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Understanding Substance Use and Recovery in Maine: A Culture-Centered Approach

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UNDERSTANDING SUBSTANCE USE AND RECOVERY IN MAINE: A CULTURE-CENTERED APPROACH

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There is ever-increasing attention to Maine's substance use problem, particularly in the case of opioid-related deaths. With yearly death tolls increasing, citizens of Maine wonder what the best methods are in approaching the issue and preventing further harm. While statistics about the issue are repeated in news coverage and by political figures, there is a need to understand what substance use and recovery actually mean to individuals who experience them on a daily basis. The following thesis uses Mohan J. Dutta's (2008) culture-centered approach to health communication to explore the meanings of substance use and recovery as well as the challenges and strategies articulated by individuals. The culture-centered approach privileges the voices of those affected by a health issue and realizes the validity of their experiences, opposed to outside "expertise" imposed by professionals who may be unfamiliar with the affected population. A total of 13 interviewees who are either in recovery, worked in recovery, or both participated in semi-structured interviews and were asked about their experiences in substance use and recovery. This thesis suggests that three categorical themes pulled from the interviews – meanings of recovery, barriers in recovery and strategies in recovery may open a new space in

understanding the issue at hand. Because these themes are drawn from the interviewees whose lives are embedded in such issues, future approaches from the state may be more well-informed with an attention to these voices.

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TABLE OF CONTENTS

LIST OF FIGURES

CHAPTER 1

INTRODUCTION

On July 18, 2018 I attended an event at the Bangor Arts Exchange in Bangor, Maine titled "One Life Project: Public Priorities." The One Life Project is an initiative inspired by Garrett Brown, a man from Augusta, Maine who allowed the Bangor Daily News to chronicle his life before he died of a heroin overdose in 2015. Consistent with the way in which the opioid crisis is regularly communicated, this event began with Mary Prybylo, a nurse and president of St. Joseph's Hospital in Bangor, emphasizing the statistic that 418 deaths occurred in 2017 in Maine from opioid overdoses. Mary mentioned Garrett Brown and the need to honor him by going forward in addressing the crisis in the state. She added that more people died of opioid overdoses than car accidents, suicide and breast cancer in 2017. Further, 1,000 babies were born exposed to substances in 2016. Mary noted the Community Health Leadership Board, which is a partnership of hospitals and healthcare professionals in the Bangor area focused on addressing this issue. She emphasized the importance of coming together in working to solve problems.

Mary's speech was followed by the main activity of the event. A total of 17 ideas on how to address the opioid crisis were given to the participants of the event, which were divided into two groups – local (Bangor) ideas for tackling the issue, and statewide ides for tackling the issue. Participants sat at round tables around the room and were given two envelopes – one for each group of ideas. Participants pulled out pieces of paper from the envelopes with the ideas written on them and were tasked with reading them out loud and creating an argument as to why their idea was effective, whether or not they personally agreed with it. After this activity went on for a number of rounds, participants placed stickers on large pieces of paper around the room to indicate votes. After this, the 2018 Maine gubernatorial candidates Alan Caron (I), Terry Hayes

(I) and Janet Mills (D) each made brief speeches on their positions about the opioid crisis. In addition, Lauren LePage, campaign manager for Shawn Moody (R), spoke in his absence. Mills opened her speech by stating that she was responsible for two long-term task forces that addressed the opioid crisis, culminating in 200 hours of meetings. She made it clear that she felt Medicaid expansion was the most important step in addressing the crisis along with lessening stigma towards medication-assisted treatment and supplying Narcan to police departments. Mills ended her speech by stating that she had recently read *Dreamland* by Sam Quinones, and she learned that the antidote to heroin is community. On November 6, 2018, Mills became the first female Governor of Maine.

After the candidates made their speeches, the results were tallied as follows:

Bangor area

1. (62 votes): Local approach on youth prevention and sustainable funding for such efforts
2. (53 votes): Recovery beyond initial treatment
3. (52 votes): Expand access to treatment

State wide

1. (71 votes): Increase funding for treatment
2. (55 votes): Focus on safe housing for people in treatment and recovery
3. (40 votes): Increase funding for diversion programs instead of sending people to jail

This event serves as an interesting example of voice and community participation around the issue of substance use disorders and opioids. Various members of the community were present and seemed to be enthusiastic and engaged in the activity, and the voting results supposedly were going to the Community Health Leadership Board to inform them on future approaches to addressing the issue. However, the event clearly privileged the voices of the most prominent community leaders and political candidates at the time. While community members made their opinions apparent through stickers on pieces of paper taped to the walls, they were not the ones headlining the event – the gubernatorial candidates were. It is likely that many of the

community participants either dealt with substance use personally or with their loved ones. I was curious as to what their votes actually did in the long run or if the Community Health Leadership Board took any noticeable action in involving them in their planning. This event was an early influence in my curiosity about what recovery means to those most closely tied to it. I wanted to know why they voted the way they did and what they experienced in their lives regarding substance use and recovery. I did not want to simply hear another politician's speech that uses these experiences to gain political footing.

Living in Maine, I have been aware of the substance use issues present in the state which have become increasingly prevalent over time and difficult to ignore in news media and personal experience. Beyond simply hearing the statistics in the news, my first encounter with these issues in a research context was with my advisor for this project, Dr. Bridie McGreavy, in working with clammers along the coast of Maine as an undergraduate. While looking at sustainability issues in the fishery through a communication lens, the issue of substance use was often present as clammers and coastal communities struggle with high rates of substance use and overdose deaths. I gained an interest in this issue through this closer look at how substance use impacts the lives of Mainers and the sustainability of industry in the state as a whole. The aim of this project is to delve deeper into what substance use and recovery means for both individuals in recovery and practitioners who work with them. I completed a total of 13 interviews between July and October 2018 with individuals in recovery and practitioners in the recovery field, asking questions about what recovery means to them and their various experiences in their recovery journeys and in their work. Using Dutta's (2008) culture-centered approach to health communication, which focuses on the three main tenets of culture, structure, and agency in health issues, I analyzed the interviews with these constructs in mind in order to gain a better

understanding of how these meanings operate within Maine. My curiosity about what recovery means, what structures are in place in Maine that may enable or constrain recovery, and how individuals express agency in their recovery and in their work guided this project. I felt that beginning to understand some of these constructs may help in addressing the issue in a way that is informed directly by those who are affected by it.

This thesis is organized into a literature review, methods, analysis and discussion. The literature review looks at recovery broadly and how recovery has been addressed in communication literature, particularly through qualitative methods. I then describe work that focuses on recovery in regards to substance use and addiction, specifically. Finally, I turn to a Maine context where I aim to show that qualitative research addressing these issues in the state is lacking and much needed. I then cover my methodology, including the relationship between my research paradigm, the research questions, and the choice to conduct interviews; the IRB process and interview data; and an overview of the culture-centered approach to health communication. My analysis details themes that emerged from my interviews that fall into three main categories: meanings of recovery, barriers in recovery and strategies in recovery. I find that recovery is an individualized process that includes gain from loss, particularly through social connection. Additionally, I find that motivations to recover vary, and that spirituality is a key component for those in the recovery process. I discuss multiple barriers described by the interviewees, including stigma and a lack of resources which stem from minimal funds and restrictive healthcare. Through these barriers I discuss the strategies interviewees describe in pursuing recovery, including a commitment to help others and a belief in a collaborative, client-centered approach. I end my analysis with reflections on the intertwining of the three tenets of culture, structure and agency and the practice of narrative and the idea of marginalization, which the culture-centered

approach focuses on. My discussion section is guided by the responses of my interviewees, where I asked them about possible benefits or useful results of this work. This provides insight to potential future directions of this work. I also note limitations in this work alongside the richness of interview data I gathered, particularly in regards to privileging the voices of those deeply involved in this issue.

CHAPTER 2

LITERATURE REVIEW

Introduction

Between 2001 and 2012, an estimated 663,715 prescription opioid analgesic overdoses and heroin related overdoses admissions occurred across the United States, with increases of heroin and prescription related opioid overdoses increasing each year (Hsu et al., 2017). In Maine, 418 drug overdose deaths were reported in 2017 (Harrison & Haskell, 2018). In 2016, 376 drug-related deaths were reported with 84% caused by at least one opioid, which was a 38% increase from 2015 (Sorg, 2016). Statistics like this are regularly gathered and reported by researchers and the news media, but the problem of substance use related deaths is only increasing in severity. While reporting these statistics is important in order to bring awareness to the issues, this alone does not seem to address or make the changes needed in order to prevent further harm.

This literature review seeks to explore the opioid crisis and sets up my theoretical framework that takes a culture-centered approach to explore meanings in substance use and recovery. First, I explore the idea of recovery as a concept and how it is explored through qualitative communication studies across a variety of health contexts. Qualitative methods such as interviews and participant observation reveal the nuanced communication processes of recovery which go beyond simple statistics. Then, I describe recovery specifically related to substance use and addiction. Next, I look at recovery in terms of opioids. Here, I discuss themes that reveal a social nature of recovery. These themes including stigma and stereotype and how they present as challenges to those seeking recovery, and the practice personal narrative construction which individuals who use substances engage in to connect with others and present a less harmful image of themselves. Additionally, social support is identified as key in successful

recovery, particularly in combating stigma. These themes tie into my broader theoretical framework which seeks to explore deeper meanings in substance use and recovery. Lastly, I propose that a research opportunity exists in a Maine context, where qualitative communication studies that explore the complexities of the opioid crisis in the state are largely absent.

Communicating Recovery

The first section of this review draws upon research that takes a communication approach to studying specific health-related recovery processes. This section does not address questions of addiction-related recovery, but rather seeks to understand how recovery as a general concept is explored in communication research. The idea of recovery, or getting better, is complex. To begin to understand this process, a look at literature regarding communication in recovery related to a variety of health issues is essential. These studies generally use qualitative methods (Boylstein et al., 2007; Bright et al., 2013; Lindemann & Cherney, 2008; Lockwood & Cherney, 2008; Lockwood & Yoshirmura, 2014; Tregea & Brown, 2013;) and provide richness in exploring the idea of recovery. Detailed accounts of recovery processes described in interviews and observation help give insight to what recovery means in certain contexts.

Communication practices such as metaphor, hope and humor may help an individual's sense of hope and ability to recover (Boylstein et al., 2007; Bright et al., 2013; Lockwood & Cherney, 2008). There is a comparable body of literature regarding communication in stroke recovery (Boylstein et al., 2007; Bright et al., 2013, Tregea & Brown, 2013) that helps demonstrate how specific communication practices shape the process of recovery. For example, Boylstein et al. (2007) interviewed veterans in the stroke recovery process, finding that common metaphors of viewing a stroke as "disaster" and a "war" lead to negative self-imagery and potentially higher levels of self-reported depression. These authors propose a "metaphor shift" to

more positive imagery may help the recovery process and minimize depression (Boylstein et al., 2007, p. 285). Bright et al. (2013) focus on the idea of hope in stroke recovery. These authors draw the distinction between passively having hope and actively hoping, suggesting that clinicians be aware of the role of hope and actively intervene within the process to facilitate it. Tregea and Brown (2013) seek to find what makes peer-led aphasia support groups successful, finding that qualities such as informality, friendship building and a supportive communication environment may be beneficial.

Yet, qualitative communication research that explores recovery is not limited to strokes. For example, Lockwood and Yoshimura (2014) study the effects of humor on recovery from cardiovascular disease. These authors identify two humor types. Antidote humor reframes one's mental state and increases feelings of control. Conversation regulation humor intends to enhance conversations that promote closeness. The former helps patients distance themselves from their problems, where the latter helps manage difficult conversations. They found that only antidote humor had positive effects on both relationship satisfaction and well-being. Lindemann and Cherney (2008) observe participants in the sport of Murderball, a wheelchair rugby game that is viewed as a rehabilitative activity for quadriplegic athletes. After three years of observation, the authors propose that the sport initially provides an empowering view of disability. However, a critique of the sport is that it upholds ideas of aggressive masculinity and aggression that may promote ableist views.

How does this literature support and extend complex understandings of recovery? The above studies identify communication, in different forms, as part of the recovery process. Patients position themselves within metaphor (Boylstein et al., 2007), establish hope with caretakers (Bright et al., 2013), enjoy informality and friendship within support groups (Tregea

& Brown, 2013), laugh through humor (Lockwood & Yoshirmura, 2014) and work to feel empowered (Lindemann & Cherney, 2008). These phenomena are both communicative in nature and are revealed through qualitative methods. While this body of literature is key in beginning this exploration, it should be noted that this body of literature is small. However, what unifies these studies is their positioning of communication as integral in recovery. With this initial exploration, the broad concept of recovery can be further specified in regards to addiction.

Recovery and Addiction

This section surveys literature that explores definitions of recovery specific to addiction. In order to ask questions about meaning regarding recovery from substance use, it is key to begin understanding how these concepts are defined and related to one another. First, Sussman and Sussman (2011) provide a thematic analysis of papers defining addiction. Next, White (2007) and Saaristo (2009) address what recovery means in regards to addiction. Lastly, Smith et al. (2016) and Walkup and Cannon (2018) exemplify communication studies that engage these ideas.

Defining addiction

Addiction, like recovery, is a complex concept that should first be explored before it is applied to further studies. Sussman and Sussman (2011) are helpful in considering the definition of this term. Through an analysis of 52 papers regarding the definition of addiction, six key themes of development were pulled. The first theme is that addiction is not an overnight occurrence, but a process that sometimes begins with individuals "feeling different" than others (Sussman & Sussman, 2011, p. 4027). This feeling of difference – for example, loneliness or incompleteness, sometimes leads to an addictive behavior. Alternatively, individuals may not necessarily feel different than others. They may simply seek a behavior because they believe it

will be enjoyable. Second, the behavior becomes a preoccupation that begins to impact various aspects of one's life, tied with cravings to engage in the behavior. Third, temporary satiation may follow, which is characterized by periods where cravings subside and the individual feels their behaviors provide them resolve of their initial problem. Fourth is a loss of control, including incomplete memory access, impulsiveness, and substantive efforts in gaining access to the behavior. Fifth, addiction results in notable negative consequences that vary across contexts. A final theme is the differentiation of addiction and compulsion. Compulsion is defined either in terms of spontaneity or urges that one experiences in order to reduce anxiety such as repetitive hand-washing or not stepping on cracks. Addiction, on the other hand, includes a "constellation of purposeful behavior to achieve satiation," (Sussman & Sussman, 2011, p. 4030). Sussman and Sussman (2011) also note that addiction is generally linked with perceived negative behaviors rather than positive ones such as work or exercise (p. 4034). Underlying this is the conceptualization of addiction that is founded in "concepts such as desire, will, compulsion, pleasure and more," (p. 4034). Sussman and Sussman's (2011) framework provides a foundation from which addiction can be defined across a variety of forms. Addiction can occur in a range of behaviors, from substance use to sex and gambling.

Defining addiction recovery

White (2007) raises important questions about what "addiction recovery" means. Working on the assumption that there is a failure of consensus towards a definition for this term, White (2007) asks questions about conceptualizing addiction and recovery that are helpful in moving towards a working definition, including questions about "ingredients" in the recovery experience (White, 2007, p. 231) and requirements for being "recovered" (White, 2007, p. 232). Finally, White (2007) proposes a definition of recovery from addiction that is both a "process

and a sustained status" that includes not only addicts but communities and the resources used to solve addiction related issues (White, 2007, p. 236). To expand this idea, Saaristo (2009) draws attention to the framing of addiction as "abnormal" and health as "normal." Through this dichotomy, Saaristo (2009) argues that a disease conception of addiction causes addicts to view normalcy as an ideal that is in opposition of their perception of their identity and behavior. Therefore, a change in this perception is necessary before recovery can begin.

