The ambiguous role of contextual dynamics in drug addiction recovery: A qualitative study of personal narratives

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Abstract

The concept of recovery has emerged as a prominent paradigm to understand processes of change in individuals with substance use problems. So far, most studies have focused on personal recovery as the key driving force of recovery journeys, generally individualizing the often disabling social realities persons in recovery face. To counterbalance this bias, this paper focuses on the contextual dynamics at stake during recovery processes, based on the lived experiences of thirty persons in drug addiction recovery in Flanders (Belgium). A Lifeline Interview Method was applied to elicit recovery narratives, which were thematically analysed. We found that interpersonal relationships, enabling and disabling places, and socio-economic factors facilitate or impede recovery in meaningful ways. The findings also show how these diverse contextual dimensions are interrelated and ambiguous. Researchers, policymakers, and treatment providers should acknowledge the relational nature of recovery and the invalidating impact of stigma across the three identified contextual levels.

1. Introduction

The majority of persons who use drugs consume these substances for their pleasant effects in a generally non-problematic manner (Moore, 2008; Schlag, 2020). Approximately 36.3 million persons worldwide are estimated to experience drug use problems, which is around 13% of all past-year drug users (United Nations, 2021). Although addiction is a contested concept, it is generally recognized as a complex, multifactorial health problem that impacts individuals' lives in multiple domains, such as physical and mental health, social relationships, finances, and quality of life (Best et al., 2020; Rudolf & Watts, 2002; UNGASS, 2016). Despite its assumed chronic nature (McLellan et al., 2000), several authors have identified substantial remission rates among persons with substance use problems. It is estimated that more than half of all individuals who had a substance use problem will achieve stable recovery (Kelly et al., 2017; Peele, 2004; Sheedy & Whitter, 2013; White, 2012). The concept of 'recovery' has emerged during the past decades as a paradigm to understand processes of change regarding individuals' substance use problems (Braslow, 2013; Laudet & White, 2010).

The adoption of the notion of recovery has driven a shift from a pathology- or disorder-oriented approach towards a person-centred, strengths-based, and wellbeing-oriented approach (Slade, 2010; White, 2007). This paradigm shift is illustrated by the distinction between 'clinical recovery' and 'personal recovery'. Addiction recovery has traditionally been conceptualized as clinical recovery or the absence of symptoms, viewing recovery as a dichotomous state instead of a process. The notion of personal recovery emerged from service users' narratives and lived experiences, underscoring the importance of personal growth, autonomy, and empowerment (Slade et al., 2008). A growing body of literature recognizes that addiction recovery is broader than just abstinence and includes changes in various life domains, such as (mental) health, legal issues, social and economic functioning, and wellbeing (Laudet, 2007; Martinelli et al., 2020; White, 2007).

The addiction recovery paradigm integrates elements from the mental health and the addiction fields that share parallels in history, grassroots advocacy movements, and treatment challenges. Both types of recovery closely connect by recognizing the importance of service user experiences and family and peer support. Other similarities refer to growing awareness about the limitations and inadequacies of biomedically-oriented treatment systems in supporting stable recovery, articulating the need for a shared paradigm shift (Davidson & White, 2007; El-Guebaly, 2012; Gagne et al., 2007). The concept of recovery introduced a move towards supporting service users as full human beings in regaining control over their lives, reclaiming and (re)constructing positive identities, actively participating in society, and

stimulating personal growth, through embracing persons' strengths (Braslow, 2013; Davidson & Roe, 2007; Deegan, 1996; Harper & Speed, 2012; Timander et al., 2015).

Since the emergence of this broader conceptualization, research into addiction recovery processes has strongly focused on personal recovery as the key driving force (Harper & Speed, 2012; van der Stel, 2012; Vandekinderen et al., 2012). Personal recovery refers to a non-linear and idiosyncratic experience in which individuals try to improve issues in various life domains and give meaning to this experience (Dekkers, De Ruysscher, et al., 2020; Neale et al., 2015; White, 2007). This can be supported through various recovery pathways, including mutual aid groups, outpatient and residential treatment, or take place without the support of addiction services (Hser & Anglin, 2010; Kelly et al., 2017; Martinelli et al., 2020). The CHIME framework has been developed by Leamy et al. (2011) to conceptualize elements that constitute personal recovery through five interwoven, and internally experienced, processes: Connectedness, Hope and optimism about the future, a positive sense of Identity, Meaning in life, and Empowerment. Although this framework was initially developed based on mental health research, it is found to also apply to addiction recovery processes (Best, Irving, Collinson, et al., 2017; Dekkers, Vos, et al., 2020).

Though the focus on personal recovery has led to insights into the subjective and multidimensional character of recovery processes and lived experiences (Bjornestad et al., 2019; El-Guebaly, 2012; Laudet & White, 2010), it has been criticized for its unilateral focus on individual aspects of recovery, disregarding the, often disabling, social and structural contexts (e.g. material deprivation, social exclusion) surrounding recovery processes (Mellor et al., 2020; Timander et al., 2015). Several scholars have criticized how such a lens is too narrow because it only focuses on the individual's responsibility to change, echoing neoliberal ways of thinking that transfer responsibility to individual citizens (e.g. Fomiatti et al., 2019; Harper & Speed, 2012; Price-Robertson et al., 2017; Rose, 2014; Vandekinderen et al., 2014). This entails the risk of individualizing and underexposing the everyday social realities that influence individuals' recovery trajectories (Hopper, 2007; Neale et al., 2014).

