

**Embarking on Recovery: When Does Stigma End?
Investigating the Experiences of Discrimination and How
These Affect Aspirations in Recovery from Substance Misuse**

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degree of Doctorate in Clinical Psychology**

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CANDIDATE DECLARATION

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Declaration and signature of candidate
<p>I confirm that the thesis submitted is the outcome of work that I have undertaken during my programme of study, and except where explicitly stated, it is all my own work.</p> <p>I confirm that the decision to submit this thesis is my own.</p> <p>I confirm that except where explicitly stated, the work has not been submitted for another academic award.</p> <p>I confirm that the work has been conducted ethically and that I have maintained the anonymity of research participants at all times within the thesis.</p> <p>Signed: _____ Date: _____</p>

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Preface

Individual journals are being targeted for publication of paper one and paper two. Journal submission guidelines can be found in Appendix A for paper one, and in Appendix B for paper two. Some similarities occur in the requirements for each submission, therefore the American Psychological Association (APA) 6th edition formatting style has been used throughout, and each paper has been written using double line spacing, in font size 12 using Times New Roman.

Word Counts

Paper one = 8,925

Paper two = 7,369

Paper three = 2,429

Total word count = 18,723

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Full Thesis Abstract

The thesis has been completed in partial fulfilment of a Doctoral training course for Clinical Psychology. It focuses on an area of personal interest to the author, developed through working with the target group both before and during completion of the course. The first paper outlines a literature review on stigma and discrimination for those with a history of drug and alcohol addiction. Paper two presents empirical research carried out to explore how personal experiences, or a fear of discrimination, impacts upon the aspirations of those entering recovery from substance misuse. Paper three comprises a reflective account of the author's learning experiences and future planning for further research. The literature review highlighted that many of those in treatment or recovery from addiction, have experienced discrimination in various settings, such as housing, employment and healthcare. These experiences often led to increased anticipation of discrimination and caused individuals to conceal their history of addiction in order to reduce the possibility of negative experiences within recovery. The literature review highlighted a lack of understanding in how such experiences impact upon aspirations for recovery, and a qualitative research project was conducted to explore this issue, using Interpretative Phenomenological Analysis (IPA) methodology. Three super-ordinate themes and ten sub-ordinate themes emerged from the data, collected from seven semi-structured interviews. The final paper reflects upon the author's learning experiences during the research, including the challenges that were faced in completing the project.

Paper One: Literature Review

What is known about stigma and discrimination associated with recovery from substance misuse and addiction?

Word Count: 8,925

Abstract

The impact of stigma and discrimination across various societal groups has been extensively researched for decades by interested researchers (Rhem et al, 2006). The literature within the field of research for addiction and substance misuse is similarly widespread when looking at the broad topic of stigma and discrimination. A review of current knowledge has been carried out into the impact of stigma and discrimination upon recovery and rehabilitation from substance abuse or addiction. A search of relevant databases identified twelve core papers for critical analysis. A review of these papers suggests that during the three phases of active addiction, treatment for addiction, and recovery, fear of discrimination from others is prevalent (Van Boekel et al 2015b; Earnshaw et al, 2012; Tran et al, 2016; Hill & Leeming, 2014). Findings from these papers were synthesised into four main themes: ‘housing, education and employment’, ‘history of substance abuse’, ‘experiences of discrimination’, and ‘views of addiction’. However, the impact of stigma and discrimination upon future aspirations for those in recovery is largely unknown, and therefore it is concluded that further research is needed to expand this knowledge. Such research could reveal how professionals may be better able to support those recovering from addiction and substance abuse.

Keywords: addiction, substance abuse, stigma, discrimination, recovery

Introduction

The stigma and discrimination of those with drug and alcohol addiction has been widely researched according to Rehm, Taylor and Room (2006). Discrimination can be described as a process of separating an individual or group of people within society based on a shared characteristic or similarity (Schomerus et al, 2011). This often affects the opportunities available to that person and can lead to a sense of status loss or rejection (Link & Phelan, 2006). It has been found that discrimination causes people to experience lower quality of life, reduced feelings of satisfaction, and decreased physical and psychological health (Bahm & Forchuk, 2009; Ahern, Stuber, & Galea, 2007). Research suggests that people in active addiction, or with previous substance abuse problems, are often more heavily discriminated against than those with mental health disorders (Crisp, Gelder, Rix, Meltzer, & Rowlands, 2000; Room, Rehm, Trotter, Paglia, & Üstün, 2001; Schomerus et al, 2011).

Berke and Hyman (2000) describe addiction as a disorder of decision making, learning and motivation. It is known that there are many types of addiction, more than alcohol and drug use, such as gambling, eating disorders, and sex addiction. Griffiths (2005) argues that all types of addiction share several common components. These components consist of salience, mood change or modification, tolerance, withdrawal, conflict and relapse. Eysneck (1997) defined addiction as an over indulgence in a substance or behaviour to an unusual or potentially harmful extent. This paper focuses on addiction to drugs and alcohol only, as this is the area of interest for the review.

In relation to the current views around the causes of addiction there has been a distinct shift in thinking. Historical explanations of addiction include the view that addiction is acquired due to its ability to serve a useful function to the individual. This was the common view in the Psychological Resource Model (Eysneck, 1997), also known as the

Model of Choice. The alternative view to addiction being a condition of choice is that of The Disease Model (Kurtz, 1999). In this model, addiction is referred to as an illness with biological, neurological, genetic and environmental sources of origin. It has been demonstrated that a sensitivity to the role of dopamine in the function of reward and reinforcement provides a mechanism by which substance use can become compulsive and habitual (Berke & Hyman, 2000). Although it is recognised that addiction may not be a disease in the conventional sense, there is evidence to support the fact that excessive use of substances can cause changes to occur within the frontal cortex and anterior cingulate of the brain. Damage to these areas is consistent with deficits in executive functioning and an increased sensitivity to immediate gratification (Kalivas & Volkow, 2005).

The current view of addiction as a disease may be linked to the type of treatment recommended to those who are afflicted. There are two main approaches currently used in the treatment of addiction to substances: abstinence and harm reduction (Behavioural Health Of the Palm Beaches, 2017). Abstinence requires complete cessation of the drug or alcohol use, whereas harm reduction focuses on reducing substance use to a level which is considered 'safer' to the individual (Friedman, 2014). Treatment for drug and alcohol addiction often requires a high level of contact with health professionals. Research into the experiences of those undergoing treatment for substance use has found that stigma and discrimination can occur from both health professionals and the public (De Vargas & Luis, 2008).

A wealth of information has been provided on how fear of stigma and discrimination impacts upon a person's willingness to enter treatment for addiction (Wahl, 1999; Rusch, Angermeyer, & Corrigan, 2005; Lundberg, Hansson, Wentz, & Bjorkman, 2009). Research investigating the perceptions and attitudes of healthcare workers has revealed a generally negative response towards those with substance abuse or addiction

histories (Van Boekel, Brouwers, Van Weeghel, & Garretsen, 2013; De Vargas & Luis, 2008). These negative perceptions derive from misconceptions regarding addiction (Stanbrook, 2012). The treatment of people presenting to healthcare services with active addiction has been found to be punitive and rejecting, suggesting an unwillingness from health professionals to help this group of people (Au, 2006; Gilchrist et al, 2011).

Research has shown that there are consequences for those who directly experience or anticipate discrimination. Anticipated discrimination can be defined as the fear or worry that rejection will occur (Angermeyer, Beck, Dietrich, & Holzinger, 2004) without evidence that this will be the case. Thornicroft (2006) found that the fear of discrimination can cause those affected to avoid threatening situations, whether or not that threat of discrimination actually exists. Studies of mental health and dual diagnosis have found similar results, in that, both actual and perceived discrimination can have an adverse impact on finding employment, general participation in society, and overall wellbeing (Link & Phelan, 2006, Link et al, 1997). This suggests that there are significant barriers in accessing drug and alcohol treatment, and discriminatory behaviour may adversely affect adherence to treatment measures. Leis and Rosenbloom (2009) suggested that individuals in active addiction should not be penalised, nor should they be refused jobs or lose current employment. Their article aimed to act on the recommendations of the 'Join Together' panel held at Boston University in 2002. Although this was not a research project, it highlights current issues within these areas.

In a review by Livingston, Milne, Fang, and Amari (2011) a systematic review of thirteen papers was carried out focusing on the effectiveness of interventions that have been trialled to reduce stigma within substance abuse. While the review by Livingston et al (2011) looked to discover the efforts made to reduce the effects of stigma through intervention, this review aims to explore what is known about the impact of actual and

anticipated experiences of stigma and discrimination on the recovery from drug and alcohol addiction.

Method

A review of the literature has been conducted to discover what is known about stigma and discrimination in relation to those in recovery from substance abuse. A systemised review was carried out to identify the most appropriate articles. The search question posed was: ‘How does stigma or discrimination affect the recovery or rehabilitation of those with current or previous addiction or substance misuse problems?’

The review was carried out using a systematic process which followed a similar structure to that of a systematic review, but did not include the use of an independent reviewer. The level of critique applied through the systematically conducted review was a rigorous process in which the core strengths and weaknesses of the research were appraised. As well as conducting an analysis of both validity and reliability (Grant & Booth, 2009).

Search Strategy

An initial search was conducted using the EBSCO host’s full list of databases between 19th September and 22nd September 2016. The databases used within the search included: The Allied and Complimentary Medicines Database (AMED), British Nursing Index (BNI), Cumulative Index to Nursing and Allied Health Literature (CINAHL), PsychINFO, MEDLINE, AgeLine, PsychARTICLES, Academic Search Complete, and many others.

Using the work of Sayers (2008), a PICO (Patient, Intervention, Comparison and Outcome) framework was used to search the databases using a specified strategy. Of the

literature search it was asked: how does stigma or discrimination (I) affect the recovery or rehabilitation (O) of those with previous or current addiction or substance misuse (P). There was no 'comparison' group within this search question, so this was omitted from the strategy. The following search terms were used:

Addict* or substance* AND stigma* or discrimination or prejudice AND recovery or rehabilitation or reintegration.

To ensure that only the most relevant articles were brought forward for review the terms 'addict* or substance*' were searched for within the title of the text, whilst the remaining two search terms were searched for within the abstracts of the articles.

Inclusion and Exclusion Criteria

Articles were included in this review based on the following criteria:

1. The focus of the research needed to address recovery or rehabilitation in some way.
2. The research should not be a mental health recovery focus unless recovery from substance abuse is considered separately.
3. The research could not be of a medical or treatment focused view point.
4. Stigma or discrimination of the target group needed to be addressed.
5. The papers needed to be written in English, unless translated versions could freely be found.
6. A date limiter was applied for articles from 1980 to the present day in order to report on the most relevant and up to date research.

Procedure

During an initial screening of the articles, the title of the paper was used to determine its relevance to the review. If this could not be determined by title alone the abstract and full text were searched for further information on its focus and direction.

Once a full screening of the articles was completed, further searches were conducted using Google Scholar and Web of Science, but no additional articles that met the inclusion criteria were identified.

The flow chart in Figure 1. shows the results of the search strategy and screening procedures applied.

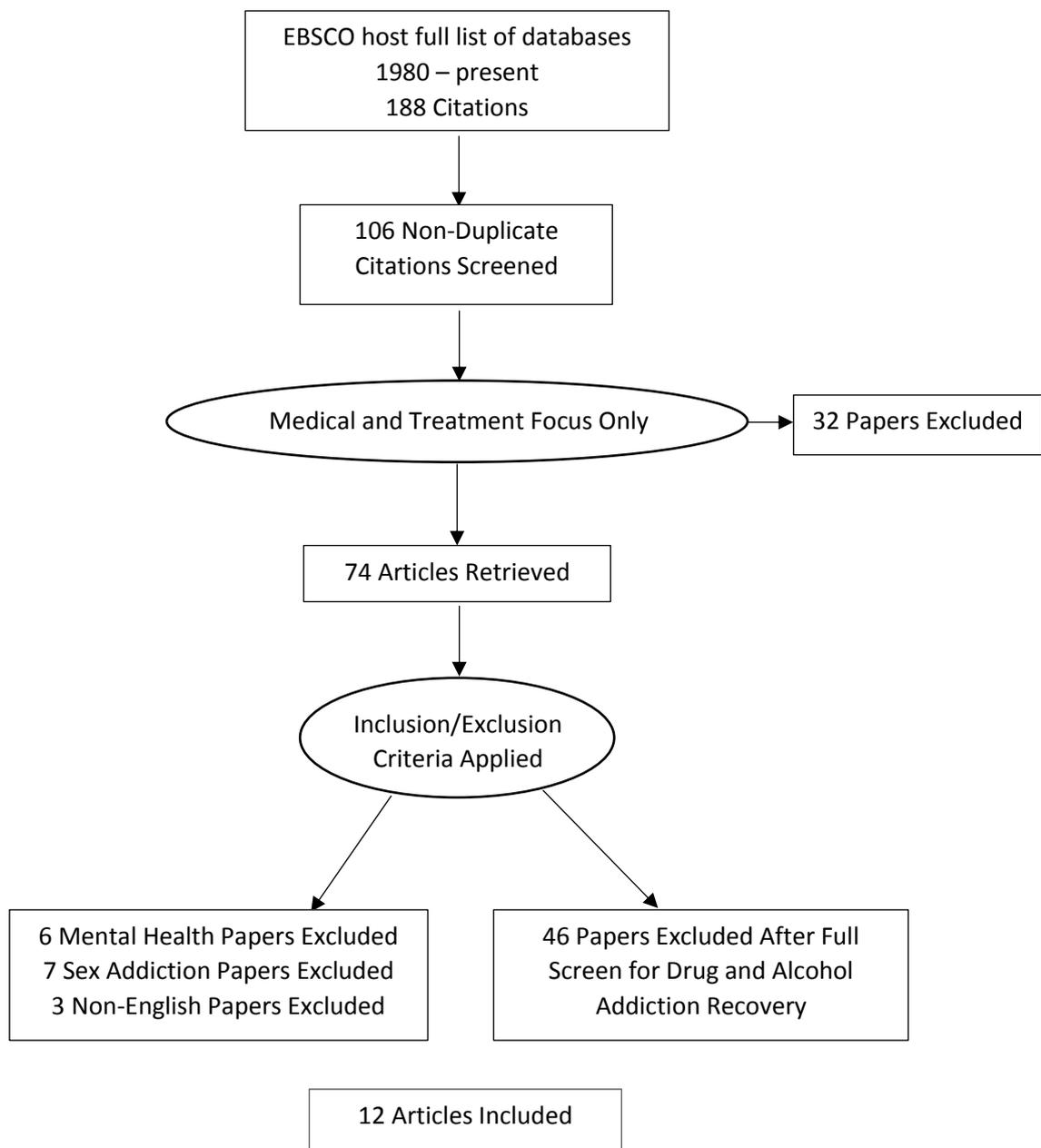


Figure 1. Flow chart of the screening process

Results

Summary Table

The twelve papers identified have been placed into a summary table for ease of comparison and simplicity of reading. The table details the title, date and author of the twelve studies, aims, sample and recruitment, design, main results, and strengths and limitations.

