An Interpretative Phenomenological Analysis of Service Users' Experiences in a Psychosocial Addictions Intervention

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Abstract:
Objectives. The aim of this study was to explore the subjective experiences of participants who; a. received a psychosocial intervention as part of an addiction recovery research trial, b. responded to treatment through drug reduction, with the intention of eliciting qualitative change processes of recovery.
Design. Data were collected using semi-structured interviews designed to capture detailed descriptions of participants' experiences of recovery within the intervention.
Methods. Eleven participants who had achieved drug abstinence or significant drug reduction by successfully completing the psychosocial intervention took part in the study. The data were analysed using Interpretative Phenomenological Analysis (IPA).
Results. Five superordinate themes were identified relating to 1. An active, individualised and skills based intervention that validates a new way of being, 2. Staff that foster good working relationships based on trust and safety within services that do not stigmatise, 3. To be understood individually, historically and psychologically and with regards to the pernicious relationship with drugs, 4. Motivation is personal, intrinsic, requires vigilance and is driven forward by periods of success through abstinence, 5. Interpersonal connectedness is essential to recovery; family is a key reason to abstain and friendships can either facilitate or hinder success.
Conclusions. These findings suggest that the success of the psychosocial intervention may be due to a combination of modality specific factors and also broader holistic aspects that were provided through intervention. Future research is required to generalise these findings to wider addictions populations.

Keywords:
Addiction, Psychosocial Intervention, Lived Experience, Interpretative Phenomenological Analysis, IPA

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Research data are not shared.

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Introduction

Drug abuse has a devastating impact on various areas of an individual's life including education, employment, social functioning and mental health. The National Drug Treatment Monitoring System (NDTMS) reveal statistics to show that of all clients in treatment for addiction 53% concern opiates and 9% non-opiates (NDTMS, 2018). Current clinical guidelines recommend Opiate Agonist Therapy (OAT) in opioid detoxification, with methadone and buprenorphine as first line treatment (NICE, 2007a). These medications show assuring results in addiction recovery but do not benefit all patients and relapse is common (NDTMS, 2018). Guidance also recommends the use of psychosocial interventions in combination with medication where appropriate (NICE, 2007b). There is strong evidence for Contingency Management (CM) which involves providing financial rewards for abstinence based on behavioural reinforcement principles. Additional non-behaviourally purist psychologically informed treatments are recommended including Brief Motivational Interviewing (MI), Self Help 12-step Facilitation, Behavioural Couples Therapy (BCT), and Cognitive Behavioural Therapy (CBT) for the treatment of co-morbid common mental health problems (NICE, 2007b). Social Behaviour and Network Therapy (SBNT) also holds an emerging evidence base in the treatment of addiction (Copello, Williamson, Orford, & Day, 2006). Despite this evidence base, understanding the process of recovery through psychosocial intervention may involve a shift from examining named techniques to instead understanding change processes (Orford, 2008).

Responding to these issues, the Addiction Recovery Clinic (ARC) randomised controlled trial that took place at a specialist addictions clinic sought to test the effectiveness of a psychosocial package labeled Personalised Behavioural Intervention (PBI) on heroin and crack cocaine users (Marsden et al., 2017). PBI involved the delivery of techniques from CM, MI, CBT, BCT and SBNT uniquely tailored to the individual's formulation, delivered by assistant and senior psychologists. Treatment fidelity was rated by an independent consultant psychologist. Participants were randomised to either OAT, as the treatment as usual (TAU), or OAT plus PBI. The researchers sought to test the clinical and cost effectiveness of PBI compared to TAU in achieving abstinence measured by self-reported abstinence for four successive weeks and a urine drugs screen test at follow up. PBI was found to be significantly clinically and cost effective; 16% of participants in the intervention group responded to treatment compared to 7% in the TAU group (Marsden et al., 2019). Whilst these results are pivotal to informing practice, the study design does not capture a picture of all of the benefits of the intervention with regards to subjective experiences of psychosocial functioning and factors associated with addiction. Specifically subjective accounts may identify emergent change processes in recovery.

