable consistency across domains and provide an optimal balance of explanatory power, parsimony, and integration of evidence.” A study by Staiger, Dawe, Richardson, Hall, and Kambouropoulos (2014) examined the relationship of impulsivity and severity of drug use with treatment outcome and the utilization of mindfulness in improving treatment outcomes. Mindfulness was defined as interventions that improved the capacity to be aware of and experience and accept thoughts and emotional states. Staiger et al. (2014) found impulsivity and severity of drug use predicted poorer treatment outcomes, however, the duration of treatment time alone contributed to better outcomes. Treatment time also affected the ability to utilize mindfulness which additionally improved treatment outcomes. Impulsivity did not have an effect on mindfulness (Staiger et al., 2014).

Stress and life experiences. In a review by Snelleman, Schoenmakers, and van de Mheen (2014), the authors examined the relationship between perceived stress caused by life events and alcohol cue sensitivity. Snelleman et al. (2014) reviewed three global categories of articles with studies that used experimental within-subject designs and provided the strongest evidence for causal relationships, between-subjects design which provide somewhat weaker evidence, and correlational studies which identify a relationship without evidence for causation. Snelleman et al. (2014) found mixed results however a substantial number of articles did indicate

increased stress levels and increased alcohol cue sensitivity. Increased alcohol cue sensitivity increases the risk of relapse. In another review by Krenek and Maisto (2013), the authors reviewed various studies that examined the relationship between life events and poor treatment outcomes and relapse. As part of their review, Krenek and Maisto (2013) discussed various theories of relapse in regards to life experiences. These theories are the cognitive-behavioral model of relapse, the stress vulnerability model of substance use and relapse, self-medication hypothesis of substance use and relapse, stress buffering effects of alcohol hypothesis, and behavioral theories of choice (Krenek & Maisto, 2013). Therefore, it can be concluded that stress is a significant contributing factor to relapse.

Additional studies and reviews have linked a variety of stressful life events to relapse and substance abuse. In a study by Pilowsky, Keyes, Geier, Grant, and Hasin (2013) the authors examined a previously collected data set in order to determine if an association existed between various life events and relapse in formally alcohol dependent adults. Pilowsky et al. (2013) found individuals that had separated, divorced or experienced a breakup of a steady relationship during the study interval were over twice as likely to relapse and return to alcohol dependence as individuals who had remained in a steady relationship by the end of the 3-year follow up period. Pilowsky et al. (2013) suggest this stressful life event is unique due to the additional stress associated with the possibility of the loss of social support as a consequent of the breakup.

A study by Liebschutz et al. (2002) revealed an astonishingly high frequency of physical and sexual abuse among both men and women admitted into an inpatient detoxification facility. The study determined 72% of participants had experienced interpersonal trauma and of this trauma group, 75% had first experienced this trauma as children. For both men and women, interpersonal violence was significantly related to greater substance abuse consequences.

Additionally, men and women with past trauma experienced worse interpersonal relationship consequences of substance use (Liebschutz et al., 2002). As trauma must often be treated on its own, it is likely an individual seeking services for a substance use disorder will not get services for both. This may lead to additional stressors later in the individual's sobriety.

In a review by Lijffijt, Hu, and Swann (2014), the authors examined the literature regarding stress on various stages of addiction including relapse. The authors reported that more traumatic events related to a higher risk of post-treatment relapse (Lijffijt, Hu & Swann, 2014). Lijffijt et al. (2014) additionally reported increased relapse risk among smokers who recently changed residency or had major financial problems. The authors concluded that regardless of specific stressors, the accumulation of negative events related to increased risk of relapse (Lijffijt et al., 2014).

Research specific to Older Adults and Addiction

As previously noted, the literature regarding relapse and recovery factors related to individuals who have achieved long-term remission (15 years or more) of abstinence is scarce. However, a few studies were conducted which are concerned with older adults in recovery as well as relapse in individuals with long-term recovery. The current research builds upon these studies and therefore these will be briefly discussed.

Strawbridge (2007) and Milliard (2006) qualitatively studied the experience of alcoholism in older men and women, respectively. Strawbridge (2007) studied the experience of men aged 55-65 with long-term sobriety (mean of 11.5 years and range of 4 to 21 years). The study found eight themes in three broad categories. These were 1) relationship with self: personality changes, changes in lifestyle, engagement in personal interest, and spiritual transformation, 2) relationship to family and friends: connectedness and caretaking including

family, friends and other AA members, and 3) relationship to community: increased involvement in community life with a generative orientation. Milliard (2006) studied the experience of alcoholism in older women and noted themes in factors related to active use and help staying sober. Factors related to active use were stigma associated with alcoholism and being older women, shame from stigma prompting silence and deceptive behavior regarding use, and low self-worth. Factors related to staying sober were spirituality and support through 12-step fellowship.

Anthony (2006) used interviews to study the experience of individuals who had 20 years or longer, maintained their sobriety and continued going to meetings. The study sample was comprised of eight men and four women who had achieved 20 years or more of sobriety and attended at least one AA meeting per week. The factors and themes that kept these individuals sober and attending meetings were commitment to meeting attendance, importance of a relationship to a higher power, history of AA services and sponsorship, social life, maturity, lessons regarding self-authorship and freedom, responsibility for self, service to others, value of sobriety, fulfillment of AA promises, mixed relationship to psychological diagnosis and psychiatric medication, and positive views of outside therapy.

Singer (2016) used surveys to study the common factors amongst 41 males and 39 females with long-term sobriety. Results indicated that 70% of participants received addiction treatment and that participants reported they were able to maintain their abstinence and recovery through a sense of belonging and connection that accompanied their participation in 12-step self-help groups. The mean length of recovery was just over 15.3 years for males and 10 years for females.

Milani (2013) studied the experience of individuals with long-term sobriety who relapsed through a descriptive phenomenological method. The sample included individuals who had previously achieved 8.5-13 years of sobriety. The study found 15 themes within the data regarding history, use, recovery, road to relapse, relapse and return to recovery. One theme related to history was the strong family legacy of alcoholism or exposure to drug use by family in youth as a priming path for use. One theme related to use was initial development of substance use problem in youth. Themes related to recovery were initial resistance of addict identify from self and family after development of addiction and realization of need for treatment as well as long term sobriety attributed to ongoing personal resolve and commitment to actively working 12-step program. Theme related to road to relapse were the consideration of self to be highly successful in life and career which led to decreased priority of working 12-step program and a sense of complacency, experiencing situational stressors that continued to decrease personal commitment to working 12-step program causing negative emotional states of isolation and loneliness, and rising negative emotional states and passive impulsive thoughts experienced as a constant urge to drink or use as a means of escape. Themes related to relapse were slip with substance rationalized as one time use with no reason to abstain, slip increases distance from 12-step program and increases negative emotional state, and relapse damages sense of maturity and inhibits return to 12-step. Themes related to return to recovery were: 1) fear of the impact of substance use on daily life which motivates the initial thoughts of returning to sobriety, 2) eventual acceptance of need to rejoin 12-step program to reestablish sobriety, 3) 12-step group experienced as healing despite fear of judgment, 4) early childhood exposure to religion allowed structure and doctrine of 12-step program to feel natural, and 5) group fellowship provided sense of optimism about self and future.

Chapter III: Methodology

Method

The research question was “What is the experience of relapsing and returning to sobriety for an individual who had achieved a minimum of 15 years sobriety?” The current study is a qualitative phenomenological study. The phenomenological approach was chosen in order to obtain an understanding of this experience from the perspective of the recovering person (Lester, 1990). This method was chosen in order to gather more data on a phenomenon that has not been given substantial attention in research. The purpose of this research was to understand the subjective experience of individuals who had re-achieved remission from substance use following a relapse despite previously having a substantial time, fifteen years or more, abstinence from substance use and to understand this subjective experience in order to gain insight into their motives and actions without the influence of “taken-for granted assumptions and conventional wisdom” (Lester, 1990). This approach permitted the research to speak for itself without the researcher’s preconceived notions or hypothesis contaminating the data (Hycner, 1985) as additional phenomenon may remain otherwise hidden and untapped as a source for future quantitative research to explore the possibilities for evidence-based interventions. As Giorgi and Giorgi (2003) and Moustakas (1990) describe in their specific phenomenological research study protocols, the benefits of having multiple participants increases the strength of meanings and experiences of each participant by allowing for the possibility of the analysis to determine similarities within the data. These units of meaning may overlap or may provide meaning that are parallel which could provide a platform for additional research.

Phenomenological research is not without some limitations and criticisms. One major concern is regarding sampling and therefore generalizability (Hycner, 1985; Lester, 1990).

Phenomenological research lacks randomization, control groups, and large sample sizes which therefore prevent research from providing evidence of causation as well as generalizability.

Phenomenological research is not random. Participants are selected who have had an experience under investigation and are additionally able to articulate this experience. The depth of data prevents the study of larger sample sizes common in quantitative research. Additionally, qualitative research analyses the data of the participants who have shared their experience and does not contrast this with participants who have not shared that experience. The current study acknowledges these limitations however as Hycner (1985) points out “the critical issue here is that the phenomenon dictates the method (not vice-versa) including even the selection and type of participants” (294). The current study did not seek to explain nor provide evidence towards a specific set of hypothesis but rather describe (Husserl, 1970) the phenomenon under inquiry with the hopes of providing a starting point for future research.