Table 1. Summary table of articles

Article	Aims	Sample	Design/Method	Key Results	Strengths/Weaknesses
Daibes et al (2016). Factors influencing Nurses' attitudes towards patients in Jordanian addiction rehabilitation centres: A qualitative study.	To examine nurses' attitudes towards addicts (drugs and alcohol) and what influences these attitudes.	21 nurses purposefully selected (29 invited to take part). One private and one government addiction facility used.	Ethnographic fieldwork, case studies. Semi-structured interviews for 9 months. Stopped the interviews after data saturation. Used NVIVO to analyse thematically	Stigmatised substance abuse clients as liars, cheaters, thieves from all nurses, tried to avoid talking to them, addiction is hopeless they can never get better, worried addiction is 'contagious', blame the media's portrayal and their upbringing, admit to lack of knowledge, feel like addicts don't respect nurses as much as other professionals.	Clear ethics section. Interpretations checked with participants to increase validity. Not clear on evidence for themes. Not generalisable
Earnshaw et al (2012). Drug addiction stigma in context of methadone maintenance therapy: An investigation into understudied sources of stigma.	To describe the sources of stigma and how stigma is experienced.	12 MMT participants recruited from an RCT – this is therefore a secondary study. Capped at 12 due to data saturation.	Cognitive interviewing about the survey items/their comprehension of survey items. 'content coded'	Stigma was both experienced and anticipated from friends, family, co-workers, and healthcare providers. Seen as untrustworthy and try to steal or elicit pain medication, felt they doubted ability to stay in recovery.	Gathering qualitative information in a relatively understudied area. Ethics granted and covered. Inter-rater reliability gained. No evidence of themes or analysis. Low generalisability, not clear on what they were asking the participants.
Hill & Leeming (2014). Reconstructing 'the alcoholic': Recovering from alcohol addiction and the stigma this entails.	To build on current knowledge by exploring individual's views.	6 participants, snowball sample from AA. Had been in recovery from 5-35yrs.	Semi-structured interviews, IPA used to analyse data. Interviews done in own home.	Still feel the negative views such as being people who lack willpower, feelings of shame motivate them to continue hiding their addiction and causes avoidance.	Well laid out, good descriptions and backed up with references, ethics is covered. No research question. No evidence table of themes and it's unclear how many participants' data was used to create a 'theme'. Not generalisable and snowball sample may mean that participants

					share similarities.
Long & Vaughn (1999). "I've had too much done to my heart": The dilemma of addiction and recovery as seen through seven youngsters' lives.	Unclear.	7 teenage participants 'committed' to recovery.	Ethnographic-phenomenological study, extensive interviews 'transcribed and coded'.	Limited family support may affect recovery and feelings of shame develop from the family. Other factors contribute to discrimination i.e. ethnicity and race. Experienced this from employers, society, and peers.	Checked participant's stories with teachers and workers. No clear aim or data analysis. Bias suggested in language used and assumption seem to be made. Very little conformity to structure of a research study and no mention of ethics.
Luoma et al (2007). An Investigation of Stigma in Individuals Receiving Treatment for Substance Abuse.	To examine the role of stigma towards substance abuse in people in recovery.	197 (108 men) 14-75yrs. This represented 20% of target population. Flyers-volunteer sample, reward \$10.	Self-report Questionnaires. Analysed using t-tests and linear regression.	46% felt treated unfairly due to knowledge of stigma, 14% felt employers paid them less. Moderate correlation between shame and experience of rejection, perceived stigma and experience of rejection, shame, and psychological functioning.	Large sample size and thorough questionnaires. Formatted clearly with subtitles for themes. Many results around 50% mark. Removed outliers and transformed data, lacks content validity. Risk of type 1 error. No control group and no ethics section.
Mackert et al (2014). Perceptions of substance abuse on college campuses: Proximity to the problem, stigma, and health promotion.	To understand how students' perceptions of addiction and recovery vary based on experience and background.	233 undergraduate students from social work (17%) and advertising (83%). Convenience sample.	Survey questionnaires, vignettes and, interview. Analysed using t-tests.	Those with more knowledge of substance abuse have lower stigmatised beliefs about the user. Students from advertising had more stigmatising beliefs and higher levels of distancing themselves from the individual.	Attempting to cover a lot of areas/questions – is this so that something is definitely found? Highly un-even groups. Did not ascertain personal experience of addiction and seems biased in trying to find support for own belief for promotion. No ethics mentioned.
Sanders (2012). Use of mutual support to counteract the effects of socially constructed stigma: Gender and drug addiction.	To gauge the level of perceived stigma in recovering addicts.	92 women from women only and mixed NA groups.	4 page Questionnaires and \$5 for completing, qualitative data collected through note taking in NA meetings. Descriptive statistics and	Still feel the stigma of being untrustworthy and selfish, seen as people who will take advantage of others and a general sense of being judged by	Mentioned ethics – consent and information letter. No research question. Questions in survey were adapted from the stigma scale used for

			t-tests were used to analyse the questionnaires. Qualitative data not analysed.	others remains. Due to this may not tell other people in order to prevent stigma. Feel there is a view that that they are bad mothers, promiscuous, mentally ill, criminals.	mental health, no specific numbers provided just fractions.
Storti (2002). The lived experience of women in addiction recovery: the haunting specter of stigma in nurse-patient interactions.	To understand the meaning of the experience of feeling stigmatised by women in addiction recovery during interactions with registered nurses.	11 women in recovery, purposive sample. 5 contacted by the researcher and the remaining were 'participant referral' and contacted by email or phone.	Interviews, analysed using phenomenological data analysis by Colaizzi (1978).	Feel mistreated by nurses, as though stigma of addiction remains, viewed differently to other women, keep it a secret due to fear, using the stigma and experiences to develop a stronger sense of self.	Ethical approval granted and covered well. Increased validity/credibility by asking participants to review the themes. Aim and research question were the same. No men – not generalisable.
Tran et al. (2016). Drug addiction stigma in relation to methadone maintenance treatment by different service delivery models in Vietnam	To examine the different levels of 'felt' and 'enacted' stigma that MMT individuals may experience across different service delivery models and health administration.	Convenience sample 1016 participants across 5 clinics	Cross sectional study. Questionnaires. Analysed using t-tests and X ² tests and multivariate logistic regression.	2.5% experienced discrimination in workplace, 1.7% from health services but over 25% did in their communities, only 14% had/would disclose their addiction/health status. Perceived stigma increased with higher level of education, anxiety/depression, presence of pain, HIV positive and number of episodes in rehab.	Had clearly defined ethics section. Did report both significant and insignificant results so confidence increased in reliability of results. No precise details of how the participants were recruited. No causal information can be inferred.
Van Boekel et al (2015a). Comparing stigmatising attitudes towards people with substance use disorders between the general public, GPs, mental health and addiction specialists, and clients	To assess and compare stigmatising attitudes between the general public, GPs, and mental health and addiction specialists.	Cross sectional, online randomised public sample, email sent to social sciences panel, 2793 general public. 23% of GPs responded = 180, mental health and addiction specialists = 167, clients = 186	Self-report Questionnaires. Analysed using ANOVA, Welch F test and linear regression.	More doubt from GPs and general public regarding whether rehabilitation would work, 49% of clients thought they would not find accommodation, 52% though they would not get a 'normal job',	Large sample and high level of response from some groups. Used a sample to balance groups and checked this against the rest of that group to increase validity, states 'large effect' but no data shown as evidence, ethics

				41% believed they could not have a relationship.	section covered. Unclear results, no raw data or figures presented as evidence.
Van Boekel et al (2015b). Experienced and anticipated discrimination reported by individuals in treatment for substance use disorders within the Netherlands.	To study the level of experienced and anticipated discrimination.	Volunteer sample of clients in treatment, reward for taking part. 186 participants from 4 services.	Cross sectional survey, questionnaires. Analysed using descriptive statistics and chi squared.	Link between experienced and anticipated stigma, only small a number anticipated stigma without prior experience. 23% anticipated in applying for jobs, 25% in applying for courses, 49% avoided close relationships, 37% concealed their substance use 'regularly or always' and 25% sometimes.	Clearly defined rationale, aim and research, good explanation of statistical analysis. Not very clearly written in places. Stated ethics did not 'need' doing.
Woodford (2001). Recovering students' perspectives: Investigating the phenomena of recovery from substance abuse among undergraduate students.	To collect and analyse examples of recovery in undergraduates.	3 undergraduates who identified as being in recovery. Intensity sample. Targeted from a substance abuse prevention programme at the university.	3 interviews with each participant. Grounded theory used to analyse data.	Chose not to disclose addiction due to negative past experience. Fear reduces with the amount of socialising with non-addicts. Commented that it is difficult at university due to no substance free housing.	Acknowledges own interest in addiction. Did think about ethics. Very small sample. Unclear sampling – were they recruited or volunteers? Not concise, difficult to read.

Critical Appraisal

Each of the twelve studies were assessed using either the Critical Appraisal Skills Programme (CASP) (Singh, 2013) or the Quality Assessment Tool for Quantitative Studies (QATQS) (Thomas et al, 2004). The CASP provides 10 questions to ask of qualitative research, and provides a framework from which research can be critically appraised using a structured method, highlighting strengths and limitations within each piece of research examined. As the CASP (Singh, 2013) was used to critically appraise articles of a qualitative methodology, the QATQS (Thomas et al, 2004) was used to appraise research of a quantitative nature. Both of these tools allow for a rigorous and reliable technique to be used in the analysis of research.

As the two appraisal tools offered different techniques to assess the quality of qualitative and quantitative methods separately, a simple ‘high’, ‘medium’ and ‘low’ rating was used to rate the overall quality of the research papers. In the QATQS this was simply converted from the ‘weak’, ‘moderate’ and ‘strong’ rating that was carried forward from analysing each research paper. In the CASP a score of 1-4 was classified as ‘low’ quality, 5-7 as ‘medium’ quality and 8-10 was classed as ‘high’ quality.

Table 2. Quality Assessment Outcomes.

Author and Title	Tool Used to Critique	Quality Rating
Daibes et al (2016). Factors influencing Nurses’ attitudes towards patients in Jordanian addiction rehabilitation centres: A qualitative study.	CASP	High
Earnshaw et al (2012). Drug addiction stigma in context of methadone maintenance therapy: An investigation into understudied sources of stigma.	CASP	Medium
Hill & Leeming (2014). Reconstructing ‘the alcoholic’: Recovering from alcohol addiction and the stigma this entails.	CASP	High
Long & Vaughn (1999). “I’ve had too much done to my heart”: The dilemma of addiction and recovery as seen through seven youngsters’ lives.	CASP	Low
Luoma et al (2007). An Investigation of Stigma in Individuals Receiving Treatment for Substance Abuse.	QATQS	Low
Mackert et al (2014). Perceptions of substance abuse on college campuses: Proximity to the problem, stigma, and health promotion.	QATQS	Low

Sanders (2012). Use of mutual support to counteract the effects of socially constructed stigma: Gender and drug addiction.	QATQS	Low
Storti (2002). The lived experience of women in addiction recovery: the haunting specter of stigma in nurse-patient interactions.	CASP	Medium
Tran et al. (2016). Drug addiction stigma in relation to methadone maintenance treatment by different service delivery models in Vietnam	QATQS	Low
Van Boekel et al (2015a). Comparing stigmatising attitudes towards people with substance use disorders between the general public, GPs, mental health and addiction specialists, and clients	QATQS	High
Van Boekel et al (2015b). Experienced and anticipated discrimination reported by individuals in treatment for substance use disorders within the Netherlands.	QATQS	Medium
Woodford (2001). Recovering students' perspectives: Investigating the phenomena of recovery from substance abuse among undergraduate students.	CASP	Medium

General Characteristics

All twelve studies addressed the topic of stigma or discrimination with reference to the 'recovering' addict, or a perception of recovery from addiction. Whilst the articles varied in their research aims and rationales they remained relevant to the search question and were therefore critically appraised through a rigorous process, in order to highlight their strengths and weaknesses, as well as to compile their collective findings regarding the search question.

Nine of the articles used a sample of individuals either in treatment for substance abuse or recovery following treatment (Luoma et al 2007; Tran et al, 2016; Earnshaw, Smith, & Copenhaver, 2012; Van Boekel, Brouwers, Weehgel, & Garretsen, 2015b; Long, & Vaughn, 1999; Sanders, 2012; Hill, & Leeming, 2014; Woodford, 2001; Storti, 2002). One article addressed the perceptions of undergraduate students towards those in addiction or recovery (Mackert, Mabry, Hubbard, Grahovac, & Steiker, 2014). One article addressed the attitudes of nurses towards those in active addiction, treatment, or recovery (Daibes, Al-Btoush, Marji, & Rasmussen, 2016). The remaining article

addressed the views of the general public, GPs, and those in treatment or recovery from addiction (Van Boekel, Brouwers, Weeghel, & Garretsen, 2015a).

Aim and Rationale

Eleven of the twelve studies clearly defined the aims and rationale for their research (Storti, 2002; Luoma et al, 2007; Van Boekel et al, 2015a; Tran et al, 2016; Earnshaw et al, 2012; Van Boekel et al, 2015b; Daibes et al, 2016; Sanders, 2012; Mackert et al, 2014; Hill & Leemings, 2014; Woodford, 2001). The exception to this was Long and Vaughn (1999), where the aim and rationale was unclear. There was a description of the research question which provided some insight into the overall aim of the study, therefore this was used to deduce the aim and rationale.

Of the eleven studies within which the aims were clear, four studies considered the experiences of those in recovery, regarding how participants have experienced discrimination in the past (Storti, 2002; Van Boekel et al, 2015a; Earnshaw et al, 2012; Tran et al, 2016; Luoma et al, 2007). Five studies addressed some aspect of how discrimination is perceived or expected within addiction, treatment and recovery (Storti, 2002; Hill & Leeming, 2014; Sanders, 2012; Van Boekel et al, 2015a; Tran et al, 2016). One study aimed to collect and analyse examples of recovery within an undergraduate student population (Woodford, 2001), and one to understand how the knowledge and experience of non-addicted, undergraduate students, impacted upon their perception of those in active addiction and recovery (Mackert et al, 2014). Two studies addressed the views of professionals and their attitudes towards substance abuse and recovery (Daibes et al, 2016; Van Boekel et al, 2015b).

Sampling and Recruitment

A variety of methods were employed to recruit participants for the various research projects. Four studies (Storti, 2002; Daibes et al, 2016) recruited participants through ‘purposive’ sampling, meaning that participants were selected according to criteria or characteristics perceived as necessary by the researcher(s) (Teddlie & Yu, 2007). It also appears that Long and Vaughn (1999), and Sanders (2012) recruited through a similar method as participants were targeted for their knowledge in the area, however there is a lack of precise information regarding their specific recruitment method. This creates potential for sampling bias as the researcher may identify similar people and fail to achieve a broader view of the research topic, potentially leading to skewed data (Palys, 2008).

Woodford (2001) stated that the participants were recruited via intensity sampling. This method requires prior knowledge of the individuals as they are selected on the basis that they are able to provide in-depth information about the area of interest. This type of sampling often leads to rich data collection (Patton, 2001), however, within the study by Woodford (2001) it appears that very few participants were available and therefore very few sampling options were available. This highlights issues in sampling bias and reduces the reliability of the results being found within the wider population. Mackert et al (2014) and Tran et al (2016) recruited participants based on a convenience sampling method. This is a pragmatic method which allows researchers to recruit participants based on their availability at the time of the research project. However, this method also produces issues in sampling bias as it is not known if the findings would also be found within a random sample of the population.

Systematic bias within the sampling methods used across the reviewed studies was extensive. Further to those already discussed above, Van Boekel et al (2015b), and

Luoma et al (2007), used a volunteer sampling method in which the research project was advertised using flyers (Luoma et al 2007). This method may also attract participants with similar characteristics and impact on generalisability of research findings (Teddlie & Yu, 2009).

Hill and Leeming (2014) used a snowball method in their recruitment of participants. They identified participants through a smaller sample, who then suggested other participants to take part. This can also impact upon generalisability and selection bias as the original participants are likely to suggest people with whom they share key characteristics.

The report by Van Boekel et al (2015a) stated that online recruitment took place via emails sent on a randomised basis to the general public, using information for a group of people who had previously signed up to a social sciences panel. There was a high number of participants who took part in the study which increases the generalisability of results, and the reliability of findings.

Earnshaw et al (2012) recruited participants via a parent study. Although consent to take part was gained, participants may have felt obliged to take part as they had taken part in the parent study.