The limitations of singularly quantitative measures are reinforced by Neale et al.'s (2014) content analysis investigating the responses of addiction staff on recovery indicators; contrary to conventional measures used, staff identified fifteen indicators of recovery including health, psychological, social, educational and well-being factors. A further study by Neale et al (2015) investigating service user focus groups to examine the difficulties of recovery measures, highlights the failure to recognise individual differences, as a limitation. This supports Orford's (2008) review of addictions control trials where he states that research underplays the role of the therapeutic relationship, unaided change in recovery, broader settings such as the family and social networks

and personal circumstances, and active contributions of service users to the knowledge about the change process. The need to address issues of subjective experience in addiction is highlighted by Larkin and Griffiths (2002) who suggest self and identity to be integral to addiction experience and crucial to an understanding of recovery. Further Koski-Jännes (2002) report that identity formation appears to be an important factor in acquiring personal meaning in recovery in order to solidify changes made. Extending our understanding of the role of identity, McKeganey & McIntosh (2001) examine the notion of recovery as repairing a "spoiled identity", impacting on motivation to stop drug use and planning a future that is potentially different. Understanding idiographic experience of the self in recovery may therefore shed light on change processes central to achieving abstinence.

The authors of the study at hand therefore propose the need to examine the qualitative dimensions of treatment recovery in participants who achieved abstinence or a significant reduction in their use of heroin or crack cocaine in the ARC intervention. Current evidence suggests we need to move beyond efficacy testing of psychosocial interventions for addiction, to also examine their mechanisms of change. We therefore investigated the experiences of the treatment responders in the ARC trial with a focus on what worked, why these interventions worked, what didn't work and what could have been improved regarding the intervention. The aim was to understand the subjective experiences of participants who responded to treatment in the ARC study and gain insight into the change processes that enabled treatment success.

Methodology

This study qualitatively investigates the experiences of individuals who responded to treatment within the ARC trial.

Recruitment

A sample of individuals who underwent the PBI treatment arm of the ARC trial and experienced treatment success was sought, yielding fifty-one individuals. The ARC data was scrutinised, initially searching for cases that achieved abstinence (non-use) in either heroin or cocaine at the final trial follow-up, yielding twenty-eight individuals. The PBI Treatment Outcome Profile (TOPS) data was then analysed and the Reliable Change Index (RCI) was calculated to determine individuals that did not achieve abstinence but did undergo a statistically significant reduction in their drug usage, yielding a further four individuals. The TOPS and RCI are validated within the addictions field (Marsden et al., 2008). Individuals were contacted in reverse chronological order from the point of completing the trial to counter against hindsight bias, and cases that achieved abstinence were contacted in priority over cases that made a significant reduction. An invitation letter was sent, followed by a maximum of three attempted phone calls. Eligibility was checked in a three-stage process; on the service data management system, with the service users' keyworker and with the service user prior to interview.

The eligibility criteria matched that of the ARC trial, excluding individuals who were outside the age range of eighteen to sixty-five years, no longer known to the recruiting service, unable to comprehend English to a level sufficient to engage in interview, living in unstable accommodation, or suffering a significant relapse or psychiatric condition impacting on their capacity to participate or provide informed consent. Those with significant negative health circumstances, suicide planning or recent (past six months) suicidal ideation or suicide attempt, and current criminal justice involvement

were also excluded. These criteria yielded twenty-two individuals who were invited to take part in the study, of which eleven responded and attended interview. Ethical approval for this study was granted by the UK Health Research Authority (London-Bromley Research Ethics Committee; 16/LO/1430).