Although some researchers stress the social and relational nature of recovery, these aspects of recovery processes have long been overlooked in mental health and addiction recovery research (Adams, 2016; Bathish et al., 2017; Mellor et al., 2020; Pilgrim, 2008; Price-Robertson et al., 2017; Topor et al., 2011). If we do not uncover the contextual dynamics at stake in recovery processes, we are at risk of perceiving recovery as a mere *"function of a given individual's effort or will to recover"* (Duff, 2016, p. 62). To counterbalance this bias, this paper focuses on the complex dynamics between persons in recovery and their environments. By doing so, we aim to address a gap in the primarily individualized understanding

of recovery processes. We focus on qualitative first-person accounts of drug addiction recovery and on how contextual factors play an indispensable role in this process. By applying a 'contextual lens' to the personal recovery narratives of persons who use(d) drugs, this study draws attention to the social and structural dimensions of recovery in prevention and treatment services.

2. Methods

2.1. Setting and participants

The current study is part of the international Recovery Pathways (REC-PATH) project aimed at mapping and assessing pathways to addiction recovery from illicit drugs. A detailed description of this mixed-methods study between research teams in Flanders (Belgium), the Netherlands, and the United Kingdom can be found in the protocol paper (see Best et al., 2018). Through treatment and mutual aid organizations, printed flyers, and social media advertisements, a convenience sample of adults who considered themselves to be in recovery from illicit drug use problems was recruited in each country. After providing informed consent, participants first filled in the online 'Life in Recovery' survey (see Best et al., 2021; Martinelli et al., 2020). A subsample of eligible respondents was invited to take part in the quantitative and qualitative study components.

For the current qualitative study, a purposive sampling technique was used to recruit a heterogeneous sample of thirty persons in self-defined drug addiction recovery from the total Flemish REC-PATH cohort who engaged in multiple questionnaires before. The sample was diversified according to gender, age, problem substance(s), self-attributed recovery stage (Betty Ford Institute Consensus Panel, 2007), and lifetime use of addiction treatment and/or mutual aid support. Respondent characteristics are displayed in Table 1, based on the initial screening data.

Table 1. Characteristics of respondents in drug addiction recovery participating in qualitative interviews in Flanders (*n*=30)

Alias	Gender	Age	Problem substance(s)	Recovery stage	Addiction support mechanism(s)
An	Woman	29	Alcohol, cocaine, amphetamine and GHB	<1 year	Outpatient and residential treatment
Andreas	Man	28	Alcohol, heroin, cocaine and amphetamine	<1 year	Residential treatment
Donna	Woman	25	Cocaine and amphetamine	<1 year	No addiction treatment or mutual aid support

Febe	Woman	30	Alcohol, (crack) cocaine, amphetamine and ecstasy	<1 year	Residential treatment
Lucas	Man	35	Alcohol and amphetamine	<1 year	Mutual aid support, outpatient and residential treatment
Marc	Man	33	Cocaine, amphetamine, ecstasy and cannabis	<1 year	Mutual aid support
Monique	Woman	23	Cocaine, ecstasy and cannabis	<1 year	No addiction treatment or mutual aid support
Raf	Man	29	Alcohol and amphetamine	<1 year	Mutual aid support, outpatient and residential treatment
Sebastiaan	Man	40	Alcohol and (crack) cocaine	<1 year	Mutual aid support, outpatient and residential treatment
Tuur	Man	36	Alcohol, (crack) cocaine and ecstasy	<1 year	Outpatient and residential treatment
Abel	Man	39	Crack cocaine, amphetamine and cannabis	1-5 years	Outpatient and residential treatment
Aimee	Woman	29	Alcohol and amphetamine	1-5 years	Outpatient and residential treatment
Cato	Woman	34	Cocaine, amphetamine, ecstasy and cannabis	1-5 years	Mutual aid support, outpatient and residential treatment
Christine	Woman	51	Alcohol and heroin	1-5 years	Outpatient treatment
David	Man	45	Alcohol, cocaine and amphetamine	1-5 years	Outpatient and residential treatment
Elsa	Woman	31	Cocaine and cannabis	1-5 years	Residential treatment
Lieve	Woman	54	Alcohol, cocaine, amphetamine, ecstasy and cannabis	1-5 years	Outpatient and residential treatment
Maarten	Man	28	(Crack) cocaine, amphetamine and ecstasy	1-5 years	Outpatient and residential treatment
Nick	Man	34	Alcohol, cocaine, amphetamine, ecstasy and cannabis	1-5 years	Outpatient and residential treatment
Nikita	Woman	29	Alcohol, (crack) cocaine, amphetamine, ecstasy and cannabis	1-5 years	Mutual aid support
Alice	Woman	41	Heroin and cocaine	>5 years	Outpatient and residential treatment