Another major concern is the accuracy of descriptions as well as validity of data. While the experience of the phenomenon is shared via a retrospective report by participants as opposed to direct, observable data, the construction and impact the experience had and therefore how the participant shares their experience provides additional qualitative data regarding the phenomenon. The experience itself is valid insofar as it is an experience that impacted the participant. A final concern is the issue of replicability. Phenomenological and qualitative data appear on the face to contain loose methods that inhibit the replicability of data. This is a valid concern as the experiences of individuals are so personal there may be a deficit of replicability, however in regards to the replicability of the study design, the author had therefore chosen a specific phenomenological protocol and described the process and steps in which he pursued gathering and analysis of the data (Hycner, 1985).

Sample

Participants were individuals who have relapsed following a minimum of 15 years of abstinence from drug and alcohol use. Participants were to have a minimum of six months of abstinence from alcohol or drug use in this current treatment episode. Participants would be members of Alcoholics Anonymous or other 12-step fellowship currently residing in Southern California. Although participants may have had additional co-occurring disorders, as is common within this population (Tonigan et al., 2018), for the purpose of this study, participants with severe mental illness were excluded as this may affect the participant's ability to provide data on their experience and may be more prone to experiencing distress due to discussing sensitive personal material.

Demographics. The sample was comprised of four males and four females ($N=8$). The overall mean age was 58.63 with a range of 51 to 70. The overall mean length of abstinence at time of participation was 3.23 years ($SD=3.61$), for males was 1.36 years ($SD=1.04$) and for females was 8.5 years ($SD=4.46$). The overall mean length of longest period of abstinence was 21.38 years ($SD=8.99$), for males was 24 years ($SD=12.57$) and for females was 17.6 years ($SD=3.5$). The overall mean of age of first use was 13.38 years old ($SD=1.92$), for males was 14 years old ($SD=.96$) and for females was 13 years old ($SD=2.71$).

Seven participants identified as Caucasian/white and one identified as "Italian." All participants endorsed English as their primary language. Four of the participants were divorced, three were married, and one was single/never married. Three had completed graduate studies, two had completed four-year college, one entered a four-year college but did not complete, two completed an associate's degree, and one has completed a high school equivalent. Seven participants were currently employed and one was retired. Five participants made over \$60,000

per year, one made between \$40,000 and \$60,000 per year, one made between \$20,000 and \$40,000 per year and one made between \$0 and \$20,000 per year.

Sampling Method and Recruitment. The study utilized a selective and purposeful sampling method as well as open sampling. According to Patton (1990), all types of sampling in qualitative research are purposeful as this type of research focuses on relatively small samples and therefore each case is selected with purpose. According to Strauss and Corbin (1990), open sampling is a method where the sample consists of those participants, places, and situations which provide the greatest access to the data which is most relevant to the phenomenon that is being illuminated. Participants were recruited from various meeting halls in the Southern California (Santa Barbara, Los Angeles, Orange County) area. Meeting halls are storefronts, buildings, or structures in which 12-step meetings are held throughout the day (Milani, 2013). Flyers were posted online on social media sites and groups for addiction recovery worker, mental health worker, and recovery networking sites. Additional snowball sampling was permitted (Warren, 2002) as other participants may have greater access to other participants who have had a similar experience, however this type of sampling did not produce any participants.

Instruments and Procedure for Data Collection

Prior to an in-depth semi-structured interview, participants completed an informed consent regarding participation in research as well as a brief demographic survey. Informed consent provided information such that the study is towards partial fulfillment of the requirements for the Degree of Doctor of Clinical Psychology, the nature of the study, as well as participant rights. Participants were told that the study is aimed to understand relapse and recovery processes of Long-Term Recovering Persons. Participants were interviewed using a pre-written interview with both unstructured (open) and semi-structured (closed) questions. The

interview format was authored by the researcher using some original questions as well as questions from previously published instruments and is attached as an appendix. Participants were asked open-ended questions regarding their experience. Additionally, probes were employed in order to expand on or retrieve more detail or clarify the experience of the participant as the interview proceeded. Sessions were audio recorded to provide a level of confidentiality and anonymity.

Active Addiction. Participants were asked to detail experience in active addiction such as length of time used, drug of choice as well as impactful events that occurred.

Early Sobriety. Participants were asked about the precipitating event(s) that lead them to contact recovery or alcohol and drug treatment. Additional information such as whether they went to a treatment center, how they felt about it, what was beneficial was explored as well as experience with physical and psychological healing.

Long Term Sobriety. Participants were asked to share experience in maintaining sobriety and life events that occurred along the way that significantly impacted the participant. Additional information regarding contact with mental health and medical professionals was explored and whether they experienced practices indicative of long-term recovery management (White & Kelly, 2011).

Relapse. Participants were asked to share about the experience of relapse. Relapse resulted in a single-use episode, multiple-use episodes or return to active addiction similar to previous research (Daley, 1987). Participants were asked about behavioral or cognitive changes proceeding the relapse as well as other external factors that may have contributed to relapse. Additional information regarding what they felt kept them from returning to sobriety was also explored.

Return to Recovery. Participants were asked to share experience about returning to sobriety and if the experience was significantly different from their previous early sobriety efforts.

Instruments and Procedures for Analysis

Following data gathering, transcription analysis was conducted as recommended by Hycner (1985).

1. Transcription: The interview data was transcribed to include literal content as well as noting significant non-verbal and para-linguistic communications. It was expected that the researcher would enlist the support of a transcription service in order to expedite transcription as well as accuracy (Hycner, 1985).
2. Bracketing and the phenomenological reduction: Prior to listening to the recordings and reading the transcriptions, it was imperative for the phenomenological researcher to become aware of and suspend biases and presuppositions. While it is unreasonable to expect “pure objectivity” in maintaining a dialogue with the self and with the research committee, the researcher enhanced his ability to maintain openness to meanings apparent in the data (Hycner, 1985) by practicing bracketing, as follows: I will now briefly describe my relationship to the research. I am a recovered member of various 12-step fellowships and therefore feel a sense of connection and compassion to others who are struggling with addiction as well as those who are attempting to or have achieved substantial remission from dependency. I have not had the experience under investigation. In my field research as well as experience in clinical work with individuals with substance abuse issues, I had noticed that relapse after long-term sobriety is due to life stressors, drifting from support groups, medical issues,

- decisions to experiment with drugs outside of substance of choice or some combination of these items listed. By preparing an interview in advance and journaling thoughts and emotions brought up in the process, I was able to investigate the data with the openness the phenomenon deserves.
3. Listening to the interview for a sense of the whole: At this point, the researcher listened to each recording several times in order to get a sense of the gestalt or meanings as a whole and continued to note thoughts or impressions that begin to emerge (Hycner, 1985).
 4. Delineating units of general meaning: This was the beginning of the intensive process of “going over every word, phrase, sentence, paragraph and noted significant non-verbal communication” (p. 282) of the data transcription in order to identify a unit of general meaning which is a combination of a cluster of communication which expresses a unique and coherent meaning (Hycner, 1985).
 5. Delineating units of meaning relevant to the research question: Following the identification of units of general meaning throughout the data, the researcher was tasked with determining if the units of meaning were relevant to or addressed the research question. Non-relevant units of meaning were set aside (Hycner, 1985).
 6. Training independent judges to verify the units of relevant meaning: The researcher enlisted the support of his dissertation committee in order to verify that delineated units of meaning were relevant to the research question (Hycner, 1985).
 7. Eliminating redundancies: As units of meaning relevant to the data had been identified and non-relevant units of meaning were set aside, the researcher eliminated units of meaning that appeared to be redundant while noting the frequency and means

- by which the redundancies were mentioned. Non-verbal communication cues were considered in order to provide context of verbal redundancies (Hycner, 1985).
8. Clustering units of relevant meaning: Having eliminated redundant and non-relevant units of meaning, the researcher continued to bracket his presuppositions and began determining whether any of the remaining relevant units of meaning naturally clustered together in order to create common themes (Hycner, 1985).
 9. Determining themes from clusters of meaning: Having determined an initial set of clusters of meaning, the researcher then determined if the clusters as a whole or in subgroups formed additional clusters of meaning (Hycner, 1985).
 10. Writing a summary for each individual interview: Following the above steps, Hycner (1985) recommends writing a summary for each individual interview which incorporates the various clusters of meaning that have been drawn from the data.
 11. Return to the participant with the summary and themes: Conducting a second interview: The researcher did not conduct a follow-up interview with the participant as indicated by Hycner (1985) due to the limited nature of this study.
 12. Modifying themes and summary: Following the second interview, the previous steps would be again utilized (Hycner, 1985). This step did not apply to the current study method.
 13. Identify general and unique themes for all the interviews: Following the completion of the previous steps for all the interviews conducted within the study, the researcher began the process of determining if clustered units of meaning and themes were consistent amongst all the interviews. The following was noted: Themes common to all interviews, themes unique to a single interview or a minority of interviews, and

- whether general themes from the interview include units of meaning not consistent with other interviews with a common theme (Hycner, 1985).
14. Contextualization of themes: Following the explication common themes across all data, the researcher placed the themes back in within the overall context from which these themes emerged (Hycner, 1985).
 15. Composite summary: Following the completion of the above procedures, a composite was written in order to accurately capture the essence of the experiential phenomenon noting commonalities amongst participants as well as individual differences (Hycner, 1985).

