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ORIGINAL ARTICLE

A Stabilizing and Destabilizing Social World: Close Relationships and Recovery Processes in SUD

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Abstract This qualitative study reports on a thematic analysis of the role that close relationships may play in recovery processes following SUD. Inspired by a framework of research involving service users, interviews with 30 participants who had fully recovered were conducted by interviewers with first-hand experience of the topic of focus. The findings are summarized through a superordinate theme that we have called "a stabilizing and destabilizing social world," and three broad constituent themes: (a) being entangled in difficult relationships; (b) people provide essential support and stability; and (c) we become different people along the pathway of our lives. We relate our findings to experiential knowledge generated from a recovery perspective, highlight reflexive processes involved in carrying out the research, and discuss implications and limitations of the present study.

Keywords Qualitative research · Service user involvement · Lived experience · Recovery · Substance use disorder

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Introduction

What role do close relationships play in recovery processes following a substance use disorder (SUD)? In this article, we examine the experiences of 30 people who have fully recovered and now lead good, meaningful lives following SUD, and explore how close relationships contributed to their personal processes of healing and growth. Four to five years after being recruited to an ongoing, naturalistic follow-along study of change trajectories, the STAYER study (n = 202), participants who met the criteria for both stable substance abstinence and adequate social functioning for a minimum of 2 years were interviewed individually. In so doing, we aimed to develop descriptive knowledge about how the people that are most important to a person with SUD contribute to his or her recovery processes.

In international health policies, the notion of "recovery" has become prominent. This is particularly so when it comes to practices related to people with mental health problems and/or substance-related conditions [1–3]. While mental illness and SUD may be seen as bearing little resemblance to each other diagnostically, processes of recovery can nevertheless be quite similar [4]. In both cases, for example, people in recovery seek to eliminate or handle their symptoms, they want to be contributing citizens in their local communities, and they aim to develop meaning and purpose in their ongoing lives [5, 6]. Furthermore, these individuals will often not only need to find ways of managing their problems and distress, but also the consequences of stigma and discrimination. Both people with mental illness and SUD risk being met with prejudice in their local communities. There are, however, important differences. Discussing a common vision for the fields of mental illness and SUD, Gagne et al. [5] write:

> […] the addictions field has had a well-developed concept of full recovery but has lacked a legitimized concept of partial recovery, while the mental health field has long promoted the goal of partial recovery but has, until recently, lacked a viable concept of full recovery. Integrating the concepts of full and partial recovery within the emerging recovery visions of both fields holds great promise for shaping mental health and addiction services and supports (p. 35).

A similar distinction has been made between clinical and personal recovery [7], and in viewing recovery as an outcome or as a process [8]. In the present study, we aim to contribute to this integration by exploring participants' descriptions of personal recovery processes in a sample of people who meet the criteria for full, clinical recovery.

An underlying idea in the vision of personal recovery is that individuals with mental illness and/or SUD are first and foremost people [5] and that recovery involves a process of reclaiming a sense of self [9]. It is a "vocation of becoming more deeply, more fully human" ([10], p. 92), and people are not their diagnoses or problems [1, 3]. As a consequence, the focus in this recovery perspective is on the person him- or herself and the individual's own efforts to live as well as possible. From this point of view, recovery is a fundamentally personal journey [11] which can be done with the assistance of treatment and care, as well as without formal support. Another central point is that recovery in both mental illness [12] and SUD [13] is described as unfolding over time. This means attention needs to be paid not only to initiation, but also to the processes involved in maintaining recovery [13].

While recovery is a personal process, it is also social and contextual in its very nature [14–16]. For most people, building a meaningful life involves being an active and contributing citizen [12, 17]. As such, factors such as housing, education, employment and recreational activities play important roles in recovery processes by providing people membership in significant social structures [15]. But recovery also involves more than the community at large. It is about people's close relationships, and studies emphasize family and friends as decisive factors [15, 18]. This is also interrelated with understanding recovery as a personal process. Because, as Schön et al. [19] argue, "It is through social relationships that the individual is able to redefine themselves as a person (as opposed to a patient)" (p. 345). As such, viewing recovery processes as personal and social are complimentary, not contradictory positions.