Eduard	Man	41	Alcohol, heroin, cocaine, ecstasy and cannabis	>5 years	Mutual aid support, outpatient and residential treatment
Herman	Man	36	Alcohol, cocaine, amphetamine, ecstasy and cannabis	>5 years	Outpatient and residential treatment
Joshua	Man	41	Alcohol, cocaine, amphetamine, ecstasy and cannabis	>5 years	Outpatient and residential treatment
Julia	Woman	31	Alcohol, heroin, (crack) cocaine and cannabis	>5 years	Mutual aid support and outpatient treatment
Louis	Man	54	Heroin, cocaine, amphetamine and cannabis	>5 years	Residential treatment
Nicole	Woman	45	(Crack) cocaine, amphetamine, ecstasy and cannabis	>5 years	Outpatient and residential treatment
Patrick	Man	42	Alcohol, cocaine, amphetamine, ecstasy and cannabis	>5 years	Outpatient and residential treatment
Rita	Woman	30	Cocaine, amphetamine, ecstasy and cannabis	>5 years	Residential treatment
Tess	Woman	42	Alcohol, heroin, (crack) cocaine, amphetamine and cannabis	>5 years	Mutual aid support

2.2. Study procedure and ethics

We applied a Lifeline Interview Method (LIM) for interviewing study participants, allowing a retrospective lens to elicit autobiographical data of personal addiction recovery stories (Berends, 2011; Schroots & Assink, 2005). The in-depth interviews aimed to engage with the lived experiences of persons in recovery concerning important moments of change relating to their drug use problems. The interviewer focused on the social realities that shaped respondents' recovery processes by directing probing questions at understanding underlying dynamics with treatment services, social networks, communities, and wider society. We designed and piloted a semi-structured interview schedule with open-ended questions. The opening question 'If you look back from the moment when drug use took over your life to where we are today, what have been important difficult or positive periods of change?' prompted respondents to share several meaningful moments about change(s) related to addiction problems, which were mapped on a timeline. Respondents were invited to talk about what happened during that time and which persons and dynamics were involved. The use of a timeline (drawn out on paper) helped to organize individuals' experiences chronologically and to contextualize these, while

respondents were giving meaning to and connecting the relationships between separate key events they recalled. Applying the LIM proved useful in engaging respondents in constructing their recovery stories and guiding the conversation (Adriansen, 2012; Assink & Schroots, 2010).

The first author conducted the interviews between July and December 2019, which mainly took place face-to-face at participants' homes but also in treatment settings or public places, depending on respondents' preference. The study was conducted according to the guidelines of the Ethical Committee of the Faculty of Psychology and Educational Sciences at Ghent University and approved by this commission (EC decision: 2018/80). Oral and written informed consent was obtained, after explaining the study design based on a detailed description of the objectives and procedure. The duration of the interviews ranged from 50 to 143 minutes, with an average duration of 96 minutes. Respondents received a 20 Euro supermarket voucher as an incentive for study participation after completing the interview. Participants were given an alias for illustrating the results in this paper.

2.3. Data analysis

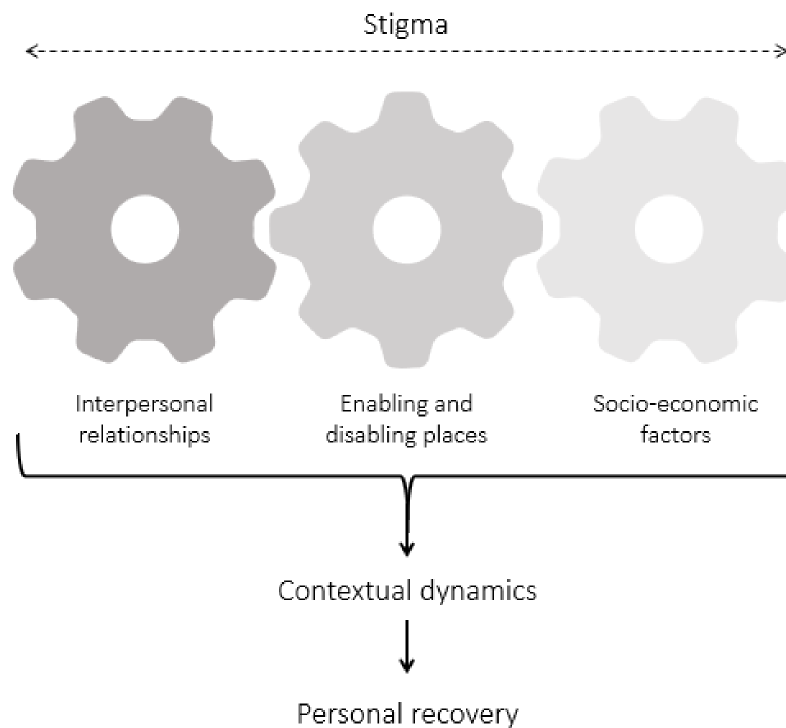
After transcribing the interviews, the first author read the transcripts while listening to the original audio recordings for accuracy, pseudonymization of personal data, and data familiarization. A thematic analysis approach (Braun & Clarke, 2006) was adopted to analyse the data regarding contextual elements in personal recovery stories, by organizing and describing the data as well as interpreting the identified data patterns. The first author read each transcript multiple times, wrote down first impressions, and identified (dynamics between) themes using an inductive approach. Attention was paid to the complex interplay of social and structural elements that can support or hinder personal recovery processes, including aspects of housing, employment and other meaningful activities, family, and community (re)integration. Individual mind maps for each interview were handwritten and combined to organize the data and to generate overarching patterns of meaning across all interviews, resulting in an initial thematic framework. To enhance the validity of the findings, the first author selected five key interviews, which were independently analysed and discussed with the second author through an iterative process of theme development. This resulted in a comprehensive thematic framework that was reviewed by all co-authors.