Ethical Issues

Confidentiality. Due to the sensitive nature of the content being collected and that stigma regarding addiction still exists, participant's identities were protected. Participant personal information was limited to first names and phone numbers collected to communicate with participants and were safely kept in a locked box at a secure location. Participants were asked not to give their full name during recording. Additionally, transcribers were instructed to change first name of participants to their first letter of their name to further protect the participant's identity and signed a confidentiality agreement.

Informed Consent. Participants were provided an informed consent document to read and agree to by completing. Participants were given a copy of informed consent with researcher contact information if the need for referrals for psychological treatment arose or if the participants wished to withdraw from the study at any time.

Harm. Due to the sensitive nature of the content collected and the likelihood that a participant could have been in early recovery, the participant might have experienced drug or

emotional triggers. In order to prevent additional harm to the participant, the participant was to be debriefed following the interview. Participants were to be asked to identify three fellow recovering individuals to reach out to if needing support and to identify a 12-step meeting they can attend following the interview. Participants would also be provided the phone number for their local Alcoholics Anonymous central office which provides an on-call individual to answer phones and provide support. Fortunately, none of the participants appeared to be in distress following the interview when they were debriefed. The majority of participants had either a mental health professional or 12 step support person they could contact.

Chapter IV: Findings

This phenomenological analysis of interviews with eight participants identified several themes regarding the experience of being a long-timer, relapsing after a minimum of 13 years abstinent, and challenges to as well as factors in returning to AA. These themes are organized as:

Long-term recovery

- Acute treatment only
- Treatment did not utilize evidence-based interventions
- Treatment did not address emotional issues
- Contact with mental health
- Long-timer
- Complacency and drifting

Relapse

- Medical issues
- New trauma
- Justification of the use of medication or marijuana

A new beginning

- Recovery challenges
 - Feelings of ostracism
 - Age-related issues
 - Shame
- Recovery factors
 - Finding acceptance and love within the fellowship
 - Cognitive reframing

- Re-engaging the program with enthusiasm

Sample Limitations

It is important to note that two participants had initially stated they had met inclusion criteria for the study however during the interview revealed they did not meet at least one criteria. Participant 3 reported he had 13 years of sobriety (below the 15-year abstinent criteria) and revealed he had smoked pot in the last few years of his current sobriety which may have affected his current sober time (possibly below the 6 month current abstinence criteria). The data from the interview is included due to its illuminating nature within a non-generalizable research format. Additionally, the longest period of sobriety for a participant in previous research (Milani, 2013) prior to relapse was 13 years and this permits the current study to provide data that is additive while maintaining continuity. This participant's desire to be interviewed provided additional context to the theme of unresolved mental health issues while additional themes were consistent with other participants who fully met inclusion criteria.

Participant 5 reported he currently had 3 months of current abstinence which was also below the 6-month current abstinence criteria. He reported current contact with a mental health professional engaging in therapy as well as compliance with medication assisted treatment. Knudson, Abraham and Oser (2011) note pharmacotherapies are evidenced-based practices for substance use treatment that improve outcomes and Olsen and Sharfstein (2014) indicate, "extended treatment that includes medication is a proven path to recovery and is associated with a lower risk of relapse" (p. 1393). This participant's data was included due to the reduced potential for harm indicated by his engagement with these resources as well as to minimize potential harm from creating shame and stress by prematurely ending an interview while this participant was sharing from a vulnerable position. The remaining participants had their longest

period of abstinence range from 15 to 40 years and their current period of abstinence range from 9 months to approximately 11.5 years. An interesting trend is the mean age that use of drugs and alcohol started was 13.375 years of age which is also consistent with previous research (Milani, 2013).

Overview of Themes

A few participants were able to eloquently describe the process of relapse following achievement of long-term sobriety. Participant 1 stated:

I loved my children so much that without going to the program, I started to worry about the things they had to go through, everything they went through and they'd get hurt a little, I got hurt 10 times more by it you know and I found myself more nervous and more involved in their lives probably than I should have been but everything that happened to them hurt me so deeply and without having a program to talk to my sponsor about it, without talking about enabling them or not enabling them or I did not have anybody to talk about it with and mothers, they have their own idea and I didn't want to get into that you know so I found that Darvocet help me calm down.

This participant summarizes the impact of drifting away from AA and social support while stressors related to mental health increased and then finding relief and relapsing when given a pain medication. Participant 4 stated, "I think, you know what I really think, I think it was a combination of getting disconnected, right through the cancer experience, not getting reconnected then thinking for some reason that I can handle a narcotic." This participant summarizes his experience of drifting away from the program while experiencing a trauma and then justifying the use and subsequent abuse of prescribed narcotics. Participant 8 explained:

...#1 not going to meetings drifting away from meetings, becoming bored with, with the... then probably not doing the program, that's why I got bored (laughter). Think about it, I mean I thought I have been doing this so long, I've taken fourth steps, you know, I have done what I can do, you know, I have done everything I can do and I stayed sober, you know, I have never been, I'll be honest with you, I never found like I never completely been able to get all the shit out of me and on paper and share with another person to my satisfaction, really you know but I had done enough in, I didn't have a drink 10, 20, 30, you know, and yeah I got character deficiency, yeah I got angry, yeah I got yada yada yada we all are fucking human you know, we all, but things are going good, had a job, had the bing, had the boom right and they just got... I don't want to go to another meeting after work, after eight hours on my feet all day, I didn't want to go to the meeting and see people that I really didn't know any more, you know because my group was, that unfamiliarity, the groups and the people, I think that contributed to it and that's all on me because I kept going to meetings right, you know but it was hard to, I wrote some stuff down uh I didn't belong to an AA clique anymore you know and slowly, slowly, slowly I was out here by myself and talking to my buddies and stuff but not really getting back into the mix.

This participant summarizes his experience of drifting away from AA by not connecting with others as well as utilizing AA as a means of relief for issues that may require the assistance of a mental health professional to resolve and increased responsibilities which made AA attendance less palatable. While these statements are quite informative, the following sections will analyze related responses with richer detail.

Long-term Recovery

Several participants mentioned beginning their recovery with at least one treatment episode. Several participants reported either continuous contact with mental health professional, some contact or no contact. For those who attended treatment, treatment was acute in nature and therefore did not address mental health issues or previous trauma. When acute care only focuses on substance abuse and does not integrate other disciplines to address co-occurring disorders, medical issues, social issues and other pertinent issues, the treatment provided may fail to meet the specific needs of the individual and may present a view that all issues can be resolved using addiction treatment interventions and self-help groups (Flynn, 2017; Wolitzky-Taylor et al., 2018). In discussing their experience as a long-timer who relapsed, participants provided rich data regarding their evolving relationship with AA as long-timers, complacency in AA, and drifting away from the fellowship while stressors increased.

Acute Treatment Only. Participant 1 referred to her treatment as a place she detoxed and was steered towards AA. Her description indicated the use of rudimentary Twelve Step Facilitation. She reported, “They had a lot of talks those days of this priest or something that they would play for us and I realized anybody could be an alcoholic” and, “what I learned was they taught me in there that I had to go to meetings to stay sober.” This participant would later return to treatment following her relapse and was one of two participants who had any form of aftercare. Her aftercare consisted of a sober living and was a result of her advocating for her needs.

Participant 2 described placement in psychiatric wards to address her substance abuse and behavioral issues. She presented this treatment as a way of detoxing which did not otherwise engage her drug and alcohol use. Participant 2 found comfort in the containment of this setting as she described in the following:

One was in [city] that I loved, I loved, I loved the psych ward. I just did, it was just safe, it was just like a big womb you know and they just catered to you and they talk to you and they listen to you, nobody ever listened to me, my mother didn't listen to me, didn't hear me, didn't see me, still doesn't that's okay today, at the time was not okay so I thrived a little bit in those, in [hospital name] and in [hospital name]. I didn't use in there and in [city], I had the opportunity to go over the wall and buy you know wine at night so I did that, I didn't think one thing had anything to do with the other because no one was discussing alcoholism.

Participant 6 referred to inpatient treatment as well. She found only attending 12-step meetings to be too difficult and was able to get herself into treatment prior to her insurance running out. Limited insurance coverage for mental health and substance use treatment has been a known barrier to care and persists today despite legislative changes (Huskamp & Iglehart, 2016). Participant 6 also entered a sober living environment following her discharge. She stated:

And that was the start and then I tried to have sobriety just by going to meetings and I found that I couldn't do it, it was too hard and I had insurance that had run out the day after I went into a 30 day treatment...And because it was the day after, it covered it and then after that I went into a six week extended program for women, an extended house for women, so I did about 2 1/2 months...It was 30 days in-hospital, that's kinda how they did it back then it was done in the hospital setting for 30 days and they were very few or at least very few that I knew, kind of Malibu, kind of you know or intensive IOP, just very different.