Qualitative studies of people with SUD experiences also highlight the role of people's close relationships in recovery processes. In a focus group study of patients' and providers' experiences in an intensive treatment program for women with SUD, Brown et al. [20] explain that participants emphasized the importance of having new recovery-oriented individuals within their networks. The researchers also found, however, that the women needed to develop ways of managing their ongoing relationships, including distancing themselves from certain people to reduce their negative impact. Providers were found to focus more on contextual barriers such as stigmatization and a lack of resources [20]. In another study, Pahwa et al. [21] conducted a grounded theory analysis of 34 interviews with formerly homeless people with dual diagnoses of mental illness and SUD. In exploring the nature and quality of their participants' social ties, the research findings demonstrate that social ties are complex and multidimensional phenomena. They included both what the researchers call "ties that bind" as well as ties "that get in the way" for people with dual diagnosis [21]. As such, there is a growing knowledge base describing nuances in how social

relationships impact recovery processes in SUD. Based on in-depth interviews with participants from a rigorous, high-quality database, the aim of the present study is to add more detail to this knowledge about the role that family and friends may play for people who have recovered from SUD. We explore the following research question in depth: What role do close relationships play in recovery processes following a SUD?

Methods

A qualitative methodology was chosen to gain a deeper understanding of participants' experiences of the role their close relationships played in their individual recovery processes. Data was collected through individual interviews conducted by interviewers with first-person experiences with the topic of focus, namely recovery from SUD. In so doing, the study was inspired by research involving service users [22–24]. The practical tool for working with our data was thematic analysis [25], and we employed a hermeneutic-phenomenological and team-based approach to this analysis [26].

Participants

Thirty people who were fully recovered from SUD over the long term participated in the present study. We recruited this sample from the STAYER study (n = 202), a prospective, naturalistic follow-along study of change trajectories for people with SUD in Rogaland, Norway. In this ongoing project, service users were recruited from outpatient and residential treatment facilities at the start of their treatment (see also [27–29]). Inclusion criteria for participation included (a) starting a new treatment sequence at the time of inclusion; (b) fulfilling the criteria for SUD; and (c) being 16 years or more of age. Both demographic and clinical information were collected from participants (Table 1).

For this interview study, eligible participants were included consecutively at their 4- or 5-years follow-up in the STAYER study. We did so in order to recruit participants who met defined criteria for stable substance abstinence and social recovery (see "Measures" section). A total of 34 candidates were contacted; of these, four individuals declined to participate. Sample size was decided upon on the basis of finding stability [30] reviewed after 19 and 26 participants. We stopped recruiting after 30 completed interviews because we the last four did not contribute substantially new information.

Measures

We used the following instruments in this study: The Drug Use Disorders Identification Test (DUDIT-C) to assess drug use [31]; the Alcohol Use Disorders Identification Test (AUDIT-C) to assess alcohol consumption [32]; the Symptom Checklist 90 Revised (SCL-90-R) to assess psychological functioning [33] based on the summarized Global Severity Index (GSI); the Behavior Rating Inventory of Executive Functions-Adult Version (BRIEF-A) to assess executive functioning [34]; and the Satisfaction With Life Scale (SWLS) for quality of life [35].

Drug abstinence was operationalized as DUDIT-C scores < 1 and AUDIT-C scores ≤ 2. Relapse was defined as the above cut-off scores for either alcohol or drug use during the past 2 years. Social functioning was operationalized using four variables related to social functioning status: housing, income, friends without addiction, and participation in work or school. Participants who met all four social variables were categorized as adequately socially functioning. For the purposes of the present study, recovery was defined as meeting both criteria for stable substance abstinence and adequate social functioning in the past 2 years.

Researchers

The authors comprise a diverse research team of several psychologists (MV, CM and JB), a social worker (TSS) and an anthropologist (SN), as well as researchers with first-hand experience of SUD (TES and AWS). All share an interest in recovery processes, qualitative research and health promotion for people with SUD.

Interviews

We developed a semi-structured interview guide to explore participants' experiences of recovery processes. This guide was structured around three main factors that may contribute to recovery processes: the person him- or herself, the environment surrounding

Table 1 Baseline and follow up demographic, clinical, treatment-related, psychological and social variables