3. Results

By focusing on contextual factors influencing recovery processes as described by respondents, we identified three main themes relating to: (1) interpersonal relationships, (2) enabling and disabling places, and (3) socio-economic factors. Interpersonal relationships were addressed by all respondents

as important supportive (or inhibiting) elements of change, whereas socio-economic factors were mentioned less. In the results, we illustrate the interrelatedness and ambiguous role of these diverse contextual dimensions of individual recovery processes (see Figure 1).

Figure 1. Visualization of the research findings: the interrelatedness of contextual dimensions of addiction recovery processes



3.1. The ebbs and flows in interpersonal relationships

Respondents generally described the role of significant others coming and going during their addiction recovery process. A common experience was loss linked to the death of a close relative (e.g. parent, partner) or relationship breakups. Loss frequently led to (re)lapse as the sudden absence of others caused intense feelings such as pain, sadness, and insecurity, impeding their motivation and coping mechanisms to manage drug use problems. On the other hand, for a few participants, the death of a relative or acquaintance acted as a catalyst for positive changes towards recovery through a confrontation with the finiteness of life, installing an urge to live a fulfilling life and, consequently, the need to cope with their drug use problems. In the case of losing a partner through breaking up, most respondents found that they experienced a setback in their recovery process, manifested by increased drug use and a reduction in general wellbeing. However, when their partner used drugs, breakups were viewed positively over the long term, especially by women in abusive relationships.

Participants often reported how dating someone who did not use drugs supported their recovery process, by spending more time and energy on the relationship instead of on drug use out of respect for their partner. Such a relationship also enhanced feelings of wellbeing, provided meaning in life, and elicited positive feelings of being loved. For Cato (34, 1-5 years in recovery), being with her romantic partner meant having access to a non-drug using social network, which supported her recovery process by not being constantly confronted with drug use triggers. A relationship with a partner who used drugs could make it challenging to quit using. As Alice (41, >5 years in recovery) explained: *"If you want to stop but the other one continues… You can say no two or three times, but you can't keep saying no"*. Her partner did not help her reduce her drug use, but at the same time, did offer her a sense of belonging and companionship.

Nick (34, 1-5 years in recovery) illustrated how (dis)continuity of social relationships can impact the addiction recovery process:

> *It was a combination of my father's death and the fact that I spent a short time with someone I'd always loved and that went badly within a week, and that was fatal. (…) I lived with my father. My father was my best friend, I couldn't have had any better. I could tell and ask him anything*.

Nick referred to the importance of support from his father, explaining the negative impact of his father's loss on his life in general and that he now lost this support for his recovery process in particular. All respondents equally addressed how support from their close social network positively assisted their recovery trajectories. Social support was generally described in the form of providing acceptance and connection, as Andreas (28, <1 year in recovery) specified:

> *I need affection. I sometimes give hugs to friends or my father. That gives me a good feeling. I feel welcome at home. I can always go home when I'm having a difficult time. (…) [It means] love, that they care about me after all*.

Being taken care of (e.g. financially, emotionally), having someone express how important you are to them, having someone willing to deal with life struggles together, and having a social network that invests in this relationship and participants' wellbeing (e.g. by ongoing invitations or visits) contributed to feeling socially supported during recovery.

The support of peers with similar experiences, mainly found in residential treatment and mutual aid groups, proved especially valuable to many participants, as it enhanced a deeper connection, leading to a sense of recognition, hope, and belonging. Nikita (29, 1-5 years in recovery) stated how crucial it was to have peers show interest in her as a human being:

You are a wreck and you have nothing to talk about but suddenly there are people who do speak to you, whom you call just to have a chat or just to have a coffee, who want to spend time with you… That was a real game-changer for me.

Some female respondents specifically indicated how bonding with other female peers was crucial in their recovery process because they often shared similar family struggles (e.g. as mothers).

Yet, social support in the form of excessive concern and worries may also hinder participants' recovery process, because it urged respondents to hide their issues from their loved ones. Tess (42, >5 years in recovery) explained how her mother was able to avoid this by providing a balanced amount of support:

She continued to live her own life and she could still do her thing without falling into misery due to my misery. That made it less difficult to visit my mother because I wasn't confronted with: Oh, she suffers so much because of me. Communication has always been open as a consequence.