Communication-focused study of addiction recovery

Walkup and Cannon (2018) may address the concern about this "binary" view of addiction by research which comes from the field of rhetoric of health and medicine. These authors conducted a study in which librarians were introduced to a women's substance abuse facility to enhance patients' mental health literacy. This was done in an effort to conceptualize addiction as more than a "brain disease" and rather a problem that was a result of a network of factors including demographics, past experiences and their own health literacy. Walkup and Cannon (2018) define their perspective as ecological, aligning it to a systems or networked approach that aims to position addiction as influenced by a number of factors. As participants "were introduced to more information about their mental health through onsite library services and group interviews, they spoke less about addiction as only a brain disease, or only as a result of personal failures," (Walkup & Cannon, 2018, p. 115). Additionally, this information improved a sense of self-efficacy in patients. Ultimately, this "ecological care model" may be helpful in providing a more holistic view of addiction and improving recovery efforts and patients' mental health by helping patients learn that their behavior is a result of numerous influences, not simply their flaws as human beings.

Similarly, Smith et al. (2016) devise a model based on a longitudinal study of women on probation or parole for drug-related offenses. These authors propose that the communication style of parole officers (either conversational or conformity) act as antecedents to psychological reactance, emotional reactance, and self-efficacy, which ultimately have effects on substance abuse within 6 months and drug related violations within 18 months. A conversational communication style of parole officers was positively related to self-efficacy and negatively related to psychological and emotional reactance, while a conformity style had the opposite effects.

Both Walkup and Cannon (2018) and Smith et al. (2016) explore how communication impacts the addiction recovery process specifically. In both, self-efficacy emerges as a theme of importance. Addiction is pulled away from an individual-blame frame, and participants are empowered. The concept of addiction and recovery as complex phenomena that are influenced by communication is largely expanded upon by literature regarding opioids. While this literature is not exclusively from a communication point of view or housed in communication journals, communication inevitably emerges – even if it is not explicitly framed that way by authors.

Opioid Addiction and Recovery

Addiction is a complex concept and any sort of recovery plan should take this into consideration (Saaristo, 2009; Sussman & Sussman, 2011; Walkup & Cannon, 2018; White, 2007). This section starts with a brief introduction of the opioid crisis in the United States and notes three primary influences identified in literature, including treatment of pain as a human right, pharmaceutical companies, and the response to the under treatment of pain (Hsu et al., 2017; Vadivelu et al., 2018). I then identify themes from literature that supports the idea that opioid addiction and recovery go far beyond a physiological level. These themes include the role

of stigma and stereotype as a barrier to recovery (Birtel et al., 2017; Frank, 2011; von Hippel et al., 2018; White, 2012), how addicts construct themselves through narrative (Jodlowski et al., 2007, Zufferey, 2009), and how addiction and recovery is a continuously social process (Cooper & Nielsen, 2016; Kelly et al., 2017). These social factors require social solutions, an idea that is extended by Yamasaki's (2017) conceptualizations of social support and community and Smith and Rosen's (2009) study on barriers to social support in older adults. As noted earlier, these solutions can manifest in communication practices and expression of support from those in an individual's social environment, and a model of recovery that goes beyond medication alone.

The opioid crisis

Beyond identifying over 660,000 opioid analgesic overdoses and heroin related overdose admissions between 2001-2012, Hsu et al. (2017) find that in-patient costs increased by $4.1 million dollars per year with an increase of hospitalization costs more than $700 million per year. Vadivelu et al. (2018) identify three primary forces that have contributed to the opioid crisis in the United States – treatment of pain as a human right, pharmaceutical companies, and the response to the under treatment of pain. These authors conclude that the opioid epidemic is a "pressing issue" that is the result of myriad factors including inappropriate prescriptions, lack of understanding of long-term therapy, misuse, abuse, and dependence.

Stereotype and stigma

Stereotype and stigma are social barriers that may prevent recovery. Birtel et al. (2017) state that individuals who use substances "face severe stigma attached to their diagnosis" and "suffer indirectly through economic and social disadvantages, even when receiving treatment" (p. 1). They add that "stigmatizing attitudes about substance abuse are widely held by the general public" (p. 1) and find through their survey of 64 individuals that perceived stigma was

associated with "lower self-esteem, higher depression and anxiety, and poorer sleep" (p. 6). Similarly, "stereotype threat" is a phenomenon where those undergoing opioid treatment may be prone to believing they are the target of stereotypical attitudes, which inhibits a feeling of social functioning and recovery (von Hippel et al., 2017, pp. 167-168). White (2012) draws attention to the development of recovery-oriented methadone maintenance, which goes beyond simple medication-assisted treatment. Stigma towards methadone maintenance is also addressed under this approach through the strategies of patient advocacy, public and professional education and increase of interpersonal interaction between stigmatized and non-stigmatized individuals and groups. White (2012) also states that a recovery-oriented approach "combined pharmacotherapy and a sustained menu of professional and peer-based recovery support services to assist patients and families in initiating and maintaining long-term addiction recovery," (p. 202). This approach focuses on concepts of affordability, accessibility, comprehensiveness and safety of both patients and those in their social networks. Like White (2012), Frank (2011) considers the role of stigma in methadone treatment as it relates to 12-step discourse. Claiming that 12-step programs often frame addiction as a personal or moral failure, Frank (2011) conducts 16 interviews and finds that individuals either in active use or recovery rely heavily on "the abstinence/morality discourse" (p. 252) which positions methadone and methadone patients negatively and is associated with with avoidance of such treatment. This avoidance, according to Frank (2011), shows a "discrepancy between methadone's demonstrated value for treating opiate addiction and its general lack of use among addicts" (p. 252).

Constructing the self through narrative

Individuals who use substances often articulate their experiences through self-narrative. Zufferey (2009) reports on research conducted in 1999 and 2004 of 31 cocaine and heroin users

in how they work to legitimize their drug use. Zufferey (2009) identifies a few main strategies of users in their construction of self-image as harmless – they view drug use as recreational, they use drugs only in appropriate settings, they are able to preserve their health, and they respect basic ethics such as abstaining from stealing. These strategies emerge from an individual drawing on "collective values and representations" (p. 170) that enables them to produce a biographical narrative of themselves in a way that reduces perceived harm. This narrative construction must be sound and avoid contradictions and match the individual's actual actions. Like Zufferey (2009), Jodlowski et al. (2007) discuss the role of personal narrative in opioid addiction. In an online communication context, Jodlowski et al. (2007) claim narratives are a "key ingredient" where individuals can "seek out the support of others," (p. 1), but note that such narratives have the potential to both unify and divide participants. In their analysis of a discourse on an online detox message board, they found that stories of suffering served to unify people through identification, where many users shared experiences of their own suffering in response to an original post that often contained the notion of perfection and the looming threat of relapse. The second discourse that was analyzed revealed division where users argued about what the definition of "clean" means in the recovery context. These arguments included differing opinions on the requirements of being clean, where the original poster ultimately felt critiqued and judged for their choice to maintain pain medication use.

The social nature of opioid addiction and recovery

The social nature of opioid addiction and recovery includes not only issues of stigma, but strategies for social support. Support often comes from friends, family, and treatment programs that encourage social interaction. Cooper and Nielsen (2016) conduct an analysis of 44 opioid-related articles, finding that stigma is an important social factor contributing to opioid addiction

and recovery, similar to von Hippel et al. (2017) and White (2012). Beyond this, Cooper and Nielsen (2016) evoke the social nature of opioid recovery by finding themes of judgmental language, blame, and stigmatized treatment experiences. They identify support coming from a variety of social sources, including family, web-based, friends, partners, and social network therapy in which family and friends are involved in therapy and recovery efforts.

Kelly et al. (2017) recognize the social nature of opioid addiction and recovery and note that recovery efforts are lacking that help friends and family members of addicts. Kelly et al. (2017) survey the non-profit support network Learn To Cope (LTC), a peer-led support group of mostly mothers of adult male opioid addicts which includes "sharing and communication of personal experiences among members and exchange of information," (p. 194). LTC is unique in the fact that monthly professional input occurs in the forms of lectures from researchers and clinicians and members of support organizations. Additionally, LTC differs from more traditional 12-step family support programs in that its model is not "detach with love" (p. 194), it encourages family members to provide "differential reinforcement" (p. 194) in practices such as attendance at treatment sessions or checking on medication compliance. Through meeting observations and surveys, Kelly et al. (2017) found that members stated an increased knowledge of the nature of addiction, feel more helpful to their loved ones, blame themselves less for the addiction and report better coping and communication skills. Qualitative responses of participants revealed several therapeutic factors of meeting attendance, including cohesiveness, instillation of hope, catharsis and altruism. Kelly at al. (2017) conclude that these feelings, along with Narcan training which takes place at LTC meetings, may help reduce deaths from the current opioid crisis.

It is important to consider more specific definitions about support that emerge from Kelly et al. (2017) and Cooper and Nielsen (2016). Yamasaki (2017) states that "Social support encompasses the verbal and nonverbal assistance, comfort, or advice we give to others to seek and receive during difficult times" (p. 257). Yamasaki (2017) adds that support is often linked to improved health and overall well-being, and that support comes in different types. However, Yamasaki (2017) notes that "Support that is not perceived as helpful or supportive may increase the recipient's stress and anxiety" (p. 257). There may be other barriers to social support. Smith and Rosen (2009) find in 24 interviews with older adults on methadone treatment that self-isolation and mistrust are prevalent forces that may prevent the invitation and maintenance of social support. Along with social support is the idea of community, which Yamasaki (2017) states "is a word that often connotes good feelings but is bandied about in so many ways that its definition has become blurry" (p. 254). Yamasaki (2017) provides a definition in spite of this, calling communities "social accomplishments that simultaneously emerge from and are maintained by communication" (pp. 253-254). Yamasaki (2017) adds that "Members of a community create and sustain shared cultural meanings through a common set of customs, rituals, rules, language, and other communicative practices" (p. 254).

These themes, including stereotype and stigma, self-narrative and social support as a whole work to complicate conceptualizations of opioid addiction and recovery. They compliment findings from the preceding section where communication was identified as influential in recovery by emphasizing stigma and stereotype, which are social phenomena, how addicts use narrative to construct their concept of self, which is tied to social interactions with others, and how specific recovery efforts are often grounded in support from social networks. This

discussion of opioid addiction and recovery will now be brought to a Maine context, noting an area of opportunity as studies similar to those described to this point are absent.

Setting the Context: Opioid Use in Maine

Maine has a particularly dire prescription drug problem, with "more people per capita in state-funded treatment than any other state at eight times the national average," (Richardson, 2011). Maine has the highest total daily opioid dose in morphine equivalents and a strong association of opioid sales and drug poisoning mortality rates in the United States (Piper at al., 2016). Maine is the only state with a Diversion Alert Program (DAP), an electronic initiative launched in 2013 that "allows health care providers to identify patients charged with drug-related crimes" (Piper et al., 2016) in order to determine the likelihood of patients to use or misuse. Additionally, The Maine Prescription Monitoring Program (M-PMP) has been recording prescriptions of Schedule II, III and IV substances since 2004 (Piper et al., 2016). Drawing from pharmacist surveys, DAP and M-PMP, Piper at al. (2016) find that hydrocodone, oxycodone and buprenorphine account for 73.1% of opioid prescriptions. As of 2014, more than one-fifth of all Maine residents received an opioid.

While plentiful statistics exist about the opioid crisis in Maine, few in-depth scholarly studies exist that provide any information or insight beyond the numbers. Noting that little research has been conducted in non-clinical populations regarding the relationship between chronic pain and addiction, Heimer et al. (2012) sampled individuals from the "general population" (p. 346) in Cumberland County, Maine. Results from a survey of 237 participants found that 41% reported chronic pain, though more than three-quarters of participants reported opioid misuse prior to chronic pain onset. These authors conclude that their findings add to

evidence that "a significant proportion of people reporting a history of opioid misuse are likely to be under-treated for chronic pain," (p. 348).

While these statistics and above study provide crucial information about understanding prevalence of opioid use in Maine, there is a gap in research regarding the complex social nature of opioid use, addiction and recovery. As developed in this review, communication plays a key role in long-term health issues and recovery, from specific communication practices to supportive social networks. Maine's opioid epidemic, despite a wealth of statistical research, remains a rapidly growing problem. In order to understand this problem more deeply, a study through a communication lens that acknowledges the complex network of factors leading to opioid use and the equally complex, social nature that is embedded in recovery effort is opportune.

The Culture-Centered Approach to Health Communication

An approach that foregrounds the culture of a population through meaning articulation lends itself to this lens. Dutta's (2008) culture-centered approach to health communication (CCA) is characterized as "an alternative lens for understanding health communication" that is "value-centered and is built on the notion that the various ways of understanding and negotiating the meanings of health are embedded within cultural contexts and the values deeply connected with them" (p. 3) A response to Eurocentric biomedical and cognitive-behavioral models, the CCA seeks to privilege localized ways of knowing and meaning-making opposed to imposing outside "expertise" indiscriminately to solve health problems. The CCA seeks to "build health communication theories and practices from the point of cultural members, foregrounding their voices in the articulation of problems, the prioritization of problems, and the development of

health solutions" (p. 3). Thus, the CCA seeks to focus on erased and marginalized voices in health discourses.

The CCA draws on a number of academic traditions. As it questions modes of knowledge creation in dominant health ideologies and the roles of structures in constraining life, the CCA draws on Marxist and critical theory, particularly in regards to economic constraints and the distribution of power within systems. In addition, the CCA draws on cultural studies in its attention to how meanings are created and postcolonial theory as it investigates the agendas of colonial efforts in controlling knowledge structures – for example, in the dichotomy of the First and Third World. Lastly, the CCA draws from subaltern studies, as it focuses on erasures and absences from mainstream health discourses. Dutta (2008) makes the point that subaltern studies scholars do not seek to "represent" (p. 12) research participants, but present themselves as co-participants who are "aware of the privilege they embody in the discursive process" (p. 12).

The three main tenets of the CCA are structure, culture and agency. Structure is defined as "aspects of social organization that constrain and enable the capacity of cultural participants to seek out health choices and engage in health related behaviors (Dutta, 2008, (p. 6). Structures are connected with material resources such as medical services and transportation, which may simultaneously constrain and enable individuals to engage in certain health practices. Culture is defined somewhat broadly, as the "local contexts within which health meanings are constituted and negotiated" (Dutta, 2008, p. 7). Dutta (2008) emphasizes culture as constitutive and dynamic, where members' understanding of health and illness are embedded in "beliefs, values, and practices" (p. 7). Culture both surrounds beliefs, values and practices and emerges from them as individuals "develop their interpretations of health and illness" and "engage in these day-to-day practices" (Dutta, 2008, p. 7). Agency refers to "the capacity of cultural members to

enact their choices and to participate actively in negotiating the structures within which they find themselves" (Dutta, 2008, p. 7). Individuals both challenge and work with structures in their health practices, and agency "taps into the ability of individuals and their communities to be active participants in determining health agendas and in formulating solutions to a variety of health problems" (Dutta, 2008, p. 7).