	Baseline (N = 30)	Year 1 (N = 30)	Year 2 (N = 30)	Year 3 (N = 30)	Endpoint assessment	
					Year 4 (N = 10)	Year 5 (N = 20)
Demographics						
Age	25.9 (5.5)	–	–	–	–	–
Male/female, n	17/13	–	–	–	–	–
Education, years	12.8 (1.8)	–	–	–	–	–
Substance use history						
Age of initial use	13.1 (1.8)	–	–	–	–	–
Years of drug use	12.9 (6.0)	–	–	–	–	–
AUDIT score	11.9 (11.4)	3.4 (7.6)	2.3 (4.1)	2.9 (6.8)	4.4 (7.0)	2.2 (3.2)
DUDIT score	29.0 (15.9)	6.6 (13.1)	3.1 (11.5)	1.9 (8.5)	0 (-)	0 (-)
Treatment						
Previous treatment attempts	1.3 (2.0)	–	–	–	–	–
Currently outpatient, n (%)	13 (43.3)	17 (56.7)	8 (26.7)	5 (16.7)	2 (20.0)	2 (9.5)
Currently inpatient, n (%)	17 (56.7)	5 (16.7)	4 (13.3)	2 (6.7)	0 (0)	0 (0)
Currently in self-help group[a], n (%)	13 (43.3)	13 (43.4)	15 (50.0)	10 (33.3)	4 (40.0)	3 (14.3)
Social variables[b]						
Permanent housing, n (%)	15 (50.0)	25 (83.3)	25 (83.3)	26 (86.6)	10 (100)	21 (100)
Stable income, n (%)	16 (53.3)	21 (70.0)	27 (90.0)	27 (90.0)	10 (100)	21 (100)
Employed/student, n (%)	5 (16.7)	7 (23.3)	14 (46.7)	19 (63.3)	10 (100)	21 (100)
Abstinent friends[c], n (%)	24 (80.0)	25 (83.3)	26 (86.7)	27 (90.0)	10 (100)	21 (100)
Psychological measures						
SCL90-R GSI	1.2 (0.7)	0.7 (0.7)	0.6 (0.5)	0.5 (0.4)	0.5 (0.4)	0.4 (0.5)
BRIEF-A GEC	67.2 (11.3)	57.2 (11.3)	54.9 (12.6)	51. (10.9)	52.5 (10.5)	50.4 (11.2)
SWLS, sum score	17.5 (6.8)	24.8 (6.7)	24.8 (5.2)	25.2 (5.4)	25.3 (2.7)	27.4 (5.0)

All numbers are mean (SD), unless otherwise specified

SCL-90-R GSI Symptom Checklist 90 Revised Global Severity Index T-score, *BRIEF-A GEC* Behavioral Rating Inventory of Executive Function Adult Version Global Executive Composite T-score, *SWLS* Satisfaction With Life Scale, *AUDIT* alcohol use disorders identification test, *DUDIT* drug use disorder identification test

[a]Currently in self-help group, such as NA/AA and alike

[b]Social variables are positive responses to yes/no questions

[c]Friends without a history of substance use

the individual, and the treatment he or she was a part of. Each of these were introduced with an open-ended question, such as "How would you describe the role people around you played in your recovery process?", and follow-up questions were used to encourage participants to elaborate or add more details to their descriptions. All interviews were conducted by TES and AWS, who received training in interview skills and who have first-hand experience with recovery from SUD. This promoted a high level of recognition and trust in the interviews, and at times it facilitated an interplay that differed from most traditional interviews. The following transcript can illustrate:

> Participant (P): How long have you been clean?
> Interviewer (I): Five years.
> P: Me too. That's a helluva long time, huh?
> I: It sure is. But I notice it's sort of a process. Or that things suddenly dawn on me. Like, "Oh, yeah, shit!"

P: It's awesome that you've been sober as long as me. You have your things and I have mine.
I: So we've both come far.
P: Yeah.
I: Yeah. And when I'm asked what keeps me from going out and getting high… For example, if I were to lose my job and lose custody of my boy too. What would keep me from going out and getting high then? That's interesting to think about.
P: It's a hard question.
I: Yeah, it is.

This interaction is perhaps most comparable to a conversation between peers [36], and may have played a part in developing a distinct dataset because the way we ask questions will necessarily impact the answers participants give [24]. We consider this to be an important facet of the present study, as it provided us with interview data that were rich in information. All interviews were conducted between October 2017 and April 2018 at Stavanger University Hospital (n = 25), at the participant's home (n = 1), or by telephone (n = 4). All interviews were audio recorded and transcribed verbatim. Their mean duration was 57 min (range 27–96 min).

Data Analysis

We used a team-based approach [26] to thematic analysis [25] to analyze the data. This is a systematic investigation of patterned meaning across a dataset that has been used widely in different health and social sciences [25]. Because the interviewers were more motivated to conduct interviews than to engage in the different stages of analysis, we arranged an initial 1-day analytic seminar where MV, CM, TSS and JB discussed and developed an overall sense of the participants' experiences. Thereafter, MV, CM and JB met to conduct the thematic analysis of accounts that reflected the participants' experiences of the role that their close relationships played in their recovery processes. In this process, we did not define close relationships beforehand, but relied on the participants' own understandings. We proceeded through six steps recommended by Braun and Clarke [25], with SN playing a key role in relating the study findings to the broader research field, and TSS, TES and AWS reviewing the initial thematic structure that was developed. These steps are: (A) familiarization with the data; (B) coding; (C) searching for themes; (D) reviewing the themes; (E) defining and naming the themes; and (F) writing up the report [25]. In this process, the transcripts were read and re-read and adjustments to our interpretations made to ensure that we stayed close to the participants experiences in the themes that we developed. For example, in the initial analytic meetings we emphasized the discontinuity in the participants social lives. Many of the participants did not have anyone journeying alongside the full length of their recovery processes, they seemed to lack what we tentatively termed a "stabilizing we". In the process of going back and forth between the dataset and our emergent themes, however, we recognized that this understanding did not capture the variations in the participants' stories. This led us to formulate the superordinate theme "a stabilizing and destabilizing social world" to communicate the tension that exists as close relationships simultaneously are stabilizing and destabilizing ingredients in peoples' ongoing lives.

