UNDERSTANDING RESILIENCE: UNCOVERING THE COMMON THEMES

By

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Abstract

Research on resilience focuses on children and adolescents, with little attention paid to adults. The intention of this study is to broaden knowledge of resilience in adults, especially those in recovery from drugs and/or alcohol. The central research question explores people's experience of resilience in terms of turning points, environmental supports, and psychological contexts. Five participants were recruited from an outpatient, non-profit counselling agency. A qualitative phenomenological method was used and data was gathered using a semi-structured, open-ended interview questionnaire. Results indicate that there are common themes that link people's experience of resilience. It is important to understand the phenomenon of resilience because it has many implications for harm-reduction, prevention, and treatment work with at-risk or marginalized populations.

Keywords: resilience, recovery, addiction, substance use, prevention, treatment

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Dedication

This thesis is dedicated to those individuals who believed in themselves despite all odds.

CONTENTS

List of Tables

CHAPTER 1: INTRODUCTION

Resilience is the gateway to effective prevention and treatment models (Cadet, 2016; Comstock, 2005). Resilience is described as an important element in maintaining and promoting mental health and acts as a life-long buffer to potential threats to well-being (Khanlou & Wray, 2014). It is a strengths-based concept that builds on an individual's strengths, rather than emphasizing their deficits. Resilience has been found to promote improvements in school, employment, and pro-social outcomes (Khanlou & Wray, 2014). Much of the attention on resilience is driven by the association with positive social outcomes (Khanlou & Wray, 2014). Despite the evidence suggesting linkages between resilience and positive social outcomes, such an association should be considered from the complexity of the social world that we live in.

It is important to dissect the differing meanings of a "positive outcome" versus a "negative outcome." These opposite outcomes are socially constructed by the society in which we coexist. Although it is useful in understanding resilience, the focus of this thesis will remain on examining resilience as a strength that results from adversity. The Eastern philosophical concept of Yin and Yang illustrates the notion of resilience based on two opposing forces: care and challenge (Grotberg, 2003). In essence, it states that the concept of resilience would not exist without having to experience adversity.

As resilience is related to adversity, it has many implications for modern day mental health concerns. The relationship of resilience to mental health is not a clear one (Khanlou & Wray, 2014). Social well-being and positive mental health illustrate subjective realities that are also affected by the structural social environments that we live in. Perspectives on life functioning, systems of poverty, coping and control, and social connections need to be addressed. Thus research is important in defining this relationship.

In terms of the helping professions and social services, research can assist in developing new and improved services and programs which can be of the magnitude to affect social policies, such as how society manages with rising mental and emotional health challenges.

Those who work in the helping professions and social services are aware of the many societal ills that befall on populations around the world. One such area of social concern involves the misuse or abuse of drugs and/or alcohol. The adverse effects of the misuse or abuse of drugs and/or alcohol and the resulting resilience represents the concept of Yin and Yang. Thus in order to fully understand resilience as a means to promote social well-being, the opposing adversities, in this case the misuse or abuse of drugs and/or alcohol, must also be examined.

In this chapter, the background to the problem is examined by reviewing drug and/or alcohol misuse or abuse in terms of: international prevalence, Canadian prevalence, youth populations, adult populations, poly drug use, mental health issues, and risk of suicide. The statement of the problem, purpose of the study, statement of the research question and importance of the study will also be reviewed. The definition of terms will include: resilience, recovery, substance use/misuse/abuse, addiction, at-risk populations, and marginalized populations. Finally, the scope of the study will be provided.

Drug and/or alcohol use is a growing concern around the world, as drugs of greater potency are becoming more available and types of harmful synthetic drugs are increasing in number, from 41 different types in 2010 to 101 different types in 2014 (Palamar, Martins, Su, & Ompad, 2015). Drug and/or alcohol use disorders make substantial contributions to global mortality and morbidity (Lynskey & Strang, 2013). International studies illustrate a need for policies and interventions to reduce global drug and/or alcohol use and the harms associated with such use, while also increasing access to and availability of treatment options for drug and/or

alcohol use disorders. It is a concern that adversely affects the inter-connected lives of many, and

the societies and communities impacted more broadly, thus there is a need to study this topic

more in-depth from all angles.

