WOOD, LESLIE L., M.A. AUGUST 2020 SOCIOLOGY

"EVERYTHING I DID IN ADDICTION, I'M PRETTY MUCH THE OPPOSITE NOW": RECOVERY CAPITAL AND PATHWAYS TO RECOVERY FROM OPIATE ADDICTION

(77 pp.)

Thesis Advisor: Clare L. Stacey, Ph.D.

Since the late 1990's, the U.S. has been struggling with an epidemic linked to the use of opiate drugs and their synthetic counterparts. While many have died in this epidemic, many also recover. In this qualitative study, I aim to gain a better understanding of how people with opiate addiction seek out, navigate and sustain recovery. Eighteen in-depth interviews were conducted with individuals in recovery from opiate addiction. Analysis of data suggests that individuals with opiate addiction utilize a wide range of resources to access treatment and engage in recovery. In this paper, I discuss four major themes and four subthemes. Specifically, individuals who suffer from addiction mobilize various forms of recovery capital, including social, economic and cultural capital (e.g. Cloud and Granfield 2008). I also find that in this sample of middle-aged, White individuals in recovery, themes and experiences such as existential pain, hope, and engagement with the criminal justice system figure prominently in narratives about recovery.

“EVERYTHING I DID IN ADDICTION, I’M PRETTY MUCH THE OPPOSITE NOW”: RECOVERY CAPITAL AND PATHWAYS TO RECOVERY FROM OPIATE ADDICTION

A thesis submitted

To Kent State University in partial

Fulfillment of the requirements for the

Degree of Master of Arts

by

Leslie Louise Wood

August 2020

Thesis written by

Leslie Louise Wood

B.S., Kent State University, 2017

M.A., Kent State University, 2020

Approved by

Clare L. Stacey_____**,** Advisor, Department of Sociology
Clare L. Stacey

Richard Adams_____**,** Chair, Department of Sociology
Richard Adams

_____, Interim Dean, College of Arts and Sciences
Mandy Munro-Stasiuk

TABLE OF CONTENTS

TABLE OF CONTENTS (CONTINUED)

ACKNOWLEDGEMENTS

I would like to sincerely thank my advisor, Dr. Clare Stacey, for her continued encouragement, helpful suggestions, guidance and patience as I worked to complete this project. Also, many thanks to the additional members of my committee, Dr. Susan Roxburgh and Dr. Robert Peralta, for their willingness to serve on my committee and especially for sharing their knowledge and extremely relevant suggestions, which helped immensely in improving the final version of this paper. Thank you to the Sociology graduate department for their support through what has been a very difficult year. Finally, I thank my family for their support, especially Eddie for his patience and Heidi for her companionship.

INTRODUCTION

One hundred years ago, the U.S. was in the midst of the temperance movement and had recently passed the Harrison Narcotics Act in attempt to curtail the use of opium and other drugs (Lindesmith 1968; Reinarman and Levine 1997a). In the decades since, no laws, social movements or wars on drugs have minimized--much less eradicated--substance use or addiction (Reinarman and Levine 1997a; 1997b; Reinarman and Granfield 2015; Alexander 2008). Today, we are years into what politicians, the media, and addiction scholars call "the opiate epidemic." Hundreds of thousands have died from what started as a prescription drug problem and became a heroin problem and then a fentanyl problem (Hedegaard, Miniño and Warner 2020; National Institute of Drug and Alcohol Abuse (NIDA)2020). Sociologists postulate that addiction is a symptom of broader social issues (Reinarman and Levine 1997a; Granfield and Cloud 1999; Reinarman and Granfield 2015; Bourgois 2010; 2015; Alexander 2008), whereas the legal system vacillates between punitive measures and coerced treatment depending on the social status of the arrested individual (Tiger 2015; 2017, Conrad and Schneider 1992). Concurrently, the medical profession touts the notion that addiction is a disease that can be treated but cannot be cured (Peele 1989; Kalant 2015; Courtwright 2015; Fox 2015).

It is widely agreed that opiate addiction is a chronic and relapsing disorder (e.g. Madras and Connery 2019; Hser, Evans, Grella, Ling and Anglin 2015; Marel, Mills, Slade, Darke, Ross and Teesson 2019). The number of individuals directly affected by opiate addiction and the frequency of relapse is difficult to estimate for various reasons including stigma towards

addiction and a lack of funding directed towards collecting accurate data (Hays 2019; McNeil 2020). The most recent mortality reports on overdose deaths show that in 2017, the peak year of the opiate epidemic thus far, there were 47,600 deaths from overdose that involved heroin and synthetic and prescription opioids. This total includes 32,377 males and 15,263 females, and 37,113 were non-Hispanic White (Wilson, Mbabazi, Seth, Smith and Davis 2020).

Despite numerous ideological battles and inconsistencies in addressing the social problems surrounding addiction, many who struggle with addiction find their way to recovery (Granfield and Cloud 1996; 1999; Cloud and Granfield 2008; Laudet, Morgen and White 2006). One recent cross-sectional study estimates that 1.2 million individuals report having resolved an opioid problem (Hoffman, Vilsaint and Kelly 2020). My research seeks to extend the current sociological understanding of how individuals with opiate addiction seek out and utilize resources for recovery. This qualitative study uses narratives collected via in-depth interviews with individuals in recovery from opiate addiction. Data I gathered through conversation with my participants sheds light on the process through which the lives of persons with opiate addiction transform from immersion in the drug subculture to immersion in recovery subcultures. I describe the barriers they faced upon seeking resources for recovery, the resources they access and utilize and those they cannot, how they learned to navigate the public health system, and the significant pain and hope that punctuate their recovery stories.

As a theoretical foundation, I use Cloud and Granfield's (2008) concept of recovery capital to illuminate the economic, social, cultural, and community resources that are vital to the recovery process. I also draw from Shim's (2010) concept of cultural health capital to explain how individuals who lack conventional forms of capital learn to navigate the public health system and gain access to treatment. I apply literature from palliative care (e.g. Kissane 2000;

LeMay and Wilson 2008) and social work (e.g. White and Chaney 2012; Laudet et al. 2006) to explore how the concept of existential pain is linked to addiction, and how this pain can merge with hope to initiate the recovery process. Finally, I illustrate the how recovering individuals undertake a "conversion" (Granfield and Cloud 1999) process, taking various forms of capital from the drug culture and directing them towards their community and helping others to recover.

I employ individual narratives of recovery in this paper because they provide detailed and powerful accounts of how recovery transpires from the perspective of individuals who have the lived experience of addiction. Many in the sample are not simply surviving but thriving within the recovery community as well as in other contexts. Much of the academic literature on addiction is written from a cold, detached and scientific perspective that depicts those with various substance addictions as research subjects or "objects of study" (Akers 1999; Pienaar, Fraser, Kokanovic, Moore, Treloar and Dunlop 2015). People addicted to substances have historically been painted in politics and the media as immoral social outcasts that are not worth saving (Granfield and Cloud 1996; Reinarman and Levine 1997b; Bourgois 2010). As a sociologist and an advocate for the recovery community, I counter this stereotype and instead offer an empirically grounded account of how individuals addicted to substances navigate access to treatment and utilize various resources for their recovery. As such, this thesis attempts to give voice to the experience, struggles and promise of those who have found a path out of addiction.

LITERATURE REVIEW

Below I provide a brief overview of sociological perspectives of addiction and discuss how these perspectives conflict with the disease model. I will discuss barriers to treatment related to socioeconomic status and race. I will then introduce the concept of recovery capital (Cloud and Granfield 2008) and how it relates to sociological understandings of capital. I will also explain how experiences of existential pain and hope can together inspire recovery. Additionally, I will explain how my research extends existing theory and scholarship.

Sociological Perspectives on Addiction vs the Disease Model

For over a century, scholars, politicians and policy makers have debated over how best to classify, police, and/or treat the behavior of individuals who use drugs and alcohol (Reinarman and Levine 1997a). Debates persist about whether drug use is a disease, a social issue, a criminal problem, or some combination of the above. The default understanding of addiction is that it is a disease, but the boundaries of this term are elusive, and its definition depends on the source (Reinarman and Granfield 2015; Courtwright 2015; Peele 1989). Generally, addiction is perceived to be a pathology of the brain, inclusive of psychological and physiological characteristics. It fits into the "disease model" as a disorder of the brain with negative symptoms (Labor 2019; Volkow and Koob 2015). The disease model of alcoholism and drug addiction dominated from the late 19th century into the 20th and is very much alive today (Reinarman and Levine 1997a; Reinarman and Granfield 2015; Kalant 2015). However, the criminal justice

system still plays a significant role in attempts to control and deter illicit drug use. Evidence shows that the disease model and the criminal model are used disparately depending on the social circumstances (race, class, gender) of the individual in question (Fox 2015; Reinarman and Levine 1997a; 1997b).

Social scientific understandings of addiction proliferated alongside medical models. Alfred Lindesmith (1938; 1968), often referred to as the father of the sociology of addiction, recognized that addiction is a social process as well as a biological one. Countless social scientists have extended Lindesmith's work, applying various theoretical perspectives including social learning and symbolic interactionist theories (e.g. Becker 1953; 1967, Zinberg 1984; Denzin 1997; Lindesmith 1938; 1968; Stephens 1991; Weinberg 2002; 2011). In recent decades, social scientists have focused on how social inequalities in race and class impact the use of licit and illicit substances, how particular drugs are portrayed by the media and perceived by the public, and how all of this impacts social policies (Fox 2015; Reinarman and Levine 1997a; 1997b; Reinarman and Granfield 2015; Cloud and Granfield 2008; Granfield and Cloud 1996; 2001; Tiger 2015; 2017; Bourgois 2010; 2015; Guerrero 2013; Guerrero, Cepeda and Kim 2012).

A common thread among sociological perspectives is a rejection of the disease model of addiction. It is often cited as reductionist because it ignores the social and environmental factors that may facilitate the early use of various types of drugs and make it very difficult for some individuals to find their way out of substance use disorders (Granfield and Cloud 1999; 2001; Cloud and Granfield 2008; Reinarman and Levine 1997a). Some also claim that it ignores personal responsibility (Fox 2015; Peele 1989). While the disease model has provided a pathway to treatment for many who need it, it is problematic in other respects. It has paved the way for

potentially predatory treatment centers and pharmaceutical companies (Peele 1989; Fox 2015; Chiauzzi and Liljegren 1993), and it also absolves the government and society as a whole from responsibility for the social inequities that are at the root of many substance use issues.

Barriers to Treatment Related to Stigma, Socioeconomic Status and Race

With considerable government and media attention on the "opioid crisis," it may seem that all one must do is ask for help and it shall be given, but this is often not the case (Cunningham, Sobell, Sobell, Agrawall and Toneatto 1993; Peterson, Schwartz, Mitchell, Reisinger, Kelly, O'Grady, Brown and Agar 2010). Many who use substances report a lack of information about treatment availability, a disbelief that treatment will help them, and the fear of stigma related to treatment (Cunningham et al. 1993). Others disagree with the ideological basis of treatment and mutual aid groups (Granfield and Cloud 1996). Individuals with substance use issues may also have diminished social skills, leading to widespread perceptions that they are unwilling or resistant to recovery, or "unmotivated and hopeless" (Best, Bird and Hunton 2015).

Social scientists often focus on stigma as a barrier to treatment (e.g. Livingston, Milne, Fang and Amari 2011; van Boekel, Browuwers, Weeghel and Garretsen 2013). Stigma is certainly present regarding substance use disorders and is a notable concern for individuals with higher levels of socioeconomic status (SES). It is important to note, however, that for persons with lower levels of SES, stigma is but one of the many barriers standing in the way of recovery. The stigma of addiction works to create further barriers for those of low SES, who contend with a plethora of resource- related impediments. For example, many report problems like not having required documentation (picture ID or birth certificate), waiting lists, and a lack of money or health insurance (Peterson et al. 2010). Others face obstacles related to pregnancy and childcare (Jackson and Shannon 2011; Shannon and Walker 2009). While stigma is undoubtedly a barrier,

it is important to consider how the presence or absence of critical resources can have major implications in relation to recovery.

Race is also a significant barrier to treatment and recovery from opiate addiction (Hansen, Seigel, Case, Bertollo, DeRocco and Galanter 2013). Whites have been the primary focus of the current opiate epidemic, but it has also had a drastic impact on other racial groups. For example, overdose deaths for Black Americans increased by 40 percent from 2015-2016, compared to the general population increase of 21 percent (Substance Abuse and Mental Health Services Administration (SAMHSA) 2020). Non-White individuals are more likely than Whites to be criminalized for involvement with illicit substances and funneled into the criminal justice system and prison rather than treatment (Hansen and Netherland 2016; Reinarman and Levine 1997a; 1997b; Tiger 2015; 2017; SAMHSA 2020).

Additionally, racial segregation creates disparities in access to treatment (Goedel, Shapiro, Cerdá, Tsai, Hadland and Marshall 2020; Hansen et al. 2013). Medication assisted treatment (MAT) is frequently touted as the gold standard for treatment, but disproportionately available in regions where residents are primarily Black and Hispanic (Goedel et al. 2020). Buprenorphine can be prescribed as a take-home prescription, while methadone dispensation is highly controlled and largely utilized in lower SES and non-White individuals with opiate addictions (Hansen and Netherland 2016; Goedel et al. 2020). The perception of prescription opioid addiction as a White suburban problem led to congressional approval of buprenorphine maintenance so that this new White suburban population of addicted individuals would not be forced to comply with methadone maintenance (Hansen and Netherland 2016).