The three tenets do not exist in isolation from one another. Structures gain meaning through cultural contexts. For example, Dutta (2008) claims that structures that limit healthcare in American inner cities are "made meaningful" (p. 7) through the stories of individuals in these cities who share their struggles "embodied in them" (p. 8). Moreover, the telling of these stories ideally holds the possibility to challenge or reify structures, as "articulation of new meanings…create points of social change" through "greater awareness" (Dutta, 2008, p. 8). Agency emerges through individuals' abilities in navigating their structures, as they both struggle with and seek ways to change them. Additionally, agency is enacted in culture, as "culture provides the conduit through which agency is realized," (Dutta, 2008, p. 8). Here, Dutta (2008) argues that the language individuals use in articulating the meanings of health is constituted by the culture in which they live. Dutta (2008) adds that the cultural symbols individuals use to communicate with each other interact with structures which enacts agency, and that this agency can both challenge these structures and dominant cultural meanings.

The CCA has been used in numerous health communication studies in a variety of contexts, with a consistent thread on investigating health disparities amongst marginalized groups. Basu et al. (2016) and Basu and Dutta (2009) examine cultural influences and understandings of HIV/AIDS, using interview data in both studies. Often, studies that use the CCA involve cultures outside of the United States. The CCA has been applied in countries such

as China (Dutta & Kang, 2017; Sun & Dutta, 2016), Nepal (Basnyat & Dutta, 2012) and Israel (Guttman et al., 2013). The CCA also looks at cross-cultural contexts. Gao et al. (2016) investigate Chinese immigrant restaurant workers in the Midwest, using interviews to identify health barriers such as lack of insurance and lack of knowledge about insurance options. Koenig et al. (2012) surveyed focus groups of Asian Indians living in the United States to gain knowledge about dietary health meanings and how these are incongruent with the biomedical model. Martinez (2017) uses the CCA to examine depression in U.S.-born Mexican Americans through interviews and questionnaires, finding that family structures in these individuals are crucial in depression treatment and that biomedical options are often a last resort. Ortiz Juarez-Paz (2017) studies the undocumented student movement in the United States, using interviews and participant observation to find that storytelling is a primary communicative tool used by the students with a focus on resistance. In addition, the CCA can be applied along lines of inquiry such as gender and race, specifically. Ross and Castle Bell (2017) use the CCA in seeking how to improve practitioner communication with transgender patients, while Villagran et al. (2015) use the CCA to study women's health identities in their transition from military service members to veterans. Dutta et al. (2017) seek meanings of health experiences of African Americans living in an underserved region in Indiana, using interviews to find that health meanings are often enclosed in narratives of stress.

While these studies cover a variety of contexts, they reflect the qualitative methodology stressed earlier in this review. Most all studies that use the CCA use qualitative methods, particularly interviews, focus groups, questionnaires and/or participant observation. It is important to note that the qualitative methods used in these studies speaks to the focus of the CCA in its attempt to co-construct knowledge with individuals who are typically absent from

mainstream health narratives. The stories of these participants become the forefront of analysis, as culture, structure and agency emerge from within them.

The CCA helps address the gap identified in this review regarding qualitative work on substance use disorders in Maine. Because a central component of the CCA is meaning making, the social processes that create meanings about substance use and recovery can be revealed through this approach. Importantly, the voices of those who are in recovery or work directly with those in recovery are privileged, opposed to a top-down approach. These meanings become critical in understanding what substance use and recovery mean for people, and potential strategies for addressing this issue may be more well-informed by such meanings. The formation of my research questions, primarily influenced by the CCA and meaning making, resulted in the following four questions:

RQ1: What does recovery mean for practitioners and those in recovery?

RQ2: What structures are in place that influence recovery in Maine?

RQ3: How do practitioners and those in recovery express agency?

RQ4: How does the interplay of these experiences of structure, culture and agency impact recovery in Maine?

CHAPTER 3

METHODOLOGY

Introduction

I begin this chapter with briefly describing my research paradigms, which overlap and include interpretivism, social constructivism and pragmatism. I introduce how my choice of qualitative research, in particular semi-structured interviews, follows this positionality. I then detail my process with the University of Maine's Institutional Review Board (IRB), recruitment practices for interviews and considerations for confidentiality. Lastly, I provide data about the 13 interviews I conducted between July and October of 2018.

Qualitative Research and Paradigms

Semi-structured interviews follow Creswell's (2014) statement that in a qualitative research approach, "the researcher seeks to establish the meaning of a phenomenon from the views of participants" (p. 19). In a health context specifically, Lindlof and Taylor (2011) state that "Qualitative methods have thus served to restore the integrity of patient subjectivity and agency in medical encounters" (p. 19). A qualitative approach is the basis of this research, which falls into overlapping paradigms of interpretivism, social constructivism and pragmatism. Interpretivism positions realities as "unique, plural, simultaneous, and local phenomena" (Lindlof & Taylor, 2011, p. 8). Social constuctivism is a view that an individual's meanings about reality are subjective, varied and influenced by interaction with others and the world (Creswell, 2014). Researchers "look for the complexity of views rather than narrowing meanings into a few categories or ideas" (Creswell, 2014, p. 7). Lastly, this research is pragmatic as it is concerned with applications and contributing knowledge to solve problems (Creswell, 2014). This paradigm was influential in my approach moving forward.

IRB, Recruitment and Confidentiality

The University of Maine IRB approval was granted in July 2018 (Appendix A). The IRB approved two separate but similar interview protocols – one for practitioners in the field of recovery (Appendix B) and one for individuals identifying as in recovery (Appendix C). In addition, separate informed consent documents for practitioners (Appendix D) and individuals in recovery (Appendix E) were approved. In order to protect patient confidentiality, practitioners were not asked to refer names of clients for the study. Instead, a recruitment flyer was created (Figure 1) and given to practitioners who were asked to distribute it either in their places of work or to those they felt might be interested. Thus, individuals identifying as in recovery had to contact me if they were interested. Practitioners were recruited from publicly available information online from recovery and mental health agencies, either by email or phone. I followed a script for both practitioners (Appendix F) and individuals in recovery (Appendix G) when recruiting.

I requested permission to audio record all interviews before they began and explained the purpose of the interview with the appropriate consent form. As suggested by the IRB, a resource handout (Figure 2) was given to those who identified as in recovery. I created the handout using an IRB template, which included local and national resources and helplines in case the interviewee divulged serious issues, such as harming themselves or others. Due to the sensitive topic nature of the interviews, names were not gathered. Rather, codes indicating population type were labeled on transcripts. Originally, populations were separated into two categories: practitioners and individuals in recovery. However, as suggested by the IRB, there would likely be overlap between these two groups as many practitioners in the field of recovery and mental health identify as in recovery themselves. Thus, transcripts were labeled P for practitioner, R for

individual in recovery, and PR for practitioner in recovery. However, three separate interview protocols were not created. I made the choice to use the practitioner interview protocol for all practitioners because I wanted to focus primarily on their work experience, whether or not they identified as in recovery. I asked all practitioners if they had experience with substance use and/or identified as in recovery, which served for my labeling purposes. For purposes of analysis, all interviewees were assigned a pseudonym. While I did gather demographic data on interviewees, I chose to omit specific agency names and this data at large for analysis to prevent identification. All data collected remained confidential. Interview transcripts and audio files were stored on my password-protected personal laptop, and shared on a Google Drive folder only with Dr. Bridie McGreavy and undergraduate research assistant Keely Gonyea who was included on the IRB. All interviews were transcribed by myself and Keely.

Interview Data

I completed a total of 13 interviews between July and October 2018. The interviews ranged from 38 minutes to 1 hour and 55 minutes. All interviews were conducted in person except for one phone interview. Of the 13 interviewees, 4 were practitioners who did not identify as in recovery, 6 were practitioners who did identify as in recovery, and 3 were non-practitioner individuals who identified as in recovery. Important to note here is that I use the word "practitioner" to broadly define anyone working in the field of mental health or recovery. Interviews mostly took place in the Bangor and Brewer area, with one taking place in Ellsworth and a phone interview taking place with an individual in Presque Isle. As suggested by the IRB, basic demographic questions were asked of all interviewees including gender identity, race, age, and socioeconomic status indicated by educational level and healthcare coverage. All interviewees were white, except for one individual who identified as half white, half Native

American. Of the 13 interviewees, 10 identified as female, 2 identified as male and one identified as genderfluid. The interviewees ranged from 27-64 years old. Five interviewees completed at least some level of a Master's degree, four completed at least some level of a Bachelor's degree, one completed some level of an Associate's degree, one held a substance abuse certificate, and two held a high school diploma or GED. All interviewees except one were covered by health insurance. Once all interviews were transcribed, I took a grounded approach through coding interviews. I manually coded all interviews, highlighting each section of interviewee text and assigning codes to them. These codes were then organized into themes which were divided into a codebook, which informed my analysis through Dutta's (2008) culture-centered approach.

FIGURE 1: RECRUITMENT FLYER

Invitation to participate in an interview

1865 THE UNIVERSITY OF MAINE

Invitation to participate in an interview about recovery

Carter Hathaway, a Masters student in the Department of Communication and Journalism at the University of Maine and Dr. Bridie McGreavy are conducting research on the meaning of recovery for those living with substance use disorders, and especially those in recovery from opioid use.

We are looking for individuals who would be willing to participate in an interview (either in-person at a location of their choice or over the phone). The interviews may last anywhere from 30 minutes to 2 hours.

This research aims to understand and help strengthen recovery support for substance use disorders in Maine. All information shared in interviews will remain confidential.

If you would like to participate in an interview and/or learn more about this project, please contact Carter Hathaway:

207-713-7217

or

carter.hathaway@maine.edu

FIGURE 2: RESOURCES HANDOUT

COMMUNITY RESOURCES		
Community Health & Counseling Services **52 Christian Ridge Road** **Ellsworth, ME 04605** (Any costs are your responsibility)	**207-667-5357** http://www.chcs-me.org/	Weekdays 8:00 am-5:00 pm
Community Health & Counseling Services **15 Kids Corner** **Machias, ME 04654** (Any costs are your responsibility)	**207-255-6786** http://www.chcs-me.org/	Weekdays 8:00 am-5:00 pm
Community Health & Counseling Services **42 Cedar Street** **Bangor, ME 04401** (Any costs are your responsibility)	**207-947-0366** http://www.chcs-me.org/	Weekdays 8:00 am-5:00 pm
Dirigo Counseling Clinic **270 High Street** **Ellsworth, ME 04605** (Any costs are your responsibility)	**207-973-0505** https://www.dirigocounseling.com/	Weekdays 8:00 am-5:00 pm
Aroostook Mental Health Services (AMHC) **710 Bucksport Road** **Ellsworth, ME 04605** (Any costs are your responsibility)	**207-667-6890** https://www.amhc.org	Weekdays 8:00 am-5:00 pm
Aroostook Mental Health Services (AMHC) **14 Steve's Lane** **Marshfield, ME 04654** (Any costs are your responsibility)	**207-255-0996** https://www.amhc.org	Weekdays 8:00am-5:00pm
Aroostook Mental Health Services (AMHC) **127 Palmer Street** **Calais, ME 04619** (Any costs are your responsibility)	**207-454-0775** https://www.amhc.org	Weekdays 8:00am-5:00pm
Northeast Crisis Services (Any costs are your responsibility)	**1-888-568-1112** http://www.chcs-me.org/index.php?id=2&sub_id=119	24 hours/day 7 days/week
Contact Your Primary Care Provider (Any costs are your responsibility)		

NATIONAL RESOURCES
Mental Health Services Locator https://findtreatment.samhsa.gov/locator
National Suicide Prevention Lifeline, Toll-Free, 24-hour Hotline, 1-800-273-TALK (1800-273-8255)

CHAPTER 4

ANALYSIS AND DISCUSSION

Introduction

In this section, I discuss the themes that emerged from my interviewees as they relate to the CCA, along with supplementary references to the broader literature in my theoretical framework. These themes are divided into three main groups – meanings of recovery, barriers in recovery, and strategies in recovery. I relate these themes to Dutta's (2008) tenets of culture, structure, and agency respectively. I find that recovery is an individualized process that includes gain from loss, particularly through social connection. Additionally, I find that motivations to recover vary, and that spirituality is a key component for those in the recovery process. I discuss multiple barriers described by the interviewees, including stigma and a lack of resources which stem from minimal funds and restrictive healthcare. Through these barriers I discuss the strategies interviewees describe in pursuing recovery, including a commitment to help others and a belief in a collaborative, client-centered approach. I then provide a synthesizing discussion of the three tenets of the CCA, highlighting the practice of self-narrative and my position on the CCA's focus of marginalization. In my discussion section, I highlight the desires of the interviewees in future directions and utilities of this work followed by an acknowledgment of limitations.

What Recovery Means

"There are many pathways to recovery"

One of the first and most consistent themes that emerged from the interviewees was that there is no singular definition or description of what recovery is. However, one common thread is that almost all interviewees described recovery as a life-long process, or something without an

endpoint. Lori, who works in an outreach position in the Bangor area, does not identify as someone with a substance use disorder. Lori described recovery as a process that "could be very curved and backwards and forwards and stopping and starting." She added that recovery does not necessarily mean abstinence, and that it is more about "moving towards some sort of stability." Leah, who interviewed alongside Lori, works at the same agency in a position closely with law enforcement. Leah and Lori agreed that recovery is "different for everybody" and that it is self-defined.

Doreen works in community health in the Ellsworth area. Doreen was the only interviewee who works in prevention rather than recovery, and does not identify as someone who has a substance use disorder. Doreen said that recovery "probably changes over time" and that certain substances, like opiates, cause such a profound change to a person physically that they will "think about and struggle with [it] every single day for the rest of their lives." Doreen added that how recovery looks depends on the substance, length of use, and physiology of the person. Karen, who identifies as someone in recovery from alcohol and who works in an administrative position in the Bangor area, responded similarly in her statement that recovery "definitely changes over time." She added that it never ends, just as addiction never ends.

This sentiment ran through almost all of the interviews. Becca, who was homeless at the time of our interview and identified as in recovery from alcohol, Ritalin and methamphetamine, told me that recovery is a "lifelong battle." She characterized this battle as hard, because "you can walk down the street and smell smells," but that "you have to be the strong person and be like, 'nope'". When I asked if there is such thing as a recovered life, she said "I believe, I'd like to believe, that there is such a thing as a recovered life. Some of us never come out of it." Miranda, who works in an administrative position in the Bangor area, detailed the challenge of

balance that emerges during the recovery process, which she said changes over time. Miranda identifies as someone in recovery from unspecified substances, starting at the age of 11. Miranda said that once "things are going well" for someone in recovery, they might feel they have less time to dedicate to their recovery practices. For example, if someone found that attending meetings worked well for them in their early recovery efforts, but now they have reached a point where they are working, going to school or raising children, they may feel there is less time to dedicate to meetings. Miranda said she felt fear whenever she added something new to her life, because she knew she had to take something away – like certain recovery practices – to balance it.