Background to the Problem

Drugs and alcohol, also referred to as substances, is a broad topic that encompasses many

areas of concern (Palamar et al., 2015; Whiteford et al., 2013). The research conducted in this

area has focused primarily on children and youth, where little research has been done on adults

(Morgen, Denison-Vesel, Kobylarz, & Voelkner, 2015). In order to shed light on this subject

matter, drug and/or alcohol misuse or abuse will be examined from the following areas of

analytic significance: international prevalence, Canadian prevalence, youth populations, adult

populations, poly-drug use, mental health issues, and risk of suicide.

International Prevalence

The misuse and abuse of drugs and/or alcohol affects millions of people worldwide

(Whiteford et al., 2013). In recent years, there has been an increase in the use of drugs and/or

alcohol globally, where the misuse or abuse of alcohol is the most prevalent across all cultural

groups and age demographics (Palamar at el., 2015; Whiteford et al., 2013). A 2009-2013

ongoing cross-sectional survey of 213, 076 individuals in the US shows that drug use has

increased from 12.3% to 29.2% in this sample (Palamar et al., 2015). Self-reported use of illicit

drugs has shown a particularly high risk of use among males (74.3% compared to 25.7% in

females), Caucasians (82.2% compared to 2.2% in Blacks, 10.1% in Hispanics, and 5.4% in

other), ages in the mid 20s to mid 30s (57% and 35.4% respectively compared to 7.6% in

adolescents), those of lower income (28% in family income <$20,00 and 32.9% in family

income $20,000-$49,999 compared to 16.5% in family income $50,000-%74,599), and among

those residing in mid to large sized cities (35.6% and 53.4% respectively compared to 10.9% in small sized cities (Palamar et al., 2015).

The vast amount of research on the prevalence of the misuse or abuse of these substances reflects data conducted internationally and is representative of different sexes, races, age demographics, socioeconomic statuses, and income levels (Palamar et al, 2015; Veidhuizen, Urbanoski, & Cairney, 2007; Whiteford et al., 2013). Much of these studies reflect self-reported measures from the participants (Palamar et al., 2015). Due to this use of self-reported measures, it has been suggested that much of the research data on the prevalence of drug and/or alcohol misuse or abuse is vastly underreported.

The repercussions of the misuse or abuse of drugs and/or alcohol does not discriminate between sex, culture, or age (Palamar et al., 2015). International studies of global drug use indicate that methamphetamine or amphetamine abuse, marijuana abuse, cocaine abuse, and opioid abuse are found in countries around the world, among both males and females (Lynskey & Strang, 2013).

Canadian Prevalence

The international data on drug and/or alcohol misuse or abuse is consistent with Canadian studies examining the national prevalence rates (Veidhuizen et al., 2007). In Canadian studies, prevalence rates appear to vary from province to province. It has been found that there is higher problematic drug and/or alcohol use in major cities compared to rural ones (Veidhuizen et al., 2007). The provinces with the highest rates of drug and/or alcohol abuse include: Nova Scotia, Manitoba, Saskatchewan, Alberta, and British Columbia (Veidhuizen et al., 2007).

British Columbia also shows a higher than average marijuana use compared to other provinces, but Quebec shows a higher than average alcohol use (Health Canada, 2014). North

American studies have found that marijuana abuse was highly correlated with marijuana dependency, where marijuana abuse disorder was positively associated with weekly marijuana use, early marijuana use, other substance use disorders, and serious psychological distress (Wu et al., 2012). This postulates that there is a correlation between marijuana use and marijuana abuse. Research suggests that this correlation may be due to the frequency of marijuana use and the elevated levels of marijuana potency. It is important to note that these studies exclude the use of marijuana as a medical aid which is legal and not viewed as an abuse.

In a Canadian national study, marijuana was found to be the most commonly used illicit drug, followed by ecstasy, hallucinogens, and cocaine (Health Canada, 2014). To this date, marijuana is still considered an illicit drug in Canada; however, upon the 2015 Federal Election in which the Liberal Party of Canada was elected a majority government, there will be a forthcoming legalization and regulation of marijuana (Liberal Party of Canada, 2015).