Sample size varied greatly within each study, and will be explored further when generalisability is addressed. As expected, studies that used a qualitative methodology had fewer participants than those using quantitative methods.

Ethics

Consideration of ethics is important as it authenticates the research, showing that the correct procedures have been carried out throughout all levels of the study. It reassures the reader that the participants have been treated fairly and informed consent

has been gained. It also means that the research has been overseen by an objective panel who have considered the wider point of the research, and whether the research is necessary in order to further develop knowledge in the topic area (Resnik, 2015).

Seven papers did not contain sections that were dedicated to addressing ethical issues of their research. In the paper by Luoma et al (2007) the collection of consent forms from participants was briefly mentioned, as was also the case in Sanders (2012). In the report from Long and Vaughn (1999), and Mackert et al (2014) nothing relating to ethical considerations was mentioned. Van Boekel et al (2015a) covered a section in their research report that described how they had sought ethical guidance, making a disclaimer that ethical approval was not necessary as there was no medical aspect to the research. They stated that this information had been provided by the central committee on research involving human subjects. There was no information regarding the collection of consent forms or the participants' right to withdraw from the study. Similarly, the research by Van Boekel et al (2015b) also stated that ethics was not necessary. However, it was stated that they followed ethical guidelines on obtaining informed consent and ensured confidentiality of data collected.

The research reports by Storti (2002), Hill and Leeming (2014) and Earnshaw et al (2012) did not have a separate ethics section. However, it is stated that ethical guidelines were followed in relation to gaining informed consent, and ethical approval had been granted.

Daibes et al (2016) and Tran et al (2016) both had clearly defined ethics sections in which the ethical approval was stated to be granted. Informed consent was gained from participants, and they were informed of their right to withdraw. Woodford (2001) appeared to follow the key considerations of ethical principles, but did not state whether approval had been granted for the study.

Methodology

Six of the studies used self-report questionnaires using likert-scale response options in order to answer the research question(s) (Luoma et al, 2007; Boekel et al, 2015a; Tran et al, 2016; Boekel et al, 2015b; Sanders, 2012; Mackert et al, 2015). Some of the questionnaires were adapted from those designed for other purposes, and this highlights a potential problem in the content validity of those questionnaires. Questionnaires that lack content validity would affect the reporting and interpretation of results.

The remaining six studies (Storti, 2002; Woodford, 2001; Hill & Leeming, 2014; Long & Vaughn, 1999; Daibes et al, 2016; Earnshaw et al, 2012) used interviews in order to gain the necessary information needed to answer the research question(s). Tran et al (2016) and Sanders (2012) used questionnaires alongside interviews. Although, in the work of Sanders (2012) the interviews focused on collecting demographic information. It is not understood why it was felt that this was necessary.

Analysis

Quantitative

Five of the studies used parametric tests to analyse the data (Mackert et al, 2014; Sanders, 2012; Tran et al, 2016; Boekel et al, 2015a; Luoma et al, 2007) and one study used non-parametric tests (Boekel et al, 2015b). Of these six studies, three used a variety of tests to examine their data. All six studies gave some level of explanation as to how and why the analysis was chosen, but this varied greatly in depth and quality.

Self-report measures were used in all six studies, which was largely acknowledged as being a potential weakness to the findings. Luoma et al, (2007) and Van Boekel et al (2015a) stated that their questionnaires had been adapted from other measures which

poses issues in content validity, as the adapted measures had not been subject to inspection for content validity in their research.

Luoma et al (2007) used t-tests and linear regression alternately depending upon the question being asked of the data. Outliers in the regression were removed and data was transformed, posing issues in altering the original findings of the data set. There was an increased risk of type 1 error in the reporting of these results, as many tests were carried out on the data set. Type 1 error increases the probability that the null hypothesis was rejected, when it was in fact true. Despite this, the explanation of why tests were carried out is detailed, and there were tests conducted to check for multicollinearity. Reports of non-significant findings were still included in the report, however, during the qualitative reporting of results it seems that results were reported with some bias and not from an objective view point. For example: '14% felt that employers paid them less'. This result indicates that 86% did not agree with this, yet this is not reported in the description.

Van Boekel et al (2015a) used ANOVA, Welch-F and linear regression to analyse their data. A full description was given around the choice of analysis and why this was necessary, again increasing the reliability of the reported results. Four groups were targeted for data collection (GPs, general public, mental health and addiction specialists and clients in treatment for substance abuse). The sample sizes of these groups varied, with significantly more participants in the 'general public' group than any other. Measures were implemented to balance the groups used in data analysis, using a random sub-sample from the general public group and comparing the mean of this sub-group to the total sample. This creates issues in data reporting, as not all of the data was used during the analysis. However, the means of the sub-group and total sample provided similar results, suggesting that the random sub-group was adequate for reporting on the results of the sample as a whole. The results section itself was difficult

to follow, and very few statistics were provided, such that figures had to be cross-referenced with tables within the report. Van Boekel et al (2015a) stated that the effect size was calculated and provided a large effect, but the raw data for this was not provided.

Clarity of reporting on statistical data was a problem with several of the studies. This reduces confidence in the results as there is reduced transparency, making the research difficult to replicate. Two studies provided qualitative descriptions of results (Van Boekel et al, 2015a; Mackert et al, 2014) and Sanders (2012) specified results as fractions. Tran et al (2016) and Luoma et al (2007) reported results from a negative viewpoint indicating issues of researcher bias.

Qualitative

Four of the seven studies that used qualitative methods were clear in their explanation of chosen data analysis, and were transparent in the analytical procedures that were followed (Daibes et al, 2016; Hill & Leeming, 2014; Woodford, 2001; Storti, 2002). This leads to the conclusion that appropriate levels of rigour were applied in order to produce reliable results. Hill and Leeming (2014), and Daibes et al (2016) used the technique of inter-rater analysis to gain increased credibility of their findings through comparison of themes across researchers. Storti (2002) increased the credibility of research findings through not only allowing for the research to be transparent in methodology, but also the application of Guba and Lincoln's (1981) criteria of credibility, auditability and fittingness.

Long and Vaughn (1999) did not mention any specific method of analysis, referring only to the data being 'transcribed and coded'. Providing such little information makes it very difficult to ascertain the level of rigour applied to the data analysis. This reduces the overall reliability of the study as it cannot be seen whether the findings of the

analysis were reliable or valid. Similarly, Earnshaw et al (2012) stated that the interview data, referred to as ‘text segments’, had been ‘content coded’, but made no reference to the type of analysis used. This decreases the level of assurance in the themes produced.

Sanders (2012) collected both qualitative and quantitative data during their study. However, no clearly defined analysis was applied to the qualitative data, and was simply referred to as ‘added narrative’. The lack of analysis applied to data reduces the reliability of reported findings as no evidence-based method was used to identify emergent themes or patterns with the data.

Generalisability

Issues of generalisability were widespread across the twelve studies used within this review. The studies that were of a qualitative nature addressed these concerns, acknowledging that small sample sizes made their findings difficult to generalise across the population (Daibes et al, 2016; Woodford, 2001; Storti, 2002; Long & Vaughn, 1999; Hill and Leeming, 2014; Earnshaw et al, 2012).

Luoma et al (2007) recruited a sample of men for their study, which they state represented 20% of the target population. As this sample did not include women, it is not possible to apply the findings to a female population. Similarly, Sanders (2012) and Storti (2002) only recruited a sample of women for their studies creating a similar issue.

In the work of Boekel et al (2015a), a large sample consisting of four target groups (GPs, general public, mental health and addiction specialists, and clients) was recruited. The general public group was originally much larger in sample size, however, this was adjusted using a random sub-sample of participants and checked for validity through a comparison of means with the total sample. Completing this process made groups sizes more equal, however there was no evidence of an effect size calculation to validate

results. Mackert et al (2014) used two sample groups which were greatly unequal in size, with no acknowledgement of the potential this had to confound results. A total of 233 undergraduate students were recruited, 17% from a social work course and 83% from an advertising course. The issue in using unequal sample sizes can cause data to be become skewed and violate the assumptions needed to validate parametric tests. It is not known how the results would alter if these groups were of equal size. This further creates difficulty in being able generalise findings to the wider population.

Findings

The results of the studies varied according to the research question(s) and aims when addressing stigma and discrimination. Using the guidelines of Braun and Clark (2006) a thematic analysis was conducted in order to synthesis the running themes across the findings of the twelve papers. Each of the results sections were coded before themes were identified and this was also cross references with each paper's discussion section. These were then grouped together and the findings were critically analysed. Four main themes were identified.

As a result of the critical analysis, the methodological strengths and weaknesses have been considered in relation to the overall findings of the reviewed papers in order to assess the validity and reliability of those results.

Housing, Education and Employment

Long and Vaughn (1999) reported that participants had experienced discrimination from employers. However, in comparison to other papers reviewed, very little can be said about the validity of this finding due to the lack of adherence to formal research procedures. In contrast, the study by Van Boekel et al (2015b) was found to be of higher merit during the critical analysis and as such provides higher research validity

and reliability. They found that 23% of participants anticipated discrimination from employers, and 25% reported that they anticipated discrimination when applying for educational courses.

Tran et al (2016) found that only 2.5% of participants had experienced discrimination in the workplace, a relatively low figure. However, the history of employment or unemployment within in the sample was not reported, making it difficult to eradicate such factors in influencing this result. It is also possible that participants concealed their addiction history in order to avoid such discrimination. Through the critical analysis this study was rated as being low in quality, partly due to having little evidence to support the validity of the tools used in data collection.

Van Boekel et al (2015a) found that 49% of clients assumed they would not be able to find accommodation, and 52% thought they would not be able to get a 'normal' job and this comes from a study considered to be of high quality. In Luoma et al (2007), 14% of participants reported that they felt as though employers paid them less compared to non-addict or recovery peers. However, during the data analysis an increased risk of type 1 error was apparent as a result of the methods used and a quality rating of 'low' was awarded during the critical appraisal process.

History of Substance Abuse

Seven of the studies (Storti, 2002; Woodford, 2001; Hill & Leeming, 2014; Long & Vaughn, 1999; Sanders, 2012; Van Boekel et al, 2015b; Tran et al, 2016) reported that participants would conceal their history of addiction, so this seems to be a common theme amongst the articles reviewed. These studies found that participants concealed information about their addiction from health professionals, employers, partners, and others, fearing the negative connotations or judgements that these people might make.

Participants from Storti (2002) and Woodford (2001) stated that they would keep their addiction history a secret from nurses due to fear of discrimination or negative judgement. This was due to past experience of discrimination in the case of Woodford (2001). In the case of Hill and Leeming (2014), it was reported that participants would hide this information due to internal feelings of shame, and the fear of judgement from others. Long and Vaughn (1999) found that feelings of shame were instilled via family members or the participant themselves. Four studies (Storti, 2002; Hill & Leeming, 2014; Woodford, 2001; Long & Vaughn, 1999) used qualitative methodology, thus limiting generalisability of the findings. This needs to be considered as it also reduces the reliability of the findings.

In Sanders (2012), secrecy regarding addiction was due to a fear of negative judgement by society. Van Boekel et al (2015b) reported that 37% of participants would conceal their history of substance abuse 'regularly or always', and that a further 25% would conceal this information 'sometimes'. In the research of Tran et al (2016), 14% of participants would not disclose their addiction or health status to others. It was also found in the same study, that the level of perceived stigma increased with higher levels of education, anxiety and depression, presence of pain, number of episodes in rehabilitation, and having a positive HIV status.

Attention needs to be paid to the methods applied during participant recruitment as none of these studies recruited participants through randomised methods, which leads to sampling bias. This was something highlighted through the critical appraisal and is something which was dominant throughout both qualitative and quantitative studies.

Experiences of Discrimination

Experiences of discrimination were connected to participants feeling unfairly treated by nurses in healthcare settings (Storti, 2002). Participants from Storti (2002)

felt that nurses perceived them to be 'different' from other women who did not have a history of substance misuse. In Luoma et al (2007), 60% of participants felt that they were treated unfairly due to knowledge of their addiction being revealed, however, neither of these studies is considered to be of 'high' quality in relation to the critical appraisal.

In Earnshaw et al (2012), participants both experienced and anticipated stigma from healthcare providers, family, friends, and co-workers. They felt they were viewed by these groups as untrustworthy people who would attempt to steal or elicit pain medication, and there was a sense of being doubted in their recovery. Although analysis of the paper found the overall study to be of a 'medium' quality one of the pitfalls in this research was the lack of rigour applied to the analysis of participant data.

Van Boekel et al (2015b) found that participants who had previous experiences of discrimination expressed higher fears and therefore anticipated increased levels of discrimination in the future. Tran et al (2016) found that only 1.7% of participants had experienced stigma in healthcare settings, and 25% had experienced stigma in their communities.

Long and Vaughn (1999) commented that experiences of discrimination are not only related to the history of substance abuse, but are also a result of race and ethnicity. Experiences of discrimination was also reported to come from society and peers. It is not clear from the research how many of the participants reported a similar issue reducing the reliability of the finding.

Luoma et al (2007) found a 'moderate' correlation between shame and experience of rejection, perceived stigma and experience of rejection, shame and psychological functioning. This was a quantitative study and therefore no causal information could be

inferred. The research itself was not high in merit and therefore this also needs to be considered when determining the power of the results.

Views of Addiction

Results compiled here address the viewpoint of other societal groups towards addiction and recovery. It also addresses the concerns of recovering addicts or those in active addiction when thinking about the stigma they may encounter.

Van Boekel et al (2015a) reported that there was a higher level of doubt from GPs and the general public regarding whether rehabilitation can be successful. Hill and Leeming (2014) reported that participants felt as though society viewed them as people who lacked willpower. Sanders (2012) found that participants felt as though they continued to be viewed as untrustworthy, selfish, and as people who will take advantage of others. They also felt that they continued to be viewed as being 'mentally ill' and 'criminals', despite being in recovery and abstaining from substance abuse. Participants in this study only included women in recovery, so a further finding was that they were viewed as promiscuous and as bad mothers. These results are supported by the findings of Daibes et al (2016), whose sample of nurses reported that they believed addicts and substance users (including those in recovery) were liars, cheats, and thieves. The nurses viewed addiction and substance misuse as untreatable conditions, from which people cannot recover, and therefore avoided interacting with them. Results are comparable to the study by Van Boekel et al (2015b), who found that 49% of participants would avoid close relationships with others due to anticipated stigma, and to Van Boekel et al (2015a), who found that 41% of clients believed they could not have a romantic relationship.

Mackert et al (2014) reported that undergraduate students with more knowledge of substance abuse had lower stigmatising beliefs about addiction and recovery. Students

studying a course in advertising were found to have higher stigmatising beliefs about substance abuse in general, and reports of social distancing were also higher in this subject group. These reports came from highly unbalanced groups, 83% were students from advertising and 17% from social work. The level of experience within individuals was not measured, and it was therefore an untested assumption that students within the social work course had more understanding of recovery from addiction, than those on the advertising course. Due to this credibility of findings is reduced and the study was considered to be low in quality, therefore affecting confidence in its reliability and validity.

Strengths and Limitations of the review

The review had the purpose of finding what is currently known about the experiences of stigma and discrimination within recovery from addiction. The review has achieved this aim through reporting on the most relevant research that was found through an extensive search of literature in this area. The method used in the search strategy has been made transparent to allow for replicability.

There was little overlap in the papers reviewed during this review when compared to the review by Livingston et al (2011). This could mean that both reviews have sampled papers from a much wider evidence base, or may indicate a sampling bias in paper selection. The aim of the Livingston review was to search for effective interventions in reducing stigma within substance abuse and therefore did not meet the same criteria as the search conducted through this review, which could explain why the reviewed papers varied.

This review was conducted by a single researcher and therefore limitations apply in the potential for bias and interpretation of data. The short-listing of relevant papers could vary if conducted by another researcher.