Thematic analysis is a theoretically flexible methodology that allows for developing themes based on the data material [25]. We have focused our analysis on the participants' lived experiences and lifeworld, meaning that we have taken a phenomenological approach. We recognize, however, that the researchers' experiential horizons necessarily will impact studies at different stages of research, e.g. by influencing our research questions, interview interactions and analytical concepts [37]. As a consequence, we have employed a hermeneutical approach to discuss how this may have both helped and hindered how we describe and understand the participants' experiences [26]. Veseth et al. [24] write:

> A participant in an interview study may on the one hand respond differently to the same question posed, for example, by a medical doctor, a psychologist, or a priest; and medical doctors, psychologists, or priests may on the other hand understand the meaning of the answer in different ways. Researchers and participants thereby exert mutual influence on each other as they develop and construct knowledge between them (p. 257).

Ethics

The study was approved by the Regional Committee for Medical Research Ethics in Norway (201/1877).

Written informed consent was obtained from all participants prior to the study. Although the aims of this project were positively formulated in exploring processes of recovery, participants talked from their own experiences of suffering from SUD. Care was taken in the interviews and in working with the material to treat these experiences with respect.

Findings

Participants' descriptions of the role that close relationships played in their recovery processes clustered around a superordinate theme that we have called "a stabilizing and destabilizing social world", and three broad constituent themes that summarize their descriptions. These are: (a) being entangled in difficult relationships; (b) people provide essential support and stability; and (c) we become different people along the pathway of our lives.

A Stabilizing and Destabilizing Social World

Participants' descriptions of the role that their close relationships played in recovery processes appeared in many forms. In one version, people's family members and friends kept them firmly stuck in difficult situations. In these cases, adversities and a demanding social context were major barriers to participants' efforts to establish meaning and purpose in life. In another version, human relationships enriched and assisted them by providing support and a sense of stability. In these instances, people were key in the participants' recovery processes.

Drawing up a continuum that summarizes our participants' experiences across these different versions, we have called this overall finding "a stabilizing and destabilizing social world." While participants' descriptions could be placed along this continuum, the experiences of their close relationships were described in many cases as simultaneously stabilizing and destabilizing. As such, a typical finding was that both versions could be present in the participants' narratives at the same time. One participant, for example, described challenges related to a family life where many members engaged in unhealthy substance use. Still, these close relationships were central to his recovery process:

> And then I'm with my family. I go to my mom's and eat when she's sober, for example. Because it makes you happy. I mean, I feel more happy than depressed. And it's worth it just for that. And then you know that your life overall is more good than bad, and that…that can't be described.

Similarly, another participant emphasized the development of a romantic relationship in her process of changing her life. When she found out she was pregnant, her need for stability and security increased. This led the participant to make important changes:

> I dated a guy who didn't really do [any drugs]. And then I got pregnant by him. And then my mothering instinct kicked in big time, and then I was just like: "No." I stopped talking to everyone, and just stayed at home with my mom and they […] Yeah, in any case it has helped a lot. That I've become a mom. It's just not tempting to go back to…it. Because I have her, and I know that it would harm her, it would harm my family, harm my body, and my brain.

Later in the interview, however, the participant nuanced this narrative, acknowledging how this man also could be brutal to her. "He wasn't that nice," she said, "even though he didn't do drugs." And then she continued: "He already had two kids, and he was kind of … violent."

A third example of this superordinate theme can be found in the interview with a participant who described struggles with developing meaningful relationships. This was both about being able to be close to others and also about letting them in; it was a challenge and at the same time a necessary step towards leading a good, meaningful life. The participant said:

> What's harder for me than almost anything I've been through is working to let people in and love them, and to let them love me and…So in a way I haven't been ready for that either, until now. And then, when I've been clean for short periods of time I haven't been…I haven't been in a position to work with that, and then maybe it loses some of its meaning and, if you hadn't had someone close to you, maybe it would be easier to keep getting high or…Yeah, I don't know.

Variances in this superordinate theme are detailed in the three constituent themes that follow below.