Treatment Did Not Utilize Evidence-Based Intervention. Participant 6 presented treatment as a way of staying comfortable and monitored while she detoxed from her substance

use. As someone who currently works in mental health, she articulated the following when responding to the use of evidenced-based interventions:

You know don't think there was as much...I don't think the clinicians were quite as trained as they are today, so that they really didn't know it but looking back now I would say the level of care was lacking, it really was kind of a warehouse hospital environment as opposed to a you know let's kind of look at the causes and condition here and get you started, it was enough you know but if there was anything detrimental that's what I would say. Dual diagnosis, also behavioral based, evidence-based, there was very little of any of that back then, but this is '88.

Participant 7 described treatment as confrontational. Current research (Scott & Dennis, 2009; Marsh, 2018; Wolitzky-Taylor et al., 2018) indicates this approach is contrary to the evidence-based practice of meeting individuals where they are at. While this approach worked for this participant it may not have worked for others who entered a similar facility. She described the following:

I wound up at a state-run program where I met a guy in there who was a hardcore, just told it like it was, he said, "you are full of shit, you are going to die and you are not going to sit in here for 30 days and do your time, so I am going to wail on you every single day that you are in here and tell you that you are full of shit" and for whatever reasons, I heard that language I knew that he was somebody that was not gonna listen to my bullshit and so the upside of that was that I got sober. That was the only time I went to treatment where I didn't want to be sober, every other time that I went I really thought I was going to get sober and this time I didn't care and something happened and I stayed sober for 15 years.

Treatment Did Not Address Emotional Issues. Participant 1 referred to recurring anxiety that increased when she became a mother. Her previous experience with treatment did not address mental health issues which may have left her more vulnerable to issues with anxiety later in her recovery process. She revealed “because my anxiety started to take over again, because I was not working the program and so when I came across painkillers, it dulled those sensors and that was a big relief.”

Participant 2 described utilizing rage as a means of coping with unresolved mental health issues and trauma due to neglect and abuse from a mother with borderline personality disorder. She appeared unable to use self-soothing techniques for distress tolerance. The fellowship of AA provided some measure of containment and tolerance to these behaviors which delayed her seeking therapy on her own. Despite receiving treatment in a psychiatric ward, she was not referred to therapy to continue to do her work. Stigma around mental health issues in AA did not promote safety in discussing these concerns. She reported:

But I was too scared to ask and I was too scared to let anybody know, I was too scared, so I was really rageful. Rage was my only emotion for a year and she, you know, they were tough and they dealt with it, they weren't intimidated then and you know I toppled over tables, threw the big book through [meeting hall] and you know they saw me through it.

Participant 3 revealed early trauma and overwhelming guilt. This individual bypassed treatment. He claimed treatment only directed patients to 12-step meetings and decided he would go to meetings on his own. Although he was able to stabilize his drinking which made living with his trauma more tolerable, he never sought out therapy to address his trauma. He stated:

I hit the girl driving a boat and she was underwater, I never saw her but I was pulling a skier so I was paying attention to the skier and didn't see the girl in the water, ran over

her and she died that night, so that was devastating for my personality and my posttraumatic stress disorder is what they call it and I had no idea what it was then, I just knew that I felt like I was going to hell and I didn't care about myself anymore so that contributed to the situation of me not really caring whether I got drunk or not.

Participant 4 made reference to early trauma due to dysfunctional family dynamics.

Although he sought out treatment to work through these issues, he was referred to AA in order to address his substance use disorder first. Unfortunately, it does not appear that this initial treatment center followed up with this participant and he did not seek any therapy until several decades into his recovery. He reported, "Mom and dad were both physically and mentally and emotionally abusive and so I thought that my behavior was the result of that."

Participant 7 also referred to a number of traumatic experiences beginning from early childhood to adulthood. She had reported going through multiple treatment programs that focused on her substance abuse and did not address these issues. She stated:

The guy that I married turned out to be incredibly abusive, which was very strange for me too because I have always been a tough cookie, so he brought me to a whole other kind of a bottom also and I came here at 28-29 to [state], had to go live with the parents in the cult I grew up in.

Contact with Mental Health. Results were mixed for contact with mental health professionals. Participants 1, 3 and 5 reported never engaging with mental health prior to their relapse. Participant 5 reported he did not seek out therapy because he did not believe he had any issues to address. It is also important to note that he was able to achieve long term sobriety without attending meetings or attending treatment. As previously noted, participant 3 stated he was able to tolerate his emotional distress from his trauma by utilizing 12-step self-help groups.

Following his relapse, participant 3 indicated he went to therapy to grieve the loss of his mother, father and brother. He also reported current issues and inferred he participated in the interview for therapeutic reasons. He stated:

I think deprivation and I think for an alcoholic, the emotions are high and probably had ulterior motives coming here today, realizing that I am going to get in touch with lots of things I'm doing right now that are going to benefit me, so selfishly I took it, I went yeah I'll do it, you understand.

Participants 2, 6 and 8 reported having periods of consistent contact with therapists after getting sober. Participant 8 reported meeting with a few therapists and continuing to see a therapist at the VA. While he stated therapy focused on his current issues, he acknowledged that he did not address the effect of these on his recovery program. Participant 6 stated she, "always had a therapist throughout" her recovery. Participant 2 was having difficulty with anger as a secondary emotion and proactively found a therapist on her own. She reported:

I sought out serious therapy... And that you know what, that worked for me because I knew I needed something else, I knew that something was missing in the steps, steps are awesome, I love those steps but I had stuff from childhood and wounds and... I had defenses and harm you know like PTSD and I didn't know the word for that then but that's basically what it was and AA couldn't deal with that.

Participants 4 and 7 reported seeking counseling briefly however terminating at the resolution of their issues after a few sessions. Participant 4 found that his anger was increasing while his wife was getting radiation treatment and this was contributing to marital conflict. He reported:

I interviewed a bunch of therapists and finally connected with this one woman who was a cancer survivor, unfamiliar with 12 steps, so she said, “what’s going on?” So I started telling her stuff and I started crying on the phone, she said, “oh baby you got to come in.” So [spouse] and I made an appointment and she immediately went to childhoods and we discovered that we both reverted back to our survival techniques that we learned, both growing up in abusive household and how we used these behavior again once the cancer was here and it was just fascinating, blew my mind and I was just like holy shit and it only took like 3 or 4 sessions.

Participant 7 shared a similar experience in terms of attending therapy due to problems in her marriage however she found therapy to not be effective. She stated:

[State] was fabulous for grandfathering in therapists that really should not be therapists, not a lot of good therapists there either. So I went to a couple of therapists that were LADACs from the program and in an effort to understand my relationship with [spouse] and my codependency with [spouse] and all that, can’t say that they ever did much... that was true, I mean there were some facts to that but I am sure they were good therapists out there, I just never ran into them and then once [spouse] and I split up then in my head there was no reason for therapy.

Long-Timer. Participants reported a variety of experiences that were particularly impactful for them. Participant 2 reported how her life became fuller, how she found passion in employment, and how she found pride in her success. She stated:

Life got full, I became a private investigator and someone asked me to do it, it wasn't like I thought this up. Then I got back to school and then I got the hours 3000 hours and schooling and just kept doing you know the working for a law firm and then I got hired

on after I got licensed by a large law firm to do many offices throughout Southern California and professionally, I became very successful but I had seven or eight years before all that happened. I am grateful that was the way it was, because I didn't need to get all that too fast, you know, it was good to slow the process for me so I kinda grew into it.

Participants 3 reported a loss of enthusiasm due to the increase in the delayed gratification required for achieving new milestones. He explained:

The double edge, they said the road gets narrower when you are at 10 years, when I hit 10 years, it was a milestone, when I had 11 years, it was sort of a milestone but now, I'm looking for 20 years and I didn't, I no longer have that warm and fuzzy feeling about it.

Participants 6 reported a sense of comfort and confidence in her time. She also explained how this contributed to her slowly reducing the recovery-oriented behaviors that kept her sober until that point. Participant 6 indicated a departure from the "one day at a time" philosophy. She reported:

You know there is a huge ego investment in being a long-timer, it's easy to, the big book says, "It's easy to rest on our laurels" somewhere and, "if we do we are in trouble." You know and I just came to a point where I didn't have to work quite so hard, now I say, now I counted the years instead of counting the days. It's a very dangerous proposition to an alcoholic.

Participant 8 presented his experience as feeling separated from other members due to a time discrepancy and no longer relating to or desiring to interact with newcomers. The longer he stayed sober, the less of his peers remained. He stated:

I don't know when I became a long timer or old timer, I think the first... I remember feeling, I am going to meetings and kids were young, lot of tats, leather and spiked hair, especially out here...feeling...you know them discussing you know their issues and problems and situation, it just became I'd heard a lot of it you know, been there, done that you know, I was too old, I was just too old to put up with that kind of bullshit, I just wasn't interested and kind of became bored, I think that's why I stopped going to meetings especially when our own group the [name of group] kind of disbanded and I was kind of more on my own.