Paulette identifies as someone in decades of recovery from alcohol. Paulette said that recovery never ends. Like Miranda, Paulette discussed how stopping certain recovery practices can be dangerous. For instance, she said that stopping attending meetings will bring you "in your own head. And that's the worst place to be." Paulette said that she remembers being told "Never go into your head. Or if you go into your head, bring a flashlight and a shotgun because it's a dangerous place." Elizabeth, who works in housing in Presque Isle, characterized recovery as "continuous." Like Karen, Elizabeth compared her recovery to her addiction to drinking, which she also characterized as continuous. Elizabeth said that just like drinking and going to church, she has "To do certain things within [her] program on a continuous basis to have a daily reprieve of wanting to trigger use."

One divergence from this was in my interview with Craig. Craig, who works with the homeless population in the Bangor area, identified as recovered – not in recovery. Craig said that he feels like he is recovered because of the change that has occurred in his life. Craig described his feelings in this way: "I am not sitting on the couch smoking crack or shooting up in my arm

anymore. I live a life of responsibility. I – you know, am a father, I work and I manage and I – I do all the things that you know, just any normal person does…" Craig added that he does not have the "compassion and compulsion to use anymore" and that he no longer attends recovery meetings. While Craig felt this way, and said he knew others who felt the same, he made sure to note that he was only speaking from his experience, and that "everyone has different views" on the recovery process. He added that "having different views on things are great."

The idea of respecting different viewpoints on the recovery process was equally as consistent as these themes. Mark, who works in counseling services in the Bangor area, felt that recovery does not end. Mark identifies as an affected other – someone who does not struggle with substance use recovery himself, but has experienced it through others. Mark also identifies as a mental health survivor. Despite his position that recovery does not end, he added that "If a person views themselves as recovered…I want to honor that, I don't necessarily agree with that but that's kind of irrelevant. Whatever works for a person is something that I need to be able to respect and honor." Mark noted that people who feel recovered often have hit some sort of milestone and now "their primary mission is to share it with others."

One of the clearest examples of difference in the recovery community is the debate between abstinence and medication-assisted treatment (MAT). In the case of opioid recovery, MAT involves two primary medications – methadone and Suboxone. Methadone is a synthetic opiate, while Suboxone is the brand name for buprenorphine combined with naloxone, an opiate overdose inhibitor (Ritter, 2011). Naloxone is often sold under the brand name Narcan and is used to treat individuals experiencing opioid overdose, which can prevent death. Karen informed me of another form of MAT that is used to treat alcoholism, a prescription drug called disulfiram that commonly goes by the brand name Antabuse. Similarly, Elizabeth informed me of Vivitrol,

which is the brand name of naltrexone – an injectable medication used to prevent alcohol and drug relapse. In addition, medical marijuana can be characterized as a form of MAT. When I asked if tensions or disagreements exist in the recovery community between those who believe in MAT and those who believe in abstinence, the general consensus was that there was some disagreement but that coming together for a common purpose was more important. Leah said that "There certainly is" a divide, and that it is often based off personal beliefs. However, Leah claimed that her organization and others "believe in working together." Lori echoed this, stating that there are many people who are insistent on either MAT or abstinence, but that it is more helpful to have people "that are a little more understanding and flexible." Cassandra, who works in residential services in the Bangor area, said that "people have their opinions" but that once they enter their professional work, these opinions are silenced. For Cassandra, this came down to judgment. Cassandra identifies as someone in recovery from unspecified substances, and claimed that MAT did not work for her. However, she said she would never judge a client of hers for choosing that path.

Some interviewees explicitly did not agree with MAT but still demonstrated respect for those who choose it. Paulette felt that MAT is not working, mostly because it is not handled the right way. Paulette felt that people are on it for "years and years," and instead of weaning off of it, they are forced to continue it. She supported her feelings with an anecdote of her daughter, who Paulette claimed was told by the Department of Health and Human Services (DHHS) that she had no choice but to continue MAT if she wanted to maintain contact with her child. MAT is often folded into the harm reduction model. As elaborated on by Leah and Lori, harm reduction is the process of changing behaviors in steps in order to reduce the harm an individual using substances causes themselves and their environment. Leah used the example of someone using

meth on the streets. A harm reduction approach would "try to work on things like – do you have a place you can sleep before you use meth? Or make sure that you're eating food before you use meth." When discussing the harm reduction model with Paulette, she said she was "split." She recalled an instance when she saw an individual injecting heroin in front of the agency Leah and Lori work at, and that she was unimpressed by it. However, she ended the discussion by saying she understands the rationale behind harm reduction, and that "if they're helping someone…I'm there. I really am there." Connie, who works in counseling services in the Bangor area, also expressed hesitation about MAT, particularly methadone. Connie said that "People take a beating when they take methadone, they really do" but that she does not push opinions on anyone. Rather, Connie said she provides as much information as possible about treatment options. Elizabeth was critical of MAT, asking of recovery, "aren't we talking about the body, mind and spirit? So why would I want to function under a legal narcotic?" However, Elizabeth's criticism was seemingly more pointed towards the pharmaceutical industry rather than individuals who elect MAT, stating that "there's got to eventually have to be an overhaul" of the industry. Elizabeth predicted that a move towards medical marijuana in the future may replace other forms of MAT.

An important factor of recovery that I learned about from the interviewees is that recovery is often not simply tied to one substance or behavior. Rather, there is often a network of factors that lead someone into recovery. These factors include histories of trauma and mental health issues, which sometimes lead to indiscriminate substance use behaviors. Mark said that in his experience, "folks who are in recovery from addiction are typically also in recovery as a trauma survivor and oftentimes as people who have multiple self-destructive conditions; eating disorders and self-harm most notably. So, I don't know that anybody is in recovery for just one

thing." As Mark noted the prevalence of trauma backgrounds and self-destructive behaviors, Becca noted the importance of mental health. Becca said that mental health "definitely plays a huge role in a lot of addiction itself and then also in recovery." Connie said that to her, recovery means "identifying the ways in which I am not well, and then doing what is necessary in order to make myself well in those areas." She noted that she not only recovers from years of addiction, but from "a pretty comprehensive trauma background" and "some of the things that happen throughout life that happen as a culmination of those things take time to recover from as well." In her experience, Connie said people often recognize the behavior that is most pertinent to them when they enter recovery – for example, a heroin addiction that resulted from being prescribed pills for pain from a car accident. However, she said there are often other behaviors that predate whatever brings an individual into recovery. She added that she had "never met anybody that wouldn't do whatever was right in front of them, for the most part." In her case, she said that "there's a high probability that I have done lots of things that I don't even know, because when I'm under the influence of say, alcohol for instance, I'll just do whatever's in front of me, I don't think twice." In her personal story, Elizabeth said "isolation, regret, you know the self-pity. What I found in recovery is that really whatever I was using wasn't my problem, it was just a symptom of what my problem was, and that is me." This network of factors, which may simply be defined as the self in the case of Elizabeth, often leads to a desire for change.

"The gift of desperation"

While recovery is something that looks different for everyone, a consistent belief among the interviewees is that it involves some sort of change. This change often leads to the regaining of something once lost in substance use, and in some cases, a better life than before. In addition, some interviewees characterized recovery as a holistic process of transformation, including

physical, emotional, mental and spiritual components. Mark described recovery as "a process of reclaiming, or in many cases claiming, one's life and identity." Wren, who identifies as an individual in recovery from substances including heroin and cocaine, described recovery as a process of "unlearning." Wren claimed that in general, we are "so conditioned" and that what we are taught "may not be the truth about how things are or maybe should be." Similar to Mark, Miranda characterized recovery as a process of "regaining something that was once lost, but improving upon that as well." She added that in their current stage of recovery, there were things in their life that they "never knew were possible and never knew [they] could achieve." Craig described recovery as "when a person decides that they want to change their life."

Often, this change is profound, affecting the totality of a person's being. Becca said that to her, recovery means her livelihood and her family. Both Karen and Elizabeth described recovery in terms of freedom. Karen said that recovery is "Freedom from not only substance use but freedom from the bondage of something controlling me besides myself. Sunshine. Absolute sunshine." Similarly, Elizabeth said that the first word that comes to mind about recovery is "freedom," in particular "freedom from the bondage from the drug and alcohol that I chose to medicate myself with." Both Cassandra and Connie described recovery as a process of change that affects an individual emotionally, mentally, spiritually and physically. Similarly, Mark said that recovery is "a process of spiritual transformation that changes one's life holistically." Simply, Paulette said that recovery means "Life, just life."

When discussing the meanings of recovery, I was deeply curious about what motivates people to recover. In the throes of substance use, I wondered what that turning point – that moment of deciding to make change, as described by Craig. While it may seem obvious that an individual no longer wants to live in the ways described by the interviewees, a question remained

as to what exactly pushes desire into action. I found that these motivations vary, much like how the recovery process varies for everyone. Doreen, my first interviewee, separated motivations into "external" and "intrinsic." Doreen characterized intrinsic motivations as simply deciding that "this isn't the way I want to feel, this isn't the way I want to spend my money, I don't want these negative health effects." External motivations could include pressures from other people, such as an employer who does drug tests. Similarly, Cassandra described internal motivations as hitting rock bottom, and a feeling of hopelessness. External motivations include children or legal pressures – for example, courts dictating an individual to attend meetings in order to maintain contact with their children. Cassandra added that people who start recovery are "spiritually dead" and that "between children, law and family" there is a "gift of desperation." Like Connie, Cassandra used the term "sick and tired of being sick and tired" to describe this gift of desperation, which makes people "want to change their life." Craig described his motivation as a desire to "have a purpose." Craig said that for a long time, he felt he had no purpose, and "really didn't know what direction [his] life was going in." Craig added that he "didn't really have a lot of reason to be sober." In a similar vein to their earlier statements that recovery looks different for everybody, Leah and Lori said that motivations also vary. Lori said that "going to prison might be a way to get somebody to hit rock bottom and turn their life around. Other people it could be their children, their spouse, their parents, their friends – you know, anything that could motivate somebody to change."

Connie, Karen, Elizabeth and Miranda all highlighted pain as a primary motivator for recovery. Connie described this pain as "being sick and tired of being sick and tired…when the pain is great enough, and you're just tired and so tired that there's one thing left to do." Echoing this, Karen said that recovery begins "when the pain gets too much, and everything else they've

tried hasn't worked." In describing her own recovery process, Elizabeth said she realized that she "was full of a sense of pain." She described this pain as "unbearable," as she was "tired of feeling depressed and high and depressed and you know, the up and down of it." Miranda said that "pain is a great motivator" along with a number of other factors, such as the criminal justice system, and "seeing the joy that other people have in their life and realizing that you hold none of that."

"The opposite of addiction isn't recovery, it's connection"

An undercurrent of these motivations to change is the notion that substance use is a powerful and debilitating behavior which isolates people and disconnects them from others and their environment. Mark described addiction as "insidious; it strips away everything that is good; it takes away a person's character, values, beliefs. It robs them of connection and progressively, we're disconnected from our own bodies, from our own minds, and we're certainly disconnected from anything that's good." With this, Mark told me about Johann Hari, a Swiss journalist and writer who surveyed dozens of cultures in their understandings of what addiction is. Mark said that the universal theme of Hari's findings was a loss of connection, including "to self, to family, to community, to the broader culture." Mark said that in his own work, he found this "to be true 100 percent of the time." In describing her life before her recovery, Becca noted widespread loss. "I lost everything. I lost my home. I lost my friends. I lost my boyfriend. I lost everything. Everything that I had ever known was gone 'cause I was binging out on meth." Leah, reflecting on the early days of her work, said that she would give clients a hug before they left her office. She remembered "two of them crying saying that was like the first time they've gotten a hug in years." Leah supplemented this memory by saying that many people using substances "have zero supports or connections to anybody." Connie echoed this, saying "A lot of people don't have

support. They don't. They are isolated from their families, or have no families. And are isolated from people around them." Before his recovery, Craig discussed how his sense of purpose dwindled in college. He said that he had always played sports in high school and never used any substances. However, when he stopped playing sports in college, he went "from having stuff and then not having anything in life. Into homeless shelters, in and out of rehabs. You know, family kind of shutting you off. Really, really kind of down in the dumps…and really feeling like this is your life and this is what you're headed for, you're headed for death or jail."

Just as the loss of connection marks addiction, the regaining of connection marks recovery. Wren said that "the opposite of addiction is not recovery, it's connection." Leah, following her anecdote about hugging her clients, said that connection is a motivator in recovery as they begin "getting these feelings and people back in their lives they haven't had in a really long time." In her early recovery, Karen said that she was isolated. However, when she began working as a volunteer at her current workplace, she became "more comfortable around people." When Karen expressed to her counselor at the time that she was lonely, her counselor challenged her to ask someone who she respects about what they do when they feel lonely. Karen followed the advice, and the woman who Karen asked responded "I don't get lonely 'cause I like myself." For Karen, this was a moment of realization that helped her connect to others through valuing herself. The woman who Karen asked this question is now Karen's sponsor. Later, Karen said "communication – that's next to the best treatment you're gonna get." Paulette, reflecting on her progress in recovery, highlighted the fact that her two daughters went from never wanting to see her to wanting to be around her and involve her in her grandchildren's upbringing. In addition, Paulette said that "people can talk with me" and that she has "a lot of experiences to share" and is happy that she can provide information and help to those who may need it.

This regaining of connection is often tied into ideas about community and togetherness on a larger scale. I asked the interviewees what community meant to them, partially because Doreen, my first interviewee, worked in community health and I was curious what this concept meant to her. Doreen said that community can be thought of in different ways – geographically, culturally, and through special interests and faiths. She added that she believes community prevents substance use, but that substance use is "kind of almost its own community, and once you're involved with that group of friends, that's all you see." With this, she added that community can shape perception. Referring to Mount Desert Island, Doreen recalled people who told her that "it's so hard to quit when everybody I know uses, like everybody on the island uses." Doreen then told me that she thought to herself that she knows "lots of people on the island and none of them use substances." Doreen said that even though there are multiple communities in her area, that there is disconnect because communities do not always overlap. Doreen said there is "social structuring that happens that people aren't aware of what other people are doing."

Becca, who volunteered at a Bangor area homeless shelter during her time of homelessness during our interview, said that she felt a sense of community at the shelter through "people being there" for her and that she felt nobody was judged. Becca felt the shelter was a "safe zone" where she and others could be themselves and that she could get through her recovery "in a positive way." Similarly, a number of interviewees who were practitioners described their workplaces as communities. Craig described his workplace as a "family" in the sense that he and his coworkers have "the same goals, same focus." Mark said that "people who work in healthcare are disproportionately people who grew up in families of addiction, families of abuse, and families of neglect." With this, Mark said that he enjoys the fact that he can work

with people who are like him. Mark said that part of his work was finding his "tribe" and that "Neurotypical people are not my tribe." Mark said he felt "very much outside the mainstream" and that the ability to work with clients and coworkers who are like him provides a connection that is "extraordinary" which felt like "kindred spirits." When asked what community meant to her, the first community Connie thought of was her workplace community, which she described as supportive. This in turn affects the clients her workplace serves. She compared community to the idea of "the village" in that "it takes all of us to manage" the problems her workplace seeks to help. Like Doreen, Connie noted that community can be thought of differently, such as church communities or mental health communities, but that "We're all one." Cassandra said that community is "selfless" and that it occurs when people are "looking out for everybody's best interest, and not just themselves."