Being Entangled in Difficult Relationships

In the interviews, participants described having led restless and strenuous lives in which their social worlds were populated by many people who themselves had been involved with risky use of substances. One participant described it with these words:

> So many people around me died the year before last. Seventeen people. It was just bang, bang, bang. It was like, I can't do this anymore. I was absolutely sure that either I would die of an overdose or someone would shoot and kill me. That's how I would end up.

Some of the participants grew up in homes where family members had their own problems with substance use or poor mental health, or in households with marked social adversities, and these relationships still had an impact on their day-to-day lives. The following quote illustrates this point:

> My mom has a pile of diagnoses. Sometimes she takes more pills than she's supposed to, and then you hear it when you talk to her on the phone: "OK, it's that kind of day." So the best time to visit her is in the morning. Then she's normal. And my brother has also been a little off and on…

This social backdrop continued to influence and cast shadows across participants' everyday lives. One of them reflected on this in the interview when discussing his ex-girlfriend. During a short but intense love affair, he had introduced her to illegal substances. Eventually, the participant hit a point where he stopped using drugs, but the girlfriend was not able to quit:

> I began to understand "Ok, dammit, I can't be bothered anymore. This life is too fucking stressful." Yeah, so it…So this is what I was coming to—so we broke up and after a few months she jumped in front of a train, took her own life, and then it was like, either/or. Then it was either open up, talk about things and be like…Do the bravest thing I could ever do. Tackle the feelings of guilt I had inside and the grief I was experiencing.

As such, both previous and present relationships lingered in participants' lives. They described struggling with guilt, sadness, shame and worries in relation to these troublesome aspects of their past and present social worlds. This impact could, however, also play out in more concrete ways. For example, one participant was in an intimate relationship with a woman also recovering from SUD. This interfered with their joint efforts to lead normal lives, of setting up a home and getting a job. In the interview, the participant explained:

> There are always more things we want to do next. And neither of us has a driver's license yet either…We haven't been able to do it before either, so there are things like that that we want to do…completely normal things for other people, but they're things that aren't totally doable because of the way we used to live.

People Provide Essential Support and Stability

Participants described in depth how close relatives and friends played a crucial role in their recovery processes. One participant, for example, emphasized how her mother had stepped in and became a key person in her journey towards finding a way out of substance use:

> The last time it was my mom who put me in the car and locked the doors and drove me far, far away, to [a different part of the country]. And I wouldn't have managed to get clean myself that time, even though I wanted to, and that's where I was like I explained just now, so I wouldn't have managed to get free from it myself, so…I don't think so anyway. At least not at that point in my life. And it doesn't need to be a family member, but to have an important person who is there exactly when you need them and who does exactly those things that are needed there and then, when you are ready in a way, but you can't do it by yourself, but all you need is that support, absolutely, it's very important.

Similarly, another participant talked about the safety others provided. For her, it was not so much about support, but rather the stability she needed in anchoring her life in close relationships, exemplified here by her boyfriend:

> The reason I managed to quit was because I had [my boyfriend], I had a safe place to be, he was borrowing a house from a friend. The structure around that was so safe that I didn't have any need to go back.

Another aspect of this safety was being able to learn about oneself in the buffered permanence of a close relationship. One of the participants explained: "It's always been important for me to have people around me who know me well. Not like a superficial acquaintance who can give me a hug at a meeting, but someone who really understands how I'm put together." For other participants again, family and friends were important in reflecting back significant aspects of themselves. Here is one account where a participant emphasized the significance of demonstrating to her mother a sense of being capable, of being able to turn one's life around and of sobering up:

> I have a mom that I've been disappointing for a long time, and I would like for her to experience some years when I'm sober. I can't say that I feel great, but at least I'm sober and stable. It's nice to be able to show this to my mom, right? Someone said to me, this week actually, that she lost her mother when she was using very heavily, and since she's clean now it's very painful for her that her mom didn't get to see her sober. And that put it in perspective. The chance I've got, and I've grabbed it. Absolutely. And it's rather nice.

As such, the essential role of people's close relationships was not only apparent in participants' initial processes of stepping away from substance use, but also in their day-to-day lives and ongoing recovery. Being connected to others gave meaning to the hardships of working towards recovery. For many of them, this was a life-long process in which the continual presence of family and friends was key. Here is another account from a man who still battled with drug cravings from time to time:

> So it's my wife who has saved my ass a couple of times, she's gotten me out of some really bad situations sometimes. I've been on the verge of relapsing, maybe meeting someone, being offered something, and then I've thought how good it would be to get that buzz, I've laid in bed and fantasized about it, but then luckily I've managed to be honest with her about it. Got it off my chest you could say, and…So it's important to have good people around you then, who you can be honest with and talk to. You can't do it alone.