Recovery Capital

Not all people with substance addictions face barriers to accessing recovery resources. In fact, many people recover from substance addictions "naturally," without accessing or receiving treatment (Granfield and Cloud 1996;1999; 2001; Sobell, Ellingstad and Sobell 2000). This fact is often downplayed by proponents of formal treatment. Many individuals "age out" of deviant behaviors including substance use during transitions related to adulthood (Massoglia and Uggen 2010; Staff, Schulenberg, Maslowsky, Bachman, O'Malley, Maggs and Johnston 2010), which is likely related to cases of natural recovery. Granfield and Cloud (1996; 1999) studied individuals who recovered without formal treatment, medication or mutual aid groups and developed an understanding of factors that would also benefit those seeking formal treatment. They conceptualized these resources as "recovery capital" (Granfield and Cloud 1996; 1999; Cloud and Granfield 2008). Recovery capital is described as "the sum total of one's resources" that can be used towards attaining and sustaining recovery from substance addictions (Granfield and Cloud 1999:179; Cloud and Granfield 2008). While naturally recovering individuals claimed to have stopped using substances without help, they did not do so alone. In fact, the most significant common resource they had was a high amount of social capital and access to resources that came with it (Granfield and Cloud 1999; 2001; Gueta and Chen 2015).

Characteristics that have been shown to predict natural recovery include a strong social support system, meaningful attachments to conventional life, high levels of cognitive awareness and feelings of self-efficacy (Granfield and Cloud 1999; 2001; Gueta and Chen 2015). Mastery, closely related to self-efficacy, has a high impact on one's coping skills, resilience, and mental well-being in the face of stressful situations (Roxburgh 2011; Turner and Avison 1992). Low levels of social support and social status have a negative impact on mastery and have been found to cause feelings of hopelessness and helplessness (Roxburgh 2011). Given this, it is possible to

conclude that the coping skills, self-efficacy and mastery that help one to recover may be disproportionately distributed among social classes.

Often, individuals who do not require formal treatment have higher levels of capital, while those who are most in need of treatment have the least capital with which to access and successfully utilize it (Granfield and Cloud 1999). Cloud and Granfield (2008) also discuss negative recovery capital. Factors such as age, race, gender, poor physical and mental health, and incarceration have been shown to have a negative impact on the probability of sustained recovery (Cloud and Granfield 2008). For example, younger and/or non-White individuals and women with children may struggle to navigate a treatment system whose foundations were built to serve empowered white males (White and Chaney 1992; Moyer 1998).

Cloud and Granfield's (2008) construct of recovery capital includes four components: physical, human, social, and cultural capital. Recovery capital has roots within the sociological understandings of capital (Cloud and Granfield 2008), so here I will explain recovery capital as it relates to Bourdieu's (1986) forms of capital. I will then briefly discuss the additional concepts of community capital and cultural health capital and explain how they advance our understanding of recovery from substance use disorders.

Physical capital (Bourdieu's economic capital)

In the framework of Cloud and Granfield (2008), physical capital is akin to Bourdieu's (1986) conception of economic capital. They describe it as income, savings and other material assets that can be converted to money (Cloud and Granfield 2008). In the context of recovery, physical capital gives individuals options and choices for treatment that are not as easily accessible to those who do not have physical capital. Medicaid expansion has made paying for

treatment easier (Sharp, Jones, Sherwood, Kutsa, Honermann and Millet 2018), but those with physical capital through employment or access to it via their families gain quicker access to more comfortable private treatment facilities (Cloud and Granfield 2008).

Social capital and perceived, instrumental and structural social support

One of the most crucial components of recovery capital is social capital (Granfield and Cloud 1999; Cloud and Granfield 2008; White and Cloud 2008; Laudet, Morgen and White 2006; Best, Hall and Musgrove 2018). Social capital is the set of resources one has access to through a stable social network, and it exists in exchanges and mutual obligations related to group membership (Bourdieu 1986). This includes tangible resources as well as emotional support (Granfield and Cloud 2008), which are beneficial for entering and sustaining a recovery lifestyle. Social support is closely tied to social capital, and various types of social support differ in significance at some points in recovery (Dobkin, Civita, Paraherakis and Gill 2002; Laudet and White 2008).

Sociological literature classifies social support into three main types- perceived, instrumental and structural (Turner, 1999; Roxburgh 2011). Perceived social support, including having a close confidant, is cited as being most predictive of well-being (House 1981; Turner 1999; Roxburgh 2011). In a recovery context, this may apply to a sponsor or a close friend in the recovery community. Instrumental social support is having people in one's life who would provide help with tasks like moving or caregiving (Roxburgh 2011). In recovery, an example is having peers to provide rides to meetings. Structural social support describes the social network in which one is rooted, including the number and quality of social ties, as well as frequency of contact (Roxburgh 2011). In terms of recovery, this would include the number and quality of

social ties in the recovery community as well as any other social ties that promote and assist with the conversion to a more conventional lifestyle.

Structural social support, like social capital, can be used to access financial assets, treatment information, employment opportunities, and various other resources necessary for a return to conventional life (Dobkin et al. 2002; Cloud and Granfield 2008). Functional social support is related to the perceived availability of emotional support and feeling of belonging that comes with close social ties (Lin, Ye and Ensel 1999; Roxburgh 2011), and is associated with positive recovery outcomes including decreased risk of relapse (Dobkin et al. 2002; Havassy, Hall and Wasserman 1991). Involvement in relationships and emotional support can provide a buffer for stress during difficult times, improve quality of life, and promote sustained recovery (Laudet et al. 2006). Social bonds with family, friends and coworkers are important supports for a recovering individual (Moos 2007; Moos and Moos 2007). Having peers in the recovery community provides emotional support and recovery role models (White and Cloud 2008; Laudet et al. 2006).

Human capital

Human capital is described as a set of characteristics that can be mobilized to participate in regular daily activities, gain and maintain access to social groups and reach personal goals (Granfield and Cloud 1999; Cloud and Granfield 2008). This range of attributes includes skills, knowledge, educational credentials, employment or employable skills, physical health, mental health, and other achieved and ascribed traits that promote one's ability to thrive (Granfield and Cloud 1999; Cloud and Granfield 2008). Human capital is essential for sustained recovery, but many who are at the cusp of entering recovery have very little to speak of. Part of the recovery

process is building human capital so that sustained recovery can be achieved (Granfield and Cloud 1999).

Cultural capital, redemption narratives, and the conversion of subculture and social networks

Cloud and Granfield's (2008) definition of cultural capital is closely aligned with Bourdieu's (1986) concept. Cultural recovery capital includes values, beliefs, dispositions and perceptions that come from immersion in a particular cultural group. Those who have substance addictions but continue to subscribe to the norms and values of dominant social groups and participate in conventional life have the advantage of cultural capital (Cloud and Granfield 2008). Others face ascribed existence in an underprivileged, disadvantaged social group (Cloud and Granfield 2008) where "street behavior" and "hustling" are normative behaviors and skills (Stephens 1991). These adaptive measures, which many have relied upon for survival during active addiction, are not always conducive to living in conventional society.

Ideally, upon initiating recovery, an individual will trade the drug subculture, including using acquaintances and the "addict" identity, for a peer group of recovering or non-using persons and an identity that is more reflective of recovery (Best et al. 2015; Granfield and Cloud 1999; Cloud and Granfield 2008). Intense involvement in new practices such as religious or mutual aid groups, enrollment in college, and commitment to exercise and healthy behaviors can take the place of activities related to drug use (Granfield and Cloud 1999). The creation of a "redemption narrative," emphasizing positive moral changes that have occurred in the transition from addiction to recovery, can be useful in deflecting stigma and sustaining recovery (Dunlop and Tracy 2013; Stone 2016). Such "storytelling rituals" are embedded in 12-step programs and other mutual aid groups (Granfield and Cloud 1999; Denzin 1997). These narratives generally include a before and after, or "what we used to be like, what happened, and what we are like

now" (Alcoholics Anonymous 2001:58). These shared stories provide a framework for self-change, and perhaps more importantly, they create pathways of mutual understanding as foundations for networks and social ties among individuals who wish to recreate their lives in a way that does not involve the consumption of mind-altering substances.

Social network ties are found to have a deep impact in changing behaviors over time (Christakis and Fowler 2011), which makes the construction of a new social network profoundly impactful to one's chances for sustained recovery. In 12-step programs, the intentional transition of environment, activities and social networks is described as "changing people, places and things." Cloud and Granfield refer to this process as "conversion." Regardless, if one remains immersed in the environment, social network and activities of the drug subculture, chances of recovery are far lower than if individuals become immersed in the recovery community. Such a "conversion" can be vital to the recovery process, but it is challenging to activate, especially for individuals with little or no recovery capital. This type of transformation has been cited as a serious obstacle for recovery (Cloud and Granfield 2008). In this study, I aim to demonstrate that such obstacles can be overcome in ways that are meaningful for the recoveree as well as other individuals seeking paths to recovery.

Community capital

Community capital is an extension of recovery capital and is often referenced in the counseling (i.e. White and Cloud 2008) and corrections literatures (e.g. Best, Hall and Musgrove 2018; Best, et al. 2015). Community recovery capital is described as "community attitudes/policies/resources related to addiction and recovery that promote the resolution of alcohol and other drug problems" (White and Cloud 2008:2). It includes community efforts to reduce stigma, recovery role models as visible examples of the recovery identity, a wide variety

of substance addiction treatment resources, recovery community support institutions, sources of sustained recovery support including mutual aid groups, and early intervention for relapse and relapse prevention (White and Cloud 2008; Best et al. 2015). While Cloud and Granfield (2008) find contact with the legal system to be negative recovery capital, I suggest that for some individuals it can be positive. Thus, I extend the definition of community recovery capital to include interaction with the criminal justice system.

Cultural health capital

Shim (2010) conceptualized cultural health capital (CHC) as "a specialized form of cultural capital that can be leveraged in health contexts to effectively engage with medical providers" (2010:3). She described a broad skill set that is required to navigate the health care system, including health literacy, the ability to communicate effectively with medical providers, the resources to practice self-discipline, and a sense of mastery and self-efficacy (Shim 2010). In the context of substance use, these traits help patients to negotiate stigma when interacting with healthcare providers. For patients who do not demonstrate CHC, stigma associated with substance use can have a negative impact (Chang, Dubbin and Shim 2016).

Shim's (2010) CHC generally refers to those with considerable capital and resources. Individuals of a minority status may find alternative ways to mobilize cultural capital and gain access to health care. Examples of this include Mexican immigrants in U.S. border communities (Madden 2015) and prisoners in carceral institutions (Novisky 2018). I posit that a similarly unique set of skills exists in the recovery community and treatment settings. I will refer to this concept as subcultural health capital (SCHC). In the recovery community, SCHC can be developed through repeated experience given the commonality of relapse. Information can also

be gathered and transmitted via acquaintances in the drug circle, often including family members, who have experienced attempts at recovery or are currently in recovery.

Existential Pain and Hope as a Combined Catalyst for Recovery

Commonly cited reasons for seeking treatment and recovery include negative consequences and the desire for "a better life" (Laudet et al. 2006). For some, treatment-seeking and recovery is a deliberate and planned action, but for others, it is the result of spontaneous events or consequences, such as a trip to the ED, the psychiatric ward, or an arrest. These "triggering events" may present an opportunity for change and the hope that life can get better (Årstad, Nesvåg, Njå, and Biong 2018).

Substance use is sometimes used as an escape from or to "self-medicate" co-occurring mental illnesses (Granfield and Cloud 1999; Cloud and Granfield 2008; Moos 2003), and evidence points to trauma of various forms as a common precursor to substance addiction (White and Chaney 1992; Moyer 1998). Emotional pain is frequently found at the beginning of the cycle of addiction because drugs and alcohol are often used as a coping skill to numb the emotional pain of past traumas and daily stressors (Cloud and Granfield 2008; Moos 2003; White and Chaney 1992). Interestingly, emotional pain is also often a part of the end of the cycle that leads to recovery (Moyer 1998). During active addiction, emotional pain increases as the chase for the substance takes over one's life and they lose all of the people and things that were once important to them. The only thing remaining in life is their substance (Bourgois 2010; Årstad et al. 2018). They are chasing drugs just to feel normal. When addicted individuals are shown hope and an opportunity for change, it provides them with a way out of this cycle (Moyer 1998).

Ironically, opiates, the class of drugs commonly used to treat severe physical pain can ultimately cause existential pain. It is widely agreed upon that a specific definition for existential pain is elusive (LeMay and Wilson 2008; Strang, Strang, Hultborn and Arnér 2004). In a study of palliative care specialists, "existential pain was described as suffering with no clear connection to physical pain" (Strang et al. 2004:241). Some of the commonly agreed upon features of existential pain in other studies include a lack of meaning, lack of purpose, demoralization (Clark and Kissane 2002), and "feelings of remorse, powerlessness, and futility" (Kissane 2000; LeMay and Wilson 2008:474) . I posit that any or all of these descriptions can be applied to the emotional state of someone in the depths of opiate addiction, whether at the beginning or the end stages. While the terminology has a home in palliative care literature, I find it is also appropriate here because substance addiction causes similar forms of moral and emotional distress and often leads to death.