Participants

The sample was homogenous due to the shared experience of the trial and comprised of six males and five females, ages ranging from thirty-two to fifty-four years. Participants identified as white, mixed and 'other' ethnic groups. Four of the participants were in voluntary employment, one in paid employment. All but three participants were single in their relationship status. Six participants had an educational level of secondary school or higher; three educated to diploma level and two to degree level. All clients achieved abstinence from heroin, cocaine or both substances. Pseudonyms are given, created by a random name generator and all identifiable information was omitted during transcription. Participants were informed of their right to withdraw from interview and their data within a six-month period.

Analysis

Interpretative Phenomenological Analysis (IPA) was used to analyse the data following the procedures outlined in Smith, Flowers and Larkin (2009); overviewing the text, collating preliminary exploratory notes categorised into descriptive, conceptual and linguistic. Initial emergent themes were identified and then clustered into superordinate themes. A cross-case analysis was completed to create a table of master superordinate themes evident across the whole sample of participants. These were then evidenced and addressed in order of prevalence and significance. Specific attention is paid to 'hot cognition', linguistic, temporal and metaphorical items, as well as those of conceptual interest. IPA as a qualitative method was chosen to address the idiographic lived experience of being in the intervention; Phenomenological analysis allowed both a descriptive and interpretative understanding of the essential meaning of their recovery as existing within the wider experience of suffering addiction. The double hermeneutic; making sense of the participant as they make sense of themselves (Smith & Osborn, 2007), enabled a subjective exploration of change processes that are difficult to determine quantitatively. As per Smith, Flowers and Larkin (2009) rigour was maintained through triangulation in supervision and the use of a reflective journal. To ensure transparency an audit trail recorded the critical stages of research and analysis as per the categories outlined by Halpern (cited in: Lincoln & Guba, 1985).

Materials and Setting

Demographics and informed consent were sought on interview and participants were provided with a patient information sheet. A de-brief sheet was provided at the end, along with a £30 voucher and pre-paid travel tickets for their time. A fourteen item semi-structured interview with 'Socratic style' prompts was used to investigate factors within and outside of the study that were helpful and unhelpful to drug reduction. Items were worded to elicit subjective experiences through 'how' and 'what' questioning in line with the method of analysis. Additionally the schedule explored three topics identified in the addictions literature; the impact of social networks, motivation and periods of abstinence, on recovery. Participants were also asked to describe their thoughts and opinions on the future development of services. Interviews were recorded on a voice recorder and later transcribed by the researcher using voice recognition software. Participants were reminded to be mindful of disclosing identifying

information during the interview. Interviews took place in a private room in an addictions service. The researcher obtained an honorary contract with the associated National Health Service (NHS) Trust and specific IPA training prior to conducting interviews. Where possible participants were contacted within twelve months for member checking of the analysis.

Results

Five superordinate themes were identified and are discussed with reference to sub-themes and evidencing quotes by participants. As per Smith, Flowers and Larkin (2009), superordinate themes were those identified in over half to nearly all participants and are presented here in order of their corresponding weighting. Particular consideration is given to an overview of convergent themes over divergent details.

Theme 1: An active, individualised and skills based intervention that validates a new way of being

All participants spoke positively of the intervention but directed criticisms at the wider context of addiction services where routine treatment was described as non-person-centred. PBI was praised for its choices of techniques offered as well as the flexibility with which it could be delivered. Participants underpinned helpful aspects of the intervention as goal driven, skills based and proactive. These factors were described by some as more important than making sense of their personal narratives. Individualising treatment to suit the personal needs of the client was deemed important whilst the CM component provided validation for their hard work through recovery. Two sub-themes demonstrate these points.