However, an important variant finding was that developing close relationships also meant having more to lose. Using drugs and alcohol could be a hedge against the vulnerabilities and risks of intimate relationships. As a consequence, the participants' movement towards connectedness also meant exposing themselves. While this allowed them to build meaning and purpose in their lives, which they sometimes perceived as adrift and without direction, this kind of commitment was also a challenge. The following quote highlights this point:

> Sometimes I toy with…the thought that I only want to get high and go into treatment again so I can relax a little because I feel the responsibility of life, that's what my feelings are about, what they deal with most now. That's what really gets to me. That I have that damn responsibility all the time. That you're supposed to be a responsible person, that people have so many expectations of you. Sometimes I feel like I'm not good enough for that kind of stuff.

We Become Different People Along the Pathway of Our Lives

When participants discussed processes of change and growth after recovery from SUD, they made it clear that being in recovery had important consequences for their social worlds. Many of them discussed this by using examples from their romantic relationships. Reflecting upon a break-up following a process in which both partners stopped using substances, one of them said: "It didn't work. Because we weren't a good match after she got sober. She didn't do drugs anymore, but still, we got to know each other when we were high." Similarly, another participant described how she and her boyfriend had slowly discontinued their use of illegal substances. It turned out, however, that their efforts did not converge enough to be mutually supportive:

> So it sort of got less and less over time. But both of us weren't totally ready then, we weren't able

to follow each other there […] Yeah, I only smoked, and later drank again. But he continued with some of the things, and so…it didn't work when we lived together.

A third participant discussed how she was about to move back in with her boyfriend after receiving inpatient treatment. At that time, the participant said, she was determined to give the relationship a second chance. In the interview, she commented on this challenge in the following way:

> And so I decided when I was in treatment that "OK, I'll try again when I get out, with a clean slate, and hopefully see things from his perspective and such," but there's also a kind of asymmetry when one person changes and the other one stands still.

To reclaim roles or develop a new position in one's social world was not only a challenge in romantic relationships. In all relationships, this could be a formidable task when recovering from SUD. One participant, for example, emphasized the challenges related to being himself in his family without the influence of drugs. This rather long excerpt details how he still would sometimes feel strange and unhomelike here:

> P: I've had family and such, but it's so hard to begin to recreate who you are in a family where you've been rather…
> I: You have to find a new position…
> P: A new position, because I have a pretty dysfunctional family with a lot of drug use and chaos. So I'm supposed to be a part of that family as someone different, as a sober person.
> I: What was that like? You were supposed to find your new position in your family and at the same time get some sort of support from it, from them. What was that like?
> P: I put boundaries on where they could get high. So I tried…Or so I used those people…Because it's not only about getting high, there are many resourceful people in my family and I think I leaned on them as much as I could. But there are still times when it's sort of strange, sometimes to be in my family now […] It's like, there's before I got clean and after I got clean.

Another central aspect of this theme is that participants' processes of making changes to their lives often implied major, abrupt shifts. Existing bonds with people who used substances themselves would immediately be cut off in order to break with their daily routines and surroundings. This was a challenge to many of the participants:

> You've cut yourself off from your whole group, you've dropped your friends, there's nothing left. So you sit there and wait for the alarm to go off so can go to work again the next day. Nobody can handle that in the long run! What's the point really? And most people who've been getting high for 10, 15, 20 years, they've pushed away all their family and friends and such for the high, everyone who was responsible and upstanding. They're gone from their life, because they've disappeared in the high.

Such processes of disconnect and isolation left participants feeling sad and lonely, and this could add to their burden. Here is another account:

> P: But I think the most difficult thing of all has been friends. Because I'm left with no friends really.
> I: Yeah, right.
> P: I still feel that way. Now I'm 30 years old, and everyone my age has a close circle of friends. And then here I come. Billy no mates just sitting at home. So I think that's the reason I had a slight relapse in the beginning.
> I: Yeah.
> P: Because I was very lonely.

Discussion

The findings of this study highlight how participants viewed the role that close relationships played in their individual recovery processes following SUD, and clustered around the different versions that we have summarized in our superordinate theme, a stabilizing and destabilizing social world. This in turn was divided into three broad constituent themes: (a) being entangled in difficult relationships; (b) people provide essential support and stability; and (c) we become different people along the pathway of our lives. How

can we understand these results? And what are their implications for research and practice?

Towards a New Direction in Life

Recovery from both mental illness and SUD is often described as consisting of complex, non-linear and dynamic processes [38, 39]. Here, the person needs to keep one eye on what he or she can do in the moment and the other on his or her personal recovery goals. As such, recovery involves dual processes of developing a good life here and now, as well as building hopes for the future. As emphasized by our participants in the second constituent theme, "people provide essential stability and support," their close relationships were pivotal in these processes. Deegan [11] summarizes her own experiences of recovery following a diagnosis of schizophrenia in the following words: "We do remember that even when we had given up, there were those who loved us and did not give up. They did not abandon us" (p. 14). An important point here is that in these relationships people will also be able to switch roles. They are not passive recipients, but people who can provide help and care to others. As such, the development of reciprocal relationships provided the participants in our study not only with stability and support, but also with opportunities to be of value and importance to their family and friends. This is a finding that relates to comparable study results from research into recovery processes [12, 15].