Complacency and Drifting. Participants reported a number of factors which contributed to complacency with working the program and to drifting away from meetings and sober social support. Participant 1 compared pros and cons of attending the meetings in the same hall and at the same time of day. She found herself getting bored being surrounded by the same recovering individuals. She stated:

The bad thing about that was it was in the clubhouse and I should have diversified where I went to different meetings, the same time, every day, different groups. It was a clubhouse and I went to the 12 o'clock meeting, the good side of that is getting to know the stories about people so when they shared I knew what happened to them before.

Participant 4 struggled to return to meetings and relate while his wife was battling cancer. He appeared to develop contempt for other members due to a perceived insignificance of the issues being discussed. He reported:

Going back to meetings again once you had looked death in the face and listen to certain things, it is, it's sort of like, really people, you think that's fucking serious, it's like losing patience because you had been through this very traumatic... and it is trauma.

Participants 6 elaborated on her declining participation in AA. She reported, “Absolutely, I got this, I don’t have to go to so many meetings, don’t have to do so much service work, don’t have to take those annoying newcomer calls, I can help the old-timers because they need me.”

Participant 7 also reported life getting busier as well as how her confidence in her sobriety interfered with her meeting attendance. As she drifted from the fellowship, she found it more difficult to deal with her stressors. She felt pressure as a long-timer to “carry the message” and felt it would be inappropriate for her to share about issues she was having. She expressed a sense of self-imposed isolation. She stated:

During that 10 to 15 years, had my daughter with [spouse] and wasn’t going to meetings per se, my arrogance had peaked, I would go once a year on my birthday to get a chip and to show the newcomer it could be done and by then you’re really in the trenches because you’re really the one with more time, so if you started to be shady or be scared or any of these things, for sure I am not going to go in and talk about it ... so you know, you can say classic stuff everyone says. I quit going to meetings or I did this but the fact when I came back the number one question for me was what happened because if I could give you the formula then it won’t happen to you and I am like there is no formula, you know, I stopped showing up, I stopped paying attention.

Relapse

One set of participants attributed their relapse to be connected with the use of medications or marijuana following an injury or medical issues. The data was split between individuals who abused these substances initially and those who began with medically compliant use. The other set of participants related their relapse following a new trauma or acute stressors.

One participant did not endorse personal experience with medical issues or new trauma however articulated her experience of others who have.

Medical Issue. Participant 1, 2, 4, 6, 7 and 8 described relapse that resulted from medical issues. One common theme is that none of these participants took the medication with the intention of intoxication or abuse. These participants may have advocated concerns about the impact of their recovery taking pain medication to their doctors and were encouraged to take medications regardless. A few participants reported openness to taking medication due to a disconnection with their recovery program. It is important to note an ongoing discussion and controversy in 12-step self-help groups around both medical and psychiatric medications. According to Woody (2015), while psychiatric medications have been categorized as the same as substances of abuse, medications for common medical disorders were not affected by this disapproval of medication. It may be time for a new dialogue. According to Gjersing and Bretteville (2018), there has been a concerning increase in overdose deaths in the last decade. This includes a threefold increase in overdose deaths from prescription narcotics and six-fold increase in overdose deaths from heroin in the United States. When prescription opioid users find difficulty in obtaining pills, they may move on to heroin, which is much more readily available on the streets, in an effort to avoid painful opioid withdrawal.

Participant 1 describes having regular contact with medical professionals and consistently advocating for her recovery. In addition to sharing her experience she also describes a possible lack of sensitivity medical professionals may have with individuals with substance use disorders:

Oh yeah regular checkups and they all do and when I went in I told them, “I am an alcoholic and potentially a drug addict so you cannot give me anything” and that is how my relapse happened...so I went to the dentist and told him, “I’m an alcoholic” and he

said, “well you are going to have surgery so I am going to give you this Darvocet” ... he said, “yeah this will be all right” because professionals don't know, a lot of them don't know, doctors, dentist, they don't know you cannot have a little touch of anything.

Participant 2 describes her experience with relapse due to prescribed medications and how she felt comfortable taking them due to her perception of her prescribing physician. She also describes the gradual realization that her sobriety has become significantly impacted with the effects of the use and increase in medication:

OxyContin... we started with Vicodin and then uhm started with OxyContin, soma and this doctor was prescribing large amounts of it. He eventually, came to find out, committed suicide, he had so many malpractice suits against him and lost his license and his wife OD'd and everything fell apart so who knew, it was just when you, he was an M.D., he was in AA and do you know when you start taking them, you don't realize that you're not okay until you realize it, until for me I knew it, there was a point that I said well this cannot be sober.

Participant 6 describes her experience with relapse and internal struggle when confronted with the decision to use medications. She felt strongly influenced by her sober social support despite vocalizing concerns for her sobriety. She also describes how the decision to put her on medication was the result of a misdiagnosis:

It was very subtle for me, at 10 years of sobriety started, got pregnant and started having horrific migraines, I had toxemia and it was misdiagnosed as, I didn't exactly know what they were saying it was, but they said, “Vicodin was a safe drug to use conservatively with pregnancy” and that was the start of it, and I was in the ER and I was crying hysterical saying to my husband, “I can't do this, this is going to fuck with my sobriety”

and he's like, "you have to do this, you don't have a choice, this is what doctors are telling you and you're going to take it as prescribed, it's not going to affect your sobriety" and so it began and you know the problem with using narcotics even in limited basis is dependency.

Participant 7 describes the experience of others who have relapsed with medications. She describes how initial medication use triggers the desire to continue abusing these medications and how this subsequently lead back to drinking:

I think it was more of these tiny little changes that happen when no one is looking you know, it's, I work with a lot of women who when they actually get sober, start talking to me about that they maybe had a plastic surgery or some kind of surgery where they had pills, and enjoyed it, and so they kept getting pills, even though they knew it was wrong and they skated for one or two years doing that before they actually picked up and drank and then acted shocked how did I get here.

Although Participant 8 did not relapse with prescription medications his relapse was preceded by an injury. His account also describes the use of marijuana. Participants were all from a geographical area where marijuana was legalized for medical use in 1996 and for recreational use for individuals 21 and over in 2018 (Sacramento County Public Law Library, 2018). He said "I got injured a couple of times on the job physically, one day somebody offered me, said, "here try this" ...it was a joint.

New Trauma. Participant 3, 4, and 5 described relapse that resulted from recent traumas. These themes are consistent with previous research (Lijffijt et al., 2014, Pilowsky et al., 2013) that describes relapse due to the accumulation of negative events as well as marital conflict or the loss of an intimate relationship.

Participant 3 referred to a series of deaths that he experienced as trauma as well as marital conflict with his wife:

My father went first, my mother, I made it through those two and the... my brother in Colorado and he had aortic dissection and I pretty much sent him away in a helicopter to Denver and never saw him again and I went, saw him dead the next day, it was pretty traumatic (cries). I am still not over it...Probably started out with pot and then later on drinking after I lost my brother...and the things I am going through with my wife right now.

Participant 4 described the impact of his involvement as a primary caretaker during his wife's battle with cancer. This participant's relapse was additionally preceded by medication use:

The trauma and what it was about and recovery that that was a whole separate recovery you know when you are present and you have to be around these people, some who died and people who are really fucking sick, you are surrounded with them almost every day so uhm that took us away a little bit.

Participant 5 described the impact of his break-up with his child's mother while his mother was dying from cancer. His remarks indicate additional acting out consistent with limbic area generated reactions that culminated into substance use:

I had been getting into fights with my ex you know, well obviously my girlfriend at the time and my mom got sick, my mom got cancer, my ex was already kind of like putting the little of feelers out that she wanted to break up because she was much younger than I was so she felt for her own reasons and wanted to move on. Then I found out my mom was dying, my mom did not have much time, it was really a couple of weeks, so long story short, I would visit my mom in the hospital and coming home and getting it from

my ex, “we need to talk about this, I need to move on, sorry you’re going through this with your mom but you know, I need to do this for my own reasons.” We have a one and a half-year-old kid, it was like too much for me and I, one time I got really mad and I threw the remote control at her you know whatever long story short, she called the cops, moved out like just right away, ready to take her stuff, she was planning on it because there was a lot of her stuff was already gone, I didn’t find out until she moved out and my mom, my mom was a week away from dying and at that point, I just, I couldn’t handle it.

Justification of the Use of Medication or Marijuana. One factor in the gradual increase of medication use and resulting dependency were cognitive distortions and beliefs regarding medication and marijuana. Participant 1 indicated she was able to justify her use of narcotics because she had a substantial amount of recovery time. She still believed she was sober because she wasn’t using alcohol, the pills did not affect her like alcohol did, and simply for the fact that they were pills despite moving on to obtain these medications from illegal sources when she developed a dependency. She stated:

I said, “yeah I would be able to handle it, I have been 17 years sober, I have not taken a drink or drug you know that whole time” and he gave me a Darvocet and my whole attitude changed it was like this doesn't make me black out, this doesn't make me fall down the stairs, I can do this and by that time I was hooked even on this little amount and I could not get them from him anymore so I bought Percocet on the street and I started using that. Now I still thought I was sober, that's how the disease will completely like, I think my mind is constructed as an addict and alcoholic but the program put the connection in the right places, as soon as I take the drug into my body, those connections

fell right back so finally somebody gave me an OxyContin, I didn't know what it was. I am a smart person but I didn't ask questions because it was a pill you know, I didn't care.