An active, skills based and goal orientated intervention; creating a new way of thinking and being

A structured intervention was met with excitement and appreciation. Sabrina describes it as *"good fun"* and exclaims "*Oh my god… Contingency management, the little goals setting things was good, I found them really helpful. […] Smart goals as well, that were achievable."*. This active intervention seemed to promote self-enablement:*"She'd try and help me think of things to do… I just had to do them instead of being a pussy, you know what I mean?"* (Eric), allowing clients to stay active in their own recovery: "*well sort of pointed me in the right direction you know, helping you, […] to reach goals to sort of push you"* (Kristina). Comparisons were made between PBI and a less structured counseling approach; "*Trying to fix something rather than just open-ended…"* (Dana), with the latter even perceived as intrusive by Sabrina and Lora. Undergoing the intervention seemed to provoke a different way of thinking in line with cognitive restructuring: "*I'd often catastrophise things; "Oh, […] it's gonna be world war three" you know?""* (Shannon) and adopting a more mindful attitude:

> *Yeah. So when I, if I get bored, I go out and do something, know what I mean? You know, sometimes I'll just go out the house and I got… I got a park across the road from where I live and I, and I analyse the seasons and the trees and how it looks back in spring, summer, autumn, you know what I… and it all come into place.* (Frank)

Whilst the intervention elicited proactive engagement from clients, this was heavily reliant on intervening at an appropriate time: "*The timing, it just all came together perfectly for me* […] *So that's, so it's good when you […] catch us. [Laughs]"* (Anne), and a number of participants describe their experience and engagement being distinct and potentially not applicable to all clients.

Vouchers were key for acknowledgement and validation but were not the sole motivator

CM vouchers were received differentially amongst participants as something to provide food, to treat selves with, and a means to 'payback' family members for the pain caused through addiction. The vouchers also had an emotional function of serving to validate hard work through recovery: *"it was like, I was given something, but then I felt like I'd, it was my first ever feeling of, I felt like I'd just been to work and then I'd been paid at the end of it."* (Anne). This validation seemed to spur on motivation to abstain: *"That's that way I look at it, as a reward. And it just made you want to do it more. Made you feel good about yourself."* (Lora). Participants felt "safe" (Anne) receiving vouchers over money as these enabled them to foster self-care: "*that was a joy again to actually start getting money and not just having to spend it on gear"* (Dana). Whilst the vouchers were validating and facilitative of a healthier lifestyle, some participants noted that they were "*more than the money"* (Irvin) and weren't valued over recovery itself: *"the vouchers were handy right, […] but I wanted to get something from it, [...] I wanted to come back with some good news"* (Shannon). Eric highlights the significance of being given the space to open up as more important:

> *People turning up just for the vouchers and that, I don't think it's the right incentive… well maybe it is just to get people there, but… it's getting people to open up I think, you know what I mean? You're not just coming for vouchers.*

Despite being a behavioural intervention, CM appeared to function through self-esteem, self-efficacy and socially driven means, and whilst it is valued it is not seen as superior to the talking therapy component.

Theme 2: Staff that foster good working relationships based on trust and safety within services that do not stigmatise

All participants praised their PBI therapist, highlighting the therapeutic relationship as one that is based on and also elicits trust and honesty. Safeness to be vulnerable and discuss difficult material was appreciated. It was important that the therapist conveyed an understanding of addiction and eagerness to empathically engage in psychological activities with the participant. Criticism was directed at wider service structures and in particular the administration of OAT, providing examples of what wasn't so helpful in the wider context of addiction services. Participants demonstrated their fondness of PBI through comparison with routine practices which they described as more impersonal and less facilitative of recovery. Psychosocial intervention was valued over medication and application of the latter without strong working relationships appeared to lead to disillusionment and even stigmatisation.

A therapeutic relationship based on trust, safeness and listening to lived experience, with staff who are proactive, personable and sensitive to distress

Participants emphasised their appreciation for their therapists: *"Yeah! She was brilliant! She was amazing! She was really good. We got on really well."* (Sabrina). Being sensitive to distress seemed to enable participants to engage with the intervention:

> *If I wasn't feeling like talking, she knew. Was, well… Cos some days I was just "urgh". And she would just gently, gently, and she'd get, she'd get where she wanted to be in the end. But she was really gentle.* (Sabrina)