According to William White in a 1998 interview, pain and "hitting bottom" can successfully elicit change for those who have significant recovery capital (Moyer 1998:10). Conversely, pain is a tolerated part of life for those who already exist at the bottom. White says that for some, the problem is not pain, it is an "absence of hope."

> At the point when the pain of late-stage addiction is experienced acutely, without hope, you will get suicide. We may not even know that it's suicide, but what we will see is death in the face of incredible pain. The essence of recovery is a collision between that experience of pain and consequences and simultaneously an experience of hope that there is a different way, some other life, not the same old drinking and drugging. It can happen in many ways (Moyer 1998:11).

In the recovery community, hope is portrayed through “visible examples” of individuals who have recovered, as they do community outreach work and actively engage with those who are new to recovery (White and Cloud 2008; Best et al. 2015). Additionally, there is a long tradition of sharing redemption and recovery narratives which express “experience, strength and hope” (Alcoholics Anonymous 2001; Denzin 1997). Illness narratives “carry the implicit promise” that change can happen for others who have a similar experience (Frank 1993). Within this paper, I endeavor to illustrate ways in which the existential pain of addiction merges with hope to initiate the recovery process.

METHODS

My research seeks to understand how individuals recover from addiction to opiates. I use data collected through in-depth qualitative interviews to explore the patterns and meanings associated with individual recovery narratives.

Recruitment of Participants

Sociologists have long noted that the best strategy towards an understanding of substance use and addiction is engagement with those who have direct experience (Lindesmith 1938; 1968; Becker 1953; Bourgois 2010; 2015). I followed this logic into the realm of recovery. My research population--individuals who self-identify as being in recovery from opiate addiction--are often located in mutual aid groups and other semi-public settings. With approval from the Institutional Review Board (IRB), I recruited participants from a range of spaces within the recovery community.

I visited recovery-based coffee shops and a church-based recovery group several times to pass out recruitment flyers. This was ultimately unsuccessful because this was my first endeavor into recruiting participants for qualitative research, and I had not yet learned the importance of initiating conversation and obtaining contact information upon meeting potential recruits. In subsequent recruitment attempts, I sought out individuals who were outspoken in the local recovery community. I visited a local recovery nonprofit, several mutual aid groups, a post-incarceration support group, the county opiate task force meetings, and I participated in a week-long training for peer recovery supporters. These organizations yielded 12 interviews. From

there, I primarily relied on snowball sampling for the remainder of recruitment by asking participants to pass on my information to anyone else who might be willing to speak to me. Snowball sampling yielded six additional interviews. In total, I interviewed 18 people in recovery. To participate in the study, individuals needed to be 18 years or older, have at least six months of sustained recovery, and include opiates as a prominent part of their substance use story. Participants were compensated with their choice of a selection of five-dollar gift cards to a local retailer. Two participants asked me to donate five dollars to a local recovery group in lieu of the gift card.

The sampling method I used resulted in a sample that is all White, primarily middle-aged or older and active in the recovery community or employed in the recovery industry. Given this, the findings are certainly not representative of all recovering individuals. However, they do provide important insights into various aspects of the recovery process and sustained recovery for particular demographic characteristics.

Sample

The final sample has 18 participants, 10 of which identify as male, and eight who identify as female. The ages range from 22-66 with a median age of 44. All of my participants are Caucasian, although one identifies as Italian. I used highest education completed as a measure of SES, and responses ranged from 10^{th} grade to various professional degrees. Ten participants completed at least some college. As for religious affiliations, six participants identify as Christian, three as Catholic, two as Methodist; two identify as spiritual but not religious, one responded “higher power” (a concept derived from 12-step programs), and four responded “none” or left the question blank. Unfortunately, I neglected to include time in recovery on my demographic survey, but participation required at least six months of sustained recovery. I was

able to roughly estimate time in recovery from information related to me during interviews. Respondent time in recovery ranged from eight months to 26 years, although most had consecutive recovery time ranging from one to six years. Table 1 below lists the basic demographic characteristics of participants.

Results from Demographic Survey (N=18)	
**Twelve participants were recruited directly, and six were recruited via snowball sampling.*	
**Fourteen were interviewed alone, and four were interviewed with another participant present.*	
Gender	
Male	10
Female	8
Age *(Range is from 22-66; mean age is 41.88; median age is 44).*	
20-29	2
30-39	7
40-49	4
50-59	4
60+	1
Race/Ethnicity	
White/Caucasian	17
White/Italian	1
Other	0
Religious Affiliation	
Christian	6
Catholic	3
Methodist	2
Higher Power	1
Spiritual, not religious	2
None	4
Highest Education Completed *(Range is 10th grade to graduate or professional degree; median is some college).*	
Less than High School	1
High School or GED	7
Some College	5
Two-Year degree	1
Four- Year Degree	2
Graduate Degree	2

I make efforts to protect the confidentiality of my participants while simultaneously placing a high value on the rich narratives they provided for my study. Direct quotes from the interviews are fundamental in my presentation of results, but for the protection of participant identity, all personal names, locales, treatment centers and other community institutions are given pseudonyms. With respect to the excerpted interview data presented in this document, I removed extraneous words and phrases for clarity and brevity, but in a way that maintains the veracity of each narrative. Verbatim text is used wherever possible.

Confidentiality and Privacy Measures

Due to the sensitive nature of the project, I took great care to protect respondent identities. I received a full board IRB approval for an unsigned informed consent, but participants were required to sign an audio-recording consent form. Interviews took place in quiet, semi-private locations chosen by the respondents, including library study rooms, restaurants during off-peak hours, mutual aid group meeting locations and sober housing facilities. Respondent names were deidentified at the point of transcription and demographic information was kept separate from interview materials in a locked space only accessible to me. I assigned pseudonyms to each participant, and pseudonyms are also used for the names of locales, treatment centers and other rehabilitative programs. All electronic files were protected by password and stored on my personal laptop computer. Only one hard copy of the data exists in a binder that is kept in a locked space only accessible to me.

Interviewing

To gain a deep understanding of how individuals experience opiate addiction and recovery, I conducted face-to-face interviews using an interview guide (Appendix A). I also

collected basic demographic information from each participant at the time of interview (Appendix B). Aware of the potential emotional difficulties of revisiting the past, I made clear to each participant that it was up to them how much they would like to disclose. Many individuals in recovery, especially those who are active in the recovery community, are accustomed to sharing their stories as a testimonial of sorts. Accordingly, my participants were generally quite candid and open to sharing information, resulting in rich data (Charmaz 2000).

I used a semi-structured guide for each interview, but I also recognized that each individual constructs their own narrative of recovery, so I remained open to unique interpretations of the term recovery as well as multiple pathways to recovery. In general, I sought descriptions of participants' experiences during active addiction, why they decided to seek treatment and recovery and what difficulties they faced in this process. I also inquired about resources and forms of support they found most helpful, and whether and how they engaged in recovery behaviors and practices. Interviews were digitally recorded with a SONY digital recorder and ranged from 28-97 minutes with a mean length of 50 minutes. I personally transcribed each interview verbatim (except for identifying information) into text files for analysis.

Data Analysis

I analyzed the data in several steps. First, I took interview notes when speaking to respondents, which allowed me to identify emerging themes throughout the data collection process and to probe for more specific details in subsequent interviews (Charmaz 2000; Strauss and Corbin 1994). Once transcription was complete, I used a printed binder of the interviews for line-by-line open-coding within the interviews and created a list of codes and themes from this process (Charmaz 2000; Lofland, Snow, Anderson and Lofland 2006). For the third stage, I used

Dedoose software to replicate and organize the open-coding process into focused coding, in a few cases merging or collapsing similar codes (Charmaz 2000; Lofland et al. 2006). From this point, reflective of constructivist grounded theory (Charmaz 2000;2009), I chose frequently reoccurring themes that I felt were best suited to tell the stories that emerged from my data and selected pertinent quotations from those themes.

From a sociological viewpoint, I find value in many perspectives on addiction. However, given the current clinical and public understandings of addiction, most participants in this study are rather partial to the disease model. Their way of understanding their lived experience is reflected in the narratives they have constructed as a part of their recovery. As the Thomas Theorem states, "If men define situations as real, they are real in their consequences" (Oxford Reference 2020). Thus, the stories told by individuals in recovery, including my participants, have significant influence on their sustained recovery and their quality of life (White and Chaney 1992; Dunlop and Tracey 2013).

Standpoint Statement

While this project does not seek to compare recovery across different racial/ethnic groups, I find it necessary to acknowledge my inherent biases (e.g. Unger 2015). I came to this research with the lens of a White, middle-aged female with a background in medical sociology and several years of involvement in the recovery community. I recognize that this is a privileged position. I also understand that my perspective makes it difficult to understand, or even know what questions to ask in relation to race in the recovery process. It was not purposeful that all of my participants were White, but I also did not go out of my way to secure a representative sample. That said, I do not ignore the fact that addiction and recovery are highly racialized phenomena. For example, Whites are more likely to engage in substance use, but far less likely

to suffer the negative consequences (Golub et al. 2007; Hansen and Netherland 2016; Peralta 2005). Additionally, White individuals are more likely to gain access to treatment, especially through the legal system, while their non-White counterparts are given lengthy prison sentences (Tiger 2015; 2017).

FINDINGS

In this section, I present my findings related to the process of recovery from opiate addiction. I discuss four major themes: barriers to treatment; recovery capital; the role of pain and existential hope as catalysts for recovery; and the conversion of subcultural capital from the drug subculture to the recovery subculture. There are also four subthemes which fall under the umbrella of recovery capital: economic capital; subcultural health capital; social capital and social support; and community capital and the criminal justice system. I first discuss barriers to treatment related to socioeconomic status and reliance on the public health system. Next, I discuss various forms of recovery capital that help individuals in their recovery process, as well as some implications when various forms of recovery capital are inaccessible. I introduce the criminal justice system as a form of community recovery capital. Subsequently, I discuss how the existential pain of addiction, when merged with hope, can be the catalyst for recovery. Finally, I demonstrate that individuals in recovery can and often do convert their cultural capital and energy into helping others to recover. Respondents believe this improves chances for sustained recovery and quality of life. For several, it also provides opportunities for employment. Table 2 below lists the themes and subthemes by gender and mean age.

Major Themes and Subthemes by Number, Gender and Mean Age (N=18)

Themes and Subthemes	Number of Participants (%)	Number of Excerpts	Male	Female	Mean Age
Barriers to Treatment	15 (83.3%)	59	9	6	39.8
Recovery Capital					
Economic Capital	6 (33.3%)	23	3	3	49.1
Social Capital	18 (100%)	73	10	8	41.6
Subcultural Health Capital	10 (55.6%)	20	5	5	35.9
Community Capital in Criminal Justice System	8 (44.4%)	22	6	2	39.4
Existential Pain and Hope	10 (55.6%)	27	7	3	39.7
Conversion of Subcultural Capital	15 (83.3%)	52	8	7	43.5

Barriers to Treatment in the Public Healthcare System

It has been very well documented that social class influences access to treatment. Individuals with economic capital have more treatment options because they have access to private self-pay facilities, while less affluent individuals have to rely on public health services. Some obstacles in public programs are remnants of the early days of methadone maintenance (see Institute of Medicine 1995; Courtwright 1992). For example, the requirement for having a specific type of substance in one's system to enter detox or treatment was mentioned by several participants in this study. Fifteen respondents (83 percent) discussed barriers related to recovery resources. What follows are descriptions of barriers to treatment that are linked to SES and the public health care system

Andrea was 34 with about four years in recovery at the time of interview, and she gave a particularly striking example of the requirement to test positive for specific drugs before admission to treatment. This requirement is related to the close regulation of methadone and other forms of MAT that can easily be abused. She was unable to enter treatment at the community health center unless she had opiates in her system. While using opiates so that she could enter treatment, she overdosed yet again.

> At the time, in order to go to the community health center, **you had to have drugs in your system…** my mom let me clean her house so I could get some money **so I could buy some dope so I could have it in my system.** Well, I didn't have somebody to split it with, so **I overdosed again, and had to go back to the hospital again**… So yeah, almost met my maker, like twice. In one week.

Another issue is the amount of time one must spend trying to access treatment. One dangerous facet of this problem is "the list," waiting lists that delay access to services because of bureaucratic and funding hurdles; some of which are tied to previous federal regulations for methadone maintenance. Several participants mentioned a list to get into detox or treatment, or even to be assessed for treatment. For someone who is experiencing a physical addiction to opiates, this means that to prevent going into withdrawal, they have to continue using drugs until their name comes up on the list for detox. Due to the nature of these substances, it is obvious why this is a precarious situation.

Brad was 54 with nine years in recovery and volunteering at a local recovery nonprofit run by Travis. Travis was 44 years old with about four years in recovery. I interviewed them individually, but both were present during the others' interview, and they frequently referenced one another in their responses.

Brad: I got a guy in from Southside Rehabilitation last night- **he got on the waiting list in October and couldn't get in until December.**

LW: So the statistics they're putting in the paper are not accurate?