Clinical Implications

Through the review it has become apparent that stigma and discrimination continue to be faced by those in recovery from substance abuse. These reports have come from those in treatment and recovery, as well as from those in healthcare professions, and from the general public (Daibes et al, 2016; Van Boekel et al, 2015b; Mackert et al, 2014; Earnshaw et al, 2012; Storti, 2002; Long & Vaughn, 1999).

Clinically it is of importance to understand more about the impact that this has upon sustaining recovery. It could be assumed that fear of discrimination could impact upon a sense of belonging in society for those in recovery, and therefore negatively impact upon quality of life and wellbeing. Ahern, Stuber, & Galea, (2007) found that discrimination of those in active addiction was associated with poorer mental health, and Bahm & Forchuk (2009) found that discrimination of those with mental health difficulties reduced their success in recovery. They concluded that Healthcare professionals need to recognise this effect, and should screen for comorbid conditions which make individuals susceptible to discrimination.

Through improving access to housing and employment services, stigma and discrimination against this group can be reduced. It can similarly be concluded here that increased training of professionals, particularly those within nursing, could reduce the experiences of stigma and discrimination by recovering addicts, increasing their success in recovery as well as improving quality of life and reducing the risks of developing further mental health difficulties.

Discussion

The review critically appraised and synthesised the findings of twelve studies, in order to discover what is known about the association between stigma and

discrimination, and recovery from substance abuse. Research has highlighted that discrimination is experienced by those in active addiction, treatment and recovery (Van Boekel et al, 2015a; Tran et al, 2016; Earnshaw et al, 2012; Daibes et al, 2016; Mackert et al, 2014; Storti, 2002). Research has also indicated that there is a strong fear that discrimination will continue to occur in the future (Luoma et al, 2007; Tran et al, 2016; Van Boekel et al, 2015b; Long & Vaughn, 1999; Sanders, 2012; Hill & Leeming, 2014; Woodford, 2001). The results of the twelve studies used in the review must be considered in terms of what can be reliably known in relation to the validity and reliability of findings. The credibility of the papers reviews fluctuated greatly and this was examined in full.

Four main themes were found through thematic analysis of overall findings from the review papers: 'Housing, Education and Employment', 'History of Substance Abuse', 'Experiences of Discrimination', and 'Views of Addiction'. It was found that experiences and fear of discrimination can impact upon an individual's willingness to disclose information about their addiction to others in society (Van Boekel et al, 2015b; Sanders, 2012; Tran et al, 2016; Hill & Leeming, 2014; Storti, 2002; Woodford, 2001; Long & Vaughn, 1999). Findings suggest that those in recovery and treatment for addiction may choose to conceal information about their addiction from others, in order to reduce the possibility of discrimination or negative judgement (Storti, 2002; Woodford, 2001; Sanders, 2012; Van Boekel et al, 2015b).

Results have also suggested that there continues to be negative view adopted from healthcare professionals (Van Boekel et al, 2015a; Daibes et al, 2016) and that this is also something which is anticipated by those in treatment and recovery (Woodford, 2001; Hill & Leeming, 2014; Sanders, 2012; Van Boekel et al, 2015b). The view that those in addiction are untreatable was found through the research by Daibes et al

(2016), and there was a higher sense of ‘doubt’ from GPs and the general public that rehabilitation could be successful (Van Boekel et al, 2015a).

Conclusion

On the basis of what has been found through this review a gap within current research has been identified. The literature discussed has focused on the past experiences of discrimination and perceived or anticipated discrimination for the future. It is currently unknown what the impact of this is upon aspirations for the future, and how discrimination, actual or anticipated, can affect aspirations in recovery. It is proposed that in order to explore this issue, a qualitative research project is carried out which will provide rich data that can be used to answer this question.

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Paper Two: Empirical Paper

Embarking on Recovery: When Does Stigma End? Investigating the Experiences of Stigma and How This Affects Aspirations in Recovery from Substance Misuse: An IPA Analysis

Word Count: 7,369

Abstract

Background - Research into the impact of stigma and discrimination during treatment and recovery from substance abuse has reported that participants experience discrimination in areas such as employment, housing, and healthcare (Storti, 2002; Luoma et al, 2007; Earnshaw et al, 2012; Long & Vaughn, 1999; Tran et al, 2016;). Further research has suggested that there is increased ‘anticipation’ of discrimination in these areas (Van Boekel et al, 2015a; Van Boekel et al, 2015b; Luoma et al, 2007). Studies reported that fear of discrimination can impact upon an individual’s willingness to disclose information about their addiction and recovery (Storti, 2002; Woodford, 2001; Sanders, 2012; Van Boekel et al, 2015b).

Aim - The aim of the study is to fill a gap within current knowledge by exploring how experiences of stigma and discrimination impact upon individuals’ aspirations in recovery from substance abuse.

Method - A purposive sample of seven participants were recruited to take part in semi-structured interviews, from which data was recorded for analysis using IPA.

Findings - Three super-ordinate and ten sub-ordinate themes were highlighted through analysis: ‘Forever an addict’, ‘the Broken Social Contract’, and ‘A new social identity’.

Conclusion - The findings of the study raise issues in the current approach to supporting those in recovery, and suggest that there is a need for increased awareness and education at various levels in society..

Key Words; Discrimination, Addiction, Substance Abuse, Recovery, IPA

Introduction

Models of Addiction

Addiction can take a variety of different forms which include alcohol and drug addiction, gambling, sex addiction, and eating disorders. The model of addiction most commonly referred to by Alcoholics Anonymous (AA) is that of the disease model. The disease model describes addiction as being a disease with biological, neurological, genetic and environmental causes (Kurtz, 1991). The creation of the AA (Alcoholics Anonymous) in 1935 and the publication of 'The Big Book' (Wilson & Cohen, 2015), along with medical advances, recognised the idea that addiction is a disease, although this was originally developed with only alcoholism in mind (Friedman, 2014). It is concluded from this approach that alcoholism is a chronic and progressive disease which cannot be cured, but can be arrested by the cessation of all alcohol and treatment using the 12 step-model of the AA (Wilson, 2002).

The most recent theory of addiction is that it is not a disease in the conventional sense, but rather a disease of choice, as abstinence is the most effective treatment rather than medical intervention (McCaully & Clegg, 2010). Not all of those who experience addiction to drugs or alcohol conform to the idea of the disease model. Although belief in the disease model can go some way to reducing feelings of responsibility and blame, which can be helpful to some, it can also permanently fix the label of 'addict' to an individual. It is therefore more acceptable for some to believe in the life-process model of addiction (Kalivas & Volkow, 2005), or psychological resources model (Eysenck, 1997). The life-process model of addiction views addiction not a disease, but rather a habitual response, and a source of gratification and security that can be understood only in the context of the individual's social relationships and experiences (Nestler, 2013). This is similar to the psychological resource model by Eysenck (1997), however, here it

is stated that the use of substances fulfils a psychological need within the individual suggesting that they have a prior disposition to addiction. This model still recognises that an individual remains able to make the choice on how to fulfil any unmet need.

Whichever of these models is subscribed to by an individual, evidence from medical investigation indicates that addiction to substances damages the frontal cortex and anterior cingulate of the brain, increasing a person's sensitivity to reward and immediate gratification. This mechanism fuels further use of substances in order to continue receiving the same level of reward experienced in the past (Kalvia & Volkow, 2005).

Attitudes Towards Addiction

Social identity theory, as described by Tajfel (1979), states that discrimination occurs as a result of inter-group processes and the awareness of differences between one's own societal group (the 'in-group'), and an outside group (the 'out-group'). Tajfel and Turner (1979) state that people need to maintain a positive sense of personal identity, and this is reinforced through increasing the positive esteem and desirability of one's own groups in comparison to that of the 'lesser' group or the out-group. Often prejudice and discrimination occurs as a result of this observed difference between two groups.

Research surrounding the stigma and discrimination of those with current or historical substance abuse has reported on the attitudes of various societal groups towards such individuals (Van Boekel, Brouwers, Van Weeghel, & Garretsen, 2013; De Vargas & Luis, 2008; Stanbrook, 2012). There is also evidence to support the fact that this will often continue to be an issue within recovery from substance abuse (Luoma et al, 2007; Earnshaw, Smith, & Copenhaver, 2012; Sanders, 2012). Reports of discrimination have not only been identified from those in addiction and recovery, but also from those working with these groups and the general public (Daibes, Al-Btoush, Marji, &

Rasmussen, 2016; Van Boekel, Brouwers, Van Weeghel, J, & Garretsen, 2015b; Mackert, Mabry, Hubbard, Grahovac, & Steiker, 2014; Storti, 2002; Long & Vaughn, 1999).

Reintegration and Recovery

Insight into the difference between actual experiences of discrimination, and perceived or expected discrimination, has been gained through research from the viewpoint of the individual (Luoma et al, 2007; Van Boekel, Brouwers, Van Weeghel, J, & Garretsen, 2015a; Tran et al, 2016; Earnshaw et al, 2012; Van Boekel et al, 2015b; Hill & Leeming, 2014; Storti, 2002). It has been found that there is fear of rejection in the areas of employment, housing and access to education (Van Boekel et al, 2015a; Van Boekel et al, 2015b; Long & Vaughn, 1999; Tran et al, 2016; Luoma et al, 2007). Experiences of the individual have led to a fear of discrimination that can impact upon their willingness to disclose information about their addiction and recovery to outside groups and society members (Storti, 2002; Woodford, 2001; Hill & Leeming, 2014; Van Boekel et al, 2015b; Sanders, 2012; Tran et al, 2016).

Research suggests that the views of others towards addiction and those in treatment or recovery continues to be one of negative connotations, and impacts upon their successful reintegration. Mackert et al (2014) reported that students undertaking an advertising course at University would be more likely than those on a social work course to avoid those with an addiction history. Daibes et al (2016) reported on the views of nurses, being that addiction was an untreatable condition and that this group of individuals were liars, cheats and thieves.

Stigma and discrimination have important implications for the mental health and recovery efforts of people in treatment (Bahm & Forchuk, 2009; Ahern, Stuber, &

Galea, 2007). Therefore, it is important to understand how experiences of stigma can impact upon an individual's recovery.

Rationale and Aims of the Study

Research to date has generally focused on the experiences of those in active addiction or treatment and has not, as yet, investigated the implications of stigma and discrimination for personal aspirations in recovery. In previous research, participants have reported that they fear stigma and discrimination from others, even when in recovery (Sanders, 2012). However, whether or how this hinders reintegration and achievement of personal goals remains largely unexplored. The aim of the present study is therefore to explore the impact of stigma and discrimination on aspirations for recovery, so as to improve understanding of the ways in which recovery can be supported.

Substance abuse and addiction caused 8,149 hospital admissions during 2014-2015 (Health and Social Care Information Centre, 2016). By supporting recovery this figure could arguably be reduced as relapse is less likely to occur during a successful reintegration following treatment. Research into how experiences of discrimination affect aspirations for recovery will increase the ability to offer appropriate support during transition and success during rehabilitation.

Research Questions

The questions being asked by the current research are:

- How do those in recovery from substance abuse make sense of their experiences of stigma and discrimination?
- How do experiences or perceptions of stigma and discrimination impact upon the future aspirations of those in recovery from substance abuse?

Method

Design

The study was of qualitative design using semi-structured interviews and Interpretative Phenomenological Analysis (IPA) to explore individual participants' experiences and views of the topic area. Each participant was asked the same open-ended questions, to facilitate exploration of their experiences within the interview (Appendix C).

Semi-structured interviews allow focus to be maintained on a specific topic, without dominating the interview time or stopping the participant from making their own interpretation or meaning from the questions (Fylan, 2005). No time limit was applied to the interviews, allowing each participant to respond in their own time to each question before moving onto the next.

Interpretative Phenomenological Analysis

Following completion of the semi-structured interviews, the data was subjected to Interpretative Phenomenological Analysis (IPA) using the guidelines set out by Smith, Flowers and Larkin (2009). Due to its roots in phenomenological psychology (Husserl, 1927), hermeneutics (Heidegger, 1927), and idiography (Harré, 1979), IPA allows qualitative data to be analysed in a rigorous manner, focusing on the lived experience of the participant along with how they have attached individual meaning and made sense of those experiences (Smith, 1999). Another important component of IPA is often referred to as the 'double hermeneutic', in which it is acknowledged that the researcher plays a key role in the interpretation of data, as they try to make sense of the way the participant is in turn making sense of their world (Smith & Osborn, 2008). In other

words, the researcher tries to look at the way in which the participant has made sense of their experiences and goes on to interpret this for analysis.

Using the guidelines of Smith, Flowers and Larkin (2009), interview data was searched systematically for extracts of interest that stood out to the researcher, completing a line-by-line analysis. Following this, the extracts were used to capture emerging themes across the first data set to encapsulate what the participant might have been trying to convey. The emerging themes were then extended and clustered together to form 'super-ordinate' themes under which 'sub-ordinate' themes were contained. Once this was completed, the themes were then checked against the original data to ensure they remained true to the text, before moving on to the next transcript and repeating the same process.

Reflexivity

The position of the researcher can create a potential bias in the analysis and conclusions drawn from the study (Malterud, 2001). In qualitative research this is often addressed as it becomes relevant to the assumptions or interpretations made during analysis (Mruck & Breuer, 2003). The main researcher is a white, British female, 30 years of age, completing the research as part of a Doctoral Thesis for Clinical Psychology Training. Previous experience of working in addiction creates a prior interest in the area of study, and could influence the process of the research through a personal desire to ensure that this group of individuals is provided with adequate support. Acknowledging this is important as being reflexive about the stance of the researcher allows for explicit awareness to be raised during the reading of the report (Malterud, 2001). There are two supporting researchers who also bring influence to the interpretation of data and this will be addressed in the following section.

Inter-rater analysis

In order to increase the reliability and validity of the findings, inter-rater analysis was carried out whereby both the author and the clinical research supervisor, completed individual analysis of the data and shared the results of this before making the final report. Due to using IPA as the methodology this is not something which is often necessary as the researcher's interpretation of the data is key in reporting upon the findings of the study (Yardley, 2000). It was therefore decided that the clinical research supervisor would conduct their individual analysis and report on what they found to be major themes within the data. However, the final decision on how to interpret and report on findings remained with the first author.

Setting

The research was carried out at an independent (non-NHS) rehabilitation service for substance misuse clients. The service has two sites in different counties of the UK. These services are both residential facilities where clients remain for an 18-week abstinence-based treatment programme. The first 14 weeks of the programme are referred to as the 'therapy phase' with the remaining four weeks being reserved for a 'resettlement phase'. After this time, clients recommence living in the community, but may return to the service for aftercare treatment should they require it. The interviews were carried out at the most convenient of these two centres for each of the participants. Rooms were available at each facility for the interviews to be conducted in an intimate, safe setting, for both the researcher and participant.

Ethical Approval

Ethical approval for the study was granted by Staffordshire University (Appendix D) and any amendments to previous proposals were returned to the same panel for approval before the study commenced.

Ethical Considerations

The nature of the study encouraged participants to think about past experiences when they had felt stigmatised or discriminated against on the basis of their addiction. The researcher was aware of this throughout the study and participants were encouraged to seek support from their therapist at the centre, or other support facilities if they felt distressed through taking part in the study. Support information was provided to all participants and was also acknowledged prior to them agreeing to take part.

Informed consent was gained from each participant before they could take part in the study. Participants were asked to read the information sheet (Appendix E) before signing the consent form (Appendix F). They were also made aware of their right to withdraw from the study at any time, and the confidentiality of the material collected through the interviews and research process was also addressed as part of the consent process.

Sampling and Recruitment

A purposive sampling method was chosen as this provides the ability to select participants based on their potential to offer specific experiences and views regarding the research question (Smith, Flowers and Larkin, 2009). Potential participants for the study were identified by the clinical research supervisor, and additionally through advertisement of the study using posters which were displayed at each of the centres (Appendix G). Those who wished to take part in the study were asked to contact the

researcher via email, in order to opt-in, and were then sent a full information sheet or would collect this from the research supervisor if they preferred. This process allowed for an informed decision to be made on whether the prospective participant felt they would be willing to take part in the study.