According to Participant 3, there may be some misinformation circulating regarding marijuana within the fellowship of AA. Even though he has the insight that smoking marijuana leads to drinking for him, he does not appear to consider it a relapse. He reported:

There are a lot of people that believe that smoking marijuana is not the same as alcoholism...even in the last couple of years, I may have smoked pot a couple of times and found out, I don't need this but my psyche wants to go, well it's not drinking you know, but one hit and then I start feeling loss of control of my reality.

When Participant 5 was probed regarding whether taking pills after having been abstinent from methamphetamine, his drug of choice, and other drugs for 15 years was acceptable because of their label as a medicine and he affirmed this. Similarly, when reflecting and paraphrasing Participant 6's responses, she also acknowledged that even though she did not intend to become intoxicated and impaired, her medication regiment moved her in this direction. She also continued to take these medications because she was prescribed the medication under a doctor's care. Participant 6 would eventually use marijuana edibles to detox and would acknowledge her relapse when she took a drink of champagne shortly after that. She explained that part of her needed to relapse with alcohol and marijuana so her relapse would appear more concrete.

A New Beginning

A final set of themes emerged as the relationship of former long-timers continued to evolve with recovery and AA. These themes are explored as recovery challenges such as difficulty returning due to feelings of ostracism, age-related issues, and shame as well as

recovery factors such as finding acceptance and love within the fellowship, cognitive reframes, and re-engaging the program with enthusiasm.

Recovery challenges.

Feelings of ostracism. A number of participants experienced ostracism from previously supportive members when they relapsed. One participant perceived stigma from his use of methadone which effectively reduced his desire to attend meetings. Participant 2 and 3 shared how they felt ostracized. Participant 3 reported “Well I felt that they weren’t, well there is a clique of people that have a lot of time, and they kind of ostracize the people with less time.”

Participant 2 reported:

They were not welcoming, they were not reassuring, it was not about you know, how they say, “we don't shoot our wounded” but they did and I.. I was appalled because I had welcomed people back for 15 years up there at [clubhouse] you know when people drink or use, I was always someone that would reach out to them and said, “you know it's okay you have today” you know, so no one is immune and I knew that part, so it was like a shock to me.

Participant 5 appeared to have a limited amount of experience with 12-step fellowships however he felt particularly hesitant to continue trying to engage with meetings due to his use of medication assisted treatment. Suzuki and Dodds (2016) indicate that individuals taking methadone or buprenorphine are not fully accepted at these meetings because these individuals are not considered abstinent when they participate in this form of evidence-based treatment. Further, 30% of the participants in their study indicated concern about non-acceptance and 37% frequently avoided disclosing their use of these medications. Participant 5 echoed this sentiment, “Yes, because even in some AA groups they don’t want you to be on methadone you know, but

for me it's like, screw you, you know, it's like, I'm going there for help but they say that I am like it's just..." and appeared very frustrated and disappointed when making this statement.

Participant 7 shared an experience of how she accidentally overheard other members speaking about her in a humiliating manner. She also articulated the emphasis AA places on continuous time abstinent and how this may dissuade individuals who have relapsed from returning to AA. She reported:

She laughed after she thought she had hung up and said, "how does it feel to have more time than [participant]?" That was the mentality of a lot of dynamics of the people that I ran around with and that was really, really hurtful and I was very angry and I think I built it up bigger in my head than it was, I had a couple of experiences like that which then made me feel like I thought everybody was judging me the same way but I think mostly it was that I judged myself, and the embarrassment and shame that I felt and that is my one criticism that I have on 12 steps, if we put this much emphasis on time then what happens if you lose your time, yeah I mean it's crazy in some aspects.

Age-related issues. Participant 2, 3, and 7 provided some data on particular age-related issues. Participant 7 reported, "I will say this time I noticed memory gaps." Participant 3 stated:

I don't want to be that way anymore, it's not comfortable to be impaired for a person at my age because I am impaired naturally, just by my age, I feel high all the time because I'm sober if that makes any sense. I don't know, I am at the age where somethings, don't, I don't remember so much, and that's fine.

Participant 2 reported increased shame that came with having to start recovery over as an older adult. She explained:

Well sure my age, when I turned 60, I freaked out, I just and I never freaked out over this number, you know 40, 50, whatever I was like I can smile, life is really good so I was good with that but when I turn 60, I thought wow this is sad, I mean this is, this is, I didn't think that I would be there at 60... my ego definitely got smashed.

Shame. Participant 3, 6, and 8 elaborated on shame. Participant 3 reported feelings of shame from having been ostracized. He provided context for the view that feeling less than is a core feature of an alcohol use disorder. He stated:

Yeah it made me feel less than. Which is part of the disease, it's the reason we did it to medicate that, the codependency issue for me is paramount, I know that from all the experiences I had, the in and out of the program, as even when I am sober working with normies, I have it come up once in a while.

Participant 6 also discussed feelings of shame and attributed this negative emotion to the reason why individuals who have relapsed may not make it back to recovery. She reported:

It was you know, I have since said I understand why people die trying to come back, it was the most humiliating, painful, didn't think I could recover from, you know, I will never forget taking those first chips because I had recovered, I was an old timer right?

Participant 8 described how shame leads to regret and other negative affective states. He stated:

I was sitting in a meeting with my now current sponsor, I was sitting over in meeting, it was like three or four days and I was, I was shaken up because I had really screwed the pooch that Saturday night and this was a Wednesday morning meeting and bunch of people took cakes, 15 20 25 years, people that I knew I would see around you know and that just, I just kinda thought what the fuck have I done for you know 40 years?

Recovery factors.

Finding acceptance and love within the fellowship. Participants who successfully returned to AA reported a sense of acceptance from members they interacted with although at times this level of acceptance may have been mixed. Participant 1 discussed a feeling of a personal connection with others who have shown her compassion and love by responding to her calls for help and allowing her to reciprocate. She reported:

I find I am more active on a personal basis of people calling me and me calling people for help and that kind of stuff than the outward, where me being some chairperson, that does not really turned me on and I really have good self-esteem because of what this program taught me.

Participant 4 shared he was met with more acceptance than judgment. He was relieved when he was not exposed to the level of humiliation he anticipated. He stated:

I was amazed at, I tell you, I was amazed at the, people were totally accepting and said this is going to be great tool for everybody, being able to share with everybody, really valuable tool for some people and I didn't expect that from certain people and from the people that I expected more acceptance, I got judgment.

Participant 8 shared that he was met by kindness and love when he first came back to the rooms. He was provided comfort and reassurance when he was at a particularly emotional and difficult place in his early recovery. He reported:

I started to melt down in that meeting and my sponsor reached out, put his hand on my thigh, I was just, he said, "[participant] this is an inside job, you are going to be all right, just hang in there, you know this program, you can get back, you're going to be all right" and that connected with me.

Cognitive reframing. Another common experience among participants who began re-engaging with the program was experiencing a cognitive reframe. Participant 3, who had previously felt ostracized and less than, was able to reframe his views by considering what he may contribute to the fellowship. He realized he can interact with a wider range of members and be equally of service to both. He reported:

Absolutely, that doesn't bother me anymore because I understand if I had... I can sit with someone who's got 20 years and converse with them and relate with them then and I can also sit and talk to a newcomer so my experience with being a slipper, I feel I can help even more people.

Participant 4 battled with regrets and feeling less than. Once he was able to reframe his relapse as an event in the road to recovery, he found himself finding more acceptance in himself and becoming reacquainted with qualities sought by many in recovery. He stated:

I would have been 29 years, so the week after would have been my birthday, people took cakes for 29, two people and I thought to myself, you know shit (laughter), should've been up there, you know and I felt a little humiliation, a little shame, but then it just turned into humility, it was just a humbling thing that I like just said, you don't fucking have it anymore, that's it, you're not gonna, that's it, they have it, you don't, so what, doesn't make any difference, doesn't make me any less you know, actually I feel like you know it's never been stronger for me to be honest with you.

As noted earlier, participant 6 struggled with the humiliation and shame at losing her time. In order to address this, she resolved to approach recovery from the vantage point of a newcomer and by doing so, was receptive to her sponsor's suggestion that she can help another person who may go through a similar experience. She reported:

You know I had to go in with the mind of a newcomer and that was very hard to do because I felt like I had a lifetime of recovery so my biggest challenge was staying humble. My biggest challenge was keeping my mouth closed and my ears open and I remember saying to my sponsor, “I don’t know why this is happening” and she said, “it’s so that you can give it back later or you can share the experience with someone else later.”

Participant 7 also ruminated about losing her time due to relapse. She found strength in reframing this loss as an opportunity to begin a dialogue about the subject in meetings she had attended. She stated:

You are left with the indelible impression that, you know, you will always be the one who relapsed and it went until I started talking in [city] especially when I started talking about my relapse in the rooms, and I would share every meeting that I went to, and I don’t care if you guys are sick of hearing from me, I just need to say this in every meeting that I go to that I had 15 years and I got drunk and you know sooner or later other people started saying you know what, “I had 12 years and I got drunk” but prior to that, it was a taboo, like nobody ever said that.