"The God-shaped hole"

In my interviews, spiritualty surrounded articulations of recovery and substance use. Particularly, when discussing the idea of connection, spirituality was a notable component. Like recovery itself, when I asked the interviewees what role spirituality plays in recovery, it was consistently described as something that looks different for everyone. The strong spiritual component in recovery often stems from its emphasis in recovery groups like Alcoholics Anonymous (AA) and Narcotics Anonymous (NA). Mark told me that "Spirituality needs to be broadly defined. It's extraordinarily important." Mark said that the starting point he often uses is an expression from AA which is "religion is for people afraid to go to Hell, and spirituality is for those of us who have already been there." For himself, Mark defined spirituality as a "connection between self and something greater than self. And anything that works for a person can be part of that process." He added that there is an acronym for God, "group of drunks," that is used in AA

to emphasize connectedness of the group. Much like recovery changes, Mark said that "spirituality evolves and changes as a person grows and changes." With his clients, Mark told me that he does not try to get people to believe in God, but to believe in themselves. Another expression Mark told me about was from NA, which is "just believe that I believe." Mark said that it is important for clients to believe that practitioners working with them believe in them.

Craig described spirituality as the "end game" of recovery, and that no matter what type of recovery an individual is in, they will find a sense of purpose. For Craig, this sense of purpose was his spirituality, and his ability to be open-minded, compassionate and honest. Leah said that spirituality is a great motivator for many people in recovery, particular stemming from the AA and NA communities. Leah said there is "a lot to be said" about individuals in recovery who find spirituality because "they're putting their faith somewhere else where they haven't done that in the past." Lori qualified this, stating that the providers she is familiar with allow room for spirituality "not to be a thing" and that "people that are agnostic or atheist that don't want to believe in a higher power. There's room for them to seek recovery as well." While Lori did make this point, the sense from all other interviewees is that a spiritual component is necessary in recovery, but that it does not necessarily have to be thought of in traditional dogmatic religions. Miranda said that the role spirituality plays in recovery varies for everyone, and that her program is characterized as a "spiritual not religious program." Miranda added that she felt the word spirituality "tends to kind of like freak people out a lot. So it takes some time for people to be really comfortable with that, and figure out what that means, what that feels like to them, and how they're going to be okay with it." Karen echoed this sentiment, saying that spirituality was "crucial" in her recovery, and that she knew "a lot of people who will say they don't have any higher power or anything like that." However, Karen felt that everyone does have a higher

power. She said "but yet they'll – absolutely obsessed with hiking or kayaking or outside stuff. Okay, that's your higher power. You may not know it, but it is. I think it's vital that we believe in something stronger than us, because if we rely on ourselves or even on each other, we're gonna fail. 'Cause a human will let you down no matter what. Anything man-made will let you down." Similarly, Cassandra said that spirituality is "central" in recovery. Cassandra explained that "there are moments where you reach out to people and they're just busy and they can't call you back and you're struggling, and you know, you really want to use. And the only person you have is your higher power. And if you don't have a strong connection with that…it's really hard to get through those hard moments alone." Cassandra added that when she entered recovery, she felt she was God, but that she learned to "surrender" and that she did not want to be God. Like Miranda, Cassandra saw this as a barrier to people entering recovery.

While this sense of openness in terms of how spirituality is defined was present in nearly all interviews, some interviewees did describe their spiritual beliefs in more traditional religious terms. Paulette's spirituality was the cornerstone of her recovery. At the time of our interview, Paulette was transitioning from her longtime recovery group to a nearby Calvary Chapel as her primary source of spiritual connection. She told me the reason she was making this transition was because she was told in her recovery group to find someone that has what you want to be your sponsor. She felt that the Calvary Chapel had what she wanted at the time due to their "wonderful community" that she felt had been missing in her life to that point. Raised Catholic, Paulette described how God and Jesus "were just there, they were with us all time." Becca focused on her faith in God in her interview. She told me that she had joined a church in the Bangor Mall that is part of the CityReach network. Becca told me that the aim of the church "is to reach the farthest from God" which made her think more about her addiction and her children,

and that her only option was to put all of her faith in God to "recover to the extent" that she wanted to. When asked what recovery meant to her, Becca ended her answer with "God is good." She added that God was a primary motivator in her recovery alongside her family. Becca said that she has always had a strong faith in God, but that she lost sight of it when she was using. She said that God is "meant to forgive" and that he has been stable in her life, adding that "He's the only man in my life right now" other than her son that she could rely on. In Becca's view, "God is essentially the answer for everything."

Connie reflected on the importance of spirituality when entering recovery. Connie identified as an atheist when she began her recovery, and said that this is common for many people who enter recovery when "they've been through some stuff" not only in addiction but in instances such as childhood trauma. Connie said that she was of the mindset that if God was real, "none of these things would be happening." Connie said that she was "steadfast" in her beliefs as an atheist, but that recovery caused her to be more "open-minded" to spirituality. For her, a core part of this process was learning that other people have choices. For example, Connie described an instance from her childhood when her mother drove drunk. Rather than attributing this fact to the idea that there is no God, Connie said that she realized that her mother had the choice to do or not do that, and that it could not be blamed on a God, or lack thereof. In her recovery, Connie said that she had "learned over time, and it took some time, to get some sort of like spiritual connectedness." She said she felt like she had a "gaping hole in the pit of [her] chest" and that during her use, it was normal for her that everyone around her "drowned their sorrows in a bottle of liquor." She then said that people in recovery will talk about a "God-shaped hole" and that building a relationship to whatever one believes in works to replace this hole. Connie said that everybody goes on a journey in finding spirituality in their recovery. Similarly, Wren said that

spirituality played a huge role for them in their spirituality. Wren said that "growing up, I didn't have a solid sense. I was, you know, made to go to church and it was a Pentecostal church and they're kind of scary when you're a kid." Because of this, Wren had ideas about "God or the universe or whatever you want to call it" which they described as "not great ideologies." Wren recalled their time in prison, where they sat with their "internal dialogue and with a desire to connect to something bigger." Wren said that this was "essential" in their recovery. Elizabeth connected the idea of spirituality back to her earlier sentiment that her use was a symptom of herself as problematic. Elizabeth said that the drug and the bottle are "a symbol of a symptom to my problem which is the spiritual malady so to speak." She added that "it's greatly important to have some type of spiritual sense of yourself and to grow that, and that again goes back to that daily recovery, the life long journey."

Dutta's culture

The above analysis addresses RQ1: *What does recovery mean for practitioners and those in recovery?* This analysis reveals key themes including that recovery is a unique experience for every individual, that it is a process of loss and gain particularly through social connection, and that it foregrounds a spiritual experience. Returning to Dutta (2008) helps to extend this analysis in his definition of culture in the context of the CCA as "the local contexts within which health meanings are constituted and negotiated." Here, culture has an emphasis on its "constitutive and dynamic nature" where "the ways in which community members come to understand health and illness are embedded within cultural beliefs, values and practices" (Dutta, 2008, p. 7). I find that the ways in which the interviewees described substance use and the recovery process creates a sort of cultural fabric to which the practices they believed best worked in recovery are built upon. The interviewees understood recovery as looking different for everybody, and that there

are many different pathways to recovery. Within this belief, a respect of difference was consistent. For example, when discussing MAT and the harm reduction model, the general consensus was that whatever it takes to help someone to recover should be encouraged. This was encouraged even if the interviewee personally disagreed with certain treatment methods. Another component of the cultural articulation of recovery is that it is life long and does not have a clear end point. However, a respect for different opinions on the matter was clear in the case of Craig, who was the one interviewee who felt he was "recovered" rather than "in recovery." Interviewees also saw recovery as a process of change, where a more complete transformation including physical, mental, emotional and spiritual aspects marked a more developed recovery.

Surrounding these meanings of recovery were the ideas of community, connection and spirituality. Interviewees consistently described the loss of connection in substance use and the regaining of connection in recovery. This reflects the view of recovery as a social process discussed by Cooper and Nielsen (2016) and Kelly et al. (2017), who identify social supports as key to successful recovery – for example, in Kelly et al.'s (2017) study of the Learn To Cope program. Interviewees often described motivations to recover as their social connections, including family and friends. Practitioners similarly described their motivations to pursue their work in terms of social connections – the desire to help others, to replicate the help they experienced, and to connect with people who were similar to themselves. In addition, interviewees described a positive sense of community. Practitioners often first thought of their workplaces as communities and then broadened their sense of the word to the recovery community as a whole, which included other agencies and any individuals dedicated to addressing substance use. These reflections on community, connection and social support reflect Yamasaki's (2017) ideas on these concepts and their role in health and well-being. Perhaps the

most consistent theme from the interviewees regarding meaning of recovery was spirituality. While characterized as something that looks different for everyone, a sense of spiritual well-being was identified as crucial to successful recovery. A sense of spirituality related to the concept of God is common, particularly as this sense is found in programs such as AA and NA. However, interviewees described spirituality broadly. This included ideas such as nature, a personal sense of purpose, and fulfilling activities.

Barriers in Recovery

Through describing primary beliefs about the experience of substance use and recovery, interviewees described a number of barriers that often prevent recovery from happening. These primarily fall into two categories – communicative barriers in the form of stigma, and material barriers in the form of a lack of resources and funds. These barriers are intertwined, as stigma may inform policy decisions and the amount of attention and resources that are devoted to the issue.

"A subset of humanity"

A primary barrier that affects state efforts in recovery is stigma towards substance use and users. Leah described stigma as "the number one barrier" to recovery, which leads to reluctance to seek providers and treatment. Related to the idea of lost connections, Leah pointed out that people who use substances have little to no social support, a result of their family and friends often ostracizing them. Leah further characterized stigma as an "umbrella" that covers all barriers that people who use substances face, including the judicial system and legislature. Lori added that the population her and Leah worked with "are marginalized in our society and not treated well and stigmatized, and I think they need all the support they can get from people that are going to help them with things that they need or advocating for them for laws that will help

them." When asked about the perception of her workplace, Karen said that some think it is "just a bunch of drunks and druggies" and that "there's always going to be that stigma" no matter how much she and others work to change it.

Often, the stigma that the interviewees described stemmed from a broader cultural attitude. Connie described a "subset of humanity that exists among us that a lot of people turn an eye to and pretend that it's not there." In this subset, people are "stuck where they're at. They don't have the…opportunity or even possibility to think about doing something different" Connie brought up opinions and biases working against these people, including "Oh, that person's on social security, they should get up and get a job," and "That woman's sucking up the welfare system." Connie followed this by recalling what a professor of hers told her once – "we tell people to pull themselves up by their bootstraps, but how how do we pull our bootstraps if we don't have any boots, you know what I mean?" Wren told me that "there's such a stigma surrounding addiction," but that they thought "more important than that is there's not a lot of knowledge about the work involved in recovery." Wren followed this by saying that people do not understand how difficult recovery actually is, and that "some people in recover have seen places you'll never want to visit" and that people "don't know what it's taken for them to be where they are today." Doreen felt that internal stigma was greater than external stigma, meaning that "people believe that other people are going to think much worse of them for being in recovery than what people actually believe." When asked why this is, Doreen elaborated that "people put a lot of pressure on themselves" due to our "independent culture." She likened this mentality to someone with a stress fracture who is told to "suck it up and keep going" which carries over into mental health and substance use. Elizabeth asserted that "if we want to talk about substance disorder and we want to talk about why is there a stigma, we have to look at the

history of the country politically, economically, racially and traditionally." Elizabeth said that stigma is "embedded" in our society, recalling the "This Is Your Brain On Drugs" anti-narcotic campaign from the 1980s, where eggs were dropped in a frying pan. Elizabeth noted a racial factor in this stigma, with "broken windows, criminal activity and the portraying of it in news cycles and tying it in together with city and urban areas." Elizabeth said that in her experience, the effects of the Nixon-era war on drugs show that it did not work, and that "some of our laws, federally, have been in such a way to diminish people of race's activity, and educational opportunities and things like that." Craig, being 10 years into his recovery, said that "I still have that stigma on me. Like, ah, he's just waiting to go back."

A topic that sometimes arose in the discussion of stigma was the conceptualization of addiction as a choice or a disease. The general consensus amongst the interviewees is that addiction starts with a choice and becomes an uncontrollable disease. Cassandra recalled her own substance use, saying that "It starts with a choice, that first time that I picked up when I was 20…was a choice. The fact that I couldn't stop that day on was not a choice. That was a biological part of my brain that took over. And it was insidious, and it was unbelievable. I can't even fathom." Cassandra brought this up when telling me that she wants people to understand that recovery is possible, but that "people are so blinded by ignorance, they don't even want to hear it." Becca echoed this, saying that "people think down on" people who use substances, and that "It is a choice. But, once you make that choice comes the disease." Connie said "the first one's free, it's the second one that gets you." Lori said that when she reads comments on Bangor Daily News articles, she sees statements such as "Oh, I hope they all die" and "they're just not worth saving" or "they're just going to relapse." Lori said that "we need to be compassionate and empathetic" and that "as a society we're losing some of that compassion and tend to be a little

more self-centered." On the notion of choice, Leah said "People who use substances – they're still people. Typically, like I kind of mentioned before, self-medicating from some sort of trauma, stress, current or past, childhood." She added "I really appreciate the term relief-seekers instead of substance users. You know, just someone seeking some type of relief from something." Lori compared this to the AIDS epidemic, where there was a stigma against gay men being "punished for their lifestyle." Lori said "again, with opioid addiction, people don't deserve that."

"Kick our feet out from underneath us"

As Leah described stigma as an "umbrella," the stigma identified by the interviewees seemed to directly impact structural barriers in the state for people in recovery. Primary challenges for recovery in Maine included a lack of resources in the state that result from minimal funding and restrictive healthcare options. These were sometimes tied to the broader political climate in the state. Often, practitioners work extended hours, sometimes at least partially on a volunteer basis or pro-bono. Connie spoke in depth on these barriers. She said "So you have somebody that's living on the street, you know, literally. And if that person can not get into a shelter and that person doesn't have, say, MaineCare then that person can't get access to housing because they need MaineCare in order to get the service, right. But then you also need a case manager in order to access those services. It's not as easy as it used to be, where you just 'Joe Shmoe' could go to say CHCS and fill out a housing application and hand it in." Connie continued to tell me that people on MAT are required to see a counselor at whatever clinic they utilize, and that case loads for these are "ridiculous, they're like 150 to 1 person." Due to caseloads, individuals "maybe see their counselor for 15 minutes every second month or something." This minimal counseling time "disqualifies them from getting substance use

services elsewhere" which is a stipulation included in Section 17 of MaineCare, Maine's Medicaid program. She continued, saying that people are often under the mindset that communities need to do more, but that "people that aren't working in the community are making all the rules and regulations that basically just kick our feet out from underneath us." She added that there is a provision in MaineCare that "funds some services" and that people on MaineCare "can receive some medicated assisted treatment, but only for a certain amount of time. And the funding is not very much" which leads to the limited number of facilities in the area receiving inadequate funding. On the problem of substance use in Maine in general, Connie said that "it's not hard, this is not one of those problems where it's like 'Oh my god, we can never figure this out.' It's not, the answer is really friggin' simple if we just had the funds and the opportunity to be able to do the thing." Here, it is clear that a number of barriers often work together in preventing recovery. Interestingly, Connie emphasizes that the issue of substance use and recovery in itself does not need to be complex or mysterious – there are plenty of trained practitioners who feel they can help those in need. However, the barriers mentioned by Connie, including restrictive healthcare, prevent this help from being given.