Travis: It's bullshit. So let me tell you a story about this, ok?... So, uh, my friend's nephew was put on the list for detox, because they used to have the list… **And this kid died waiting for a bed** because… that bed stayed open overnight. **And more than one person I know died on that list…but they don't fill the beds.** They don't fill the beds. So in all this time, they had this wait list, **and all these people died, and all they had to do was change their policy** and just stop the thing and just say, come in.

A waiting time between detox and inpatient treatment may increase the likelihood of relapse. There are support groups available for individuals who are waiting, but many do not have the emotional and psychological tools or the coping skills to maintain abstinence as they wait for treatment. Additionally, people who are addicted to opiates often lack the economic capital to have a safe place to stay after detox and must return to the drug subculture they emerged from, where there are few resources to stay connected to the treatment community. Matthew was 22 years old and had been in recovery for about one year at the time of interview. He gave the following description of this problem.

But a lot of **people I know have been in detox, they just get out… it's like the wait list**, because I've heard people waiting for a bed for Westside Rehab for months. And **when I get there, there's a lot of open beds**. Which I never—I guess they have to have some open, but there was always a lot of open beds, **even though there are people waiting**.

Being on a waiting list for inpatient treatment after detox is hazardous because drugs are often found in outpatient treatment settings. Casey was a 32-year-old male who had about 10 months of recovery at the time of interview. In a support group he attended while on the waiting list, Casey used drugs provided by another participant.

> …when I first got here in October **I went to like a treatment readiness group** while I was on the list to get into Southside Rehabilitation Center, and **this dude who came in there… he brought some shit and I did it** so that's why my sober date isn't October, it's November.

While Medicaid expansion has helped many to obtain insurance that covers treatment, a multitude of obstacles remain in the process. Some of these are related to the necessity of relying on public health services. Unfortunately, these organizations appear unable to effectively triage individuals with opiate addiction, for whom getting into treatment may be a life and death situation. Travis had this to say.

> **It's two weeks just for an assessment.** If you go through detox, that assessment should count for your treatment…But no, now they have to set an appointment with ADM and then do an interview process and then an assessment… for who knows how long, and **then if you're lucky you get put on the list when there's open beds for another 4-6 weeks**. We just don't have that time. **We don't have that time**. And there's beds open, I can tell you right now there's beds open.

Matthew's experience further supports Travis's account of the situation.

> I had tried to get into treatment for a very long time, just never was able to. **There's a lot of hoops you still have to jump through to get in rehab**. I thought you just tell them

you want to go; you get to go. It's not …**the whole getting into rehab was hard**. There's a wait list…

Others had less of a gap in care, but still an extremely long wait time for inpatient treatment. While pregnancy expedites some forms of outpatient treatment, women who are pregnant or have children have an especially difficult time getting into inpatient treatment. Lacey, a 41-year-old female and mother who had been in recovery for six years at the time of interview describes her experience with access to treatment.

> **I got put on several lists**. The lists were—some were three months long; some were six to eight months… **because I had my kid**... But there wasn't a lot of options, they didn't offer me a lot at all. And the ones that they did offer were just, you know, I had to wait six to eight months. **What was I going to do for the six to eight months? Where was I gonna go?** I would have been using again. If it wasn't for community health center that got me in [to the MAT program] …

Those who seek recovery find various ways to negotiate and overcome these barriers, but they do not do so alone. Like addiction, recovery is not merely biological; it is a highly social process. The next section provides examples of resources and forms of capital that participants used in the process of recovery.

Recovery Capital: The Positive Impacts of Economic Capital, Social Capital, Instrumental and Structural Social Support, and Subcultural Health Capital on the Recovery Process

Economic capital and access to treatment and recovery resources[1]

Individuals with economic capital have a much easier time accessing services and treatment than those who do not. Most participants in this study were reliant on social services for treatment, but some were more fortunate. Six respondents (33 percent) discussed ways in which economic capital positively influenced their recovery, including health insurance through their jobs, access to capital via their families, or both. Following are examples of those who had access to economic capital and how it helped them to access treatment.

Brad's entry into the treatment system was facilitated by economic capital related to the health insurance he had through his job.

> LW: How would you describe any resources you found available in the community regarding addiction recovery?
>
> Brad: Awesome. And I went into [local] treatment center, got hooked up with AA, just learned a different way to live.
>
> LW: Did you have any problems gaining access to treatment, or were you given different options?
>
> Brad: **I had no problem, I had good insurance and good doctors.** I had good recommendations, so it wasn't hard for me**. It was hard to go, but it wasn't hard to find**.

[1] While Cloud and Granfield (2008) used the term "physical capital" as described in the literature review section, for the remainder of the paper I use the term "economic capital" to avoid confusion for those who are accustomed to sociological terminology.

Donna suffered significant losses by the time she sought recovery, but she had health insurance, as well as income from her disability support and benefits from her deceased spouse. Her health was poor, but she recognized the advantage she had over other women due to her income. She was 57 at the time of interview with about two years in recovery. She described her experience with a local aftercare program for women.

> I was in Heritage House for almost a month, and it wasn't looking good on me getting back on my feet again. I had nothing. But I did…I hustled… and **I was fortunate enough to have an income**, because I get my disability and my husband died so... I get his benefits. So that together gave me **a bit of an edge that nobody else had**… So, yeah. I felt sorry for people that didn't have any income...

Dr. Nancy was in medical school when she sought help for her opiate addiction. She was 39 years old at the time of interview, and today she is a practicing physician in the field of addiction medicine. She had excellent access to treatment due to her social location. However, she relied upon her family's economic capital to pay for treatment.

> …they were insistent that I do residential treatment, and they were able to get me in …although **my family had to pay for it out of pocket. But the resources were available, there was lots of places I could go..**. I can't say for sure how readily resources would have been available to me if I had to be entirely reliant on my insurance.

Matthew's parents provided the economic capital to send him through numerous expensive treatment programs as a juvenile, which were ultimately unsuccessful. As a young adult, he was estranged from his parents and no longer had access to economic capital, so he had to learn how to navigate the system on his own. He struggled for some time before he learned

about public assistance and how to access it, but when he finally acquired Medicaid it was quite beneficial to his attempts at recovery.

> …a lot of people in my family gave me trouble over being on Medicaid… I know where I work I ain't paying into my insurance. **I did have help from the government**, I had food stamps and Medicaid... **That's the reason why I was able to get into rehab three times in one year as an adult**… I was homeless and didn't even have food stamps, I don't know how that happened. **Nobody told me…My parents are well off**, they own their own business, **they don't ever talk about this stuff.**

Cloud and Granfield (2008) posit that age can operate as a form of negative recovery capital. For Matthew, his young age was tied to inexperience with how to function as an adult. Until he had some experience in attempting recovery without help from his parents, he was severely limited in navigating the system. However, he was able to develop the subcultural health capital necessary to effectively seek treatment.

Subcultural health capital: navigating the treatment system without conventional cultural health capital

Subcultural health capital in the recovery community is a set of skills specific to the treatment and recovery community including negotiation (and sometimes manipulation) skills and the active mobilization of experientially acquired or socially transmitted knowledge. Ten respondents (56 percent) discussed navigating the system in ways that diverge from Shim's (2010) conception of CHC. Here I give examples of how participants developed and/or utilized their subcultural health capital (SCHC) to gain access to treatment.

Ricky was 31 years old at the time of interview with about one year in recovery, and today he works as a recovery coach for Randy's nonprofit. He had numerous experiences with treatment and relapse. Some years ago, he relapsed and overdosed, which landed him in the hospital for a lengthy physical rehabilitation and was the impetus for his penultimate period of recovery. His experientially acquired SCHC empowered him to know exactly where to go when he felt was ready to make a sustained change.

> I had already had this **fairly decent connection with Ellis Hall** [local outpatient treatment center] **so I went back through them for drug addiction and they… let me stay**, keep coming to the outpatient groups for about a year, until I felt comfortable enough to get out on my own.

Lacey described learning where she could go for help from others in "the circle" of the drug subculture, and she used this socially transmitted SCHC to seek treatment. "**I kind of just knew, just from being in the circle, you know, the drug circle**…you hear about ADM [local alcohol, drug and mental health board] and this and that. So, I went to ADM."

Andrea knew she had to get help when she got pregnant, because she did not want to have her baby taken away. Because of her sister's experience, she was aware that her pregnancy would expedite her case through the system if she wanted to use the medication assisted treatment (MAT) program and not inpatient treatment.

> Andrea: Yeah, I went to the community health center, because I knew because I was pregnant I could get in right away, like I could do all my appointments in one day, whereas if you're not, or if you're a man, it's like spread out over like six weeks or something… **so you kind of gotta know…it's fucked up how to work the**

system…Like I was gonna hustle, it was like I kind of knew, I always have to have a hustle. It's fucked up that doing that you have to have a hustle [laughing].

LW: It's government stuff, you almost have to.

Andrea: You know, I'm telling you! **Like the ins and outs, the ins and outs, you know? The ins and outs. Unless you like know, firsthand, unless you know, no one's gonna tell you these things.**

Andrea's SCHC includes utilizing information she gained from family members in recovery. To mobilize this knowledge, she used a skill she calls the "hustle." In the drug subculture, a "hustle" refers to the skills involved in acquiring drugs (or the money to buy them). In a later section, I will describe how embodied subcultural skills like the hustle are often converted or translated from the drug subculture into useful skills in the recovery community.

"You must find the tribe": The importance of social capital and instrumental and structural social support from families and peers

Social capital, including social and emotional support, can play important roles in recovery capital and sustained recovery. Social capital is commonly a result one's social location and social class, so it may be more effective for privileged individuals. Unfortunately, many people with opiate and other substance addictions are immersed in a drug subculture where acquaintances and often even family members are in active addiction. Building a peer support network in the recovery community can help one gain access to social capital, because social networks can heavily influence one's behaviors over time (Christakis and Fowler 2011).

Social capital and structural and functional social support are closely related and often coexist in the same personal relationship. They can be provided through relationships with

family and peers in the recovery community, which also often overlap due to nature of addiction as a "family disease." Eighteen respondents (100 percent) discussed topics reflective of social capital in reference to their recovery. The following examples illustrate the coexistence of social capital and structural/instrumental social support.

Dr. Nancy had social capital in the form of structural social support due to her social location in medical school in addition to her family's economic capital. While emotionally it was still quite difficult to enter recovery, she had a lot of assistance once she asked for help.

> Dr. Nancy: I was **at a family medicine office where I was doing a rotation** …I just rolled up my sleeves and showed her all my track marks and started crying, like I don't know what to do. So she **started the process of getting me in touch with people that help doctors,** and yeah, that was pretty much it…
>
> LW: Ok. How would you describe the resources you found available at that time regarding addiction recovery?
>
> Dr. Nancy: For me, **they were great**, because again, I got **immediately in touch** with like physician monitoring agencies, and while they are not very forgiving in terms of you get to choose what you do, **they are very accommodating in terms of getting you into places.**

Donna described the importance of her family's instrumental social support, including the significance of sharing recovery with her daughter.

> **Well, my daughters…they're very supportive. And my son**…But, like Marcy, my youngest, she's always there. Like today when I needed a ride from the pharmacy**… I couldn't do it without their support**, you know? And my oldest daughter was like

> doing meth ...and **when I got to my one-year anniversary of clean, she quit that day**. So, when I hit my two-year anniversary, she hit her one-year anniversary.

Randy was 58 at the time of interview with 26 years in recovery, and he was close to achieving his Ph.D. when I spoke with him. He described encouragement from his family, and more importantly, he explained the relevance of instrumental social support from peers for those in recovery.

> I would say, initially, my parents were thrilled, and both would later rejoin me in recovery, five and six years later, both my mother and my father… I would say, **you must find the tribe**. Or you must find a recovery tribe. Whatever that is for you, **that would be at the very center.**

"The tribe," Randy explained, is a group of individuals also in recovery, who can provide friendship, emotional support, and assistance in building recovery skills. The tribe may also act as fictive kin for those whose families have cut ties and/or are still in active addiction.

Randy's nephew Casey was working as a residential supervisor for his one of his uncle's sober houses when I interviewed him. Casey had the emotional support of his uncle even during active addiction, so it was less difficult for him to ask for help. Additionally, his uncle has a lot of connections in the recovery community. This relationship is demonstrative of social capital in the form of instrumental as well as structural social support.

> …my **uncle Randy. I'm pretty sure he's known the whole time**. Even when other people didn't. He's **messaged me about every 6 months for the last 8 years**. Saying, you ready? And every other time, I'd be like, nope. Until this last time… it was just to a

point where I was ready to say, yeah man... So yeah, **once I found there was resources here**, in [Midwest city] that **if I wanted it I could get it**, that was like the game changer.

Ricky emphasized the importance of structural social support from his mother and instrumental social support from his peers after a relapse. While his outpatient treatment was important to reentering recovery, he found that instrumental and emotional social support from the recovery community was necessary to sustain recovery and enjoy life.

My mom **introduced me to Randy**, and I started coming to the meetings**,** and got myself back…before I started doing heroin again... I knew if I did that shit again, I would die…**I got connected with everybody**…**started going back to my meetings, got a sponsor**, started doing all kinds of fun stuff that we do here…Eventually **I moved in over here** at Randy's Recovery Institute. Thing have been wonderful since.