Re-engaging the program with enthusiasm. Participants who re-engaged with the 12-step self-help groups found a new spark of interest and sense of enthusiasm. For example, participant 1 experienced this sense of enthusiasm to continue engaging the program due to the posttraumatic growth she experienced when she returned. During her relapse, participant 1’s daughter committed suicide and was devastated. She explained:

If you get dry without the program you might as well get high because you're going to live miserably either way, you know? If you have a program of recovery then you could

get happy even in my circumstance, I feel joy, I feel a connection with my daughter and it is all because of the spiritual part of the program.

Participant 4 found new social support helped him re-engage with the program.

According to Singer (2016), the sense of belonging or connection that accompanies recovery heavily contributes to the maintenance of recovery. Participant 4 reported that he was able to replace that feeling of connection. He reported:

So people that I used to talk to more, I don't talk to as much because I just don't feel that same connection with them but now some of the people that I didn't have a strong connection with them, now I have stronger connection with them.

Chapter V: Discussion

The aim of this study was to learn about the experience of individuals who have relapsed after achieving long-term sobriety and challenges they faced in regaining remission from their activated substance use disorder. In addition to learning about these experiences, the study sought to find themes that correlated within their experiences and observe how these related to previous research. As Milani (2013) notes, there is very little research on the experience of older adults with substance use disorders, even though this group has an abuse rate as prevalent as the general population, and despite findings that increasing age and opiate use increases mortality risk (Gjersing & Bretteville, 2018). The current study contributes an additional layer of context to previous research while maintaining continuity.

The themes discussed in the Findings are connected in the following way. Participants entered recovery with unresolved mental health issues or trauma and if treatment was utilized, their acute symptoms were stabilized in a short-term treatment center that did not address these emotional issues nor use evidence-based practices. They also did not get connected to aftercare programs. Participants were more likely to remain unmonitored following discharge and were less likely to pursue long-term therapy to address their mental health concerns because they were utilizing the program of Alcoholics Anonymous as their main tool to cope with distress. They began to become more complacent in AA and drifted away from both sober social support as well as meetings while their stressors increased. At some point, participants developed a medical issue or became overwhelmed with new trauma that resulted in relapse. This medical relapse was not acknowledged due to the justification of the use of medications. It is possible that they entered another acute treatment center with moderate improvements from their initial experience however were less likely to be monitored or pursue a step-down aftercare plan. Participants

found difficulty returning to AA, their primary source of recovery, due to feelings of shame, humiliation, and ostracism. These issues may have been compounded by issues related to age or status as an older adult. They would eventually find acceptance and love within the fellowship, find a way to reframe their negative thinking, and re-engage the program with enthusiasm.

Recent research and clinical experience are driving treatment for substance abuse towards the integration of other disciplines and shifting conceptualization of care from acute to long-term. McKay et al. (2009) indicates, “that research studies have consistently indicated that effective continuing care interventions are likely to include some or all of the following components: extended monitoring; incentives and consequences for performance at the level of the patient, counselor, and program; alternative forms of service delivery; and utilization of community supports” (p. 127). Dennis and Scott (2007) state, while many individuals can be treated from an acute framework, findings suggest that more than half of individuals entering treatment will require multiple episodes of treatment over several years to achieve and sustain abstinence. Dennis and Scott (2007) also point out that the acute care model has encouraged the belief that patients will be cured after a single episode of specialized treatment and will be able to maintain lifelong abstinence. Scott and Dennis (2009), however, explain that while illnesses that are time-limited are more likely to be treated in a single episode of acute-care, chronic illnesses have cyclical natures and their course is not fundamentally altered by acute episodes of stabilization. Flynn (2017) states, “much progress has been made in the United States in recognizing drug addiction as a chronic health condition rather than a social problem” (p. 1337). Additionally, while acute care assists with the stabilization of addiction, it focuses on reducing consequences and utilization of a coping skill (albeit negative and harmful) without an equal

amount of time spent increasing rewarding and enriching activities in recovery which are required to sustain long-term sobriety (Flynn, 2017).

The following will provide recommendations to address the aforementioned themes which may have implications for all recovering individuals. Limitations of the current study will be discussed as well as directions for future research.

Recommendations

The first recommendation is to continually provide psychoeducation regarding medication use in sobriety and expanding the dialogue regarding Medication Assisted Treatment (MAT) and psychiatric medications. A common theme amongst participants was the use of opioid pain medication that resulted in relapse as tolerance and dependence increased. Treatment recommendations may include discussing the pros and cons of using medications that may impact recovery, creating a safety plan if medications are required, and using transparency with sponsors, family and social support. This is consistent with previous research which notes, people in recovery need a community of family, employers, and peers from 12-step self-help groups with whom they interact with “total transparency” in order to initialize ongoing support which includes the monitoring of progress and receiving a rapid response when they begin to have trouble (McKay et al., 2009). Additionally, previous literature has already expanded the dialogue regarding MAT and psychiatric medications. Inpatient as well as outpatient treatment centers must be willing to discuss these potential sources of benefit with their patients.

Alcoholics Anonymous came into existence at a time when effective medications for substance use disorders or psychiatric disorders did not exist and despite advice from early founders who suggested recovering individuals should remain open to medical developments which could increase the likelihood that members get and stay sober, current thinking amongst older members

indicates an aversion to these types of medications (Galanter, 2018; Woody, 2015). A consequence of the medication/no-medication divide has been that the two systems of treatment have not integrated and do not interact well with one another. Recently, the DSM-5 has attempted to resolve this “no-medication” problem by indicating that individuals with a substance use disorder can be in remission while using these types of medications (Woody, 2015). Research also indicates treatment with medication has, “the potential to improve clinical outcomes for individuals and reduce the negative impact of substance abuse on families and communities” (Knudsen et al., 2011) (p. 375). Knudsen et al. (2011) also stated, “pharmacotherapies for the treatment of substance use disorders are evidence-based practices that improve clinical outcomes when combined with psychosocial therapeutic interventions” (p. 375). While MAT and psychiatric medications may not be needed or desired by all individuals seeking services, these useful interventions should be communicated about openly to maximize possibilities for achieving abstinence.

The second recommendation is to integrate the use of psychotherapeutic interventions such as Cognitive Behavioral Therapy (CBT) and Dialectical Behavioral Therapy (DBT) to address mental health issues while using Twelve Step Facilitation (TSF) and Motivational Interviewing (MI) to assist patients resolve ambivalence and engage with 12-step programs in order to prepare them for long term social support and to address trauma with specifically trained therapists on an outpatient basis. The majority of participants in the study presented with some form of trauma or other mental health issue indicating other recovering individuals may also have similar issues that may remain unaddressed. Dennis and Scott (2007) have indicated a mismatch, between the etiology of substance use disorders amongst patients and treatment approaches, reduces the ability of clinicians to assist individuals with addiction issues. Tonigan

et al. (2018) reference an estimate that indicates there are more than seven million individuals with co-occurring disorders which most often include mood and anxiety disorders, posttraumatic stress disorder, and personality disorders such as anti-social personality disorder and borderline personality disorder. Tonigan et al. (2018) also indicate a general consensus amongst providers, clinicians, and researchers that best clinical practice for co-occurring disorders is integrated mental health and substance use treatment along with AA attendance. Despite this general consensus, Wolitzky-Taylor et al. (2018) indicate that individuals with a substance use disorder and for example, an anxiety disorder, are more likely to get treatment for their substance use issues than for their mental health issues or both even though anxiety is a pathway that maintains and exacerbates drug use. Findings demonstrate that psychiatric comorbidity, which contributes to the maintenance of substance use disorders may require more integrated treatment (Wolitzky-Taylor et al., 2018). Flynn (2017) suggests that integrated treatment will assist in meeting the needs of the whole patient. While integrated treatment should address mental health symptomology, it should also connect individuals to 12-step programs which have a wealth of supporting research (Kelly, 2017). One of the primary mechanisms of change for recovering individuals is social support (White, 2009). Kelly, Stout, Zywiak and Schneider (2006) report, “patients who participated in AA had better outcomes regardless of which treatment they had originally received” (p. 1382). A quasi-experimental study found being treated in a TSF program predicted greater frequency of working with a sponsor and more frequent attendance at meetings at a 1-year follow-up (Humpreys & Moos, 2001).

The third recommendation is for treatment providers is to integrate a multi-disciplinary team which includes substance abuse counselors, psychotherapists, case management, psychiatry, general medicine, and other disciplines. It is also recommended to include the patient

in decision making which tailors treatment to the individual and addresses substantial barriers to achieving sobriety. NIDA (2018) indicates, “the best programs provide a combination of therapies and other services to meet the needs of the individual patients.” According to Marsh (2018), there is growing evidence that substance abuse treatment is more effective when issues such as health, mental health, parenting, vocational, housing and legal are also addressed. Services that adjust care and titrate intervention intensity and duration to the needs of individuals with the understanding that one size does not fit all provide better treatment outcomes (Day & Mitcheson, 2017). Further, according to Huskamp and Iglehart (2016), “The American Academy of Family Physicians, the American Board of Family Medicine, the American Academy of Pediatrics, the American College of Physicians, and the American Medical Association have all released statements calling for improved integration of mental health care and general medical care” (p. 691) which is driving innovative changes across the country. For example, behavioral couple therapy improves both substance use outcomes and marital satisfaction in patients who present as alcohol-dependent (McKay, 2017). Patient-centered health care refers to engaging patients in dialogue about outcomes that are important to them and often consulting if their goals have changed (Kolind & Hess, 2017). Individuals entering treatment are able to identify needs when they are asked and when patients are involved, “they are more likely to remain in treatment, reduce post-treatment substance use, and to be more satisfied with treatment” (Marsh, 2018) (p. 999).