In another autobiographical account by Coleman [40], the role of family and friends is similarly highlighted. Here, however, a different aspect of recovery is emphasized; recovery necessarily implies that the person does not stay the same. He or she will not go back to the way they were, but develop further and stake out a new life direction. In a phenomenological interview study, Mackintosh and Knight [9] similarly found that recovery from substance use involves an important process of reclaiming a new identity through integration of the self within a supportive environment. Coleman [40] discusses how the health care system failed to take this into consideration in meeting his problems following traumatic childhood abuse, voice hearing and excessive alcohol use, and writes:

> What they did not do was consider the possibility that I could return to being a person. Not as I once was, but the person that I could become; perhaps even more than I once was. Indeed, I could become Ron Coleman (p. IX).

This resonates well with our third constituent theme, "we become different people along the pathway of our lives," and also corresponds to what Rogers [41] terms the actualizing tendency in all living organisms:

> Whether we are speaking of a flower or an oak tree, of an earthworm or a beautiful bird, of an ape or a man, we will do well, I believe, to recognise that life is an active process, not a passive one. Whether the stimulus arises from within or without, whether the environment is favourable or unfavourable, the behaviours of an organism can be counted on to be in the direction of maintaining, enhancing, and reproducing itself. This is the very nature of the process we call life (p. 100).

Interestingly, this line of thinking also highlights a central aspect related to our superordinate theme, "a stabilizing and destabilizing social world." As human beings we are all continuously and inescapably in process, because, as Davidson et al. [8] write, "Life is not an outcome." This means, however, that so too are the people we surround us with. In this sense, other human beings will inevitably also have a destabilizing potential.

Meaning and Close Relationships

In the popular science book *Love and Addiction*, Peele and Brodsky [42] argue that SUD is not a disease but a fundamentally human experience. And because we are relational beings, the social world becomes key in understanding these experiences. They write: "The antithesis of addiction is a true relatedness to the world, and there is no more powerful expression of that relatedness than love, or true responsiveness to another person" ([42], p. 25). Similarly, the closing remarks in Johann Hari's [43] well-known TED Talk on substance use highlight the importance of people's social world: "The opposite of addiction is not sobriety; the opposite of addiction is connection." An interesting finding in our study is that this also resonates well across the accounts of the participants that we interviewed. All of them had been abstinent for a minimum of 2 years, and for them, family and

friends took center stage in their processes of overcoming SUD. Challenges related to this are described in the first constituent theme, "being entangled in difficult relationships," and the recovery processes involved are highlighted in the second, "people provide essential support and stability."

From a recovery perspective there is also a wide range of studies that underscore the value of people's close relationships. For example, Leamy et al. [6] found in a systematic literature review of recovery from mental illness that one of the fundamental processes in recovery is to connect with others. Similarly, an interview study by Granfield and Cloud [44] with 46 people who had experienced natural recovery following drug- or alcohol-related problems emphasize how recovery is markedly affected by a person's position within the larger social structure. They describe their participants as "two-worlders," people who managed to simultaneously have one foot in the conventional world and the other in the world of drugs or alcohol. This mitigated the consequences of participants' problems and made re-engagement with both their close relationships and the larger community possible [44].

Drawing on a metaphor by Mitchell [45], we could say that using drugs and alcohol is like firecrackers exploding in the dark night—they are mind-blowing, but also inevitably momentary. Fireworks will eventually be experienced as more and more trivial, and at some point, they seem to lose their value and meaning. As highlighted in our theme "people provide essential support and stability," close relationships are, on the other hand, packed with meaning. In discussing the impact of a particular type of social bond, intimate relationships, Mitchell [45] asserts:

> Romance is […] closely related to meaning, but not the ponderous kind or the important sort of meaning that can be generated by suffering and travail. The kind of meaning associated with romance is the feeling that life is worthwhile, that important events can and do happen within it (p. 27).

Leading a life that comprises important interpersonal events will, however, demand commitment and engagement. While this can be a challenge, as highlighted by participants in our study, it is also an important part of recovery processes. For example, Davidson [12] describes how developing new responsibilities is key in recovery, and Deegan [10] argues that what she calls the "dignity of risk and the right to failure" (p. 97) was a necessary foundation for her personal recovery.