Evie was 33 at the time of interview with about two years in recovery. Today she works as a recovery coach. She described the importance of learning to acquire sober support when she was in treatment, and how she shares it with others who are new in recovery. Sober support is a term for peer support that is often used in 12-step and other mutual aid groups. It can come in the form of structural support and connections to recovery resources. More often, it is instrumental and/or perceived social support, including emotional support and assistance with learning the necessary skills to sustain recovery.

It [inpatient treatment] saved my life. **It saved my life**… And it introduced me to AA and **taught me how to have sober support**… the thing I remember most is saying, Hi, my name is Evie, do you mind if I have your number for sober support? And I work with people too, and if I try and teach them [how to ask for sober support] because **I don't**

know where I would be without all the different people that I met. And helped me get through stuff.

Travis was 44 at the time of interview with about four years in recovery. He did not receive formal treatment, but he had exposure to Alcoholics Anonymous and worked through the program on his own motivation while he was in prison. Here, he describes how instrumental social support helped him when he first got out of prison.

> Shit, **everything was a challenge in the beginning**. **I have a good support system**. I have my family, you know, once I got out of prison… **They were very supportive**. And the people here [at the nonprofit he runs]- I can call them day or night…**And I was so nervous coming home**. Yeah, my family, Brad, in the beginning.

Jonathan was 44 with about two years in recovery when I met him, and he was excited to be starting college. He talked about the instrumental and structural social support he found in a residential community corrections program (RCCP) that was inarguably important to his recovery pathway. It led him to an accumulation of role models and social capital that helped him get to where he is today.

> …I met a **good group of guys** when I first got locked up, because I went in with nothing to RCCP…**so they gave me clothes**, and they were doing like this Bible study on Friday nights, and **they asked me to come**… there was an AA group that came on Sunday mornings…Instead of being in the snowball of bad, everything has been a snowball of good for me. So…**It was just amazing people, doing for me what I couldn't do for myself**, that kick-started it.

Jonathan's story, which I will return to later, is an example of how, mostly for White individuals, the criminal justice system can be a resource for recovery and a source of social capital and social support that people addicted to substances may access to facilitate recovery.

Existential Pain and Hope as a Combined Catalyst for Recovery

People in the throes of opiate addiction are accustomed to pain. Individuals who are addicted to substances frequently find that the meaning of their lives revolves entirely around the cycle of chasing drugs to prevent going into withdrawal (Bourgois 2010; Årstad et al. 2018). In some cases, they are waiting to die, wanting to die, sometimes even attempting suicide. When they see an opportunity for hope, it gives them an alternate way out of the cycle. Ten respondents (56 percent) in the sample discussed ways that their existential pain merged with hope to provide a catalyst for recovery.

Jane was 37 at the time of interview with about three years in recovery. She had a long history of using pain medicine and psychiatric medications as prescribed prior to her illicit substance use. Today she is active in the recovery community. She recently founded a local dual diagnosis recovery meeting and would like to become a recovery coach. Here she describes the pain that led her to decide to get help.

> I had lost my sister to heroin and I lost my cousin to heroin and one day, I almost used heroin. The pain was just so exceedingly—**I was in excruciating pain.** [crying slightly, sniffling] …So when I was driving past Serenity Street [local behavioral health center] one day… the moment that I went in that door, **I knew I was going to change, and I knew I wanted to recover,** whatever it took.

Casey explained how the cycle he was caught in finally became painful enough that he wanted to find a way out.

> **I'm a drug addict. And I'm gonna die. That's just how it is**. The only thing that makes me happy is doing drugs. So, I just really didn't know that you could get better, but yeah, it got to the point where it was, life was so unfulfilling. And I knew I was **in this cycle of it just fucking sucked**. So, I finally just got to the point where…**my level of pain living like that was finally greater than the pain of trying something else**.

Alex was 23 at the time of interview with about 18 months in recovery. He experienced a similar feeling of being caught in a cycle. When he saw the older men around him in jail and treatment centers, he realized that if he did not change, he would be just like them. He also recognized the value of emotional pain and exhaustion to his recovery and willingness to change.

> I just, it just kind of started sinking in like **I don't want to do this for the rest of my life**. I had people around me who were twice my age, and I just felt like, I'm no better than they are if I don't get ahold of this…and at that point I just- **I felt like I had enough pain**. And I was ready to give it my best shot at a different way of living…But it does- I do believe that ultimately, **the person has to be broken down enough** to the point where they're ready to listen to suggestions and be open minded…

Brad described how emotional pain led him to an unsuccessful suicide attempt, which in turn presented him with an opportunity for recovery.

> I'm walking around suicidal... **I get pissed off when I wake up in the morning, I want to die in my sleep**. I don't want to wake up and do this again. It was like groundhog's day…. Chase the drugs. Get high. Commit the crimes. Do whatever I had to do. And I

finally got sick of it one night, took about 45 pills, ended up in a coma for three weeks, got out of the psych ward after about 14 days, and went into treatment…**The pain is what's gonna make you change. When the fear of staying the same is greater than the fear of change, something is gonna happen.** What's your choice gonna be? My philosophy in life is there's two things. There's a problem, and there's a solution. There's nothing in the middle. You've either gotta live in the problem, or you gotta live in the solution.

Evie described her hopelessness and resignation to the idea that she was going to die from an overdose.

I carried a note in my book bag to my son for when they found me dead. It was my way to just say bye to him. You know, I really thought that that was gonna happen. When they found me overdosed somewhere, that…**and I was ok with that being my goodbye…**I had no real relationship with any of my family. A lot of my friends are doing like long terms in prison, or they're dead. But I kept continuing to go around the same people that are just – they just wouldn't get better**. So I really didn't have a lot of hope**…

Evie also described the hope she found after being arrested and given the opportunity for treatment.

…And I went to Southside Rehab and there was girls there that worked there that I had actually been in jail with… So, it was the first time I saw people that had been where I'd been but they made it out, and they seemed like happy, and really… **it was just the first**

time I actually had like a living example of somebody that had been in my spot and they made it out. And so, it gave me hope that I could do it too.

"Getting rescued": The Role of the Criminal Justice System in the Community Capital of White Individuals with Opiate Addiction

Cloud and Granfield (2008) argue that incarceration is a "direct assault" on social and cultural recovery capital, thus creating negative recovery capital. While I do not disagree with their position, my data demonstrates that there is more to the story. In fact, one of the most powerful narratives from my interviews involves the transformation of a man who went to prison. Today he runs a successful recovery nonprofit. My data is supportive of the notion that the criminal justice system can indeed be a valuable resource for recovery when a person is ready to change. Participants described arrest and involvement in the criminal justice system as sources of hope and opportunities for recovery. I propose that in some cases, especially for the White respondents in my sample who faced considerable barriers to finding treatment, the criminal justice system can be a source of what authors call community recovery capital (White and Cloud 2008; Best et al. 2015; Best et al. 2018).

Eight participants in this study (44 percent) were, at the time of interview, in sustained recovery after an arrest or by way of other involvement in the criminal justice system. While it may seem counterintuitive, during my time in the community I have never heard anyone who is in recovery complain about being arrested or being put in jail, prison, or court mandated treatment. They often recognize that if they had not been removed from their situation, they would likely be dead. These situations are referred to as "god doing for me what I could not do for myself," or getting "rescued." While participants also say there are drugs in jail and treatment, and that many individuals leave and immediately "go back out" into active addiction, I

think it is worth discussing that there are pathways to recovery from within the legal system. For some, it offers access to support and resources that they could not find elsewhere. Following are some examples of how the criminal justice system functions as community recovery capital.

Marie was 38 years old with about four years in recovery at the time of interview. Before she was able to sustain recovery, she had several previous encounters with treatment and the legal system. This excerpt illustrates that she placed trust in the drug court rather than the hospital to help her get the treatment that she felt she needed to save her life. Today, she works as a recovery coach for the very same drug court program that she credits here.

> …But it was the same day I overdosed…then with the drug court, I called my case worker and said I overdosed…. I showed up at court Thursday morning, and the judge was like, what are you doing here? We thought you were in the hospital, and I said, I was, but I need to go to treatment. **If you guys do not send me to treatment, I'm gonna die**…So within not even a week they had me in treatment…

Jonathan had several close brushes with death during active addiction. This included returning to heroin immediately after having open heart surgery that his doctor did not expect him to survive. Upon finding his brother dead from an overdose, Jonathan finished off the remaining heroin that had killed him. Soon after that, he chose to switch to methamphetamine because it seemed less dangerous, which led him back to the legal system.

> …after losing my brother, I realized that I didn't- **I wanted to live**, so I stopped the heroin… **I don't know people overdosing on meth, so I sold meth and I got locked up**… it was kind of like that **god doing for you what you can't do for yourself**…I realized after a couple of months that **if they wouldn't have intervened, I would be**

dead…This time I actually decided that **I wanted something different**. The all-day hustle and chasing that dragon just- I was 42 years old when I got locked up, so it just wasn't worth it to me anymore.

Travis described his gratitude for being arrested since he had not found any other way to get help. Here, he explains why he viewed his arrest and subsequent imprisonment as an opportunity to recover and change his life.

Well, I always say that **I didn't get arrested, I got rescued**. I really wanted to quit, but I didn't have insurance, and detox wouldn't accept anybody with methamphetamines in their system... And at that point **I was just surviving**, you know...**I wanted to quit**, man, I really did. **I knew I had to change**, so **I was relieved when the detectives knocked on my door.** And that was the start of the change…. **And had I not got rescued when I did, I'd be dead. No doubt, I'd be dead.** So yeah, I got influenced—**I kinda got voluntold** to get clean. I really wanted to though. So prison was—I knew I didn't want to spend any more time in jail or prison. **And I knew that with my experience I could help people**…

Vincent was 57 years old with about five years in recovery when I spoke with him at the very restaurant where he says an arrest saved his life. He is on disability today, which gives him time to be very active in the recovery community, as well as time to help feed and clothe the local homeless population. Over a few decades, he had numerous previous encounters with the legal system but had never been offered help. This time he was, and it turned his life around.

...this is **god doing for me what I couldn't do for myself**- I pulled in [a fast food restaurant parking lot] right beside the DEA…and the guy didn't even have to leave his

> car seat to film me doing a drug transaction. **And I got arrested here**…**But it saved my life**… **They saved my life**. I caught a felony...and I just sat down and said, I'm too old to go back to prison. But this was the first time in my history of being involved with the court system that **they offered me help**…I was always just put in jail or locked up- never was I offered help… And for the first time in my life, I listened…

Vincent's description illustrates that novel approaches like drug courts can create viable pathways to treatment when individuals are not simply "locked up" for their substance use. Evie was also last arrested at a fast food restaurant. She described feeling so low that she did not think she was worth saving, but today she is able to help others using her experience.

> I caught a possession case, was sitting outside of a [fast food restaurant] with needles and drugs in my car…**I had already been to prison, and I got caught**…and I went in and I told my parole officer…**I wanted to stop, I just didn't know how**... If I was worth saving, or if I was able to stop, like I would have been able to stop before... So I really didn't think that treatment was gonna be able to help me. **I thought I was too far gone.** So, I was court ordered to go there, but I was also pretty broken at that point…

Evie's path of sustained recovery began in the parking lot of a fast food restaurant and led to employment as a recovery coach at a local hospital. As the reader may have noted, many of my participants either work voluntarily or are gainfully employed in the recovery community. This may be an artifact of the snowball sampling used in my study. However, it also demonstrates active participation in the recovery community as a strategy for maintaining recovery and potentially enhancing one's quality of life (Laudet et al. 2006). This tactic likely originated from the program of Alcoholics Anonymous, which abides by the belief that the best way to stay sober is to help another alcoholic. In fact, it is part of their origin story (Alcoholics

Anonymous 2001). This belief follows through many mutual aid groups, regardless of the substance one is addicted to. The next section explores the conversion from immersion in the drug subculture to immersion in the recovery community, which often involves helping and supporting others in their recovery process.

Reverse of the Hustle: The Conversion of Subcultural Capital

Immersion in the drug subculture requires a distinct skill set, including learning the "ins and outs" and having a "hustle" to maintain a lifestyle that generally revolves around the prevention of being dope sick. Immersion in the recovery community requires a comparable set of skills and knowledge, but they are focused in a very different direction. Converting one's cultural capital and peer groups from addiction into cultural capital and peer groups associated with recovery has been described as one of the most difficult challenges of recovery (Cloud and Granfield 2008). However, my participants demonstrate that it is possible. Interviewees demonstrate how particular types of capital that were once useful in the drug subculture can be successfully redirected or repurposed for use in recovery. According to Jonathan,

> **Everything that I did through addiction, I'm pretty much the opposite now**…If you truly want recovery, you can have it, you just have to put the work in. **Think about how much work you put into getting high every day. Put a quarter of that into your recovery and you'll be happy the rest of your life.**

There are undeniably experiences of loss from the conversion of capital in the recovery process. There is emotional strain, stigma, loss of relationships, grieving over the loss of a substance as coping mechanism, and grieving over friends who relapse and die (Furr, Johnson and Goodall 2015). However, the participants in this study feel that the negative aspects and

obstacles pale in comparison to the improved quality of life and hope that is promised on the pathway to sustained recovery. According to Travis,

> But **my worst day sober is better than my best day high**. Any day of the week. All that uncertainty and…it's a wonder I didn't kill myself, you know? So depressed all the time, smile through the pain, and just be high. Numb. But **I can't enjoy the good unless I experience the bad.**

Evie shared a similar sentiment. "I just- **I never ever have a day where I say, I wish I was still getting high.** Sometimes stress and stuff will make me want to get high, but I never miss where I was."