Whilst participants valued a therapist who allowed them to space sessions according to their own needs, it was also particularly important to be prompted and directed by the therapist. Eric praises his therapist: "*she was very keen to get on with… [the intervention]*". Participants describe unconditional positive regard in their accounts of feeling "special", "care for", and "listened to" (Shannon, Anne and Susie). Anne's use of hyperbole: *"I felt that I had special time for me. Um, I felt important. I felt seen. I felt real, like a real person."* emphasises immense gratitude for this unique relationship and iterates the de-stigmatising nature of this: "*I didn't feel um, ashamed of um, what… The problems I was having."* (Anne). The importance of honesty and congruence is highlighted by clients: "*Well I would come in and be honest"* (Sabrina) and *"so our relationship, I, I really relied on her, that she was […] honest… and tell me the truth, […] I could be vulnerable around her."* (Anne). Dana comments on a therapist that was "*genuinely delighted that I was doing well and surprised actually as well, I think?"* signposting the exceptional nature of being attended to. Being trusted seemed to create a sense of duty to the therapist in Shannon: *"I honestly felt that um, I didn't want to let her down. Do you know what I mean? [...] I didn't want to disappoint her."* Some participants emphasised the need to listen to lived experience of addiction. Lora and Sabrina describe working with staff that don't appear to value lived experience: "*You, you just see how they act, how they carry on towards you. And more into their books and thingamajig's than…"* (Lora) and "*I call them textbook junkies. The ones that think they know it all from what they've learnt in uni, in college. They haven't actually had a drug addiction."* (Sabrina). Irvin suggests it is not essential for workers to have lived experience but rather is helpful: "*I-I'm not saying that, a person that wasn't errr, habit, cannot be a good key worker, or cannot … I'm not saying that, but what I'm saying is that errr… it's easier for the people who, have an addiction before."*

Staff treatment and the way a service is set up directs whether it will facilitate recovery or stigmatise and degrade

Whilst participants talk positively about the intervention and its therapists they reveal their difficulties with the wider services. Eric highlights the distinction between staff that are trust worthy versus staff that "*just can catch you out",* signifying the sense that some staff would be judgemental towards him using drugs. He advises: "*Yeah just with being open with people and that and mm, not trying to… not trying to suss em out [...] just taking them for how they are. Find out why they're doing this. You get to the grassroots of it and then you're halfway there, you know."* Dana re-iterates the idea that trust and understanding are key to motivating clients: "*rather than being pissed off with me for lying about stuff I think… It sort of starts you on another course"* and speaks highly of staff where: "*I didn't feel that there was any agenda […] it felt like they were there … for you? You know? They're on your side rather than … there to fix you or … you know?"* Irvin describes the need to be empathetic

and normalise the reasons for addiction: "*So was helpful to, to, to have someone that is saying to you listen "You were sick. You cannot […]take on the weight of the world or even, on your back forever""* and warns us of services that do stigmatise clients, where despite years of abstinence may be treated as if "*you are just a junkie, that's it…"*, for accessing services. Dana describes a situation where staff become jaded because *"addicts are terrible because we just keep relapsing and we keep lying to people*", whilst Dean expresses the need to *"Not see people as an addicts of heroin or addict of alcohol but going […] in his life. You have to go in his life to know what the hell is wrong with that person, because even sometimes we don't know what's wrong with us."* He highlights that addiction services are distinct from other health care services but their needs are just as important: *"If this is seen as an illness, we're not treated as ill people."* These narratives emphasise the importance of a good trusting working relationship where clients feel safe and have space to talk. Lora explains that staff need to commit themselves to working with addiction: "*You gotta love, love the job, you know."* echoing a sentiment evident across cases that working in this field requires more dedication than other roles.

Theme 3: To be understood individually, historically and psychologically and with regards to the pernicious relationship with drugs

Most participants explain that it is fundamental to recovery to be understood and go on to describe this across various dimensions; to understand their pernicious relationship with drugs and the impact of drugs on mental health and vice versa. These areas link to a wish to have personal histories known in order to facilitate empathy from others. Understanding an addiction identity as unique from others was also important in facilitating recovery.