The fourth recommendation is for treatment providers to begin setting up an aftercare plan with long term recommendations as soon as possible after intake and assessment (to avoid issues when a patient must be discharged early due to non-payment from managed care) and to designate staff dedicated to ongoing monitoring of discharged patients and assisting them with

transitions. A well-known barrier to the receipt of services is inadequate medical coverage as well as limited insurance coverage for these services (Gallanter, 2018; Huskamp & Iglehart, 2017) which increases the urgency for the need of aftercare planning. According to McCollister et al. (2013), “most treatment clients complete an episode of residential or outpatient care without any link to continuing-care services” (p. 2167). For our current treatment system to effectively transition into a continuing care long term model, it is paramount for more effective integration of the initial treatment phase and the continuing care phase (McKay et al., 2009). Bergman, Hoepfner, Nelson, Slaymaker and Kelly (2015) indicate attending “step-down” aftercare such as residential treatment following detoxification, and outpatient treatment following residential treatment, along with entering a sober living environment, were more likely to lead to continuous abstinence. Additionally, research suggests that what is required to influence an individual to seek services is different than what is required to sustain remission (Kelly, 2019; White, 2009) and step-down services will continue this dialogue with patients. Case management staff can assist with the continuity of care and ongoing monitoring staff can assist with extended monitoring of sobriety status and pro-recovery behavior which is the continuing care component with the greatest evidence of effectiveness (McKay et al., 2009). Scott and Dennis (2009) suggest more assertive monitoring by staff lead to improved outcomes and prevent further deterioration and decompensation by patients who have relapsed. Kelly et al. (2006) found that ongoing professional interventions can include ongoing face-to-face group or individual counseling or telephone counseling or case monitoring. Several studies have been conducted to determine the effectiveness of the recovery management checkup model (RMC) (Dennis & Scott, 2007; Scott & Dennis, 2009). The core assumption of RMC is “long-term monitoring through regular checkups and early reintervention will facilitate early detection of

relapse, reduce the time to treatment re-entry, and consequently improve long-term participant outcomes” (p. 960). Rather than relying on participants to identify increasing issues, staff are more proactive with quarterly assessments and feedback. MI techniques are used to re-engage participants with treatment if necessary. Results from both studies indicated patients in the RMC group returned to treatment in greater numbers, returned to treatment sooner, attended treatment on more days, and were less likely to be in need of treatment after two years than patients in a treatment as usual group (Dennis & Scott, 2007).

The final recommendation is for treatment providers to encourage patients to attend yearly check-ups with primary care physicians who are knowledgeable about addiction as well as recovery needs and are notified about the individual’s past issues with substance use (with patient consent). Treatment providers should also invite patients back to treatment for at least one outpatient counseling session every three years to address new stressors or decreased attendance at 12-step meetings. According to McKay et al. (2009), “continuing care should be available through other medically oriented service delivery systems, such as primary care or community mental health centers” (p. 129). A study by Chi et al. (2011) found that individuals who completed a substance abuse treatment program had reduced negative consequences of relapse and increased likelihood of remaining sober when they met yearly with primary care physicians who understood needs specific to recovering individuals and also met with a mental health professional every three years. This study involved Kaiser which is a managed care organization that integrates a number of services. For treatment providers that do not have the same resources, efforts can be made by ongoing monitoring staff to link patients to these services and encourage them to not only attend but to provide releases of information permitting the exchange of data.

Limitations and Future Research

The current study is not without limitations. First, this study is qualitative and as noted earlier, limitations of qualitative research center around sampling and generalizability. The sample in this study was not random and was not compared to a sample of individuals who did not relapse. The sample of the current study was small ($N = 8$) which is not generalizable. Additionally, participants were primarily Caucasian which did not capture culturally relevant factors that may impact the sobriety for other groups. Participants had been attending meetings in southern California which has an exceptionally high concentration of treatment centers and meetings and therefore information about individuals with long-term sobriety in areas with less access to these recovery resources were not obtained.

It may be beneficial for future research to focus on the following. Investigation into the quality of substance use and mental health remission for individuals who are offered treatment that addresses mental health issues, trauma and substance abuse in order to explore the benefits of offering patients services in this format. Additionally, investigation of whether individuals in the 5-10 year range of abstinence benefit from trauma-focused psychotherapy and if there are positive outcomes for sustained recovery and quality of life. A quantitative study exploring relevant themes from the current study and others (Milani, 2013; Singer, 2016) in order to compare results from individuals with long term sobriety who have remained in sustained recovery and those have relapsed may provide more generalizable data. Phenomenological research similar to the current study with participants from diverse cultural backgrounds will provide more context in understanding if there are other needs that treatment providers must also address when tailoring services. Future research should provide additional data that will lead to

an increase of funding to treatment providers to incorporate the recommendations research including the current study have indicated will lead to better treatment outcomes.

Conclusion

The current study provides new phenomenological data which suggests that an acute care model that does not integrate other disciplines may negatively affect the ability for an individual to sustain long-term recovery. Stages for the resolution of severe substance abuse issues are the destabilization of addiction, recovery initiation and stabilization, and recovery maintenance (White, 2009). Although policymakers, clinicians, patients, families, and the general public believe that patients should be cured and remain abstinent for their lifespan following a single treatment episode (Scott & Dennis, 2009), current research confirms the limitations of the acute care model as indicated by deficits in attraction, access, engagement, and retention, as well as increased treatment readmission rates (White, 2009). These findings along with recent post-treatment relapse rates and increased mortality invalidate the assumption that acute care can provide immediate or sustained positive recovery outcomes (Scott & Dennis, 2009). In fields other than substance use treatment, the severity and progression of chronic conditions have been positively impacted by ongoing management even though these conditions could not have been prevented and may not be cured (Scott & Dennis, 2009). The research and current study demonstrate the necessity of shifting from an acute biopsychosocial stabilization model to one of sustained recovery management similar to the treatment conceptualization driving outcomes for other chronic health conditions.

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Questionnaire for Interviews

Active Addiction

Can you tell me what active addiction was like prior to getting sober or while in the process of getting sober?

Can you tell me about the length of use and the progression of choice of substance?

Can you share any events or experiences during this time that were particularly meaningful to you?

Early Sobriety

Can you tell me what prompted you to stop using drugs and/or alcohol?

Can you describe the means by which you were able to discontinue drug and/or alcohol use?

What was that experience like?

What did you find particularly beneficial about any treatment episodes? What did you find particularly harmful or detrimental about any treatment episodes?

What did you notice about the progression in regards to the healing of your physical, emotional and mental health?

Can you share any events or experiences during this time that were particularly meaningful to you?

Long term Sobriety

Can you tell me what it was like to become a long-timer?

Can you share what was helpful in regards to your support group?

What type of contact did you have with mental or medical health professionals during this time with regards to your recovery?

Can you share any events or experiences during this time that were particularly meaningful to you?

Relapse

Can you share about your experience with relapse?

Looking back, what factors do you feel contributed to your relapse?

Did you notice any behavioral or cognitive changes that occurred as you were headed towards relapse?

During your relapse were there any factors that made it more difficult to getting sober again?

Can you share any events or experiences during this time that were particularly meaningful to you?

Return to Recovery

Can you describe the experience of returning to sobriety?

Was treatment, if sought, a different experience than when you initially got sober?

What challenges have you noticed in this attempt at sobriety? How are these different than before?

Can you share any events or experiences during this time that were particularly meaningful to you?

Demographic Information

Please check or fill in each answer when applicable

1. **Gender:** ___ Male ___ Female
2. **Age:** ___ years old
3. **Ethnicity with which you identify:**
 ___ African American
 ___ Asian American/Pacific Islander
 ___ Caucasian American
 ___ Latino/Latina
 ___ Other: _____
4. **Marital Status:**
 ___ Single/Never Married
 ___ Married/In a committed relationship
 ___ Divorced
 ___ Separated
 ___ Widowed
5. **Highest Level of Education:**
 ___ 8th grade or less
 ___ High School or equivalent (no degree)
 ___ High School graduate
 ___ 2-year college
 ___ Trade/Vocational School
 ___ Community college or 2 year program
 ___ 4-year college or university; not completed
 ___ 4-year college or university graduate
 ___ Graduate degree
6. **Annual Household Income over Past Year:**
 ___ \$0-20,000
 ___ \$20,001-40,000
 ___ \$40,001-60,000
 ___ \$60,001 and above
7. **Primary Occupation** _____
8. **Primary Language Spoken** _____
9. **Age First Started to use Alcohol/Drugs** ___ years old
10. **Longest Consecutive Period of Sobriety** ___ years old
11. **Current Consecutive Period of Sobriety** ___ months and ___ years