Inclusion Criteria

The research aimed to investigate the experiences and views of those who were most likely to experience or be thinking about the research topic of stigma or discrimination based on addiction. It was therefore important that participants who engaged in the study had completed the ‘therapy’ component (first 14 weeks of the programme) and were either in the ‘resettlement’ phase or had graduated from the full 18-week programme within the last four weeks. During this time, it was thought that participants would be most able to offer insight into the research question. Participants had to be over the age of 18.

The recruitment poster (Appendix G) which was displayed at both facilities informed participants of the inclusion criteria.

Participants

Eleven clients across the two centres made email enquiries about taking part in the study. Of those eleven, only seven met the inclusion criteria for the study. Of the seven that took part, one was female and six were male. Their ages ranged from 32yrs to 47yrs, and all fulfilled the inclusion criteria by having completed the rehabilitation programme in full and were recently graduated clients, or in the remaining four weeks of resettlement.

Materials

A dictaphone was used to record the interviews so that the data could subsequently be transcribed for analysis. Consent forms and information sheets were also provided prior to a participant taking part in the interview.

Findings

Three super-ordinate themes were generated, containing ten sub-ordinate themes. Details of super-ordinate and sub-ordinate themes, along with how many participants supported each theme can be found in Table 1. An example of line-by-line coding can be found in appendix H. Codes were identified from each individual transcript and clustered into emergent themes (Appendix I). The emergent themes were then searched for connections in order to map out super-ordinate and sub-ordinate themes (Appendix J).

Table 1. Table of Themes

Super-ordinate Theme	Sub-ordinate Theme	No. of Participants
Forever an Addict		
	Illness or Choice?	7
	The Impact of the Label	4
	Discrimination in Employment	5
The Broken Social Contract		
	We Know We've Done Wrong	7
	"Dipping My Toe In"	7

	Secrecy and Concealment	5
A New Social Identity		
	I'm Not Like the Others	5
	Active Addicts	5
	Rejecting Society	5
	The Recovery Family	6

Forever an Addict

This super-ordinate theme describes the participants' views on addiction being a life-long condition, whether in active addiction, treatment, or recovery. The subordinate theme 'Illness or Choice?', describes the personal beliefs of the participants regarding whether addiction is an illness or developed through choice, and therefore whether or not there can be a 'cure'. The theme 'The Impact of the Label', highlights the views of participants' regarding reintegration into society and how being labelled as an 'addict' maintains the societal divide. This relates to the super-ordinate theme as it addresses concerns raised about being permanently labelled as an addict. Finally, the theme of 'Discrimination in Employment' describes the participants' views on how addiction affects their employability and places a 'cap' on their potential achievement. It appears that this is the area most prominent in the thoughts of the participants as where they fear they will continue to experience a lack of understanding and continue to be judged for their previous addiction behaviours.

Illness or Choice?

All seven participants described their personal view on whether addiction is an illness or a choice. All of the participants made reference to addiction being a disease or illness and therefore not something which was within their control.

'...the way it happened to me, is something that could happen to anybody, you know, it wasn't that I just decided one day I was going to use heroin, ...' (Lucy)

One of the participants spoke about addiction in a similar context to epilepsy, classifying it as a medical condition.

'And plus, you know, I also suffer from epilepsy as well ...' (George)

The participants spoke of being in control of their recovery and this being something that they had personal responsibility for. It was a concern to Harry that defining addiction as an illness would allow him and others to use this as an excuse to continue abusing substances or relapse. Harry explains that despite addiction being an illness he still takes responsibility for his behaviours.

'I think people – myself included – when we use this illness term it's not used as - although in the past I have used it as a justification - I'd like people to understand that I don't use that as a justification now.' (Harry)

The participants' beliefs regarding addiction as an illness reveals some external level of control. This can be a protective factor, helping them to find commonality with those who have not suffered with addiction by believing that they had a susceptibility or pre-disposition making them vulnerable to addiction. It has also been highlighted that despite addiction being an illness it is still the participants' responsibility to remain abstinent and recovery is possible.

The Impact of the Label

Being labelled as an ‘addict’ has an impact upon how the participants feel they are being viewed by others in society. For four of the participants, it was important to convey the need to lessen this divide by looking for similarities with non-addict peers and working together to overcome the negative view of addiction. Lucy described how she was working with services to reduce the negative perception of addiction.

‘....there’s a thing that I’m getting involved with..... all the services that deal with people that have got a potential to have, alcohol and substance misuse problems. And the wider public....(to)give the wider public a more balanced insight into the realities of addiction.’ (Lucy)

Martin felt that the label of being an addict was something that could not be removed, and that this would result in a permanent divide in society. His concern was that people, even in recovery, would never be considered as good enough compared to a ‘non-addict’.

‘I think they look down on me to be honest and viewed me ‘them up there and me down there in the gutter’. (Martin)

William described how ‘playing the part’ of a non-addict during active addiction was important in order to reduce the potential for the label of addiction to create negative experiences.

‘I always thought, you know, kept myself really clean, fresh, clean clothes, clean --- yeah, I wouldn’t --- I tried playing the part --- look the part that I wasn’t actually feeling inside,’(William)

Labelling by society creates a 'difference' between those in recovery and those that have not experienced addiction. The idea that this label is permanent can damage the future reintegration of participants into society.

Discrimination in Employment

Five of the participants directly commented on how having a history of addiction would impede them in finding future employment. Three of these participants spoke of their decisions regarding whether to reveal their history during applications for employment.

'I was thinking "Well should you say, should you not say" and I think it's best to be honest because then if somebody finds out later about it and you've not disclosed it, you could potentially lose your job' (Martin)

One of the participants talked about his previous experience in working within the recruitment sector, and acknowledged that during his work, he would raise concerns about people who had 'gaps' in their employment history. Being in treatment for 18 weeks himself has now created a sufficient gap within his own working history, alongside times when he was unable to work due to the effects of his addiction.

'...if I can see documented on their CV for the application that they'd give in that they've got lapses in their employment history....if, they weren't for a specific reason that I thought was justifiable then it would be a big negative,' (George)

It appeared that as a result of fear regarding discrimination in the workplace, participants found it difficult to see themselves working within 'mainstream' employment. For one of the participants however, they had recently had a positive experience regarding employment and had been offered a position.

'she was brill and the reason it was so good for me was I explained to her that I had meetings, so sometimes I can't work certain hours in the day. That's why it was important. And she was very flexible when I called her back and she said it was no problem.' (Daniel)

The Broken Social Contract

This super-ordinate theme demonstrates an issue in regards to a breakdown in trust between participants and society. This issue of trust appears to flow both ways and the sub-ordinate theme of 'We Know We've Done Wrong' highlights that participants are aware of the damage caused in relation to gaining the trust of others. The theme of "Dipping My Toe in" reflects the level of doubt participants have about society accepting them. Finally, the theme of 'Secrecy and Concealment' explains how the participants felt that, to protect themselves from rejection or discrimination, they must conceal their history of addiction.

We Know We've Done Wrong

All of the participants discussed how their actions in active addiction impacted upon their relationships with family, friends and others around them. Participants often acknowledged and empathised with the fears of others. They discussed how, through their past behaviours, they had given society reason to doubt them. It was acknowledged by William that as he has relapsed in the past when trying to abstain from addiction and his family and friends seem reluctant to trust him to remain in recovery.

'they've seen me try loads of times and they've all seen me fail so they can only base it on what they've seen I suppose.' (William)

For five of the participants, it was recognised that those close to them may be trying to protect themselves from further hurt or disappointment by maintaining a distance to them.

'I mean, it was something that they tried to help me with at first, but when they couldn't really see me moving on then it was almost as if they'd just cut me off...'
(George)

Four of the participants spoke about being able to rebuild the broken trust and achieve acceptance from others if they worked hard to repair the relationships over time. Jeff explained his experience with a housing support service who he had been in contact with.

'...and in time, if I engage with all the support networks probably, you know, they bend over backwards to get my own property in time to come' (Jeff)

Participants are aware that their behaviours in active addiction continue to impact upon the relationships with people around them. This is demonstrated through difficulty in redefining trust.

“Dipping My Toe In”

All seven of the participants spoke about taking time, whilst early in their recovery, to gradually reintegrate into the ‘mainstream’ society through taking part in voluntary work. Three participants spoke about using voluntary work as a way back into more permanent work, and specifically within areas that are accustomed to having volunteers who are in recovery. There was an element of this being a ‘safer’ way to reintegrate, as the services they are working with are aware of them being in recovery, and therefore less likely to discriminate against them.

“I’ve started working.....doing some voluntary work to sort of help build my confidence of being back out there in a community.... but these are agencies that deal with people that have had, alcohol and substance misuse problems” (Lucy)

The participants also spoke about slowly reintegrating as a way to re-discover their interests and abilities. Voluntary work offers them the opportunity to try something new.

“voluntary work’s what I definitely want to do--because I’ve got all this knowledge now and I’ve got understanding for people so it’s something I want to just dip my toe in and have a look to see if I like that side of things” (William)

Participants spoke of feeling untrusting towards society as a result of negative experiences whilst in active addiction. There was a fear that this would continue to be the experience in recovery. Martin commented that his previous experiences of rejection have led him to a worry that this will continue.

“So, even if I didn’t know them I’d still --- it was running through my head they’d be thinking things like that about me,” (Martin)

Secrecy and Concealment

Five of the participants spoke about making the decision to conceal their history of addiction in order to guard them from potential discrimination or negative judgement. William did not wish to lie about his addiction, but was concerned about the consequences of being honest.

“I’m proud of the fact that I’ve done it and I’d rather --- I’d rather just --- for me now, I’ve just got to be honest with everything in my life so I’m not worried about what other people think about me. It might affect me, I’m not sure.” (William)

There was a desire from participants to be accepted back into society. Lucy spoke about not revealing her history to other parents as she felt that in doing so she would be seen as a bad mother. Being in recovery has increased the confidence to share some information, however, the concerns about the views other people will take remain a concern.

“I think it’s generally something that before going through the programme and now being in recovery, - it’s something that I would never want to admit to anybody because of being judged, because of the stigma attached to having, erm, substance misuse problems and especially being a mother.”

A New Social Identity

In this super-ordinate theme, the social identity of the participants is described. The theme ‘I’m not like the others’ describes how the participants retrospectively compare themselves to other people in addiction. The themes of ‘rejecting society’ and ‘active addiction’ highlight how the participants now feel that they cannot fit within either of these social groups, leading them to acceptance of being in ‘the recovery family’, where participants describe feeling part of a new societal group from which they can build confidence and self-esteem.

I’m Not Like the Others

Five of the participants referred to themselves in addiction as being different to other addicts. They spoke about the idea of being a ‘functional user’, meaning that they remained in employment, and had partners and children, in order to mask their addiction. For some of the participants this concept of being a ‘functional addict’ before treatment allows them to believe they have a higher chance of being accepted back into society.

“I mean I was drinking very heavily at the time and, erm ---and the job I was in, I didn’t lose my job through drinking, it was a very good and a very well paid job.”
(George)

Martin used this sense of being different to explain that he can be more successful in recovery, and feels proud of having the strength to seek help and treatment.

“I’ll be straight with people, most people in the world wouldn’t do rehab anyway if they’ve got an addiction problem. Most people wouldn’t have the strength to do it, so I’m quite proud of myself in that regard, very proud.” (Martin)

Active addicts

Due to the need to protect their own resolve in abstinence, there was the explanation from five of the participants that they would no longer be able to socialise with people in active addiction. This was discussed as having to also limit the time spent with anyone who uses substances due to the temptation it may create for them.

“So, I’m keeping away from anyone who’s doing --- anyone who’s not good for my recovery I keep away from. So yeah, it’s mostly the people I want to do things with now are people who have either gone through recovery or completely clean.” (William)

Being around people who remain in active addiction felt dangerous to the participants, and this required them to keep a physical distance between themselves and other whom they knew whilst in active addiction themselves. This is due to feeling vulnerable in early recovery and not wanting to be around temptation that could influence potential relapse.

“I wouldn’t have lasted five minutes, you know, it’s the area. The area’s the hardest situation for me. It triggers off the young people and they’re all criminals, drug addicts. Yeah, I do know loads of people round there but they’re just a minority.” (Jeff)

Rejecting Society

Five of the participants spoke of not feeling aligned or connected to the ‘mainstream’ society. It was highlighted that this was experienced through both society maintaining a distance from them, or them rejecting others in society, due to feeling that they lacked the understanding and empathy needed to support and connect with the participant. Being able to understand recovery was important to the participants as having they firstly needed to remain abstinent, and this needed to be something that others in society would fully support (i.e. not offering them alcoholic drinks, or trying to encourage nights out in pubs).

“If they don’t know --- if you don’t know you don’t understand, you can’t understand it.” (Daniel)

Two of the participants describe not being able to influence or change the views of others, so the result of this would be to stay away from such people.

“I’ll be open and honest with absolutely anyone about it, I don’t --- and then if they want to see it in a certain way that’s their problem not mine.” (William)

Harry spoke about society not respecting or listening to those with histories of addiction, further creating a sense that it was hard to accept the mainstream society.

“to better understand the guy that is stood on the street with a needle in his arm, to better understand the position he’s in. If he’s trying to explain the position he’s in, people don’t want to listen” (Harry)

As a result of not feeling understood by others, and being powerless to alter this, the participants make the decision to step out of the normal societal group, and there is a reduction in the ability to connect with those who have no experience of addiction.

The Recovery Family

Six of the participants describe being part of the recovery community following treatment. This is regarded as their new social group within society, from which they can continue to grow in confidence and self-esteem.

“ , the support of my peers, AA and NA, erm, it’s just built my self-esteem, built my confidence, made me see that I am a person, I’m not my addiction. It’s a part of my past, a big part of my past, but it’s not who I am as a person, you know. It’s given me a lot more confidence in who I am now as a person, the whole therapy programme...”

(Lucy)

Two of the participants draw strength and confidence from the recovery group and notice that self-esteem is higher by being a part of this group.

“-- I want to keep them in like a social circle, like a social network where, you know, I can do more things ---.” (William)

Jeff spoke about feeling safe as a result of being within the recovery group.

“...because it’s only a small-knit community, you know, we all try and stick together kind of thing, yeah” (Jeff)

Discussion

Interpretative phenomenological analysis of seven semi-structured interviews found three super-ordinate themes, and ten sub-ordinate sub-themes. The aim of the study was to explore how participants made sense of their experiences of stigma and discrimination, and how this impacted upon their aspirations in recovery from substance abuse.

The super-ordinate theme of 'Forever an Addict' encapsulated the participants' beliefs regarding addiction as an illness. For the participants, this was a protective factor, helping them to find commonality with those who have not suffered with addiction, and in believing that they had a biological susceptibility, or pre-disposition, making them vulnerable to addiction. This theme has a strong connection to the disease model of addiction, in which addiction has been regarded as an illness with biological, neurological, genetic and environmental sources of origin (Kalvias & Volkow, 2005).

Whilst the view of addiction as an illness allows participants to feel less responsible for their addiction it was also demonstrated that taking responsibility for maintaining their recovery lies with them. Four of the participants felt that others in society would doubt their recovery as a result of addiction being a life-long illness, and felt that this could hinder their reintegration. Labelling by society creates a 'difference' between those without addiction histories and those with them. The idea that this label is permanent can damage the future reintegration of participants into society. This is consistent with previous findings in which participants spoke of feeling that society views them negatively (Hill & Leeming, 2014; Luoma et al, 2007; Tran et al, 2016; Van Boekel et al, 2015b; Long & Vaughn, 1999; Sanders, 2012).