In the midst of the recovery community, I learned that there are individuals referred to as "resource brokers." One of the clearest examples from my data is Travis. As described earlier, Travis "got rescued" and spent some years in prison. Upon release, he transformed himself into a significant figure in the local recovery community. Today he works tirelessly to help others. Instead of helping individuals to acquire and use illicit substances, he now helps them to find resources including detox and treatment, employment and housing, and other services that are supportive of their recovery and life in the conventional world.

> Waking up sober, not having to worry about trying to find drugs…**Now it's reversed**. Now these people seek me out because they want what I've got [in terms of recovery]**. People depend on me,** which is huge in my recovery. I'm able to give things to people that can't give me anything in return…**Knowing that the caliber of friends I have now, judges, senators, governors, mayors, police officers, detectives, prosecutors,**

probation officers, parole officers, lawyers, doctors… are friends. These are all people that I hated! Well, I thought I hated them, but it wasn't them, it was me.

How does someone go from being a drug dealer to a broker of resources for recovery? From my perspective, the way Travis did this was to make a firm decision that he wanted to change, and he took the amount of energy and knowledge he previously utilized to use and deal drugs and applied it to his recovery. In essence, he converted the subcultural capital and resources he once used for survival in the drug subculture into recovery capital. Instead of being a resource broker for drugs, he became a resource broker for recovery. He learned from his life experience and uses it for the good of others.

And so, we step in a pile of shit. Do we keep walking, or do we try and clean it off and then walk? **It's what you do after you make your mistake**…I fucked my life up. I made a lot of mistakes, and **now they're my strengths instead of my weaknesses.**

I found this pattern with of fifteen of my participants (83 percent). While they are not all so industrious as Travis, these individuals have immersed themselves in the recovery community just as they were once immersed in a subculture of drug use. Some direct or work for recovery nonprofits or practice addiction medicine; others provide informal forms of recovery support and do other types of volunteer work. Each have each found a way to convert their subcultural capital, their social capital, their hustle, and their energy from the complex assortment of tasks required to function as an addict into the ultimately more fulfilling tasks of going about recovery and helping others.

For many respondents, serving others in the recovery community is a strategy for the maintenance of their own recovery. Brad, for example, volunteers at Travis's recovery resource center, and believes the experience gives his life meaning and purpose.

> And me **sharing my experience helps me,** gives me a reason to get out of bed in the morning… **helping the next guy that wants to live. And showing them what to do**. That is what God has called me to do…**I'm here for a reason.** And I accept that and I do whatever God puts in front of me…**My mission in life is to save a life. Just one. If I save one life before I die, I did my job**…the number one life I've saved today is mine. Because if I can't swim, I can't save you if you're drowning. If I jump in the water to try to save you when I can't swim, we have two victims. Now what? So what do I gotta do? I gotta learn how to swim if **I want to save drowning people**. And God has showed me that path.

Sally, who reported that she was once married to the "biggest drug dealer in Detroit," is very involved in the recovery community today. She is active in mutual aid organizations and helps to manage a group of sober homes for women. She was 66 at the time of interview with about 16 years in recovery. She explained how helping others helps her.

> Getting busy in AA. **Being of service to other people**. Helping other people keeps me going…**Because you're not thinking about yourself**. **You're thinking about other people**. And you're **sharing your experience** and you see what they're going through, and **you know you've been there, but you can help them along the way**. Especially somebody that wants to drink again or use again…**Service to humanity helps**. I do all kinds of things…but **just helping people in general**.

In addition to managing his recovery nonprofit and working on his dissertation in social work, at the time I spoke with him, Randy was working to train and supply recovery coaches for a year-long pilot project at a local hospital. Evie works as a recovery coach for that pilot program, and in her spare time she finds various other ways to help others.

> I'm a recovery coach now, and I work in the pilot MAT program at [local] hospital… **I spend a lot of my time trying to help others**. Like if I'm not at work, **I really spend a lot of time just trying to love somebody**. And I feel like that's what God made me for, and that's what he wants me to do…"

Marie, as previously mentioned, works as a recovery coach for the drug court she graduated from, and is also quite active in other areas of the recovery community. Like other participants, Marie has the attitude that what she does to help others in the recovery community is a privilege, and she is grateful to do it.

> …had I not been in that drug court program…I probably would have used again. And maybe even have died. **So, thank god for that program... And so I'm the recovery coach for that program now**….But I also got involved with the opiate task force …and I was able to go to [the state capitol] and speak to the legislators…**I feel so blessed** to be able to be in the position I am today. **And be that example to other people and let them see the hope for their recovery**. People are just so amazed when I tell them **I graduated from this program.** They're like, you did? Yeah, that PO used to be my PO. They're like, what? [Laughs]. Yeah.

These findings make it apparent that individuals in recovery from addiction can convert their previous social skills, energy and cultural knowledge into valuable lay-expertise and

specialized careers through which they help others to recover. It is unquestionably a challenging endeavor that requires daily attention and maintenance, but the hustle from a lifestyle of addiction can be transformed into a hustle for recovery.

DISCUSSION

The above findings suggest that while there are considerable barriers to recovering from opiate addiction, many White individuals find ways to access treatment through a combination of individual and extra-individual means. Interview respondents identified several considerable organizational and structural barriers to treatment, including waiting lists to get into detoxification and/or treatment, the requirement of having specific substances in their system in order to be approved for treatment, and lacking childcare or access to a treatment center that would accept children along with their mothers while they undergo treatment. To overcome these barriers, individuals with substance addictions possess and utilize (to differing degrees) various forms of recovery capital (Cloud and Granfield 2008; Granfield and Cloud 1996; 1999; White and Cloud 2008; Best et al. 2015; Best et al. 2018), such as social capital including structural and functional social support, subcultural health capital, and community capital.

The criminal justice system---particularly in the form of drug courts—also served as a form of community recovery capital for several respondents and provided the necessary influence and support to spur on recovery. On a more individual level, existential pain and hope coalesced in profound ways for many respondents, who were able to transform their anguish into meaningful change. Finally, the data suggest that individuals in recovery often convert their subcultural capital and energy into helping others to recover. The hustle for a fix becomes a hustle to fix others.

This research adds to the literature on recovery from opiate addiction and other substance addictions in several ways. First, I add to the existing discussion regarding recovery capital (Cloud and Granfield 1996; 1999; 2008; White and Cloud 2008; Laudet et al. 2006; Best et al. 2015). I demonstrate how economic capital, social capital and social support are important resources for recovery, and describe instances where recovery is undermined by the absence of capital. I present examples of structural and functional social support as vital facets of the recovery process.

I have extended Shim's (2010) concept of cultural health capital to demonstrate that for those who do not have access to conventional forms of cultural health capital, subcultural health capital can be developed. Individuals of lower SES who do not possess the embodied cultural capital of those with economic resources can create their own modified version of cultural health capital to engage and negotiate with the recovery and treatment system. This finding aligns with work related to minority immigrants and how they negotiate health care despite numerous barriers (Madden 2015), as well research regarding how prisoners manage their health under challenging circumstances (Novisky 2018).

I demonstrate how existential pain with the added dimension of hope can be a catalyst for recovery. Where pain is existent, sources of hope can be provided in the context of community recovery capital. Hope is not merely an individual level abstract idea; it is fostered through interactions with others who have recovered. Recovery role models (White and Cloud 2008) can be found in spaces including mutual aid groups and in the form of recovery coaches. These visible examples of individuals who have recovered (White and Cloud 2008) demonstrate the recovery identity as one that is achievable and valid (Best et al. 2015). People construct narratives that help them recreate their identities when facing a chronic or fatal illness (Frank

1993), and in the recovery community, these narratives are shared to help others. Individuals who are contemplating recovery or new to it can be pointed towards these examples of hope.

I have shown how interaction with the criminal justice system can provide hope and recovery resources for those who faced barriers accessing help elsewhere. It can also be a 'turning point' that directs someone towards the decision to recover (Årstad et al. 2018; Brunelle et al. 2015). These findings nuance simplistic understandings of the criminal justice system as an institution that invariably undermines recovery. However, it must be noted that all of my participants are White. Whiteness is an advantage in the criminal justice system. Racial disparities exist in drug courts just as they do in the legal system as a whole (Tiger 2015; 2017). In relation to drug offenses, Whites are often perceived as addicts and funneled towards drug courts, whereas persons of color are viewed as criminals and handled punitively (Tiger 2015; 2017). With the knowledge that it can be helpful, the system should work towards being an effective resource for recovery in a broader racial context. Further attention should be given to ensuring that non-White individuals have equal access to recovery programs and are not processed directly into prison due to racial bias in community policing (Fan 2014).

Finally, I clearly illustrate that individuals in recovery from addiction can and often do redirect their resources and energy into the recovery community and helping others. Their work, whether voluntary or through formal employment, bridges gaps in care related to mental health and addiction services (Videka, Neal, Page, Buche, Wayment, Gaiser and Beck 2019; Eddie, Hoffman, Vilsaint, Abry, Bergman, Hoepner, Weinstein and Kelly 2019). They also work to demonstrate to the larger community that addiction does not have to be a hopeless condition (Best et al. 2015). Life does not have to end with overdose for those who use opiates, nor should it. These people matter. Losing them to addiction and death is not merely a loss for their friends

and families, it is a loss for society. When my participants found sources of hope and opportunities to recover, they showed that they are energetic, passionate, determined, creative and often brilliant with an immense amount to share with and do for their community and the world.

LIMITATIONS AND CONCLUSION

Through retelling the stories of those who participated in this study, I strive to honor their narratives and their experiences. However, given the small scale of this study, in addition to the fact that all participants are White and reside in or near a small city with a relatively strong recovery community, the information is not generalizable to the larger recovery population. As a woman who is middle-aged, White, and actively involved in the recovery community, my personal perspective and interpretation of the data may be a both a benefit and a limitation. Some may question the validity and reliability of this study because I did not perform any form of assessment to verify that my participants were indeed addicted to opiates. However, the narratives they provided when asked to speak about their active addiction were quite compelling, and I did not find reason to question them.

Due to the snowball sampling method used, I primarily reached White individuals who have close ties in the recovery community. The patterns and findings from this sample-- largely middle-aged or older and volunteering or employed in a recovery-based field— can only be used to draw conclusions for this group of White individuals. The instrumental and structural social support they receive and reciprocate from their recovery networks are important to their recovery outcomes. Recovering individuals who are not embedded in the recovery community may have very different perspectives on the topics discussed above, especially individuals who are not White. While recovery from opiate addiction is by no means easy for anyone, Whiteness itself could be considered a form of recovery capital. The unintentional absence of non-White

individuals in the sample is reflective of the fact that non-White individuals are more likely to be found in jails and prisons than in treatment or the recovery community (Tiger 2015; 2017; Hansen and Netherland 2016; SAMHSA 2020; Golub et al. 2007). Thus, data describing a significant portion of the recovering population is missing.

I also want to state emphatically that while the participants in my study were able to mobilize various forms of recovery capital to engage in recovery, there are countless others who continue to struggle for various reasons, through no fault of their own. Regardless, I believe the findings enrich our understanding of the various forms of capital that help to promote or undermine recovery. While realities vary by geographical, political, and cultural context, recovery capital is undoubtedly at play in any locale.

Recovery capital and other resources described here are applicable for multiple pathways to recovery. Research that explores the social, economic and cultural resources necessary for individuals to recover from substance addictions will be relevant for many years to come, for even when the struggle with heroin and synthetic opiates declines, other drugs will move in to replace them. We must continue to grapple with finding better ways to help individuals transform their lives from addiction to recovery, while also addressing the social problems at the root of substance use and addiction.

REFERENCES

Acker, Caroline Jean. 1999. Addicts as Objects of Study: Clinical Encounters in the 1920's." pp. 279-300 from *Addiction: Entries and Exits*. Jon Elster ed. New York, NY:Russell Sage Foundation.

Alcoholics Anonymous. 2001. *Alcoholics Anonymous: The Story of How Many Thousands of Men and Women have Recovered from Alcoholism.* 4th ed. New York: Alcoholics Anonymous World Services, Inc.

Alexander, Bruce K. 2008. *The Globalization of Addiction: A Study in Poverty of the Spirit.* Oxford and New York: Oxford University Press.

Årstad, Janne, Sverre Martin Nesvåg, Anne-Lill Mjølhus Njå, and Stian Nissen Biong. 2018. "How Enough Becomes Enough: Processes of Change Prior to Treatment for Substance Use Disorder." *Journal of Substance Use* 23(4):429–35.

Becker, Howard S. 1953. "Becoming a Marijuana User." *American Journal of Sociology* 59: 235–42.

Becker, Howard S. 1967. "History, Culture and Subjective Experience: An Explanation of Social Bases of Drug-Induced Experiences." *Journal of Health and Social Behavior* 8: 163–76

Best, David, Karen Bird and Lucy Hunton. 2015. "Recovery as a Social Phenomenon: What is the Role of the Community in Supporting and Enabling Recovery?" Pp. 194-207 in *Positive Criminology*. Edited by N. Ronel and D. Segev. London: Routledge.