In this regard, reciprocity, mutual respect and trust, acceptance, and being able to talk openly were common aspects of beneficial social support throughout respondents' recovery journeys.

While social support was generally deemed essential to initiate and maintain addiction recovery, social disconnection was shown to be an influential hindering factor for most participants. Disconnection often resulted from losing or purposefully avoiding contact with others as a consequence of continued drug use problems, such as disruptive behaviour towards relatives, often leading to social isolation. Some respondents encountered family members who set an ultimatum and threatened to end all forms of contact and support. This could lead to a sense of urgency to deal with drug use problems out of fear of losing significant others but could also increase drug use due to the anxiety to fail. Many participants saw how they disconnected from their family members (e.g. relatives who stopped talking, parents redirecting their energy towards other siblings) and understood this as a way to protect their own wellbeing by keeping distance from respondents' drug use problems and related behaviour. They frequently noted how dynamics of gradually (re)building trust were essential for their own and their families' recovery processes.

Loneliness and a lack of connections are reflected in respondents' narratives in many ways, posing a barrier towards change and growth. Andreas (28, <1 year in recovery), for example, mentioned: *"I miss that [affection] because I'm not in a relationship. I don't need a relationship, but I do need friendship and attention and conversations and such. I have enough conversations with care workers but that is not sufficient"*. He and some other participants mentioned difficulties building reciprocal connections with novel persons and experienced how other persons who use drugs did not always appear to show genuine interest by seemingly interacting with them instrumentally to gain access to drugs. In Nicole's

(45, >5 years in recovery) case, her family was unwilling or unable to talk about emotions, which impeded connectedness: *"They avoid everything because: What are people going to say?. That's pretty much the culture in my family. So when you say: How are you? and you say: Not good, then my mother almost runs away immediately"*. Nicole assumed that public stigma regarding addiction and mental health problems was the reason why her family never visited her in prison nor supported her during her recovery process.

Nicole's story links to experienced stigma resulting from prejudices regarding drug use and addiction, which was present in almost half of the narratives. Respondents often reported how they were blamed, or at least felt that they were deemed responsible, for their drug use problems by family members, friends, neighbours, and society at large. Abel (39, 1-5 years in recovery) reported: *"They [relatives] said: It's his fault, you shouldn't be doing drugs, we told you so. That's not dealing with it constructively, is it? So I wasn't supported"*. Such stigma negatively impacted participants' relationships by imposing barriers for significant others to support them due to misconceptions, resulting in feeling disconnected from their social network.

3.2. Enabling and disabling places for change

Besides interpersonal relationships impeding or supporting change, specific places or settings, in particular addiction services and prison, were underscored in respondents' accounts as important experiences of change during their recovery process. Except for two participants, all respondents used either formal treatment or mutual aid support. Various institutional and relational aspects in these settings were put forward as enabling or disabling individuals' recovery journeys. Enabling elements were: psycho-education, person-centred support on multiple life domains (e.g. finances, housing, family), transparency about the treatment process and goals, attention for lived experiences, and the provision of a structured and safe place to reflect, make mistakes, and grow in a stepwise manner.

Within these places, interpersonal dynamics played a significant role, such as peers who acted as confrontational role models and professionals whose interactions were characterized by authenticity, equality, non-judgemental acceptance, flexibility, and empowerment. Abel (39, 1-5 years in recovery) formulated this as follows:

> *A very important aspect of recovery is being able – and allowed – to make your own choices, and experiencing responsibility for those choices. A second aspect is being considered a full partner, not by people who look down on you like: You are the patient, you have this diagnosis, we give you that and you just have to deal with it*.

The role of addiction treatment was specifically important for respondents who felt that their informal social support system was flawed. Though others experienced sufficient encouragement and assistance from their loved ones, they still mentioned how crucial it was to talk to professionals who could adopt a more neutral position concerning their drug use problems.

Yet, certain elements of addiction treatment were experienced as impeding recovery processes. Some participants were reluctant about treatment because they feared, for example, unemployment due to prolonged sick leave while staying in residential treatment or losing child custody by disclosing drug use problems. Lack of continuity of care, mainly related to outpatient support, was often suggested as a reason to doubt treatment utility, as expressed by Raf (29, <1 year in recovery): *"I went to [name outpatient organization] for the second time and even the replacement was sick. She was going to contact me for another appointment, but I never heard from them again. So, if you're in trouble…".* Other institutional barriers mentioned were waiting lists, refusals on the premise that the treatment program did not fit respondents' personality or problems, time restrictions (e.g. therapy duration), and insufficient follow-up.

Residential treatment was equally linked to certain disadvantages, as it was sometimes described as separating participants from their everyday realities, making the transition to daily life after treatment challenging, especially when reintegration (or aftercare) was not properly provided. Although addiction treatment could yield companionship by peers, a few respondents pointed out that these peers could also be triggers, for example, if they were not committed to recovery themselves. Moreover, a mere abstinence-based and medical treatment approach and the feeling of being treated impersonally (e.g. as just another patient) were perceived as barriers by some respondents. Participants mentioned that a one-sided abstinence-oriented treatment approach was insufficient, whereas creating space for discussing negative and positive reasons for and consequences of drug use was regarded as helpful in understanding addiction and recovery processes as well as dealing with ambivalence.