A pernicious relationship with drugs; a complex form of self-abuse and abuse to others

Participants describe their relationships with drugs as futile, causing mental and physical pain but also as hard to walk away from. Frank's contradictory: "*it soothed a lot of wounds but I initially done it for a bit of fun […] It's rubbish. It's rubbish what… what has it done for me?"* captures a sense of turmoil in this relationship. Kristina and Lora describe drugs as self-abuse reflecting abuse done to them in earlier life: "*I've been abusing myself. I've been abused, right, by somebody and abusing myself, can you imagine? That's even worse. [Laughs] Letting that hurt me, you know."* (Lora). Her laughter denotes a perceived absurdity about using drugs in this way. Dean suggests drugs use is not entirely within his control:

> *This problem is not logical. Like, people they don't understand it. Hell like, for people for twenty years, they, they are maybe crying all the time because they don't want to take the drugs, but they still doing the drug every single day. So is something, it's not logical. Is something there. Is, is, it snaps some people brain, or it turns people ideas like, upside down.*

This is extended by Frank's personification of heroin as "*not there for Christmas, it's there for the rest of your life"* whilst cocaine is *"such a selfish drug"*, and they take on a life of their own:

> *I mean first of all, first, I thought it was a bit of fun. But then I found that it… done something for me that no other drug could and that was to not think about*

the past and I, I never because that was my love life; heroin. It was my wife, my partner, my friend, my best friend.

Mental health and addiction impact each other in a symbiotic process; a difficult personal history is the backdrop to addiction

Participants seem to want staff to understand addiction as a mental health problem yet that it is distinct from other mental health difficulties: "*someone who drinks and takes drugs has got some mental problem somewhere… they're not happy"* (Eric). They signpost their own mental health struggles in anxiety, depression, self-esteem, psychosis (Eric, Shannon, Dean, Susie), whilst the majority of participants signpost difficulty through earlier experiences without diagnostic terminology. Kristina, Lora, Susie and Shannon describe instances of abusive histories leading to addiction and many participants reflect on the idea of compartmentalising earlier life abuse without leaning on drugs: "*You can't keep blaming the rest of the world and filling your body with drugs because it's always gonna be there. But you just have to find ways of dealing with it. And I think I've done that now."* (Kristina). Many participants indicate that mental wellness marks recovery and that understanding personal history is vital to recovery.

Addiction identity is both shared and individual, and it's vital to listen to lived experience

Participants describe it as critical to understand the mentality of the service user: "*Na, but you've got to get into a junkie's mind, do you know what I mean?"* (Frank). Participants use the interview to inform the reader of what this identity encompasses:

> *And there's something in that, th-that's really appealing to an addict is that, not having to care, not having to give a shit" […] "that addiction sort of thing which is just "sod everything" "it doesn't matter" and that's kind of the appeal of it. It's the simplicity. You just go and score. Nothing else matters. As long as you've got that fix.* (Dana)

This identity is described as "radical" and impulsive (Dean), "selfish" (Frank), and "stubborn" (Dana), suggesting that to engage them in treatment special considerations need to be made: *"I don't think anyone likes being told what to do but addicts especially not really … you know?"* (Dana). Dean also highlights the importance of understanding this identity through intervention, in order to make sense of himself: *"Um, [finding out] who Dean was actually and um, being aware of that person, […] he changed my perspective."*

Theme 4: Motivation is personal, intrinsic, requires vigilance and is driven forward by periods of success through abstinence

Participants describe motivation as something that cannot be externally elicited alone, but rather intervention needs to occur at a point when they have high levels of motivation.

Motivation is personal and intrinsic. It needs to be fostered and the intervention timed appropriately.