It is acknowledged that, as much of the discrimination spoken about is perceived or anticipated, it may prove useful to encourage those in recovery to pursue their goals, as

fear could be holding them back unjustly. This was particularly true in the area of employment, as five participants expected that they would be treated unfairly, without personal experience of this having occurred so far. One of the participants reported a positive experience in being offered employment. This is consistent with previous research by Van Boekel et al (2015b) who found that 23% of participants anticipated discrimination from employers. Van Boekel et al (2015a) reported that 52% of participants in recovery thought that they would be unable to find employment.

The results of this study suggest a difficulty is being able to challenge and alter the public perception that those with previous addiction will never get better, or will not be able to maintain their recovery. By viewing those in addiction as untreatable there may continue to be a reluctance not only to offer support when in active addiction, but also to offer support and encouragement in recovery. Daibes et al (2016) reported on the views of nurses, who were reluctant to treat those in addiction and felt that recovery was unachievable.

The super-ordinate theme of 'The Broken Social Contract' demonstrates that there is a breakdown in trust between participants and society. This issue of trust appears to flow both ways and highlights that participants have an empathy for the people they have hurt through their actions in active addiction. Having relapsed in the past appears to impact on both the participants and their families, and participants are aware of the damage caused in relation to regaining the trust of others. Further contributing to the broken social contract, this theme also revealed a fear common to many participants, of being unable to regain acceptance back into society and therefore keeps them from believing that they are part of the 'mainstream' society. This can lead to reluctance in divulging addiction history to others. Five participants believed that by keeping their history of addiction concealed from employers they are able to protect themselves from

potential rejection or discrimination. This is consistent with the findings of Van Boekel et al (2015b) in which 37% of participants reported that they would conceal their addiction regularly or always.

The third super-ordinate theme of the 'A New Social Identity', demonstrated that many of the participants have tried to create a new social group in recovery from which they can continue to build their confidence and self-esteem. This links to the theory of social identity (Tajfel, 1979) in which those in the 'out-group' attempt to compare and contrast the strengths of their own group, making their own group feel more prestigious. Being part of a new social group, that of the 'recovery family', allows participants to feel protected and included. It is hypothesised that finding a group from which those in recovery can feel that they have an important role to others, either through educating others on the dangers of addiction, or increasing the ability of services to support and understand addiction and recovery, helps them to increase the esteem of their recovery group.

The research question of how perceptions and experiences of stigma and discrimination impact upon future aspirations has been answered through the methods by which participants reintegrate within society. It was highlighted that participants remain hesitant to some degree, and debate whether or not to disclose their history of addiction to others. Being hesitant and doubtful in their encounters with those in society could be holding those in recovery back from fully reintegrating into society, keeping them feeling that they are not supported and accepted by others.

Reflexivity has been at the forefront during the reporting of study findings and it is important to acknowledge that the researcher's interpretation of data may have influenced the themes which emerged through analysis. This has been minimised as far

as possible through the use of inter-rater analysis to provide increased validity of themes.

Limitations

Being of qualitative design, only a small number of participants were used in this study. This makes findings difficult to generalise to the rest of the population. However, it is not unusual for qualitative studies to have a limited sample size (Smith, Flowers, and Larkin, 2009), as depth of information is being sought and this has been achieved through the study.

Participants used in the study had been through residential treatment over an 18-week period. During this time, the group aspect of treatment may have united their knowledge and views about recovery, stigma and discrimination, creating an increased potential for their views to become aligned. Using a sample of participants from varying treatment methods would combat this and may provide support to the research findings, or conversely, it could expose differences that add to current findings.

Respondent validation of themes would have increased the credibility of the findings. However, time limitations did not permit this. This would fit within the broader consideration of triangulation, as it would also have added further support to the findings if a similar project was carried out using an alternative methodology. Follow up interviews conducted later in the reintegration process would highlight whether findings remain relevant throughout a longer time period.

Clinical Implications

Findings from this study can be used to further provide insight into the research area and increase understanding around the negative impact of stigma and discrimination on recovery from substance abuse.

In clinical practice, services supporting individuals suffering from addiction, should encourage a group based approach to recovery as this has been proven to increase confidence and self-esteem. This has been encouraged through the work of the AA since 1935 and is supported through the findings of this study. It was also considered a successful intervention in the review of Livingston et al (2011), where it was reported that a group based ACT intervention had significantly reduced feelings of shame and internalised stigma. Being able to connect with others in recovery forms a stable base from which individuals are able to branch out and make positive moves towards re-joining their community in voluntary work and education.

More needs to be done to address issues of discrimination, whether actual or perceived, in the area of employment. Removing inclusion barriers here will increase the physical and emotional reintegration made possible in recovery from addiction as this has not only been highlighted through this research, but also in previous research explored (Van Boekel et al, 2015a; Van Boekel et al, 2015b). It was found in previous research that negative attitudes among the general public towards heroin and alcohol dependence was significantly reduced through the use of educational leaflets depicting more positive views of those within substance abuse (Livingston et al, 2011). This is something that could be done by targeting key employers and presenting them with information about addiction recovery. Posters and leaflets could also be displayed in GP surgeries which will target the general public and those affect and need further support.

Professionals treating those in addiction and recovery can improve their effectiveness by better understanding the aspects involved in recovery and what this means to individuals. Through empathising with and respecting the recovery of those who have been in active addiction, clients are more likely to adhere to treatment, and therefore more likely to maintain their recovery which can reduce hospital admissions.

Conclusion

The study has been a powerful tool in gaining insight into the effects of both actual and feared discrimination for those in recovery from drug and alcohol addiction. Results from this research have shown that there are many considerations that need to be addressed from the point of view of the recovering addict, and these are both at an individual and societal level. A project of this sort has not been conducted before and it therefore offers a much needed perspective on the impact of how discrimination impacts upon the fears of those in recovery and this impacts upon their aspirations. It Suggestions have been made about how the impact of this can be reduced. The original research questions have been addressed and participants were able to comment on how they feel that discrimination affects their aspirations in recovery.

Future research may involve piloting group based reintegration strategies, such as encouraging recovery communities to seek employment together. Further research into reducing the barriers into employment for those in recovery would help to increase the effectiveness of reintegration.

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Paper Three: Reflective Paper

Personal Reflections on Undertaking the
Thesis Project: Learning and Personal Growth.

Word Count: 2,429

Abstract

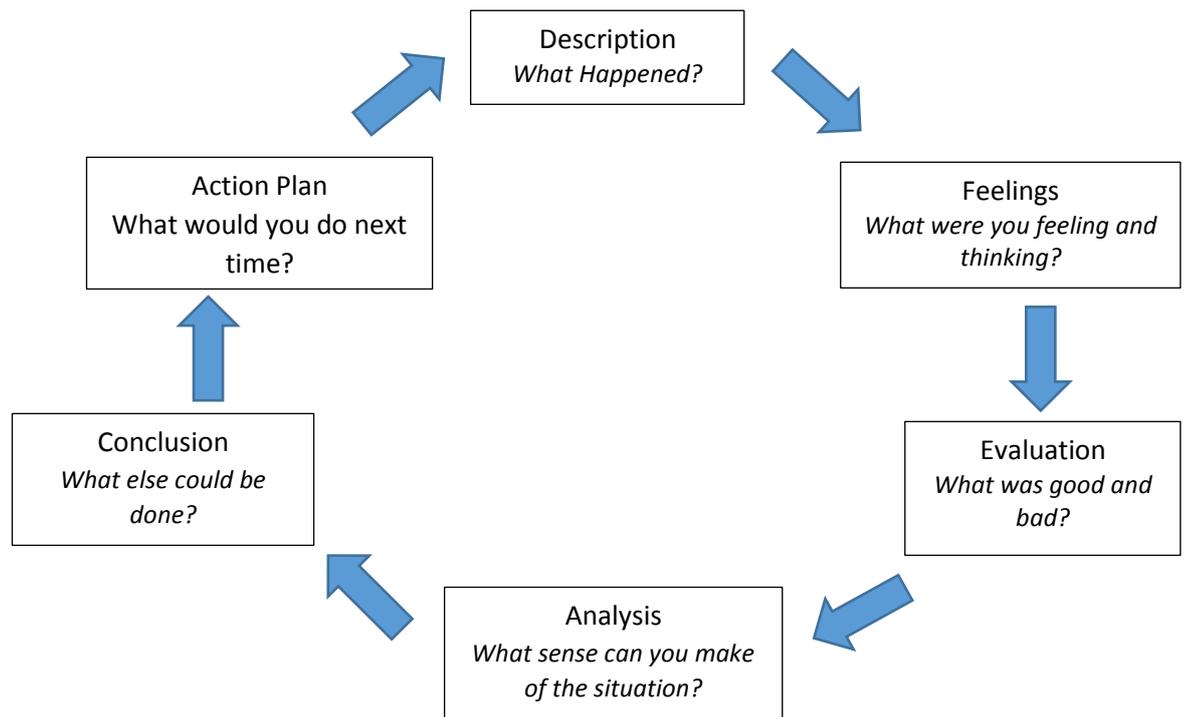
This paper follows the reflective process of carrying out a thesis during a Clinical Psychology Doctorate course. The original learning objectives are explored and compared with the outcome now that the body of research is completed. This is conducted using the Reflective Model of Gibbs (1988), based on the theory of Experiential Learning (Kolb, 1984).

Introduction

The reflective journal describing the process of producing the thesis has been an on-going piece of work developed and updated throughout each stage of the assignment. It has in itself felt like a taxing process at times, but on the whole, it has been a valuable exercise which has allowed for some form of *debriefing* from what has been a major project both emotionally and mentally. Whilst there are many models for reflective practice the chosen method during this paper is Gibbs (1988). In this model, a structured debriefing process is used to build upon the learning experiences of the practitioner. This is expanded from the theory of experiential learning by Kolb (1984) and allows the practitioner to reflect upon an experience using six key states of reflection; description, feelings, evaluation, analysis, conclusions and action plan.

During this paper, each of these stages have been used as part of the process of reflecting and will be addressed during different points of the paper. Having a structured method for reflecting on the process and the learning during the production of the thesis has allowed for additional knowledge to be gained regarding the strengths and limitations of the work, as well as the positives that can be taken forward regarding what has been learnt and can be built upon in the future.

Figure 1. Gibbs (1988) Reflective Model



Epistemological Position

Reflecting upon my own epistemological position helps to provide insight regarding the way that I myself make sense of the world. There are many positions to consider but the one that rings true within my belief system is that of the social constructionist position. This position assumes that knowledge is socially constructed within the basis of its context. This suggests that the reality which is experienced by an individual is constructed, but is experienced as *real* by the person or people concerned. This allows for changes within knowledge and experience to occur dependent upon a given situation (Ormston, Spencer, Barnard & Snape, 2013). I recognise that this is the position from which I have interpreted my experiences of completing the thesis, and also within interpretation of my analysis and the experiences of others. This has been

constructed through observation, exploration and interpretation. I have constructed my own meaning based on my experiences and used this to build knowledge and *truth*.

Reflecting on the Process

Preparatory Work

Considering the areas of most interest seemed like a good way to decide upon a proposal for the empirical piece and this began further investigation into the area of addiction and associated stigma and discrimination of this group. Through scanning the current research in the area, it became apparent that there was a lack of knowledge surrounding the concerns of those in recovery, regarding stigma and discrimination after they leave treatment and reintegrate into society.

Ideas for the thesis research topic came originally from a previous piece of research completed at master's level, but which unfortunately never became a published article. One of the aims therefore from the beginning of the thesis was to learn more about having a publishable paper and became a key learning objective early on in the process. This has increased investigations into conducting research to a standard suitable for publication and has provided more knowledge in this area.

Once the topic area had been decided, I created a proposal to investigate how stigma and discrimination affect the aspirations of those entering recovery. Once the idea and proposal had been accepted by the university it was time to approach a potential clinical supervisor. It was truly encouraging to be greeted with such enthusiasm and excitement around the project. It not only increased personal inspiration, but also led to reflection on the motivations of the clinical supervisor and how these may influence the research and differ to those of my own and that of the research supervisor. This would be of interest during the write up of the report as it may be that the interpretation of the data

and focus of the study could be different between myself and the clinical supervisor. With this considered, and due to the eagerness of the clinical supervisor and praise regarding the research questions, some of the anxiety around the project subsided.

The focus then moved more towards making the project something that could be of interest to others and useful clinically. My experiences early on in the project created a feeling that doing the thesis project could be an enjoyable and fulfilling process, rather than a compulsory university assignment.

Ethics

The process of achieving ethics was relatively straightforward which was surprising given the emphasis placed on this during the course. It did not seem to go well for all students and this has enhanced personal insight into how to achieve ethical approval through different panels. It seems that if a client focused piece of research is being carried out within the setting of the NHS then this increases the difficulty in being able to achieve ethical approval quickly. However, by using client groups outside of the NHS (charity and private organisations) the process can become much faster and this will be something that is important to recall in the future. It has however left a gap in the experience of applying for ethics through the NHS, as only one panel had to be approached to gain approval for my research project. It would have perhaps been more valuable to experience this side of applying for ethical approval, as the knowledge of this could have also benefitted any future trainee that I may supervise once qualified.

My main concern during the ethical approval process was whether the rest of the population would find this research to be of any value to society, or in fact, if it would be of any interest to others. This is where contacting potential Journals for later publication was important because it allowed for scoping of whether the research could be of interest to the population. It was a surprise when academic journals responded so

swiftly to emails about publishing and this gave extra motivation to completing the research to a high standard.

Recruitment and Data Collection

Following ethical approval my next step was to agree a contract with each supervisor and set a plan for when and how each stage of the research would be conducted. One of the factors that impacted upon this, however, was becoming pregnant. This meant that the research would take a year longer to complete and was a great concern in regard to keeping the supervisor on board. The longer-term plan did not seem to trouble the clinical supervisor, but later in the course of carrying out the write up he seemed to lose interest, perhaps due to the research becoming disjointed through the length of time between data collection and the final write up of the research report. He was responsive when asked to complete the analysis on the data to provide inter-rater analysis: however, it was noticed that following this there was markedly less contact unless it was initiated by myself.

I began to collect my data quite quickly after receiving ethical approval and aimed to complete this before taking maternity leave. I had chosen to use semi-structured interviews to collect the data from my participants due to the knowledge that this would assist with guiding the direction of the discussion, whilst at the same time not being overbearing during the interview (Fylan, 2005). The first interview was completed in a shorter time than expected (20mins) but it felt as though the interview reached a natural ending and there was nothing else that the participant wanted to say. This felt unnerving as I wondered if it was my fault – were there not enough questions? were the questions I asked open enough? was I good enough at interviewing people? During my reflections on this I recognised that each participant would be arriving to the interview with an agenda of their own and this may not fit with mine. I questioned whether or not I

needed to probe further in each of the following interviews, but I was also conscious of not wanting to influence the participants too much, or make them feel that I wanted to guide their answers. Further to this I then became aware of the fact that as I had written the interview schedule I was already making assumptions about the way in which the questions might be answered, and the information that could be gained. It does not, however, mean that the participant was receiving the questions in the same way that I may have unconsciously intended, and they could in fact be interpreting the questions differently. This was a valuable reflection as I was able to understand more about why reflection during qualitative research was so important and enhanced the quality of making use of my own interpretations.

Analysis

I chose to use Interpretative Phenomenological Analysis (IPA) for the research as I thought this would be the most appropriate analysis given my former work in the area of addiction. IPA allows for the interpretation of the researcher to be taken into account more so than other qualitative methods and this felt like an important factor. The double hermeneutic considered in IPA takes into account the meaning that the researcher is making of the experiences of the participant, and how they are making sense of their experiences, allowing for increased understanding as it is not possible to completely suspend your own views as a researcher (Smith & Osborn, 2008).