About a third of the participants discussed aspects related to the criminal justice system and incarceration. For some of these participants, time in prison enabled recovery by creating distance from drug use triggers (e.g. drug using networks, drug availability), structured space, and time to reflect. At the same time, stories related to incarceration equally encompassed barriers towards addiction recovery, such as its impersonal character, insufficient accessibility of addiction treatment and mental health care services (e.g. waiting lists), lack of meaningful daily activities, and shortage of future-oriented support and aftercare (e.g. financial aid, housing support). The latter is illustrated in Julia's (31,

>5 years in recovery) description of being confronted with everyday reality outside prison and losing hope after experiencing unassisted detoxification together with her ex-partner while in prison:

I remember when they said we were allowed to leave and I said: Let's start all over again, I still have 100 euros. (…) We had no place to go, we had nothing. I said: We can choose: either we go to a motel for a room and sleep there or… and then he said: You know what I'm going to do, I'm going to buy heroin with those 100 euros.

Other participants experienced prison as a disabling place because drugs were still available, criminal behaviour could be copied from other inmates, or prison guards expressed stigma towards individuals who use drugs. Herman (36, >5 years in recovery) summarized his experience with the criminal justice system as follows:

You are punished for doing things that are not okay, but I don't think that's exactly the way to go. People reject you, punish you while… Maybe people should sometimes ask: What's going on and how can we help you with that?

Some participants were referred to addiction treatment as an alternative to a prison sentence, which was experienced as recovery-supportive because it provided the opportunity and support to deal with their drug use problems. Louis (54, >5 years in recovery) stated:

I was lucky enough to be able to do a treatment program and stay out of prison. That has also been a bit of a control mechanism, because I knew that when I left [the treatment setting], I had to go back or otherwise I had to go to jail.

Besides these experiences within formal settings, participants also explained the importance of having a place to feel at home. On the one hand, taking care of a house of one's own (e.g. keeping the place tidy) provoked a sense of responsibility and accomplishment for some participants which contributed to their recovery process. Having a home could provide a safe place to take some time alone for self-reflection, rest, and cultivate individual interests (e.g. drawing), including a place shared with significant others. Julia (31, >5 years in recovery), for example, expressed how she longed for a warm place where she feels loved. When sharing her treatment history, she mentioned the role of an outpatient service: *"That was my home, where I could go to with my questions. I had no one and I could go there"*. Hence, although places to feel at home mainly involved participants' own houses, some respondents mentioned the role of other welcoming places, such as those of family, friends, and sometimes treatment settings. On the other hand, a place to call home could be associated with feelings of loneliness if respondents felt disconnected from the outside world, especially when they struggled with building new friendships. This experience was often related to the desire for a so-called 'normal' life that does not only consist of

creating a home-like place but also of finding a place in society through developing connections through, for example, social networks and colleagues at work.

3.3. The role of socio-economic factors

Socio-economic factors emerged throughout several respondents' recovery stories, with employment being the most recurrent topic. Having a job, for example, provided daily structure, feelings of belonging, financial autonomy (although this also generated the opportunity to buy drugs), and a sense of normalcy. Many participants lost their job as a consequence of their drug use problems. David (45, 1-5 years in recovery), however, reported that his drug use was tolerated by his manager since it increased his productivity working as a bartender. Some participants articulated how employment expectations are too demanding and stressful for them, and may inhibit their recovery journeys which also require energy and focus. Since finding flexible, part-time jobs adapted to their capacities, needs, household responsibilities, and transportation options was often challenging, access to volunteer work was mentioned as an important recovery-supportive alternative as it provides a sense of stability, meaning, responsibility, and social connection but with less stress compared to a paid job. Some participants were, however, criticized by their social network for doing volunteer work, mainly because it was not viewed as a 'full' contribution to society.

Respondents who received welfare benefits during their recovery trajectory experienced these as a necessary tool to help maintain financial stability and enable recovery (e.g. for joining a treatment program, continuing education). Yet, Abel (39, 1-5 years in recovery) explained the stigmatizing effects of receiving welfare benefits:

> *It also has a very stigmatizing effect, people look down on it. I've had friends say: I have to work and you don't. I have to give up so much of my wage because you're busy with drugs. That is all very short-sighted and not nice to hear*.

In relation to financial struggles, often resulting from drug use problems (e.g. being fired, buying large amounts of drugs), debt mediation support was occasionally discussed as a factor enabling change. Participants addressed the value of transparent communication and arrangements that left sufficient room for making autonomous choices (e.g. being able to buy a birthday present).

The role of proper housing conditions was equally underscored by participants who had experienced difficulties in this domain (e.g. homelessness). In search of accessible accommodation, Lieve (54, 1-5 years in recovery) was told she was not sufficiently dependent on welfare support to be eligible for supported housing, which urged her to rent an apartment on the private housing market. On the other hand, Herman (36, >5 years in recovery) asserted:

We were given a social housing apartment. We didn't want to go back to [name of city] because it caused too many triggers, but they put us in the apartment blocks of that city anyway. (...) We had to take it or leave it, but there was a lot of [drug] use in that area and people we knew.