Cassandra described the state's transition to a fee-for-service model, where agencies receive single reimbursements for each service they perform, opposed to an annual contract where the agency receives a predictable sum of money throughout the year which can be adjusted later. Cassandra said this change has affected the staff of her workplace and her clients, where "hours with clients have to be separate from like our group hours, to our screening hours, to our assessment hours." Cassandra said that clients are still able to have meeting hours, but that they used to be "quite more than an hour" which is now limited. Cassandra said that her agency relies more on fundraising efforts like recovery walks and car washes with less funding from the

state. In addition, Cassandra said this change has made "our waiting list really long." Waiting lists are dangerous according to Cassandra, who said that "if anyone is like I was, if I want recovery you had to get it to me then. Because the next day I might be like, screw that." Miranda echoed this concern about fee-for-service, saying there are concerns about the "sustainability" about residential programs and that "the state seems to think that it's like, going to work out" but that "their perception of how residential works I think is really iconic of the fact that they know nothing about how residential works, which ultimately is tragic for the client because they're the one that's going to suffer the most." However, not all interviewees viewed the transition to fee-for-service the same, namely Elizabeth and Craig. Elizabeth said that the transition is simply a matter of creating "an accounting system with debits and credits" and that instead of a lump sum, the state is now saying "No, you're not gonna get that money ahead of time. What are you doing to bill us for that money?" To Elizabeth, this was "an accountability thing." Craig, while admitting that finances were outside of the scope and interest of his personal work duties, said that "I'm a strong believer that, you know, it's not gonna hurt us" and that "Everyone hates change." Like Elizabeth's point on accountability, Craig said that "people don't want to do the work" involved with documentation for fee-for-service. Because of the restrictive funding sources placed on many agencies, and the lack of healthcare coverage in many clients, many agencies work on a volunteer basis or offer pro-bono services to those without care. In Mark's view, "organizations and healthcare do not collaborate, they compete."

In addition to the barriers of restrictive healthcare, extended work hours, minimal funding and financial transitions, housing is seen as a primary need for the recovery process, sometimes characterized in terms of Maslow's hierarchy as a basic safety need. While some believe housing should come first, others offer the caveat that housing may enable isolation or the return to old

behaviors if not provided in conjunction with other recovery efforts. No matter where housing is placed in the recovery process, it is seen as important. Mark said that housing is "vitally important" and that it is "basic life need fulfillment and for folks to stay clean and sober." Mark added that he thinks "Maslow had the right idea." Karen also found housing crucial, and noted that "There are so many very large vacant buildings in this area that could be used to such valuable resources for people that – and it just breaks my heart when I drive by and see it just falling apart. And then two streets down, there's somebody sleeping underneath a tree because they do not have a home." Connie held a similar sentiment, telling me "We don't have any housing. It's awful…it's one of those most important things, shelter. It's been my experience that when somebody is worried about where they're going to sleep tonight, that they are not very worried about anything else." Craig, who deviated from the idea that housing should come first, said that "a person needs to go get some treatment and have some solid foundation before they go into housing." Wren characterized the housing situation in Maine as a "shit show" and said that in their experience, "what is available is ridiculously overpriced." In addition, Wren said that housing options are often cramped with other people, and that sober houses are more available for men than women. Paulette noted that local low-income housing options kick tenants out for substance use, and she was unsure "if you would ever be able to get back on." Paulette added "there's a big need" for housing and "not enough," and ended her response that she "ended up lucking out" to get in her current housing. Cassandra told me that "A lot of people graduate a 6-month program and have to go to the homeless shelter. You know like to me, that's just not right, they've done all this work. They're doing so well, and then you're going to put them back in that environment."

Additional challenges described by interviewees include geographic and social factors, including the geography of the state and small communities that may make recovery difficult. When asked about primary challenges in her work, Miranda responded that "rural country" is a barrier. She added that "there is like an entire 2/3rd's of the state above us that needs services and resources and we're kind of – I mean we're here for them, but we don't have enough to offer them that is convenient." Speaking from Presque Isle, Elizabeth described challenges in Aroostook County, including a dwindling, older population and a lack of work opportunities outside of the service industry. She added that communities are isolated from one another, and that "there is a lack of things going on around here." Wren echoed this sentiment, speaking from the Bangor area, saying "There's not a lot to do up here. There's not a lot of opportunity up here. You know, and you work a job and you're working that job for however long and then if you get tired of that job, you're working at a similar job making similar pay." Connie described the challenge of geographic spread, saying many clients "might be an hour away from their closest counseling office" or "two hours away from a food pantry." Paulette, who recently moved to the Bangor area from Aroostook County at the time of our interview, said that she moved because medical appointments were up to 6 hours round-trip. Despite her love of Maine, Cassandra said that she "could point out drug houses" in the area and that it is "definitely hard" due to the small community around her. When asked about primary challenges in her recovery, Becca said that substance use is "all around" and that "you get asked by friends sometimes if you want to use and it's tempting." She added that "It's hard to live here in this town especially with needles on the ground all the time. I mean, everywhere you turn there's somebody passed out because of drinking. You smell alcohol on people's breath that makes it hard. There's bars and clubs down Main Street."

Dutta's structure

The above analysis addresses RQ2*: What structures are in place that influence recovery in Maine?* The analysis reveals the barrier of stigma which surrounds material barriers including minimal funding, restrictive healthcare, and lacking resources. The analysis of these barriers can be extended by Dutta's (2008) description of structures. Dutta (2008) defines structure as "aspects of social organization that constrain and enable the capacity of cultural participants to seek out health choices and engage in health related behaviors" (p. 6). Structures are "deeply connected" (p. 6) to available material resources and affect the day-to-day choices that individuals make with their health. While I characterized this section of my thematic analysis as "barriers," it is important to note that Dutta (2008) does not see structures as only limiting or constraining, but enabling as well. The interviewees did speak frequently about barriers, however, and I find these to be the most notable structures mentioned in the interviews. Dutta (2008) states that "Communicationally, structures constrain human action by setting up communicative barriers" (p. 62). Dutta (2008) adds that "structures create conditions of stigmatization which continue to construct those at the margins as inferior, primitive, and passive recipients of interventions targeted at them" (p. 62). Certainly, stigma was a major barrier noted by my interviewees, which reflects the role of stigma in recovery noted by von Hippel et al. (2016) and White (2012). Leah and Lori, for example, conceptualized stigma as an umbrella to which all other structural barriers to recovery fell under. This can be related to von Hippel et al.'s idea of "stereotype threat" which often prevents further recovery efforts, and White's (2012) point that patient advocacy and support is important particularly in the case of MAT. Additionally, Frank's (2011) findings on stigma towards MAT and those who use it are important to consider here. While the interviewees themselves did demonstrate a respect of

difference in treatment options, stigma that stems from the idea that addiction is a personal or moral failure was noted in the general society. Connie's discussion of a "subset of humanity" speaks to the idea of erasure and Dutta's (2008) focus on the influence of the subaltern, unnoticed part of a population, which reflects Birtel et al.'s (2017) assertion that stigma is prevalent in the general public and works alongside economic and social disadvantages. Additionally, while social support and connection were discussed as essential in recovery, it is worth considering barriers to seeking and maintaining social support as they are influenced by stigma and isolation in some circumstances, as found in Smith and Rosen (2009).

There is something to be said for the fact that a number of agencies and organizations do exist in the Bangor and Brewer area that are devoted to recovery, which can show how structures do in fact enable individuals to be participants in their health. However, the limits on these agencies described by the interviewees exemplifies Dutta's (2008) point that structures often simultaneously constrain and enable individuals in their healthcare choices. Interviewees described a lack of funding both federally and from the state to be a primary issue. This leads to long hours, working on a volunteer or pro-bono basis, an off-balance client-to-practitioner ratio and extensive waiting lists. Housing is seen as a critical structure that enables individuals to recover safely – however, interviewees said that housing is lacking in the area. A limited number of residential services exist with limited beds, and with funding chances such as the fee-for-service model, some interviewees working in these positions fear for the sustainability of their programs. Cassandra's point that people who graduate rehab programs often return to a homeless shelter speaks to this issue. While not always explicit in the interviewees, the sense that stigma somehow influences the level of importance that recovery is given did emerge to an extent. At the time of my interviews, former Governor Paul LePage was in office, who was often criticized

for his handling of the state's opioid crisis, causing controversy over his position that the state's drug problems are the result of people of color coming into the state and impregnating white women (Phillips, 2016). Connie spoke of this, saying "we have a governor who thinks anybody with a substance use disorder should die, you know. They're not human, which is awful. He – is just awful." Beyond this, politics were referred to more generally, as in Elizabeth's statement that an understanding of the country historically and politically is needed to understand current substance use issues. Aside from politics, law enforcement was seen as a growing ally to the recovery community. However, limited resources for training were mentioned as a barrier. Despite the many barriers described by the interviewees, many expressed strategies in reaching recovery in this challenging environment.

Strategies in Recovery

Interviewees noted several strategies and practices they follow in striving for recovery either for themselves or for their clients. These strategies often begin with a commitment to help others in a similar way that they were once helped themselves. The interviewees felt that a client-centered approach is best for reaching recovery, meaning that individuals seeking recovery need to make decisions on their own terms and will only accept help that they are willing to receive. Alongside a client-centered approach, interviewees felt that collaboration from multiple stakeholders is needed for recovery to occur. Lastly, interviewees described success in multiple ways, ranging from a small-scale level including the harm reduction approach, to policy-level change. This ability to recall examples of success in multiple ways is noteworthy knowing the multiple barriers facing the interviewees.

"I know that if I want to get well, I need to help other people get well"

Despite the numerous challenges and barriers described by interviewees about recovery, all remained optimistic for various reasons about the possibility of recovery in the state. When asked about motivations to pursue their work, practitioners often described a sense of helping others that they experienced in their own recovery, or a general desire to help others who face the barriers described. Connie described a reciprocal process, saying "I know that if I want to get well, I need to help other people get well, and they in turn also help help me to stay well and continue to grow." Similarly, Craig said "I got into it because when I first got into recovery, someone helped me out. And that I really wanted to give back. Just a little bit and to be able to do the same thing for someone else." For her work, Karen said "I like to help first off. Everyday is different yet it's still somewhat the same. Every story is different but we all come from the same kind of chaos and pain. And I just love to watch it when their lives change." Cassandra told me that she originally planned to be a surgeon, but that once she became addicted and went into recovery, her passion changed. She said that "one addict helping another, one alcoholic helping another is kind of therapeutic in itself."

I asked the practitioners about their core beliefs and commitments in their work. These core beliefs and commitments include personal traits such as honesty and integrity, to commitments in practitioner's work including a belief that recovery is possible and absolute commitment to clients. Mark described recovery as "a process that [is] eminently possible" if there is "a willingness to do whatever it takes." Beyond this, Mark believed in "being completely genuine and working extraordinarily hard and continuously growing so that I can be of better service to others." Elizabeth's core commitments in her work were honesty, integrity and friendliness, while Connie said that she believed "that people are innately good" and that there is

no difference between her and her clients. Similarly, Doreen said "I think that everybody does the best that they can. I don't think anybody ever wakes up and says, 'Today I'm going to make some really bad choices and hurt some people.'" She added that "our structures and our personal histories get in the way of us doing the best that we can." When asked to elaborate on what she meant by structures, she said "the way our society is structured. The rules, the laws, the policies." Leah said that empathy was important in her work, and Lori added that "every person matters. Regardless of what they're coming in our door with." I also asked the interviewees who were in recovery about their beliefs and commitments which yielded varied answers. Paulette said "honesty and respect" were important to her, while Wren said that their parents "were both workaholics" and that "education and work" were instilled in their youth. Wren said that these beliefs gave them the belief that they had to "exhaust [themselves] at every cost" which they found was untrue for them at the time of our interview. Becca said that from a young age, the importance of God was instilled in her, which she brings into her recovery.

"Meeting people where they are"

When discussing approaches to recovery work, both practitioners and individuals in recovery described a client-centered approach to varying extents. The interviewees expressed that autonomy and decision making is important for individuals in recovery, and that it is impossible to force someone to recover or engage them in recovery options that they are not willing to engage in. Elizabeth described this process using the metaphor "you can lead a horse to water but you can't make him drink." Leah described working with clients as a balance, saying "you can certainly provide them with the information and present it…if going to a 9-month rehab is never a goal of theirs, but they're mandated by the courts to go, they're probably going to fail." Leah added that "I'll put in 49% of the effort if you are willing to put in the 51%

…can't be working harder than you but that also gets them to own their success when they're actually feeling it." Craig noted the importance of genuine listening and having conversations with clients, saying that the process is about "what they want how they want to see their recovery go…if you force your opinions and your views on someone, they're doing it more for you and not for themselves." Similarly, Cassandra said that at her agency, "We believe in giving the client some autonomy…when you're in the grips of addiction or in early recovery, it's really hard to like point out what's going on with you because you don't know. So what we do is we use like motivational interviewing and we have them try to figure it out on their own." Karen said that in the practitioner-client relationship, "It's absolutely the person who makes the decision," meaning the client. She explained "There's no way that any one person, no matter what their title, can do anything for a patient unless that patient is willing to try." Miranda said that it is important for practitioners to provide information and resources, but that practitioners have to make sure that "the client is interested in those resources, because if they're not ready or they're not willing, there's no sense in wasting the client or that other provider's time and resources."

Alongside a client-centered approach, interviewees described a sense of collaboration amongst stakeholders and communities at large as effective in recovery. In particular, I asked interviewees what role they saw law enforcement playing in recovery. In general, interviewees had a positive view on law enforcement, adding that more training and resources would be beneficial to improving the relationship between law enforcement and substance use. Leah worked closely with law enforcement in her position, particularly in a diversion program in the area where police officers are given the option to refer substance users to recovery agencies opposed to arrest as long as the individuals meet certain criteria. Leah said that law enforcement

alone is “certainly not” a pathway to recovery, but that it does not have to be a barrier. She said that this goes back to “the stigma associated with substance use and mental health” in that “We’re criminalizing substance users and people with mental health issues.” Lori said that the Penobscot County Jail is described by some members of law enforcement as the “biggest detox and mental health facility in the state” and that members of law enforcement are changing their mind on incarceration and drug use. In her own use, Miranda told me a story of her probation officer choosing to send her to rehab instead of arrest, and that she was “grateful that he was going to give [her] another chance.” She said that this choice saved her life. Karen said that “we’re at a point right now where law enforcement and the medical field and the recovery field absolutely have to hold hands, and educate each other and work together because what’s out there on the streets right now, not one single organization can fight it alone.” Connie expressed a need for more funding to go both into training officers in individuals with mental health and drug enforcement. In particular, she said that this funding should be directed at enforcement to drug dealers, using the example of dealers who cut heroin with fentanyl, which she described as “a lot more depraved” than simple supply and demand. Like Leah, Elizabeth felt that law enforcement in general is not a deterrent, but that “they give us a reality check because sometimes we forget about the children that are being affected or the older parents that are being robbed.” She followed this by saying that “collaborative approaches are better than just pointing the fingers.” Similarly, Craig said that “Law enforcement, substance abuse agencies, you know. Housing agencies, everyone…Be on the same page to try to help an addict who’s struggling to get better,” while Mark said “I still see a huge need for us to come together and build more alliances amongst ourselves.”