The process of conducting the analysis was time consuming and this is the first point at which there was a dip in the motivation to continue with the project. It led to all sorts of questions about what other researchers might make of the interpretations I was making, and led to some insecurity about whether my themes were 'right' or 'wrong'. Although I knew that there was no strict 'right' or 'wrong' answer when developing themes, I did feel acutely aware that other people may not agree. I did feel reassured during feedback

from the clinical supervisor, who also conducted their own analysis of the data, providing their themes independently of my own. At this point I wondered if it would also provide more reassurance by seeking the views of the participants as I had done this in previous research. However, this was not possible due the time that had elapsed in-between collecting the data and carrying out the analysis. Over a year had passed by this point and I was aware that many of the participants had relocated to different counties. I would consider this in future research and seek to have this consultation with participants as it would provide further validity to the study.

The Write Up

Perhaps the most challenging part of the entire project has been to remain motivated and focused on the completion of the finished article. This has felt like a lengthy process and has caused further reflection upon how important motivation can be to the quality of written work. The lower the motivation, the poorer the quality of the writing, and then the poorer the writing, the more critical feedback seems which then further lowers morale.

In the first instance, it was exciting to begin writing up the project as it felt that this somehow signified getting towards the finished product. However, this feeling did not last when the realisation of how much time and energy it would take to reach the end set-in. At this point I began to feel more 'assessed' than I have experienced so far, knowing that the work I had conducted would be rigorously scrutinised by several highly professional people. This was a daunting process to go through and the support of my peers was highly valued as there was a shared concern at this time.

Although a systematic review had previously been performed at master's level it was difficult to recall this and make use of previous experience in the systematic searching of previous research. It has been a steep learning curve but a considerably valuable one

as it allowed for a fuller understanding of the value in carrying out a unique piece of research.

The write-up has been the most difficult process due to its 'never-ending' feel. The deadlines may draw nearer, but being able to get there with a publishable report has not always seemed entirely possible. It has therefore been of great importance to use internal and external resources to keep the pace going. This has come in the form of projecting into the future and imagining life after training. It has also, to some degree needed a firm attitude within and an internal encouraging voice to keep saying that the work must be done and completed no matter what.

Conclusion

There is a variety of approaches that can be used to complete a project of this size and importance. Personal experience now has led to the sense that self-discipline and motivation are key in being able to push through the difficult stages. Encouragement and support from others has been important, as has the ability to keep up with time constraints. Reflecting on this can now be done in a more positive light and areas of improvement for the future can be seen and used within any further work that is carried out.

Doing the project has led to a great sense of achievement and the prospect of becoming a published researcher adds a great sense of pride and accomplishment. I also feel that completing the research will add something significant to the area of research.

In terms of correcting potential areas of weakness within the research itself, it might be that applying for ethics in the NHS could assist future learning about the processes of research here, and it is interesting to consider the way that becoming a supervisor in a

project like this could change the perspective and potentially help those in this position in the coming years.

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Appendix A: Journal Submission Guidelines for Paper One

The International Journal of Psychosocial Rehabilitation

Standards & Submission Guidelines

Content: This peer reviewed Journal is dedicated to the continuing development and ongoing evaluation of psychosocial rehabilitation, ACT programs and therapeutic techniques. As such, all articles remotely pertaining to such treatment will be considered for publication. However, the International Journal of Psychosocial Rehabilitation reserves the right to reject any and all articles, but will only do so in cases in which article content does not apply to the goals of the Journal.

Style: Though this journal maintains the publication standards set forth in the American Psychological Association's Publication Manual, we also recognize this may not be available to all practitioners throughout the world. We therefore view the manual as guidelines and not religious canon. Do your best to comply with the style manual, but submit your material anyway.

Editing: In keeping with the spirit of free speech across the internet, the materials presented for publication will not be edited beyond simple conversion to HTML format and presentation layout. It is therefore in your best interest to REALLY EDIT YOUR MATERIAL WELL. It will probably be published as submitted.

Format: All articles for consideration must be submitted in text, DOS text, hypertext or Word for Windows 'doc' format; transmitted in text, binary, or mime format. All Tables and Figures must be submitted in either Hypertext, Word for Windows 'Doc' format, GIF or JPEG files. There can be no exceptions to this policy as the technology for graphic insertion is limited. There are no size limitation on articles.

Preparing the Manuscript

Target Audience: mental health care professionals, applied researchers and service users in mental health or substance misuse programs

Length: Flexible, ranging from 1000 to 10,000 words (10 to 20 double-spaced, typed pages), plus photos, charts, tables, and illustrations. Subjects that require extended treatment may be presented as a series (ie, Part I, Part II).

Organization: Where possible, articles presenting original data should be organized using standard scientific sections and subheadings: Introduction, Materials and Methods, Results, and Discussion. For articles in which these headings are not appropriate, such as review articles, descriptive subheadings should be provided to clarify the article's content. Reviews and other types of articles may be organized in a similar manner. For example, the introduction to a review article could describe the number of studies reviewed and the basic conclusions reached.

Essential Elements of a Manuscript

Author Responsibilities: It is required that all authors who (including every author of a multi-authored article):

Guarantee their sufficient participation in the planning, design, analysis, interpretation, writing, revising, and approval of the manuscript.

Disclose any and all financial information relevant to the article.

Every manuscript should contain the following elements, each beginning on a new page:

Title page

Abstract and keywords

References

Tables and Illustrations

Title Page: The title should be concise and informative. Authors should be listed by first name, middle initial, last name, and degree(s). A primary academic title and department affiliation should be provided for each author. Give the name, mailing address, and email address of the author responsible for correspondence.

Abstract and Keywords: The abstract, structured or unstructured as appropriate, should highlight the significant content of the article. A list of 3 to 5 keywords should be provided beneath the abstract for use by indexing and abstracting services.

manuscripts should be accompanied by an unstructured abstract of up to 150 words. Unstructured abstracts should address the objective, main points, and conclusion of the article. Abstracts are not required for editorials, commentaries, policy papers, book reviews, or special features.

References: References should be listed in alphabetical order. Use APA style for references. Please remove all autoformatting and automatic reference numbering from the final document.

Captions: Captions for graphics or other supplemental material should be no more than 50 words. Include magnification, stain, and other pertinent data where applicable.

Acknowledgments and Permissions: Illustrations and tabulated data from other publications must be acknowledged and must have received permission from the previous publisher. Provide the following information where applicable: author(s), title of article or chapter, title of journal or book, volume number, page number(s), month and year of publication, and publisher name and location. The publisher's signed permission to reprint or adapt must be submitted with the manuscript.

Informed Consent: When human or animal subjects have been used in experimental investigations, the Methods section of the manuscript should include confirmation that appropriate institutional review board approval has been secured. When human subjects have participated in the investigation, the Methods section should also include a description of how informed consent was obtained from the patients.

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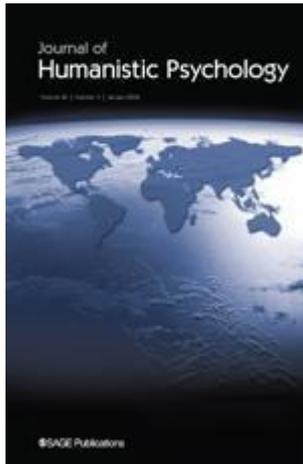
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Manuscript Submissions: Send all submissions with associated files via E-Mail to:

The Editor

Appendix B: Journal Submission Guidelines for Paper Two



Share

Journal of Humanistic Psychology

2015 Impact Factor: 0.622

2015 Ranking: 96/129 in Psychology, Multidisciplinary

2016 Release of Journal Citation Reports, Source: 2015 Web of Science Data

Published in Cooperation with the Association for Humanistic Psychology

Submission Guidelines

The Journal of Humanistic Psychology is an interdisciplinary forum for contributions, controversies and diverse statements pertaining to humanistic psychology. It addresses personal growth, interpersonal encounters, social problems and philosophical issues.

Manuscripts must be submitted electronically at <http://mc.manuscriptcentral.com/johp>, where you will be required to set up an online account on the SAGE Track system powered by ScholarOne. Include a cover letter with address, e-mail, phone number, and fax number.

Manuscript Preparation

Manuscripts should be prepared using the APA Style Guide (Sixth Edition). All pages must be typed, double-spaced (including references, footnotes, and endnotes). Text must be in 12-point Times Roman. Block quotes may be single-spaced. Must include margins of 1inch on all the four sides and number all pages sequentially. Manuscripts should not exceed 15-20 double spaced pages.

The manuscript should include four major sections(in this order): Title Page, Abstract, Main Body, and References.

Sections in a manuscript may include the following (in this order): (1) Title page, (2) Abstract, (3) Keywords, (4) Text, (5) Notes, (6) References, (7) Tables, (8) Figures, and (9) Appendices.

1. Title page. Please include the following:

Full article title

Acknowledgments and credits

Each author's complete name and institutional affiliation(s)

Grant numbers and/or funding information

Corresponding author (name, address, phone/fax, e-mail)

2. Abstract. Print the abstract (150 to 250 words) on a separate page headed by the full article title. Omit author(s)'s names.

3. Text. Begin article text on a new page headed by the full article title. The maximum length is 20 pages, double spaced.

a. Headings and subheadings. Subheadings should indicate the organization of the content of the manuscript. Generally, three heading levels are sufficient to organize text. Level 1 heading should be Centered, Boldface, Upper & Lowercase, Level 2 heading should be Flush Left, Boldface, Upper & Lowercase, Level 3 heading should be Indented, boldface, lowercase paragraph heading that ends with a period, Level 4 heading should be Indented, boldface, italicized, lowercase paragraph heading that ends with a period, and Level 5 heading should be Indented, italicized, lowercase paragraph heading that ends with a period.

b. Citations. For each text citation there must be a corresponding citation in the reference list and for each reference list citation there must be a corresponding text citation. Each corresponding citation must have identical spelling and year. Each text citation must include at least two pieces of information, author(s) and year of publication. Following are some examples of text citations:

(i) Unknown Author: To cite work that do not have an author, cite the source by its title in the signal phrase or use the first word or two in the parentheses. Eg. The findings are based on the study was done of students learning to format research papers ("Using XXX," 2001)

(ii) Authors with the Same Last Name: use first initials with the last names to prevent confusion. Eg. (L. Hughes, 2001; P. Hughes, 1998)

(iii) Two or More Works by the Same Author in the Same Year: For two sources by the same author in the same year, use lower-case letters (a, b, c) with the year to order the entries in the reference list. The lower-case letters should follow the year in the in-text citation. Eg. Research by Freud (1981a) illustrated that...

(iv) Personal Communication: For letters, e-mails, interviews, and other person-to-person communication, citation should include the communicator's name, the fact that it was personal communication, and the date of the communication. Do not include personal communication in the reference list. Eg. (E. Clark, personal communication, January 4, 2009).

(v) Unknown Author and Unknown Date: For citations with no author or date, use the title in the signal phrase or the first word or two of the title in the parentheses and use the abbreviation "n.d." (for "no date"). Eg. The study conducted by of students and research division discovered that students succeeded with tutoring ("Tutoring and APA," n.d.).

5. Notes. If explanatory notes are required for your manuscript, insert a number formatted in superscript following almost any punctuation mark. Footnote numbers should not follow dashes (—), and if they appear in a sentence in parentheses, the footnote number should be inserted within the parentheses. The Footnotes should be added at the bottom of the page after the references. The word "Footnotes" should be centered at the top of the page.

6. References. Basic rules for the reference list:

The reference list should be arranged in alphabetical order according to the authors' last names.

If there is more than one work by the same author, order them according to their publication date – oldest to newest (therefore a 2008 publication would appear before a 2009 publication).

When listing multiple authors of a source use “&” instead of “and”.

Capitalize only the first word of the title and of the subtitle, if there are one, and any proper names – i. e. only those words that are normally capitalized.

Italicize the title of the book, the title of the journal/serial and the title of the web document.

Manuscripts submitted to XXX [journal acronym] should strictly follow the XXX manual (xth edition) [style manual title with ed].

Every citation in text must have the detailed reference in the Reference section.

Every reference listed in the Reference section must be cited in text.

Do not use “et al.” in the Reference list at the end; names of all authors of a publication should be listed there.

Here are a few examples of commonly found references. For more examples please check APA(6th Ed).

Books:

Book with place of publication--Airey, D. (2010). Logo design love: A guide to creating iconic brand identities. Berkeley, CA: New Riders.

Book with editors & edition--Collins, C., & Jackson, S. (Eds.). (2007). Sport in Aotearoa/New Zealand society. South Melbourne, Australia: Thomson.

Book with author & publisher are the same--MidCentral District Health Board. (2008). District annual plan 2008/09. Palmerston North, New Zealand: Author.

Chapter in an edited book--Dear, J., & Underwood, M. (2007). What is the role of exercise in the prevention of back pain? In D. MacAuley & T. Best (Eds.), Evidence-based sports medicine (2nd ed., pp. 257-280). Malden, MA: Blackwell.

Periodicals:

Journal article with more than one author (print)--Gabbett, T., Jenkins, D., & Abernethy, B. (2010). Physical collisions and injury during professional rugby league skills training. *Journal of Science and Medicine in Sport*, 13(6), 578-583.

Journal article – 8 or more authors-- Crooks, C., Ameratunga, R., Brewerton, M., Torok, M., Buetow, S., Brothers, S., ... Jorgensen, P. (2010). Adverse reactions to food in New Zealand children aged 0-5 years. *New Zealand Medical Journal*, 123(1327). Retrieved from <http://www.nzma.org.nz/journal/123-1327/4469/>

Internet Sources:

Internet – no author, no date--Pet therapy. (n.d.). Retrieved from http://www.holisticonline.com/stress/stress_pet-therapy.htm

Internet – Organisation / Corporate author-- SPCA New Zealand. (2011). Your dog may be dying from the heat [Press release]. Retrieved from

<http://www.rnzspca.org.nz/news/press-releases/360-your-dog-may-be-dying-...>

Examples of various types of information sources:

Act (statute / legislation)--Copyright Act 1994. (2011, October 7). Retrieved from <http://www.legislation.govt.nz>

Blog post--Liz and Ellory. (2011, January 19). The day of dread(s) [Web log post]. Retrieved from

<http://www.travelblog.org/Oceania/Australia/Victoria/Melbourne/St-Kilda/...>

Brochure / pamphlet (no author)--Ageing well: How to be the best you can be [Brochure]. (2009). Wellington, New Zealand: Ministry of Health.

Conference Paper--Williams, J., & Seary, K. (2010). Bridging the divide: Scaffolding the learning experiences of the mature age student. In J. Terrell (Ed.), *Making the links: Learning, teaching and high quality student outcomes*. Proceedings of the 9th Conference of the New Zealand Association of Bridging Educators (pp. 104-116). Wellington, New Zealand.

DVD / Video / Motion Picture (including Clickview&Youtube)--Gardiner, A., Curtis, C., & Michael, E. (Producers), & Waititi, T. (Director). (2010). *Boy: Welcome to my interesting world* [DVD]. New Zealand: Transmission.

Magazine--Ng, A. (2011, October-December). Brush with history. *Habitus*, 13, 83-87.

Newspaper article (no author)--Little blue penguins homeward bound. (2011, November 23). *Manawatu Standard*, p. 5

Podcast (audio or video)--Rozaieski, B. (2011). Logan cabinet shoppe: Episode 37: Entertainment center molding [Video podcast]. Retrieved from <http://blip.tv/xxx>

Software (including apps--UBM Medica.(2010). iMIMS (Version1.2.0) [Mobile application software]. Retrieved from <http://itunes.apple.com>

Television programme--Flanagan, A., & Philipson, A. (Series producers & directors).(2011). 24 hours in A & E [Television series]. Belfast, Ireland: Channel 4.

Thesis (print)--Smith, T. L. (2008). *Change, choice and difference: The case of RN to BN degree programmes for registered nurses* (Master's thesis). Victoria University of Wellington, Wellington, New Zealand.