This demonstrates how the social housing location made his recovery more complicated.

4. Discussion

This qualitative study focused on contextual dynamics that can influence drug addiction recovery processes, based on the lived experiences of a heterogeneous sample of individuals in recovery. Using a Lifeline Interview Method (LIM; Assink & Schroots, 2010; Berends, 2011), respondents narrated their recovery stories by sharing meaningful moments of change that were influenced by external factors that inhibited or supported their recovery process. We found that recovery processes were influenced by: (1) interpersonal relationships, (2) enabling and disabling places, and (3) socio-economic factors. These three contextual elements are intertwined and mutually interact (see Figure 1). Whether someone has, for example, access to enabling places (e.g. addiction treatment, proper housing) partly depends on their socio-economic situation. Also, how addiction treatment can positively contribute to recovery processes is partly contingent on the supportive role of significant others. Personal recovery, as described in the CHIME framework (Leamy et al., 2011), is not only supported or hampered by contextual factors but takes shape within these contexts (Price-Robertson et al., 2017).

4.1. Ambiguities underlying contextual dynamics during addiction recovery

The findings underscore the ambiguous role of relational dynamics since some contextual factors can simultaneously contain positive and hindering recovery elements, even within the same individual. Social support has been widely stressed as an essential component of recovery trajectories, as interpersonal relationships can provide a sense of stability, belonging, and trust and help to create supportive and safe places for change (Dekkers et al., 2021; Schön et al., 2009; Veseth et al., 2019). In light of the results, however, the ambiguity of interpersonal relationships should be considered, as significant others can also have a destabilizing impact (Veseth et al., 2019). A partner who uses drugs, for example, can positively (e.g. connectedness) as well as negatively (e.g. drug use triggers) shape recovery processes (Beckwith et al., 2019; Best et al., 2016). Moreover, tension was observed between non-judgmental and unconditional support from members of the social network versus support that can be experienced as overwhelming and disempowering. This points out the need to create a good balance, for example with the help of Community Reinforcement and Family Training (CRAFT) that focuses on learning family members how to cope with addiction-related behaviours from a loved one in more constructive ways (Copello et al., 2005; Hellum et al., 2021; Smith et al., 2008).

The findings similarly show the dual position persons in addiction recovery experience towards time in prison. Incarceration can provide opportunities to deal with drug use problems, for example, by offering treatment, but the quality and continuity of care provided are crucial to maintaining recovery. At the same time, individuals have to deal with boredom, social isolation, stigma, and drug use triggers while being incarcerated, which can undermine recovery initiation and maintenance. Prison settings need to take these possible barriers into account by creating opportunities for change and recovery-supportive environments (Crewe & Ievins, 2020; Jamin et al., 2021; Nugent & Schinkel, 2016; Van Roeyen et al., 2017).

With regard to socio-economic circumstances, mental health and addiction research (e.g. Dunn et al., 2008; Pouille et al., 2021) consistently underscores that having a daily activity (e.g. paid employment, volunteer work) enables recovery processes in many ways, for example, by providing daily structure and predictability, creating possibilities to develop a valued sense of being, competence, and purpose, and strengthening social inclusion. These meanings attached to work are not specific for persons with substance use problems, they are valued by humans in general in our present-day society (Borg & Kristiansen, 2008). Besides the barriers persons with (former) drug use problems face towards entering employment (Harris et al., 2014; Kemp & Neale, 2005; Sutton et al., 2004), certain elements can hinder one's recovery journey while being employed, even when simultaneously encountering work-related benefits. For example, participants reported difficulties to establish a good work-recovery balance (Borg & Kristiansen, 2008; Kinn et al., 2011). As some respondents perceived regular paid jobs as highly demanding, volunteer work afforded similar positive work experiences (e.g. feeling connected), without setting the same expectations and leaving room for flexibility. However, public perceptions of volunteer work tend to devalue its societal importance. In this regard, Roets et al. (2007) have discussed the difficulties individuals face regarding employment due to a disabling society that consists of attitudinal and systemic barriers. A better understanding concerning various ways to support work participation that fits the individual needs of persons in addiction recovery is warranted, taking into account that standardized measures often do not meet individuals' unique everyday lives, potentials, and ambitions (Borg & Kristiansen, 2008). Such an approach can counteract *"the normalization that runs through the recovery discourse"* (Rose, 2014, p. 218), as recovery is currently highly normative in attaining certain goals, such as full-time paid employment (Vandekinderen et al., 2014).