Implications

The present study highlights how recovery processes unfold within the textures of people's daily lives. As a consequence, we need more knowledge about people's everyday recovery and the role their social world plays in these processes. The answer to SUD cannot be found in the illness or disorder, only in the person and the circumstances of his or her life [42]. Another important implication of this study is that it underscores the multiple paths of recovery and the diverse roles that people's close relationships may play. We suggest that additional studies are needed to disentangle the different characteristics of both stabilizing and destabilizing relationships for people with SUD. Furthermore, our findings demonstrate that recovery is a continuous process. Even though all participants were defined as fully and clinically recovered for a minimum of 2 years, they still described challenges in relation to building a good, meaningful life. We argue that this needs to be taken into consideration both on a community level and in designing health care services for people with SUD.

Reflexivity

Qualitative research can be seen as a shared product of the participants, researchers and their relationship [24]. This understanding has consequences for how we consider the quality of studies. Finlay [37] states: "Rather than objectivity, the challenge here is to juggle the contradictory stances of being 'scientifically removed from,' 'open to' and 'aware of' while simultaneously interlacing with research participants" (p. 23). As a result, researcher self-awareness—reflexivity—becomes an important tool for analyzing how subjective and relational elements influence the research process at different stages [24, 26, 37].

As demonstrated, it has been important for us to examine how the interviewers' (TES and AWS) first-hand experiences with SUD and recovery might have informed the process of collecting data in the present study. By establishing trust and familiarity, this may have encouraged participants to open up and also

helped to bring the interview interactions closer to the experiential level [46]. An interesting difference between the mental health field and addiction field is that while people with mental illness share many of the same experiences, e.g. in finding ways of handling their symptoms or in meetings with the health care system, people with SUD have many more everyday practices and sociocultural settings in common, what Bourdieu [47] calls habitus. This is important in the context of the present study because people with the same habitus may understand each other more intuitively because of their shared language and social practices, which are important qualities in both interviewing and analyzing the data. As such, there may be a specific added value in partnering with people with lived experiences of SUD in research studies.

Another central point to consider is how the professional background of the analytic team might have influenced the understandings we arrived at. As MV, CM and JB all are clinical psychologists, it is possible that basic assumptions in psychology may have had an impact on the present study. For example, although our analytical questions focus on people's social worlds, it can also be argued that they are developed from an individually oriented viewpoint. The focus is on the role of this social world for the person, and there is a need to develop explorations of recovery that move beyond placing the individual at center stage [14]. For instance, a more collaborative effort in our analysis may have helped to establish a more complete view of recovery as an inherently social process, highlighting how "we are not beings in relationship, but rather relational beings from the outset" ([14], p. 112). It is possible that assembling a more diverse analytic team could have expanded our understanding [24].

Limitations

There are limitations in this study. First, we chose a flexible approach in conducting the interviews in order to reduce enrollment barriers. The lack of nonverbal communication and visual cues in the four interviews conducted by telephone may, however, have impacted the data material. These interviews were shorter in duration and less vivid, but we could not see any differences in the information shared between the participants interviewed by telephone and those interviewed in person. Second, our sample size is large. Because the research question was broad and the interviewers were novice researchers, we planned to recruit a significant number of participants. While this allowed for rich, varied material, it may also have complicated the process of obtaining a necessary overview of the data [48]. As a pragmatic response to this, we arranged two analytic meetings. In the first, we aimed to develop an overall understanding of the interviews, and in the second, we analyzed the aspects of the interviews focusing on the part close relationships played. A third limitation is that we did not interview participants' friends and family members. Additional in-depth interviews with them could have elaborated on the understandings developed in this study and possibly provided us with more details about the role of close relationships. Fourth, we chose to use thematic analysis as our practical tool for analyzing participants lived experiences. This helped us identify patterns across the entire dataset, but may have impeded processes of developing knowledge on the unique characteristics of each individual participant. As such, further studies should consider using more idiographic approaches to explore the role of close relationships in recovery from SUD. Finally, the study participants, who were predominantly white, Norwegian citizens, were all recruited from the same health care context and social security system. This homogeneity may have affected our findings, and care needs to be taken in transferring the knowledge generated in this study to other contexts.

Conclusion

In this qualitative study, we researched the experiences of 30 people who have recovered following a SUD to explore what role their close relationships played in their individual recovery processes. We found that the participants' experiences clustered around a superordinate theme that we have called "a stabilizing and destabilizing social world", and three broad constituent themes that summarize their descriptions. These are: (a) being entangled in difficult relationships; (b) people provide essential support and stability; and (c) we become different people along the pathway of our lives. We have discussed our findings in relation to existing research, pointed out possible implications for future research, described our process

of reflexivity and highlighted important limitations in this study.

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