Thesis (online)--Mann, D. L. (2010). *Vision and expertise for interceptive actions in sport* (Doctoral dissertation, The University of New South Wales, Sydney, Australia). Retrieved from <http://handle.unsw.edu.au/1959.4/44704>

Non-English reference book, title translated in English

Real Academia Espanola. (2001). *Diccionario de la lengua espanola* [Dictionary of the Spanish Language] (22nd ed.). Madrid, Spain: Author

IMPORTANT NOTE: To encourage a faster production process of your article, you are requested to closely adhere to the points above for references. Otherwise, it will entail a long process of solving copyeditor's queries and may directly affect the publication time of your article. In case of any question, please contact the journal editor at shawn.a.rubin@gmail.com

7. Tables. They should be structured properly. Each table must have a clear and concise title. When appropriate, use the title to explain an abbreviation parenthetically. Eg. Comparison of Median Income of Adopted Children (AC) v. Foster Children (FC). Headings should be clear and brief.

8. Figures. They should be numbered consecutively in the order in which they appear in the text and must include figure captions. Figures will appear in the published article in the order in which they are numbered initially. The figure resolution should be 300dpi at the time of submission.

IMPORTANT: PERMISSION - The author(s) are responsible for securing permission to reproduce all copyrighted figures or materials before they are published in JHP . A copy of the written permission must be included with the manuscript submission.

9. Appendices. They should be lettered to distinguish from numbered tables and figures. Include a descriptive title for each appendix (e.g., "Appendix A. Variable Names and Definitions"). Cross-check text for accuracy against appendices.

Authors who want to refine the use of English in their manuscripts might consider utilizing the services of SPi, a non-affiliated company that offers Professional Editing Services to authors of journal articles in the areas of science, technology, medicine or the social sciences. SPi specializes in editing and correcting English-language manuscripts written by authors with a primary language other than English. Visit <http://www.prof-editing.com> for more information about SPi's Professional Editing Services, pricing, and turn-around times, or to obtain a free quote or submit a manuscript for language polishing.

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Appendix C: Interview Schedule

Discussion about stigma, meaning and descriptions to understand what the participant feels about these topics.

Questions;

- What are your previous experiences of stigma or discrimination, prior to treatment or during treatment, that you feel have been related to your substance misuse?
- Are there any specific perceptions/stigmatisations held in society about people who have been in addiction or substance misuse?
- Have you got any ideas/thoughts about how you may be treated or how others will view you once you leave treatment?
- Are your experiences of stigma connected to what you think these stigmatisations/perceptions are? (explain more thoroughly with examples if needed i.e. you think people will refuse you a job based on history of addiction, but has this ever happened to you?", or "you have been refused a job in the past while in addiction, do you think this will happen in recovery if people are aware of your history?")
- What are your aspirations following treatments?
- How are your aspirations in recovery connected to experiences or perceptions of society?

Appendix D: Ethical Approval Letter



ETHICAL APPROVAL FEEDBACK

Researcher name:	Faye Hall
Title of Study:	Embarking on recovery, when does stigma end? Investigating the experiences of stigma and how this affects aspirations in recovery from substance misuse: An IPA analysis.
Award Pathway:	DClinPsy
Status of approval:	Approved

Thank you for forwarding the amendments requested by the Panel

Action now needed:

Your project proposal has now been approved by the Faculty's Ethics Panel and you may now commence the implementation phase of your study. You do not need to approach the Local Research Ethics Committee. You should note that any divergence from the approved procedures and research method will invalidate any insurance and liability cover from the University. You should, therefore, notify the Panel of any significant divergence from this approved proposal.

You should arrange to meet with your supervisor for support during the process of completing your study and writing your dissertation.

Signed: Professor Karen Rodham
Chair of the Faculty of Health Sciences Ethics Panel

Date: 24th November 2014

Appendix E: Information Sheet



Embarking on recovery, when does stigma end?

Investigating the experiences of stigma and how this affects aspirations in recovery from substance misuse: An IPA analysis

INFORMATION SHEET

I would like to invite you to take part in a piece of research on the above topic. This sheet provides information that can help you understand why the research is being done and what it would involve for you. If anything is unclear, or if you would like more information, please contact myself or the research supervisors using the information at the bottom of this sheet. Please take time to read the information carefully before deciding to take part.

What is the purpose of the study?

This study aims to identify people's past experiences of stigma and discrimination as a result of drug and alcohol use, and whether this has had any long term affects. The research being carried out will investigate the unique experiences and views of each person who takes part.

Why have I been invited?

You have been invited to take part in this study due to being identified as someone who has completed at least 14 weeks of the treatment programme at the BAC and O'Connor Addiction Centres. This is relevant to the study as it is felt that you will be able to share information about your views of stigma in relation to substance misuse and also report on what you would feel able to do in recovery after treatment.

Do I have to take part?

You are completely free to decide whether you would like to participate or not. If you do decide to take part you are still free to withdraw before the data is analysed (4 weeks after being interviewed), without giving a reason. Declining to take part in the research **will not** affect your treatment with the BAC and O'Connor centre in any way.

What will I have to do if I take part?

You will first be given a participant reference number which is unique to you. This number should be kept somewhere safe as it is used to keep your data confidential. You will find your participant number on the top of your consent form. You will then be asked to take part in a 30-45 minute interview with the researcher which will need to be recorded using a dictaphone. During the interview you will be asked to detail some of your personal experiences of stigma in relation to many areas of your life, and also what your hopes are for the future. You can refuse to answer any of the questions if you wish and are free to say as much or as little as you like.

After the interviews have taken place, all the data from every participant in the study will be collated and used to write a report on the findings of the study. The report again will not identify any individual who has taken part.

What are the possible advantages of taking part?

There may not be any direct benefit of taking part in the research for you individually, unless you feel it is something that you would enjoy. The research may be used to inform future treatment programmes and provide insight into this topic area for improvements to be made within the health services available to substance misuse clients.

Are there any disadvantages?

Due to the topic of stigma and discrimination some people may find that this is a difficult subject to discuss in a research setting. If you are unsure whether you should participate perhaps you could speak with your therapist about the appropriateness of the study for you.

Once agreeing to take part you can still opt out of the research at any time before analysis, this includes stopping the interview if you feel it is not something you wish to continue with.

What will happen to the information after the research?

Information about you and your responses during the interviews will be kept strictly confidential. Electronic files will be deleted and paper copies will be shredded after five years, in line with the British Psychological Society guidelines (2005) on retaining information intended for publication. A final report will be prepared and submitted for marking as part of a thesis project at Doctoral level in Clinical Psychology, following this the report may be further disseminated for scientific benefit and you can request a copy of the report if you like. No information revealing you as a person who has taken part will be detailed anywhere in this report.

Who should I contact for further information or if I have any problems or concerns?

Project lead/Researcher

Faye Rwatschew
Trainee Clinical Psychologist
Staffordshire University, ST4 2DE

Other people who are involved in the research project that you may prefer to contact are:

Academic Supervisor

Helen Dent
Clinical Psychologist
Staffordshire University

Clinical Supervisor

Kevin Langan
Lead Therapist

Appendix F: Consent Form



Participant Identification Number for this trial:

Age: _____

CONSENT FORM

Title of Project: Embarking on recovery, when does stigma end?

Name of Researcher:

Please Tick box

1. I confirm that I have read the information sheet dated..... for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected.
3. I understand that the information collected about me could be used to support other research in the future. The research may be published, but kept anonymous.
4. I agree to take part in the above study.

Name of Participant

Date

Signature

Name of Person
taking consent

Date

Signature

Appendix G: Recruitment Poster



Life after Treatment

Be part of a research project into past experiences during active addiction and your aspiration for recovery after treatment

- Have you completed at least 14 weeks of treatment in the BAC and O'Connor centre?
- Are you willing to talk about your actual experiences or perceived views on stigma and discrimination?
- Do you want to share your thoughts on how improvements to treatment in substance misuse can be made?

The purpose of the research is to investigate the experiences you may have had in regards to stigma and discrimination as a result of substance misuse. The aim is to understand what impact this has had on future aspirations.

Participants will be interviewed individually for 30-60 minutes. The information gathered will be confidential between the participant and the researcher.

Once the research is complete it may be published (anonymously) and may be used to inspire new ways of working that can reduce the effects of stigmatisation and discrimination.

*If you think you might like to take part please speak to **Kevin Langan** or leave a message with the therapy team for **Faye Hall** and you will be provided with more information about taking part.*

Appendix H: Example of Line-by-Line Coding

177 *Interviewee* Yeah, very dangerous; well you can die from doing that, can't you so, erm, yeah,

178 you would have thought that a service that's dealing with so many people with substance misuse

179 issues would have more knowledge.

181 *Interviewer* And do you have any, erm, sort of reservations or concerns I guess still about

182 how society will view you?

184 *Interviewee* Yeah. I think I'm in quite a fortunate position when I'm looking for work

185 because I'd like to work, I'd like to give something back to, you know, within this sort

186 of area, but if say I was working or if I was going to apply for a job in sales, I'd be very

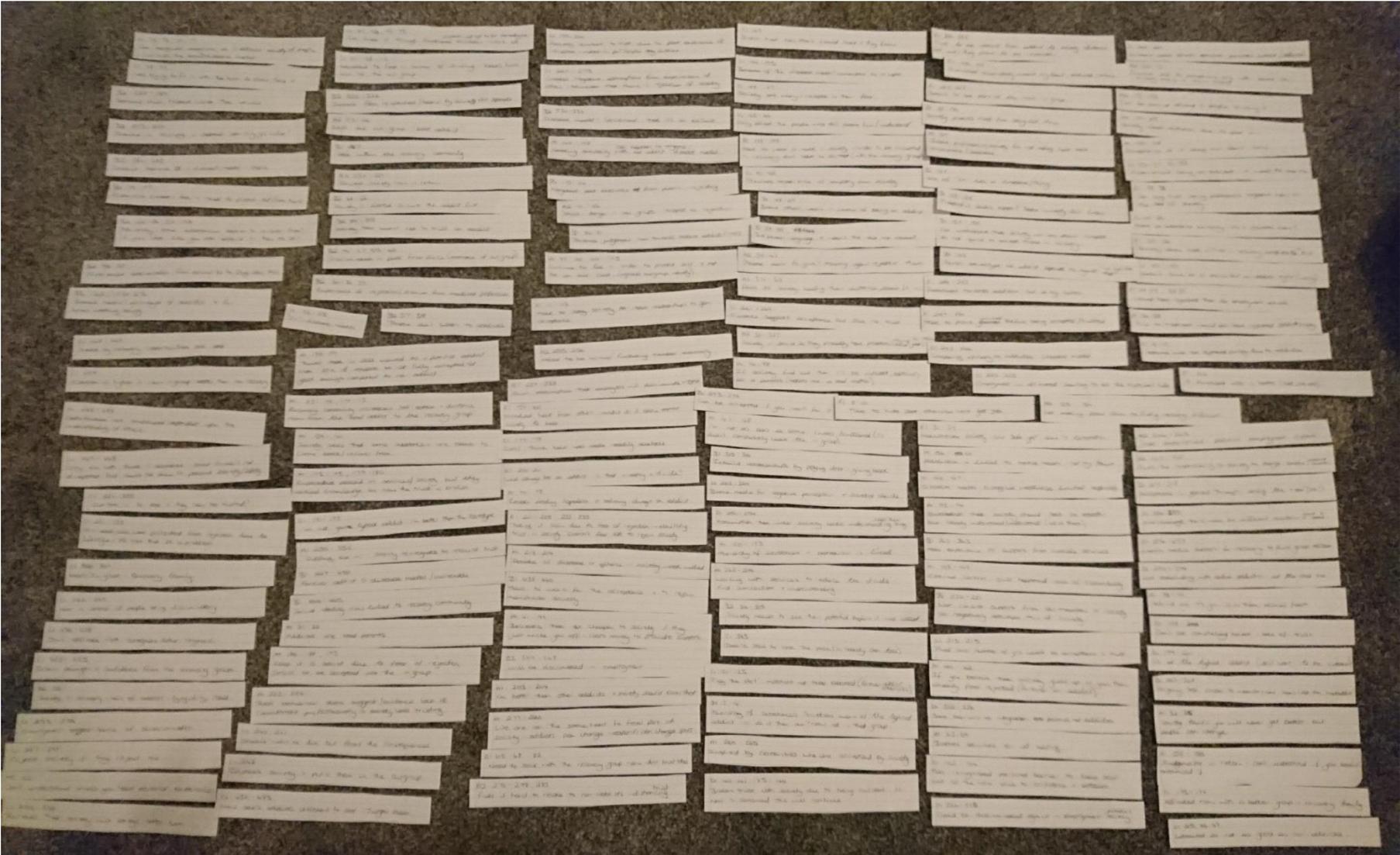
187 iffy about what I would say first of all, you know. Maybe once I'd got to know people,

188 because it's not something I want to be --- I'm ashamed of, but then I would worry about the

189 stigma and the judgment.

Coding	Emergent Theme
Professionals can be Dangerous/lack knowledge	Lack of Trust Blaming others
Feelings lucky in Some ways	Lucky to be in recovery
Repay society and Help others	Rebuild Relationships
May not reveal Addiction	Secrecy of History
Fear discrimination	Fear

Appendix I: Clustering of Emergent Themes





Appendix J: Table of all Super-ordinate and Sub-ordinate Themes

Super-Ordinate Theme	Sub-Ordinate Theme	Participant and Line Number
Forever an Addict		
	Illness or Choice?	Lucy: 56-61, 70-73, 125- 128, 166-167, 168-169, 213-214 Daniel: 40-42 Jeff: 37-39, 48-49, 167, 447-450 Harry: 280-282, 330-333 William: 73-74, 78-79, 92-93 Martin: 35-37, 51-53 George: 145-149, 242-244,284-285
	The Impact of the Label	Lucy: 32-35, 107-108, 268-270, 277-280 William: 121-125, 157-157, 163-164, 255-256 Martin: 25, 46-47 George: 210-211
	Discrimination in Employment	Daniel: 244-245, 255-256 Harry: 247-248, 295-299 William: 224-225, 253-254, 468-469, 488-489 Martin: 226-228 George: 36-38, 58-59, 148-149, 237-238
The Broken Social Contract		
	We Know We've Done Wrong	Lucy: 198-199, 222-224 Daniel: 79-85 Jeff: 157-159, 188-190, 293-294, 315-316, 438-440 Harry: 84-85, 64-66 William: 188-189, 199-200, 213-215

		Martin: 217-218 George: 111-113, 129-132, 257-261
	“Dipping My Toe In”	Lucy: 41-44, 63-64, 78-79, 160-162, 173-175, 179-180, 250-252 Daniel: 276-278, 283 Jeff: 220-221, 362-363 Harry: 194-197 William: 51-52, 261-264, 269-275 Martin: 140-141, 145-146 George: 93-95, 159-160, 169, 177-178, 221-225, 232-233, 311-312
	Secrecy and Concealment	Lucy: 96-98, 99-100, 104-105, 186-188, 193 Jeff: 123-125 William: 240-241, 343 Martin: 198 George: 8-10
A New Social Identity		
	I’m Not Like the Others	Lucy: 147-148, 203-204 Jeff: 142 William: 432-433 Martin: 199-201, 294-296 George: 142, 191-193
	Active Addicts	Lucy: 30-32 Daniel: 25-26, 173-174 Jeff: 80-81 Harry: 128 William: 87-89, 92-93, 107-108, 112, 447-448
	Rejecting Society	Lucy: 92-94, 152-155 Daniel: 39-41, 122, 101-102, 314-315, 381-382

		<p>Harry: 237-239, 317-318, 322-324 William: 231-233, 248, 297-298, 436-438 Martin: 251-254</p>
	The Recovery Family	<p>Lucy: 113-115 Daniel: 130-131 Jeff: 198-199, 240, 464-465 William: 366-367, 422-425, 477 Martin: 193-194, 207-208 George: 65-68, 82, 205-207</p>