Overarching supportive and inhibiting characteristics of these contextual factors concern the nature of their underlying dynamics. The findings show how being respected (e.g. by treatment providers) as a unique human being with multiple social identities and developing a reciprocal relationship can be beneficial to one's recovery journey. Enabling places (e.g. treatment services) and interactions with

others revolve around experiencing connectedness and being valued in one's strengths and vulnerabilities (Schön et al., 2009; Veseth et al., 2019). These needs do not seem specific for persons in recovery but are universally shared. In contrast, recovery is hampered if others (especially professionals) relate to persons in recovery as merely 'patients' who need to receive a predetermined treatment program without acknowledging personal needs and strengths. Individualistic beliefs about drug use problems and addiction recovery disregard how recovery processes depend on contextual factors (De Ruysscher et al., 2019; Topor et al., 2011). Public health policies should be recovery-supportive through counteracting social and economic inequalities by allocating public resources to address these, such as by providing affordable housing and tackling negative societal attitudes towards persons who use(d) drugs (Henwood & Whitley, 2013).

4.2. Stigma as an overarching contextual barrier

Stigma emerged as a cross-cutting finding since participants' stories highlighted how persons who experience(d) drug use problems are often confronted with negative perceptions from their relatives, service providers and practitioners (e.g. prison guards), and the general public (Corrigan et al., 2009; Lloyd, 2013; van Boekel et al., 2015, 2016). Research has linked stigma to causal attribution beliefs (Corrigan et al., 2003; Weiner et al., 1988), such as perceptions of controllability, responsibility, and chronicity regarding substance use problems (Corrigan et al., 2009; Crisp et al., 2000; Nieweglowski et al., 2018; Schomerus et al., 2011). Studies show that stigma is associated with lower quality of life, impaired life opportunities (e.g. quality housing, employment), poorer physical and mental health (e.g. feelings of disempowerment, anxiety, self-doubt), decreased social participation, and reduced help-seeking (Ahern et al., 2007; Crapanzano et al., 2019; Frischknecht et al., 2011).

The adoption of an intersectionality framework to drug stigma and addiction research is warranted, as the interplay between numerous social identities (e.g. gender, social class, ethnicity) and related stigmatizing attitudes can adversely impact the daily lives of individuals in recovery (Cole, 2009; Kulesza et al., 2016; Pouille et al., 2021). This accounts, for example, for those who have been incarcerated, resulting in multiple stigmatized identities (Best, Irving, & Albertson, 2017; Colman & Vander Laenen, 2012). Future research should address drug stigma in relation to other social categories to add more nuance and complexity to our understanding of contextual dynamics and intersecting forms of stigma (Turan et al., 2019). In line with Link and Phelan (2001), we suggest that any approach to change stigma should be multi-faceted (i.e. addressing various underlying mechanisms) and multi-layered (i.e. directed at individual, social, and structural forms of stigma). The effectiveness of interventions will otherwise *"be undermined by contextual factors that are left untouched by such a narrowly conceived intervention"* (Link & Phelan, 2001, p. 381). Such anti-stigma approaches should accentuate the humanity of

individuals who use(d) drugs, recognizing their universally shared responsibilities, rights, and capacities (Brown, 2020; Del Vecchio, 2006).

4.3. Limitations

This qualitative study allowed us to gain more insights into the contextual dynamics during drug addiction recovery journeys based on individuals' lived experiences. The findings of this study should, however, be considered within the context of several limitations. Although we purposively selected participants with diverse addiction and recovery experiences (e.g. recovery stage), it is unclear whether the findings can be generalized to the entire population of persons in addiction recovery due to the small sample size, the focus on illicit drugs, and specific geographical location of the study. As we adopted a LIM to elicit autobiographical information about important moments of change, our interview approach might have evoked narratives about specific and more clearly demarcated contextual factors (e.g. treatment episodes), leaving less room for more anecdotical and subtle relational recovery aspects. We derived insights about contextual dynamics based on the meanings that participants assigned to them, but future research could add further insights by assessing recovery-related aspects at the macro-structural level (e.g. housing) more in-depth. Furthermore, thematic analysis is not without some disadvantages that mainly involve the replicability of the inductive data analysis process, as it is influenced by the biographical and professional backgrounds, perspectives, and interpretations of the researchers involved in the process (Braun & Clarke, 2006; Roberts et al., 2019; Smith, 2004). Through an iterative process of developing and discussing the thematic structure and interpretations with multiple co-authors, we aimed to strengthen the validity of the findings (Nowell et al., 2017). However, we did not adopt a process of member checking to enhance the validity of the findings by checking if they accurately represented respondents' lived experiences (Birt et al., 2016). Future studies could apply more participatory and co-creative research methods, acknowledging ethical issues concerning knowledge construction (Damon et al., 2017; Pettersen et al., 2018; Russo & Beresford, 2015; Tomlinson & De Ruysscher, 2020; Van Steenberghe et al., 2021).

5. Conclusion

This study set out to address a gap in the primarily individualized understanding of recovery processes by focusing on contextual factors in first-person accounts of drug addiction recovery. We found that interpersonal relationships, enabling and disabling places, and socio-economic factors facilitate or impede recovery in meaningful ways. The findings support the growing recognition that it is crucial to acknowledge the relational nature of addiction recovery and the embeddedness of persons in their social milieu by providing insights into how this is shaped by contextual factors (Adams, 2016; Bathish

et al., 2017; Topor et al., 2011). More research is needed to further our understanding of underlying dynamics and the invalidating role of stigma at different contextual levels in addiction recovery processes.

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