The intrinsic nature of motivation is summarised: "*If there's no drive, you're not gonna get nowhere. You've gotta have motivation."* (Sabrina) and their needs to be a certain amount of pressure applied on themselves: *"So it was a bit difficult but I knew, I knew…*

[…] it's not what I wanted to do, but that's what I needed to do." (Dean). We see a combination of pull motivators by being driven through the challenge itself (Sabrina) and push motivators such as not wanting to let down or lose friends and family (Eric, Frank, Dean, Susie, Irvin and Kristina), and reaching a threshold of frustration with using: *"I really have had enough. Of the lifestyle. I can't take it any more"* (Susie), and *"Umm it [Heroin] wasn't doing anything for me, it's just err, when I can have it. It was up and down and err…"* (Eric). Their own success through abstinence becomes a driver for further motivational processes. Kristina reflects on how this extends to feeling more motivated to engage with life in general as she now enjoys getting up in the morning.

Recovery requires vigilance, personal responsibility and listening to intuition.

Sabrina describes the need to listen to intuition as a driving force: "*Like I say, I always analyse stuff and I should just follow my gut. And sometimes I don't. So… and my guts always right.*" whilst Dean explains that motivation is sustained through personal responsibility:

> *Consistency. Consistency and um, patience.* […] *I mean, I think ummm, you guys seen addicts, probably every day. Patience is not one of the virtues we have, I think. So erm, we need to like force ourselves to be patient again or to, to give opportunity to, to listen to other people but, but for all of that to happen you have to understand we have a problem. You have to understand, you have to sort out your problem, and err do something about it. And when you decide to do something about it, you actually have to do something about it, to take the action about it.*

Theme 5: Interpersonal connectedness is essential to recovery; family is a key reason to abstain and friendships can either facilitate or hinder success.

Participants describe strong social networks in family and friendships as protective against relapse whilst drug-using networks are destructive. A lack of social connectedness blocks the road to recovery.

Family as protective and a wish to not let them down

Family networks provide a reason to abstain. Shannon describes wanting his daughter to *"be proud of me* […] *to value me"*, whilst Lora describes being able to see her son again who was in care and working towards seeing her other children. Anne however describes the conflicting pulls between drugs and her family: *"But that pull of addiction is just as strong. So you know, even with my family in the middle, you've got* […] *the abstinence and freedom there. And then you've got my children"*. We see stigma internalised as Frank wants to abstain so as to avoid the embarrassment to his family if he were to die an addict: *"[laughs] It's not a way for your kids to think about ya.* […] *"Ah, what did your dad die of?" "Ah, he died of a heroin overdose" "what, you sure?""*. Eric extends this with:

> *Um, well it's that I wanted to do it anyway, it's just like umm… I'm getting on… I'm a granddad now so it's like… [...] Like, my children know I'm a heroin addict, so… it's a bit shameful I think.*

Fostering new friendships that are beneficial and moving away from drug using friendships that are a risk for relapse

Participants describe the harmful effects of drug-using networks: "*With drug addicts I've got this, I'm sorry but I can't stick up for a lot of them because they, they do shit on you, is the word"* (Susie) and "*at the end of the day they're all trying to f- fuck me over",* (Shannon). Eric describes assurance from seeing himself as different from them now: *"Yeah and that gave me confidence as well because going… watching them going downhill and going slowly… becoming more stupid every bit until… until more crap [laughs]"*. Participants describe the paradoxical nature of being drawn to these social circles, but also how it is fundamental to recovery to make new social circles.

Discussion

This study qualitatively investigated what worked for participants within the addictions intervention, giving weight to major themes that identify possible change processes. Intervention techniques that were identified as personally effective were goal setting, behavioural activation, cognitive restructuring and mindful thinking. However these results may be biased because CBT formed part of the intervention protocol. Future research would therefore explore change processes in a variety of psychosocial treatments. The description of growing psychological awareness as educative, transformative and meaningfully impacting on their recovery identity relates to Orford's (2008) suggestion for the active contribution of service users' knowledge about the change process. Their narratives also expose the possibility for caveats around the traditional application of these techniques; in goal setting for example, where removing the self from triggering environments and peers is a priority over working towards new aspirations.