"Everyday a person stays clean, that to me is a success"

The interviewees defined both small and large successes. Smaller scale successes include getting an individual fed or sheltered for the night, which falls under the earlier described harm reduction model. Success is also defined as sobriety for any period of time. Large scale successes are often defined in stories of absolute transformation of individuals or policy-level change. For example, Doreen explained that her agencies "most effective accomplishments come at the policy level, the town level." She gave an example of her agency helping push a non-smoking policy at a local state fair, and that her agency participated in a panel and provided information about marijuana use which lead to a local town banning retail sales of marijuana. Miranda described a recent conference from her agency in which donors told her they "realized they had been putting funding in the wrong places, because they had not been asking people in recovery how to help people in recovery." However, success was more commonly defined on the small scale. Connie said that "sometimes just moving someone from under the bridge to an apartment is successful, and that's all we're gonna do, you know what I mean. And for that person that might be enough. Not everybody wants to recover." On harm reduction, Leah said that for an individual, getting food or sleep before they use meth would be a success, and that it is a matter of "redefining" what success means for people who use. Wren described their successes as going back to school and holding employment, adding "it's not so much what maybe an average person would picture as success…Keeping my appointments, you know, showing up on time, learning to set boundaries, you know, speaking up for myself, those are successes to me that were foreign you know, five years ago." Becca said her success was being at the shelter she was in during out interview, which she described as a "blessing." In addition, an instance of success for her was walking a man home who was drunk the night before our interview. In her work, Cassandra told

me that "Everyday a person stays clean, that to me is a success." She added "you know, a lot of people don't – they don't understand that. My clients don't understand that. Like, oh, you know, I got 8 days, you know. That's huge. You know, before that they couldn't stay clean for 8 minutes." No matter the type of success that was articulated, all interviewees were able to recall success either in their work or in their own recovery.

Dutta's agency

The above analysis addresses RQ3: *How do practitioners and those in recovery express agency?* I find that agency was expressed in multiple ways, including the client-centered approach and the ability to define success. This analysis can be extended by Dutta's (2008) description of the concept. Dutta (2008) defines agency as "the capacity of cultural members to enact their choices and participate actively in negotiating the structures within which they find themselves" (p. 7). A notable expression of agency is in the client-centered approach that is favored by the practitioners I spoke with. Practitioners believed that there should be a balance between provider and client in decision-making in recovery, but that it is ultimately the client's choice-making that directs their recovery process. The harm reduction model is folded into this mindset, where making small steps to reducing the harm someone is causing such as finding them temporary shelter or food is prioritized rather than immediate abstinence or "full" recovery. This can additionally be considered in Yamasaki's (2017) statement that not all social support is perceived as helpful. Harm reduction respects individual's ability to make choices and does not seek to force them into a one-size-fits all program. This speaks to Connie's statement that "Not everybody wants to recover" and that providers cannot make a plan work unless the individual is willing to first. It is important to note that interviewees implicitly described a complete or near complete loss of agency in their substance use or in their clients' use, which lead to widespread

loss in their lives. It seems that recovery marks the regaining of agency, which I described as a process of regaining connection. Here, I use the term recovery broadly to include the harm reduction model which may contradict traditional notions of what it means to be recovered. Although Connie stated that "Not everybody wants to recover," I took this to mean that not everybody has a complete, abstinence-based model of recovery in mind when they have a desire to change. For some individuals, small steps in reducing harm on a daily basis like finding food and shelter are a priority. The importance of regaining agency is acknowledged by practitioners – for example, Cassandra and Craig both described the technique of motivational interviewing where those early in recovery are spoken with in a way where they can come to their own conclusions about what choices they want to make rather than being told what to do and accepting information passively. The question of whether or not addiction is a choice or disease came up in a number of interviews. The general consensus is that addiction begins with a choice and progresses into an uncontrollable disease – an expression of a lack of agency on the individual's part. One interesting consideration here is Leah's choice of the term "relief-seeker" in describing individuals who use substances. Leah said that people who make the choice to use substances are often seeking some sort of relief in their lives. This raises the question of blame, which is related to agency – who can we blame for the state's current substance use problems? Leah's view seems to be one that is more structural – while individuals do have agency and make the choice to use substances, it is typically because their lives are in a state in which that choice makes sense to them in a need to seek relief. This relates to the broader idea of connection described by many interviewees, where those who use substances both lose all of their connections in use but may have never had strong connections in the first place, as described by Mark in his mention of Johann Hari's work on addiction. Similarly, in the question of

medication-assisted treatment (MAT) and abstinence, those who may have personally disagreed with MAT like Elizabeth and Paulette blamed how it is handled at a structural level rather than placing blame on individuals who utilize it. While an individual who is on MAT may be perceived as having less agency because they are continuing their dependence on a substance, it is questionable how much control these individuals have over their treatment plans, particularly in their decision to stop treatment which can be dangerous. Lastly, I find that agency was expressed in the many ways the interviewees described success. Despite the structural constraints on them, interviewees described success in many ways, from staying clean on an hourly basis to policy-level change. Interviewees said that their recovery communities were strong despite a lack of resources and held a strong sense of optimism about the possibility to recover, often based on their own experiences or in the experiences of individuals they had worked with.

Synthesizing the Culture-Centered Approach

In considering RQ4: *How does the interplay of these experiences of structure, culture and agency impact recovery in Maine?* I find that the relationship between agency and structure is explicit. As mentioned, interviewees described a major lack of resources and structural complications such as restrictive healthcare. However, interviewees were consistently able to describe instances of success. Practitioners described positive outlooks they had on their workplaces with anecdotes of success stories in their clients, while individuals in recovery described that the resources they were able to access and the connections they were able to make were all crucial in their recovery process. However, an impact on recovery can be seen in the fact that practitioners often have to work long hours, sometimes on a volunteer or pro-bono basis, and independent fundraising efforts often have to occur in order for agencies to continue. While practitioners and agencies try to make themselves available to the amount of need in the state,

waiting lists and client-to-practitioner ratios are a challenge to recovery. Dutta (2008) claims that structures gain meaning through the context of culture. Cultural meanings of recovery in this context serve as a backdrop to which the importance of structures are considered. For example, when Cassandra noted that people go to homeless shelters after they graduate from recovery programs, or when Karen described the sadness she feels when seeing abandoned buildings that could be used for housing lining the streets, the structure of shelter and housing becomes meaningful because it is considered a crucial component to recovery. Similarly, the structure of a waiting list becomes meaningful due to the fleeting desire for some in recovery to make change as described by Cassandra.

Furthermore, I see the interplay of these three components as a space where social change may be possible. Specifically, I see this through the practice of narrative and identity articulation which is described by Dutta (2008), Jodlowski et al. (2007) and Zufferey (2009). Dutta (2008) claims that "culture offers the substratum for structure, such that structures are both reified and challenged through the cultural meaning systems that are in circulation within the culture. It is through the articulation of new meanings that cultures create points of social change" (p. 8). Jodlowski et al. (2007) emphasize that narratives are a key ingredient in finding support from others, while Zufferey (2009) claims that individuals in active use use narratives to produce an image of themselves that reduces perceived harm. Because my interviewees described the structures that constrained and enabled them, awareness is increased to a certain extent to these structures and how they are impacted the cultural beliefs about recovery in my interviewees. In addition, Dutta (2008) states that agency is enacted through the lens of culture. The ability or agency for individuals to recover in the context described through my interviewees becomes more nuanced through the structures described and the beliefs about what recovery is and how it

differs for every individual. Dutta (2008) claims that the sharing of stories "open up the discursive space to alternative articulations of knowledge by bringing into question that which we know and the ways in which we know it through the struggles and challenges of the ill" and that "narratives are intrinsically connected to the culture as they are stories told by the members of the culture, drawing upon the repertoires of meaning available to cultural members" (p. 103). For example, the cultural meanings about recovery articulated by the interviewees including that recovery looks different for everyone, that is centers around connection, and that harm reduction rather than immediate abstinence is valued are likely alternative ways of understanding recovery and substance use than what is traditionally known. These meanings provide a different lens to consider the importance of structures that may further enable recovery, and how we consider the agency of individuals in their recovery processes.

A final consideration I want to bring attention to in my analysis is the idea of marginalization. Dutta (2008) claims that the CCA focuses on marginalized people who have limited access to healthcare and who are often targets of outside medical interventions that do not take the time to understand the culture, structures, and agency already present within these populations. Specifically, Dutta (2008) defines marginalization as "being at the periphery of a dominant system" which "implies a status of inaccess to the dominant healthcare system" (p. 150). Dutta (2008) adds that "Marginalization is embodied in the position of being under, or being silenced, of being without a voice and of being without resources" (p. 151). While this is a core component of Dutta's (2008) positionality, what constitutes as a marginalized person or population should be considered carefully. While some of my interviewees like Lori, Leah and Connie did use the word marginalized to describe the populations they work with, not every interviewee did. In a way, for someone outside of a culture or population to characterize them as

marginalized goes against the CCA, which focuses on the importance of narrative and self-definition. While it is important to acknowledge the many structural barriers that are present in this context, and while many of the stories of substance use I heard may be tied to conventional ways of considering marginalization, this label should not be used as a broad generalization.

Discussion

I asked each of the interviewees what they could see as a useful result or output of my work. I aim to use these responses to guide the discussion of my analysis, as they reflect potential future directions of this work and focus on what the interviewees saw as most important to them. Doreen, my first interviewee, hoped that this work would bring multiple perspectives from different practitioners in different areas together in order to make sense of what may be effective or not. Doreen noted "a sense of urgency" in her work and other's work that often prevents her and others from fully communicating with one another due to demanding schedules. She added "I think we don't talk enough. We don't meet enough because we're so busy, we don't have time for another meeting." Similarly, Mark said that he would like to "compare and contrast perspectives" while Connie said that she would like to see if any similarities exist in evidence-based treatment methods in order to see how effective they are to "convey to professionals what works and what doesn't work." Elizabeth hoped this work could help practitioners "expose" themselves for who they are through demonstrating different training methods and interactions they have with stakeholders. Elizabeth felt there should be research into what methods are working and what potential shortcomings may be that prevent "collaboration better amongst agencies." Wren hoped that this work could demonstrate "firsthand what our community actually lacks" and "how to best offer resources for people" which related to their interest in the tie between criminality and addiction.

Leah hoped that work like this could provide "any data or numbers or stories around how the services actually promote recovery and abstinence. I think that would be cool, huge. And kind of like an eye-opener for some people who don't believe that." Similarly, Miranda said that "if there's any way you can do any advocacy with what you're compiling to like show the importance and to get the fact out there that there are people recovering and doing miracles all over the place. To get it out there in a way that people can't deny that it's happening. I think that would be important." Cassandra also hoped this work could show that "recovery is possible." Karen said that she hoped people learn that addiction is "not something we choose. It is a disease. And it does take a community to recover, no one person can do this alone." Cassandra also emphasized the point that addiction is a disease, not a choice. Lori, Mark and Cassandra all touched on the hope that this work could reduce stigma or open up conversations that may reduce stigma, while Paulette and Craig said that a better understanding of substance and use and recovery across multiple stakeholders could be beneficial for promoting a collaborative approach. Paulette said "I would love to have the – like the first responders. The nurses, the doctors, the people who care for the addicts and the addicts and alcoholics. The legislature. The politicians. To hopefully get an understanding of this." Craig said that "If everyone could be on the same page, I think we could help a lot of people." Becca noted the importance of emphasizing mental health in conversations about substance use, telling me "I want to say that there are true addictions out there. There really are. But, there's also a whole bunch of other – there's a huge scope of non-drug related, life-altering things out there in the mental health spectrum. There's depression, anxiety, and all this other stuff that you get when you're in recovery because you don't have that substance anymore to help you know you have those things. It's your sense of happiness, is when you're high."

What I find interesting about my interviewees' responses to this question about my research is that any sort of action-oriented results or directions, such as bringing together stakeholders or collaboration amongst agencies, is preceded by a greater understanding of recovery and substance use. The interviewees desired for a reduction in stigma and an understanding that recovery is possible and that it does happen, along with other complex factors like the mental health piece noted by Becca. In addition, interviewees stressed the point that while addiction begins with a choice, it turns into a disease that is uncontrollable. I find this interesting because this focus on understanding and meaning is inherent to the CCA. By privileging the voices of those most involved in a health issue, the CCA recognizes the meaning-making of these individuals as valid and worthy of attention to future health interventions or planning.

Study limitations

There are notable limitations in this work. Firstly, only a small number (13) of interviewees participated, leaving out many potential voices in the area and the state as a whole. The geographic spread of interviews was also limited – most interviews took place in the Bangor and Brewer area, with one in the Ellsworth area and one phone interview from Presque Isle. A study with more interviewees and a better geographical spread would be beneficial in gaining a deeper understanding of substance use and recovery in the state as a whole. The interviewees were racially homogenous – all identifying as white with one interviewee identifying as half white, half Native American. In addition, all but three interviewees identified as female. A more diverse population of interviewees would be beneficial in hearing multiple perspectives about substance use and recovery. Despite these limitations, the meaning-making that emerged from the interviewees was rich. As Dutta (2008) states, "narratives are intrinsically connected to the

culture as they are stories told by the members of the culture, drawing upon the repertoires of meaning available to cultural members" (p. 103). These repertoires are apparent in the interviewees' articulations of their experiences with substance use and recovery, especially in how they are tied to their core beliefs of what recovery is and what helps it occur. It is through these meanings that a better understanding of substance use and recovery emerges, which may help to better inform approaches to this issue in the future.

CHAPTER 5

CONCLUSION

The aim of this project was to gain a better understanding of what substance use and recovery means to individuals in Maine who are deeply affected by the phenomenon. Additionally, I wanted to gain an understanding of the structures in Maine that may constrain or enable recovery, and how those negotiating such structures express agency. My initial curiosity for this project stemmed from a general awareness of the opioid crisis in Maine and nationally, which also informed how I approached my literature review and the formulation of my interview protocols. This project begins to reveal meanings through the conversations I had with 13 individuals who shared deeply personal stories about their life and work experiences. Through these stories, I identified three major categorical themes: meanings of recovery, barriers to recovery, and strategies in recovery. These three themes align with Dutta's (2008) three main tenets of the CCA: culture, structure and agency respectively. I learned that there are many pathways to recovery, which is a concept in itself that is different for everyone but often involves some sort of change. However, I learned that when we talk about recovery, it can not be narrowly focused on just one substance or behavior, but a complex network of factors that lead to an increased rate of use. I learned that substance use and recovery may primarily be an issue of connection, which is lost in use and gained in recovery. Surrounding all of these ideas is spirituality, which the interviewees consistently defined as central to the recovery process. These ideas opened a window into the cultural beliefs and practices of the individuals I spoke to.

Through identifying meanings about substance use and recovery, the interviewees identified barriers in the State of Maine. These barriers are the result of a combination of stigma and a lack of resources in the state, including restrictive healthcare, a lack of funding and a lack

of housing. However, through these barriers, the interviewees described several strategies and a general sense of hope and optimism about the ability to recover. Those who work in the fields of mental health and recovery are often motivated by their personal experiences and need to help others. I learned that a client-centered approach may be best in recovery, where clients are given agency in making decisions about their recovery process and their end goals. In addition, interviewees described a need for collaboration from multiple stakeholders in addressing the issue. Lastly, interviewees were able to define success in multiple ways, despite the numerous challenges the state of Maine presents.