Best, David, Lauren Hall and Amy Musgrove. 2018. "The Bridge between Social Identity and Community Capital on the Path to Recovery and Desistance." *Probation Journal* 65(4):394-406.

Bourdieu, Pierre. 1986. “The Forms of Capital.” Pp. 241-258 in *Handbook of Theory and Research for the Sociology of Education*, edited by J. G. Richardson. New York: Greenwood Press.

Bourgois, Phillipe. 2010. “Useless Suffering: The War on Homeless Drug Addicts.” Pp. 238-254 in *The Insecure American: How We Got Here and What We Should Do About It.* Edited by H. Gusterson and C. Bestemen. Berkley and Los Angeles: University of California Press.

Bourgois, Phillipe. 2015. “Disciplining Addiction: the Biopolitics of Methadone and Heroin in the U.S.” pp. 172-186 from *Expanding Addiction: Critical Essays*. Robert Granfield and Craig Reinarman eds. New York and London: Routledge; Taylor and Francis.

Brunelle, Natacha, Karine Bertrand, Michel Landry, Jorge Flores-Aranada, Catherine Patenaude and Serge Brochu. 2015. “Recovery from Substance Use: Drug- Dependent People’s Experiences with Sources that Motivate them to Change.” *Drugs Education, Prevention and Policy* 22(3):301-307.

Chang, Jamie, Leslie Dubbin and Janet Shim. 2016. “Negotiating Substance Use Stigma: The Role of Cultural Health Capital in Provider-Patient Interactions.” *Sociology of Health and Illness* 38(1):90-108.

Charmaz, Kathy. 2000. “Grounded Theory: Objectivist and Constructivist Methods.” *The Handbook of Qualitative Research*. Edited by N.K. Denzin and Y. Lincoln. Thousand Oaks, CA: Sage Publications, Inc.

Charmaz, Kathy. 2009. “Shifting the Grounds: Constructivist Grounded Theory Methods.” Pp. 127–55 in Developing Grounded Theory: The Second Generation, edited by J. M. Morse,

P. N. Stern, J. Corbin, B. Bowers, K. Charmaz, and A. Clarke. Walnut Creek, CA: Left Coast Press.

Chiauzzi, E.J. and S Liljegren. 1993. “Taboo topics in Addiction Treatment: an Empirical Review of Clinical Folklore.” Journal of Substance Abuse Treatment 10:303-316.

Christakis, Nicholas A., and James H. Fowler. 2007. The Spread of Obesity in a Large Social Network Over 32 years." *New England Journal of Medicine* 357(4): 370-379.

Clarke, David M. and David W. Kissane.2002. “Demoralization: its Phenomenology and Importance.” *Australian and New Zealand Journal of Psychiatry* 36:733−742.

Cloud, William and Robert Granfield. 2008. “Conceptualizing Recovery Capital: Expansion of a Theoretical Construct.” *Substance Use & Misuse* 43(12–13):1971–86.

Conrad, Peter and Joseph W. Schneider. 1992. *Deviance and Madness: From Badness to Sickness.* Philadelphia: Temple University Press.

Cooper, Sasha and Suzanne Nielsen. 2017. “Stigma and Social Support in Pharmaceutical Opioid Treatment Populations: A Scoping Review.” *International Journal of Mental and Addiction* 15:452-469.

Courtwright, David T. 1992. “A Century of American Narcotic Policy.” Pp. 1-62 in *Treating Drug Problems.* Volume 2. Edited by D. Gerstein and H. Harwood. WashingtonD.C.: National Academy Press.

Courtwright, David T. 2015. “The NIDA Brain Disease Paradigm: History, Resistance and Spinoffs.” Pp. 62-72 in *Expanding Addiction: Critical Essays*. Edited by R. Granfield and C. Reinarman. New York and London: Routledge.

Cunningham, John A., Linda C. Sobell, Mark C. Sobell, Sangeeta Agrawal and Tony Toneatto. 1993. “Barriers to Treatment: Why Alcohol and Drug Abusers Delay or Never Seek Treatment.” *Addictive Behaviors* 18(3):347-353.

Denzin, Norman K. 1997. *The Alcoholic Society: Addiction and Recovery of the Self.* New Brunswick and London: Transaction Publishers.

Dobkin, Patricia L., Mirella De Civita, Antonios Parahakis and Kathryn Gill. 2002. “The Role of Functional Support in Treatment Retention and Outcomes among Outpatient Adult Substance Abusers.” *Addiction* 97:347-356.

Dunlop, William and Jessica L. Tracy. 2013. “Sobering Stories: Narratives of Self-Redemption Predict Behavioral Change and Improved Health among Recovering Alcoholics.” *Journal of Personality and Social Psychology* 104(3):576-590.

Eddie, David, Lauren Hoffman, Corrie Vilsaint, Alexandra Abry, Brandon Bergman, Bettina Hoeppner, Charles Weinstein and John F. Kelly. 2019. “Lived Experience in New Models of Care for Substance Use Disorder: A Systematic Review of Peer Recovery Support Services and Recovery Coaching.” *Frontiers in Psychology* 10(1052):1-12.

Fan, Mary. 2014. “Street Diversion and Decarceration.” American Criminal Law Review 50:165-209.

Fox, Kathryn. 2014. “Ideological Implications of Addiction Theories and Treatment.” Pp. 159 171 in *Expanding Addiction: Critical Essays.* Edited by Granfield and C. Reinarman. New York: Routledge.

Frank, Arthur. 1993.” The Rhetoric of Self-Change: Illness Experience as a Narrative.” *The Sociological Quarterly* 34(1):39-52

Furr, Susan R., W. Derrick Johnson, and Carol Sloan Goodall. 2015. “Grief and Recovery: The Prevalence of Grief and Loss in Substance Abuse Treatment.” *Journal of Addictions & Offender Counseling* 36(1):43–56.

Goedel, William C., Aaron Shapiro, Magdalena Cerdá, Jennifer W. Tsai, Scott E. Hadland and Brandon D.L. Marshall. 2020. Association of Racial/Ethnic Segregation with Treatment Capacity for Opioid Use Disorder in Counties in the United States.” *JAMA Network Open: Substance Use and Addiction* 3(4):e203711.

Golub, Andrew, Bruce D. Johnson and Eloise Dunlap. 2007. “The Race-Ethnicity Disparity in Misdemeanor Marijuana Arrests in New York City.” *Criminology and Public Policy* 6(1):131-164.

Granfield, Robert and William Cloud. 1996. “The Elephant that No One Sees: Natural Recovery Among Middle-Class Addicts” *Journal of Drug Issues* 26:45–61.

Granfield, Robert and William Cloud. 1999. *Coming Clean: Overcoming Addiction Without Treatment.* New York and London: New York University Press.

Granfield, Robert and William Cloud. 2001. “Social Context and ‘Natural Recovery’: The Role of Social Capital in the Resolution of Drug-Associated Problems.” *Substance Use & Misuse* 36(11):1543–70.

Guerrero, Erick G. 2013. “Examination of Treatment Episodes Among Women and Racial and Ethnic Minorities in Addiction Treatment.” *Journal of Social Work Practice in the Addictions* 13(3):227–43.

Guerrero, Erick G., Alice Cepeda, Lei Duan, Tina Kim. 2012. “Disparities in Completion of Substance Abuse Treatment among Latino Subgroups in Los Angeles County, CA.” *Addictive Behaviors* 37:1162-1166.

Gueta, Keren and Gila Chen. 2015. “Pulling Myself Up by the Bootstraps: Self-Change of Addictive Behaviors from the perspective of Positive Criminology.” Pp. 221-233 in *Positive Criminology*. Edited by N. Ronel and D. Segev. London: Routledge.

Havassy, Barbara. E., Sharon M. Hall and David A. Wasserman. 1991. “Social Support and Relapse: Commonalities among Alcoholics, Opiate Users, and Cigarette Smokers.” *Addictive Behaviours*, 16, 235–246.

Hedegaard, Holly, Arialdi M. Minino and Margaret Warner. 2020. “Drug Overdose Deaths in the United States, 1999-2018.” *National Center for Health Statistics Data Brief*. Retrieved May 27, 2020 from www.cdc.gov/nchs.

House, James. 1981. *Work Stress and Social Support*. Reading, MA: Addison-Wesley.

Hser, Yih-Ing, Elizabeth Evans, Christine Grella, Walter Ling and Douglas Anglin. 2015. “Long Term Course of Opioid Addiction.” *Harvard Review of Psychiatry* 23(2):76-89.

Jackson, Afton and Lisa Shannon. 2012. “Barriers to Receiving Substance Abuse Treatment Among Rural Pregnant Women in Kentucky.” *Maternal and Child Health Journal* 16:1762-1770.

Kallant, Harold. 2014. “What Neurobiology Cannot Tell Us.” Pp. 73-81 in *Expanding Addiction: Critical Essays*. Edited by R. Granfield and C. Reinarman. New York and London: Routledge.

Kelly, Sharon M., Kevin E. O’Grady, Robert P. Schwartz, James A. Peterson, Monique E. Wilson and Barry S. Brown. 2010. “The Relationship of Social Support to Treatment Entry and Engagement: The Community Assessment Inventory.” *Substance Abuse* 31(1):43-52.

Kissane, David. W. 2000. Psychospiritual and Existential Distress. *Australian Family Physician* 29: 1022−1025.

Hansen, Helena and Julie Netherland. 2016. “Is the Prescription Opioid Epidemic a White Problem?” *American Journal of Public Health* 106(12):2127-2129.

Hansen, Helena B., Carole E. Seigel, Brady G. Case, David N. Bertollo, Danae DeRocco and Marc Galanter. 2013. “Variation in Use of Buprenorphine and Methadone Treatment by Racial, Ethnic and Income Characteristics of Residential Social Areas in New York City.” *Journal of Behavioral Health Services and Research* 40(3):1-14.

Hays, Stephen. 2019. “Stigma, Addiction, Discrimination, Recovery and Politics—With Ryan Hampton.” *Invisible Illness*, December 23. Retrieved June 29, 2020 from medium.com.

Hoffman, Lauren A., Corrie Vilsaint and John F. Kelly. 2020. “Recovery from Opioid Problems in the US Population: Prevalence, Pathways, and Psychological Well-Being.” *Journal of Addiction Medicine* 14(3):207-216.

Institute of Medicine (US) Committee on Federal Regulation of Methadone Treatment. 1995. "Federal Regulation of Methadone Treatment." Rettig RA, Yarmolinsky A, editors. Washington DC: National Academies Press. Retrieved May 31, 2020 from https://www.ncbi.nlm.nih.gov/books/NBK232105/.

Labor, Nicole T. 2019. *The Addictoholic Deconstructed: An Irreverently Quick and Dirty Education by a Doctor who says F*ck, a Lot*. Laborhood Change Project, Inc.

Laudet, Alexandre B., Keith Morgen, and William L. White. 2006. "The Role of Social Supports, Spirituality, Religiousness, Life Meaning and Affiliation with 12-Step Fellowships in Quality of Life Satisfaction Among Individuals in Recovery from Alcohol and Drug Problems." *Alcoholism Treatment Quarterly* 24(1–2):33–73.

Laudet, Alexandre B. and William L. White. 2008. "Recovery Capital as Prospective Predictor of Sustained Recovery, Life Satisfaction and Stress among Former Poly-Substance Users."*Substance Use and Misuse* 43(1):27-54.

LeMay, Katerine and Keith G; Wilson. 2007. "Treatment of Existential Distress in Life Threatening Illness" A Review of Manualized Interventions." Clinical Psychology Review 28:472-493.

Lin, Nan Xiaolan Ye and Walter M. Ensel. 1999, "Social Support and Depressed Mood: A Structural Analysis." *Journal of Health and Social Behavior* 40(4): 344–359.

Lindesmith, Alfred R. 1938. "A Sociological Theory of Drug Addiction." *American Journal of Sociology* 43(4):593-60.

Lindesmith, Alfred R. 1968. *Addiction and Opiates*. Chicago: Aldine Publishing Company.

Livingston, James D., Teresa Milne, Mei Lan Fang and Erica Amari. 2012. “The Effectiveness of Interventions for Reducing Stigma related to Substance Use Disorders: a Systematic Review.” *Addiction* 107(1):39-50.

Lofland, John, David Snow, Leon Anderson, and Lyn H. Lofland. 2006. *Analyzing Social Settings: A Guide to Qualitative Observation and Analysis*. 4th ed. Belmont CA: Wadsworth Cengage Learning

Madden, Erin Fanning. 2015. “Cultural Health Capital on the Margins: Cultural Resources for Navigating Healthcare in Communities with Limited Access.” *Social Science and Medicine* 133:145-152.

Madras, Bertha K. and Hilary Connery. 2019. “Psychiatry and the Opioid Overdose Crisis.” *Focus: The Journal of Lifelong Learning in Psychiatry* 17(2):128-133.

Massoglia, Michael and Christopher Uggen. 2010. “Settling Down and Aging Out: Toward an Interactionist Theory of Desistance and the Transition to Adulthood.” *American Journal of Sociology* 116(2): 543-582.