An effective therapeutic relationship is identified as being closely aligned to Rogerian principles. In addition, the need to disclose was described as essential. These relationship features provided a sense of safety emboldening their own ability for honesty in the relationship, which in turn facilitated pro-social behaviour towards the therapist, expressed in a sense of duty to them. Importantly an inability to describe the effective characteristics of the therapists alludes to the notion that inherent and inexplicable qualities make a good therapeutic relationship. Services may conclude that whilst Rogerian principles are necessary, they may not be sufficient in this population; providing empathy to enable difficult disclosures may be key to facilitating a working relationship. A limitation of this study may be the difficulty of distinguishing the suggested mechanisms of change that are attributable to features of the therapist from that of the intervention. Future research may want to measure therapeutic alliance features more precisely.

The need to be understood may be a relevant tacit feature of what works within the therapeutic alliance. However, it may also connect to issues of interpersonal identity; to be able to communicate a personal narrative that reinterprets aspects of drug using lifestyle, reconstructs a sense of self and provides an explanation for recovery may be critical to recovery (McIntosh & McKeganey, 2000). Participants describe how identity as an 'addict' alienates them and perhaps interferes with a working alliance. The impact of internalised stigma is evident in self-depreciating comments of feeling ashamed for rather than empathic towards addiction. Such issues therefore require further investigation into the interplay between social, identity, motivational, and therapeutic alliance factors.

The participants highlight the fluid and dynamic nature of motivation; shifts between trans-theoretical model (Prochaska & DiClemente, 2005) change stages are evident. However, they occur through a more complex rather than linear process, interwoven

with social factors. In line with discourses by Miller and Rollnick (2013), motivation is described as needing to be inherent to the individual, rather than cultivated. All participants converge strongly on the notion that threats to close interpersonal relationships instigate an active motivation to change. These results are limited by the possibility that the participants were motivated to engage in the RCT and in this retrospective investigation, revealing the need to explore the link between interpersonal factors and motivation with larger samples.

Participants describe interpersonal connectedness as a key reason to recover and non-drug using friendships as essential to maintaining abstinence. Relationships to others and to drugs are addressed in the attachment model of addiction (Davis, Patton, & Jackson, 2018). These results suggest the need for secure attachments to replace the role of drugs in emotion regulation. The intervention may therefore have been in-part successful because it addressed social networks and allowed exploration of interpersonal relationships. This signposts the need to foster good family and social relationships as a replacement for drug relationships. A good working relationship with staff may serve to model this at early stages of treatment. It is also important to note that due to the study taking place in the UK the results may have Eurocentric implications; more collectivist cultures may show different examples of utilising relationships and supporting one another to facilitate recovery.

Conclusion

In summary these narratives provide insight into what worked and what hindered within an evidence-based psychosocial intervention. Whilst convergent themes are highlighted it is important to also recognise the individual experiences portrayed by each participant; each narrative communicates a unique tonality conveying the ability to direct a bespoke intervention to meet individual needs. This reflects the importance of identity factors as highlighted in the qualitative addictions research. Whilst this study conveys the complexity of change processes, the design prevents a description of the wider factors generalisable to addictions treatment. In establishing homogeneity of the sample the authors only approached individuals who had successfully completed the intervention, potentially positively biasing these observations. Future research could therefore consider qualitative investigations with different participant groups. It could also consider quantitative explorations of the potential variables emerging from this study to determine change mechanisms in treatment. The implications of this study are that it provides clinicians with an insight into the experience of evidence-based interventions, creates suggestions for possible mechanisms of change and also confirms prevalent themes pre-existing in the addictions literature.

Declaration of Interest

The primary author of this study worked on the ARC RCT as an Assistant Psychologist administering the psychosocial intervention. They were not involved in the service at the time of completing this study and did not interview participants that they had worked with.

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