In considering the utility of this work, I asked all interviewees what they saw as potential benefits or results of my research. They hoped that this work, and future developments of work like this, could provide a better understanding of substance use and recovery as a whole, and to demonstrate that recovery is possible and that there are multiple instances of success. The interviewees hoped for a reduction in stigma and better collaboration amongst agencies who may be able to compare and contrast the opinions and strategies of others they may not be exposed to otherwise. While this work is limited in the sense that I engaged a relatively small number of interviewees in one area of the state, the hope is that the richness of meanings and experiences these interviewees shared may open the door for more developed work. This work provides a broad survey of multiple topics and themes regarding substance use and recovery – all of which could be developed on further in their own right. Important to note is that the aim of this project was not to "theory test" but rather use the CCA as a framework to organize ideas about health in a context that is challenging in many ways. These ideas may contribute to existing conversations about substance use and recovery, with particular importance considering they are coming from people whose lives are deeply enmeshed with the issue at hand.

In reflecting on the event I attended on July 18, 2018, I think about the numerous conversations I was not able to hear at the round tables. I wonder what decisions, arguments, and exchanges of ideas occurred at these tables that lead the multiple people at the event to place stickers on posters and rank strategies for best approaching substance use in Maine. My hope is that the interviewees who participated in this work may shed light on substance use and recovery beyond stickers on posters that were used as a backdrop to political campaign speeches. As Dutta (2008) states, "It is through the articulation of new meanings that cultures create points of social change" (p. 8). It is my hope that this project may open up space for this to occur.

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APPENDIX A: IRB APPROVAL COVER PAGE

APPLICATION FOR APPROVAL OF RESEARCH WITH HUMAN SUBJECTS
Protection of Human Subjects Review Board, 400 Corbett Hall

PRINCIPAL INVESTIGATOR: Carter Hathaway — **EMAIL:** carter.hathaway@maine.edu
CO-INVESTIGATOR: Keely Gonyea — **EMAIL:** keely.gonyea@maine.edu
FACULTY SPONSOR: Bridie McGreavy — **EMAIL:** bridie.mcgreavy@maine.edu
(Required if PI is a student):
TITLE OF PROJECT: Communicating Recovery in Opioid Addiction
START DATE: ~~June 2018~~ 7/5/2018 **PI DEPARTMENT:** Communication and Journalism
FUNDING AGENCY (if any): Diana Davis Spencer Partnership for a Sustainable Maine

STATUS OF PI: Graduate student

1. **If PI is a student, is this research to be performed:**

☐	for an honors thesis/senior thesis/capstone?	X	for a master's thesis?
☐	for a doctoral dissertation?	☐	for a course project?
☐	other (specify)		

2. **Does this application modify a previously approved project? N**
If yes, please give assigned number (if known) of previously approved project:

3. **Is an expedited review requested? Y**

Submitting the application indicates the principal investigator's agreement to abide by the responsibilities outlined in Section I.E. of the Policies and Procedures for the Protection of Human Subjects.

Faculty Sponsors are responsible for oversight of research conducted by their students. The Faculty Sponsor ensures that he/she has read the application and that the conduct of such research will be in accordance with the University of Maine's Policies and Procedures for the Protection of Human Subjects of Research. REMINDER: if the principal investigator is an undergraduate student, the Faculty Sponsor MUST submit the application to the IRB.

Email this cover page and complete application to UMRIC@maine.edu

****

FOR IRB USE ONLY **Application # 2018-06-02** **Review (F/E): F Expedited Category:**
ACTION TAKEN:

☐ **Judged Exempt; category** **Modifications required?** **Accepted (date)**
☐ **Approved as submitted. Date of next review: by** **Degree of Risk:**
X☐ **Approved pending modifications. Date of next review: by 6/19/2019 Degree of Risk: Minimal**
Modifications accepted (date): 7/5/2018
☐ **Not approved (see attached statement)**
☐ **Judged not research with human subjects**

FINAL APPROVAL TO BEGIN **7/5/2018**
Date

01/2017

APPENDIX B: INTERVIEW PROTOCOL FOR PRACTITIONERS

Practitioner questions

What does recovery mean to you?

What motivates you to work with people in recovery?

What do you think motivates people who want to recover?

What does a "recovered" life look like?

Does recovery end? If no, does it change over time?

Have you personally dealt with substance use and recovery?

What is something you would like the general public to know about recovery?

What professional experience have you had prior to this position?

What do you do on a day-to-day basis?

Do you see your program as different than other initiatives in the state? If so, how? If no, why not?

What are some challenges that you find yourself facing in this position?

Have you had any specific experiences you would describe as successful? What happened?

How does a feeling of independence in clients play a role in recovery, and how do people working in recovery negotiate different levels of support?

What do you think are some common perceptions of your work, and the people you work with?

How does your actual work experience compare to people's perceptions of it?

What is the role of law enforcement in recovery?

What role, if any, does spirituality play for people in recovery?

What is the role of housing in recovery?

How is substance use disorder treatment funded?

Do you see a tension between practitioners who follow AA or abstinence models, versus practitioners who follow medicates assisted treatment approaches?

What is it like to work in (area) of Maine?

What are some of your core beliefs or commitments that you bring to your work?

In the area that you work in, how would you characterize community? What does community mean to you and others?

What role does gender identity play in recovery, if any?

What are the personal and professional backgrounds of your clients?

What would be useful for you from research that is interested in drug addiction recovery? In other words, since my research is broad, what would be an output of my work you would find valuable?

Are there any other questions I should be asking?

Demographic information

How old are you?

What is your race?

What is your gender identity?

What is the highest level of education have you completed?

Are you currently covered by health insurance?

APPENDIX C: INTERVIEW PROTOCOL FOR INDIVIDUALS IN RECOVERY

We are interested in learning more about your experiences with substance use and recovery. We'll start with some questions about substance use and then ask about your recovery process.

Individuals in recovery questions

Do you struggle with substance use? If so, what substances have you used in the past?

How did you come to use these substances?

Would you say that you have a substance use disorder? Why or why not?

Would you say you are in recovery now? Why or why not?

Do you use the term addiction to describe your experiences with substance use? Why or why not?

What has your recovery process been like? Can you walk us through this journey?

What are key ingredients to the recovery process?

What does recovery mean to you?

What motivates you to recover?

What does a "recovered" life look like?

Does recovery end? If no, does it change over time?

What role, if any, does spirituality play for you or others in recovery?

What is something you would like recovery workers to know about recover that they might not know already?

What is something you would like the general public to know about recovery?

What experiences have you had with recovery workers or recovery programs?

What is most helpful in your interactions with recovery workers or in recovery programs?

What is not helpful in your interactions with recovery workers or in recovery programs?

What are primary challenges you face in your recovery?

Do you feel you have control over the level of support you receive?

Have you had any specific experiences you would describe as successful? What happened?

What is the role of housing in recovery?

What do you think are some common perceptions of people in recovery, or who use substances in general? How do your experiences compare to these perceptions?

Do you see a tension between practitioners who follow AA or abstinence models, versus practitioners who follow medication assisted treatment approaches?

What is it like to live in (area of Maine)?

Did you grow up in (area of Maine)? What was it like?

What role does gender identity/sexuality play in recovery, if any?

Do you have any beliefs or values that were instilled in your upbringing that you think about in your recovery?

What is your sense of community in your area?

What would be useful for you from research that is interested in communication of drug addiction recovery? In other words, since my research is broad, what would be an output of my work you would find valuable?

Are there any other questions I should be asking?

Demographic

How old are you?

What is your race?

What is your gender identity?

What is the highest level of education you have completed?

Are you currently covered by health insurance?

APPENDIX D: INFORMED CONSENT FOR PRACTITIONERS

Project Title: Communication of recovery with substance use disorders and opiates.

You are invited to participate in a research project being conducted by Carter Hathaway, a Masters student, and Dr. Bridie McGreavy, faculty advisor, in the Department of Communication and Journalism at the University of Maine. The purpose of this research is to understand what recovery from substance use means for both individuals working in recovery-focused organizations and individuals who identify as being in recovery themselves. We appreciate you taking the time to share your perspectives with us. You must be at least 18 years of age to participate in this research.

What Will You Be Asked to Do?
You will be asked to participate in an interview that will ask you about your experiences working with substance use counseling and recovery, and especially opioid use recovery. If you decide to participate, you will be asked questions including "What does recovery mean to you?" "What are some challenges that you find yourself facing in this position?" and "What motivates you to work with people in recovery?"

You will also be asked basic demographic information including your age, race, gender, and whether or not you have healthcare.

If given permission, I will audiotape the interview and the interview will be transcribed to text. Your name will not be used and the interview will remain anonymous. The interview will last anywhere from 30 minutes to 2 hours, depending on what topics you would like to cover.

Risks
Except for your time and inconvenience, there are no risks to you from participating in this study.

Benefits
Although the project may not benefit you directly, the research hopes to reveal new insights to individuals who consider recovery to be a part of their lives. These insights may provide more understanding substance use in Maine.

Confidentiality
Care will be taken to protect the confidentiality of the interview. Your name will not be gathered and the interview data will remain anonymous and will be labeled by group membership (practitioner, individual in recovery, practitioner in recovery) rather than name. Transcription of interviews will be done primarily by me, and the aid of the transcription service Verbal Ink may be used. Interview transcripts will be kept on my password-protected personal laptop, and only shared to other members on the research team on a computer in a locked office at the University of Maine. Hard copies will be kept in my locked office. After the thesis is complete, transcripts and hard copies will be kept indefinitely with me, and data shared with other team members will be deleted off of the computer in the locked office before December 2019.

Voluntary
Your participation is completely voluntary and you are free to withdraw at any point. For any other reason, you are always free to stop the interview or not answer the question.

Contact Information
If you have any questions about this study, please contact Carter Hathaway at 207-713-7217 or carter.hathaway@maine.edu or Bridie McGreavy, bridie.mcgreavy@maine.edu If you have any questions about your rights as a research participant, please contact the Office of Research Compliance, University of Maine, 207/581-1498 or 207/581-2657 (or e-mail umric@maine.edu).

APPENDIX E: INFORMED CONSENT FOR INDIVIDUALS IN RECOVERY

Project Title: Communication of recovery in substance use disorders and opiates

You are invited to participate in a research project being conducted by Carter Hathaway, a Masters student, and Dr. Bridie McGreavy, faculty advisor, in the Department of Communication and Journalism at the University of Maine. The purpose of this research is to understand what recovery associated with substance use disorders means in recovery-focused organizations and individuals who identify as being in recovery themselves. We appreciate you taking the time to share your perspectives with us. You must be at least 18 years of age to participate in this research.

What Will You Be Asked to Do?
You will be asked to participate in an interview that will ask you about your experiences with opioid use recovery. If you decide to participate, you will be asked questions including "Do you identify as being in recovery?" "What experiences have you had with recovery workers or recovery programs?", "What does recovery mean for you?" and "What are your sources of support in the context of recovery?"

You will also be asked basic demographic information including your age, race, gender, and whether or not you have healthcare.

If given permission, I will audiotape the interview and the interview will be transcribed to text. Your name will not be used and the interview will remain anonymous. The interview will last anywhere from 30 minutes to 2 hours, depending on what topics you would like to cover.

Risks
Beyond your time and inconvenience, you may feel uncomfortable answering certain questions about your recovery. You will be provided a handout of resources available to you.

Benefits
Although the project may not benefit you directly, the research hopes to reveal insights to individuals who consider recovery to be a part of their lives. These insights may provide more understanding substance use in Maine.

Confidentiality
Care will be taken to protect the confidentiality of the interview. Your name will not be gathered and the interview data will remain anonymous and will be labeled by group membership (practitioner, individual in recovery, practitioner in recovery) rather than name. Transcription of interviews will be done primarily by me, and the aid of the transcription service Verbal Ink may be used. Interview transcripts will be kept on my password-protected personal laptop, and only shared to other members on the research team on a computer in a locked office at the University of Maine. Hard copies will be kept in my locked office. After the thesis is complete, transcripts and hard copies will be kept indefinitely with me, and data shared with other team members will be deleted off of the computer in the locked office before December 2019.

Voluntary
Your participation is completely voluntary and you are free to withdraw at any point. For any other reason, you are always free to stop the interview or not answer the question.

Contact Information
If you have any questions about this study, please contact Carter Hathaway at 207-713-7217 or carter.hathaway@maine.edu or Bridie McGreavy, bridie.mcgreavy@maine.edu If you have any questions about your rights as a research participant, please contact the Office of Research Compliance, University of Maine, 207/581-1498 or 207/581-2657 (or e-mail umric@maine.edu).

APPENDIX F: EMAIL/PHONE SCRIPT TO RECRUIT PRACTITIONERS

Hello:

My name is Carter Hathaway. I am a graduate student from the University of Maine. I am working on my Masters thesis in the Department of Communication and Journalism with my faculty advisor, Dr. Bridie McGreavy. We are interested in learning more about what recovery from opioids means for practitioners and individuals who identify as in-recovery.

I found your name and contact information _____ (state where I got the informants name, phone, or email).
I would like to ask you a few questions about your experience as an individual working in recovery.

Would you be willing to participate in an interview, which would take about 30 minutes to 2 hours of your time, but most likely not more than 1 hour? And with your permission, we would like to audio record the interview.

If yes,
Would you prefer to meet in person or answer questions over the telephone?
Phone: When (day and time) would be most convenient for you?
Person: When (day and time) and where would be most convenient for you?

Before we begin the interview, we will describe our project to you in more detail and explain your rights as a research participant. For now, you should know that any information you provide
will be kept in strict confidence and your participation is completely voluntary. You can withdraw from the interview at any point and you are always free to not answer any question.

If no, thank you for your time and have a nice day.

APPENDIX G: EMAIL/PHONE SCRIPT RESPONSE TO INDIVIDUALS FROM FLYER

Hello:
Thank you for your interest in my project and contacting me. My name is Carter Hathaway. I am a graduate student from the University of Maine. I am working on my Masters thesis in the Department of Communication and Journalism with my faculty advisor, Dr. Bridie McGreavy. We are interested in learning more about what recovery from opioids means for practitioners and individuals who identify as in-recovery.

I would like to ask you some questions about your experience with recovery from substance use, particularly with opioids if they apply to you.

Would you be willing to participate in an interview, which would take about 30 minutes to 2 hours of your time, but most likely not more than 1 hour? And with your permission, we would like to audio record the interview.

If yes,

Would you prefer to meet in person or answer questions over the telephone?
Phone: When (day and time) would be most convenient for you?
Person: When (day and time) and where would be most convenient for you?

Before we begin the interview, we will describe our project to you in more detail and explain your rights as a research participant. For now, you should know that any information you provide
will be kept in strict confidence and your participation is completely voluntary. You can withdraw from the interview at any point and you are always free to not answer any question.

If no, thank you for your time and have a nice day.

BIOGRAPHY OF THE AUTHOR

Carter Hathaway was born in Lewiston, Maine on May 10, 1995. He was raised in Turner, Maine and graduated from Leavitt Area High School in 2013. He attended the University of Maine and graduated in 2017 with a Bachelor's degree in Journalism. He continued directly to pursue his Master's degree in Communication at the University of Maine in the fall of 2017. After receiving his degree, he will be starting the next chapter of his life with his fiancé who is serving in the U.S. Army. He is a candidate for the Master of Arts degree in Communication from the University of Maine in May 2019.