Marel, Christina, Katherine L. Mills, Tim Slade, Shane Darke, Joanne Ross and Maree Teesson. 2019. “Modeling Long-Term Joint Trajectories of Heroin Use and Treatment Utilization: Findings from the Australian Treatment Outcome Study.” *Eclinical Medicine* 14:71-79.

McCabe, Sean Esteban, Michele Morales, James A. Cranford, Jorge Delva, Melnee D. McPherson and Carol J. Boyd. 2007. “Race/Ethnicity and Gender Differences in Drug Use and Abuse Among College Students.” *Journal of Ethnicity in Substance Abuse* 6(2):75-95.

McNeil, Greg. 2020. “The Pandemic’s Impact on the Opioid Crisis: A Live Conversation with Nationally Known Experts.” *Cover2 Resources,* viewed on Zoom June 24, 2020.

Moos, Rudolf H. 2003. “Addictive Disorders in Context: Principles and Puzzles of Effective Treatment and Recovery.” *Psychology of Addictive Behaviors* 17:3-12.

Moos, Rudolf H. 2007. “Theory-Based Active Ingredients of Effective Treatments for Substance Use Disorders.” *Drug and Alcohol Dependence* 88(2–3):109–21.

Moos, Rudolf H. and Bernice S. Moos. 2007. “Protective Resources and Long-Term Recovery from Alcohol Use Disorders.” *Drug and Alcohol Dependence* 86:46-54.

Moyers, Bill. 1998. “Bill Moyers Interview with Bill White, Spring 1998.” Retrieved May 1, 2020 from www.williamwhitepapers.com.

National Institute on Drug Abuse. 2020. “Opioid Overdose Crisis.” Retrieved May 27, 2020 from drugabuse.gov/drugs-abuse/opioids.

Novisky, Meghan A. 2018. “Avoiding the Runaround: The Link between Cultural Health Capital and Health Management among Older Prisoners.” *Criminology*. Retrieved May 27, 2020 from onlinelibrary.wiley.com.

Peele, Stanton. 1989. *Diseasing of America: Addiction Treatment Out of Control*. Boston: Houghton Mifflin Company.

Peralta, Robert L. 2005. “Race and The Culture of College Drinking: An Analysis of White Privilege on Campus.” *Cocktails and Dreams: Perspectives on Drug and Alcohol Use*. Upper Saddle River NJ: Prentice Hall.

Peterson, James A., Robert P. Schwartz, Shannon Gwin Mitchell, Heather Schacht Reisinger, Sharon M. Kelly, Kevin E. O'Grady, Barry S. Brown and Michael H. Agar. 2010. "Why don't Out of Treatment Individuals Enter Methadone Programs?" *International Journal of Drug Policy* 21(1):36-42.

Pienaar, Kiran, Suzanne Fraser, Renata Kokanovic, David Moore, Carla Treloar and Adrian Dunlop. 2015. "New Narratives, New Selves: Complicating Addiction in Online Alcohol and other Drug Resources." *Addiction Research and Theory* 23(6): 499-509.

Reinarman, Craig and Robert Granfield. 2015. "Addiction is Not Just a Brain Disease." Pp. 1-24 in *Expanding Addiction: Critical Essays*. Edited by R. Granfield and C. Reinarman. New York and London: Routledge.

Reinarman, Craig and Harry G. Levine. 1997a. "Crack in Context: America's Latest Demon Drug." Pp. 1-17 in *Crack in America: Demon Drugs and Social Justice*. Edited by C. Reinarman and H. Levine. Berkley and Los Angeles: University of California Press.

Reinarman, Craig and Harry G. Levine. 1997b. "The Crack Attack: Politics and Media in the Crack Scare." Pp. 18-51 in *Crack in America: Demon Drugs and Social Justice*. Edited by C. Reinarman and H. Levine. Berkley and Los Angeles: University of California Press.

Roxburgh, Susan. 2011. "Stressors and Experienced Stress." Pp. 147-178 in *The SAGE Handbook of Mental Health and Illness*, edited by David Piligrim, Anne Rogers, and Bernice Pescosolido. London: Sage.

Sharp, Alana, Austin Jones, Jennifer Sherwood, Oksana Kutsa, Brian Honermann, Gregorio Millett. 2018. "Impact of Medicaid Expansion on Access to Opioid Analgesic

Medications and Medication-Assisted Treatment." *American Journal of Public Health* 108:642-648.

Shannon, Lisa And Robert Walker. 2008. "Increasing the Recognition of Barriers for Pregnant Substance Users Seeking Treatment." *Substance Use and Misuse* 43:1266-67.

Shim, Janet K. 2010. "Cultural Health Capital: A Theoretical Approach to Understanding Health Care Interactions and the Dynamics of Unequal Treatment." *Journal of Health and Social Behavior* 51(1):1-15.

Sobell, Linda. C., Timothy P. Ellingstad and Mark B. Sobell. 2000. Natural Recovery from Alcohol and Drug Problems: Methodological Review of the Research with Suggestions for Future Directions. *Addiction*, 95(5), 749−764.

Staff, Jeremy, John E. Schulenberg, Julie Maslowsky, Jerald G. Bachman, Patrick M. O'Malley, Jennifer L. Maggs and Lloyd D. Johnston. 2010. "Substance Use Changes and Social Role Transitions: Proximal Developmental Effects on Ongoing Trajectories from Late Adolescence through Early Adulthood." *Developmental Psychology* 22(4): 917-932.

Stephens, Richard C. 1991. *The Street Addict Role: A Theory of Heroin Addiction*. New York: State University of New York Press.

Stone, Rebecca. 2016. "Desistance and Identity Repair: Redemption Narratives as Resistance to Stigma." *British Journal of Criminology* 56:956-975.

Strang, Peter, Susan Strang, Ragnar Hultborn, and Staffan Arnér. 2004. "Existential Pain—an Entity, a Provocation, or a Challenge?" *Journal of Pain and Symptom Management* 27(3):241–50.

Strauss, Anselm and Juliet Corbin. 1994. “Grounded Theory Methodology: An Overview.” *Handbook of Qualitative Research*. Edited by N.K. Denzin and Y.S. Lincoln. London: Sage Publications.

Substance Abuse and Mental Health Services Administration (SAMHSA). 2020. “The Opioid Crisis and the Black/African American Population: An Urgent Issue.” *Office of Behavioral Health Equity*, SAMHSA Publication No. PEP20-05-02-001.

Thomas Theorem. *Oxford Reference.* Retrieved May 27, 2020 from https://www.oxfordreference.com.

Tiger, Rebecca. 2015. “Drug Courts and the Logic of Coerced Treatment.” Pp. 187-195 in *Expanding Addiction: Critical Essays*. Edited by R. Granfield and C. Reinarman. New York and London: Routledge.

Tiger, Rebecca. 2017. “Race, Class, and the Framing of Drug Epidemics.” *Contexts* 16(4):46-51.

Turner, R. Jay 1999. “Social Support and Coping.” Pp. 198-210 in *A Handbook for the Study of Mental Health: Social Contexts. Theories, and System*. Edited by A.V. Horwitz and T.L. Scheid. Cambridge, MA: Cambridge University Press. pp. 198–210.

Turner, R. Jay and Avison, William R. 1992. “Sources of Attenuation in the Stress-Distress Relationship: An Evaluation of Modest Innovations in the Application of Event Checklists.” Pp. 265-300 in *Research in Community and Mental Health*. Edited by J. Greenley and P. Leaf. Greenwich, CT: JAI Press. pp. 265–300.

Unger, Jennifer B. 2012. “The Most Critical Unresolved Issues Associated with Race, Ethnicity, Culture and Substance Use.” *Substance Use and Misuse* 47(4):390-395.

Van Boekel, Leonieke C., Evelien P.M. Brouwers, Jaap van Weeghel and Henk. F.L.Garretesen. 2013. “Stigma among Health Professionals towards Patients with Substance Use Disorders and its Consequences for Healthcare Delivery: Systematic Review.” *Drug and Alcohol Dependence* 131(1-2):23-35.

Videka, Lynn, Jodie Neale, Cory Pate, Jessica Buche, Caitlyn Wayment, Maria Gaiser and Angela J. Beck. 2019. “National Analysis of Peer Support Providers: Practice Settings, Requirements, Roles and Reimbursement.” *University of Michigan Behavioral Health Research Center.* Ann Arbor: UMSPH.

Ventegodt, Soren, Joav Merrick, and Niels Jorgen Andersen. 2003. “Quality of Life Theory I. The IQOL Theory: An Integrative Theory of the Global Quality of Life Concept.” *The Scientific World Journal* 3:1030–40.

Volkow, Nora D. and George Koob. 2015. “Brain Disease Model of Addiction: Why is it so Controversial?” *Lancet Psychiatry* 2(8):677-679.

Weinberg, Darin. 2002. “On the Embodiment of Addiction.” *Body and Society* 8(4):1-19.

Weinberg, Darin. 2011. “Sociological Perspectives on Addiction.” Sociology Compass 5(4):298 310.

White, William and Rita Chaney. 1992. *Metaphors of Transformation: Feminine and Masculine*. Bloomington, IL: Chestnut Health Systems. Excerpt retrieved May 6, 2020 from www.williamwhitepapers.com/.

White, William L. and William Cloud. 2008. “Recovery Capital: A Primer for Addictions Professionals.” *Counselor* 9(5):22-27.

Wilson, Nana, Kariisa Mbabazi, Puja Seth, Herschel Smith IV, Nicole L. Davis. 2020. “Drug and Opioid Involved Overdose Deaths—United States, 2017-2018.” *Morbidity and Mortality Weekly Report* 69(11):290-297.

Zinberg, Norman E.1984. *Drug, Set, and Setting: The Basis for Controlled Intoxicant Use.* New Haven: Yale University Press.

Appendix A: Interview Guide

Recovery from Opiate and Opioid Addiction
Interview Guide

PART I: INTRODUCTION AND BRIEF HISTORY

[*Introduce myself and tell them a little bit about my experience in the recovery community to expand the subject's comfort level. Next, I want to get a basic idea of their experience with addiction]*.

- I'd like to hear about your experience with opiate addiction. You can start wherever you feel comfortable.
- How did you realize that you had become physically dependent on (drug of choice)?
- How has addiction changed or affected your life?
    - Probe: (if not mentioned) How did it affect your relationships?
    - Probe: (if not previously mentioned) How about your finances and employment?
    - Probe: (if not previously mentioned) How did it impact your living/housing situation?
    - Probe: (if not previously mentioned) How did it affect your health?

PART II: LEARNING ABOUT THE SPECIFIC RECOVERY PROCESS OF THE SUBJECT -HOW AND WHY

[The goal of this section is to learn why and how the subject initiated recovery, and to learn more about the resources they found available in the community. I also want to learn about any potential or perceived barriers to recovery pathways]

- Tell me what was happening in your life that made you decide to try to recover? How were you influenced by family, friends or other factors?
- How did you go about seeking help?
- How would you describe the resources you found available in the community regarding addiction recovery?
- Tell me about your experience with gaining access to treatment. What kinds of options were you given?

Probe: (if applicable) How did you feel about your experience with inpatient treatment or outpatient treatment?

Probe: (if not previously mentioned) Do you have experience with medication assisted treatment? Tell me about your experience with medication assisted treatment.

SECTION III: SOCIAL SUPPORT RESOURCES- SUPPORT GROUPS, FAMILY AND FRIENDS, RELIGIOUS OR SPIRITUAL RESOURCES

[The goal of this section is to learn about the importance of various social support resources to the subject, what challenges they face, and what resources they perceive to be available for help with those challenges]

- I'd like to know about any experience you have with twelve-step or other types of support groups. How do you feel that support groups of any type have helped you in your recovery process?

  Probe: (if not previously mentioned) What do you feel you have learned from the group(s) you attend?

  Probe: (if not previously mentioned) Do you find some groups to be more accepting of drug addiction than others?

  Probe: Do you still attend support groups? Tell me about the importance of these groups to your continued recovery.

- Tell me about your experience with medication-assisted treatment in combination with counseling and/or twelve-step support groups.

  Probe: (if applicable) How did you feel about mentioning MAT within an abstinence-based environment? How did it effect your interactions with others in the group?

- In what ways are your friends and family supportive of your recovery process?
- In what regards, if any, has spirituality or religion played a role in your recovery?
- What other activities or habits have you created to support your recovery?

  Probe: (if applicable) How has overall health, i.e. physical activity/exercise, or healthier eating habits played a role?

- Tell me about the challenges have you faced in the recovery process? Who do you turn to for support with these challenges?

SECTION IV: BENEFITS OF RECOVERY AND FUTURE PLANS

[The goal of this section is to conclude the interview on a positive note, and to get an understanding of whether having hope for the future has an impact on the subject's sustained recovery]

- What are some of the benefits of recovery in your life? How has your life improved?
- Tell me about your hopes and plans for the future. How have they evolved since you began recovery?
- How do your hopes for the future encourage you on difficult days?
- What advice would you give to someone who is seeking recovery from opiate addiction?

Appendix B: Demographic Survey

DEMOGRAPHIC QUESTIONS

- What is your age?
- What is your gender identity?
- Where were you born?
- Where do you live currently?
- What is your racial/ethnic identity?
- What is your religious affiliation, if any?
- What is the highest level of education you completed?