Research data also confirms a steady increase in the misuse and abuse of psychoactive pharmaceutical drugs, such as opioid pain relievers (OxyContin, Demerol), stimulants (Ritalin, Adderall), and sedatives (Valium, Ativan), across all age groups within Canada (Health Canada, 2014). However, greatest misuse and abuse had been found in Canadians aged 25 and older.

Youth Populations

International studies on global drug and/or alcohol prevalence rates have revealed that cannabis use appears to be normative among mid-adolescents (Ter Bogt, Schmid, Nic Gabhainn, Fotiou, & Volleberh, 2006). These rates show that cannabis use is higher in males than in females and that the greatest amount of use globally is seen in Canada and in the United States. It has been projected that cannabis use is expected to increase and gender differences in use to decrease.

Research on drug and/alcohol use in youth has also been linked to sexual exploitation (Homma, Nicholson, & Saewyc, 2012). Sexual exploitation describes the exchange of sexual activities for money, drugs, or other compensation among under aged youth. Research suggests that youth who had ever exchanged sex for money, drugs, or other goods were more likely than those with no such history to report binge drinking, earlier onset alcohol use, regular alcohol use, and alcohol-related problems.

It has been found that delinquency and drug and/or alcohol use are more likely to co-occur in adolescence compared to earlier and later developmental periods (Monohan, Rhew, Hawkins, & Brown, 2014). Research on youth who use drugs and/or alcohol reveal that most youth transitioned from abstinence to delinquent behaviour and then escalated to co-occurring problematic behaviours.

Youth experience greater harms due to this illicit drug use compared to any other age group (Health Canada, 2014). Harm in this sense describes problems in any of the following areas: physical health, friendships and social life, financial position, home life or marriage, work, studies, employment opportunities, legal problems, difficulty learning, and housing problems.

Adult Populations

There is a gap in research examining the drug and/or alcohol use in adults and older adults (Morgen et al., 2015). However, as the global population ages, there is a growing number of older adults struggling with issues involving drugs and/or alcohol as well.

Research has found that adults 25 years or older represent the largest population that abuses psychoactive pharmaceutical drugs such as OxyContin, Ritalin, and Ativan (Health Canada, 2014). This age group also represents the largest population of those who consume alcohol, whereby males consume more than females. Research has found that factors associated

with risky alcohol use include: being male and middle aged, having experienced negative life events such as depression, and coming from a lower socio-economical status (Roche et al., 2015). Males represent the largest population of users, where use is associated with risky behaviours and related harms of use (Roche et al., 2015). These harms include: being verbally or emotionally abused, feeling threatened, and being physically hurt (Health Canada, 2014).

Worldwide, approximately 3.3 million people die every year as a result from harmful alcohol use (World Health Organization, 2015). Approximately 25% of these deaths attributable to alcohol belong to the age group of 20-39 year olds. The harmful use of alcohol can also result in harm to self, harm to others, as well as result in significant health issues and social and economic burden to society as a whole.

Poly-Drug Use

Poly-drug use is also increasing among all populations (Leatherdale & Burkhalter, 2012; Patra, Fischer, Maksimowska, & Rehm, 2009). International studies examined the relationship of social influences to use of drugs, such as a friend's drug and/or alcohol use, with lifetime poly-drug use for adolescents (Epstein, Botvin, & Doyle, 2009). The results indicate that friends' smoking and drinking habits, and permissive/ambivalent parental attitudes towards drinking were associated with poly-drug use.

Although Canadian drug use of all kinds is on a steady decline, global comorbid use of drugs is slowly increasing, where alcohol remains the most prevalently used substance (Health Canada, 2014; Leatherdale & Burkhalter, 2012). North American research examining the types of drugs used by convicted DUI offenders found that alcohol was the most common, followed by marijuana, sedative medications, and prescription analgesics (Pilkinton, Robertson, and

McCluskey, 2013). The research states that among poly-drug users, 78.4% reported combining alcohol with other licit and illicit drugs.

Mental Health Issues

Although the individual and societal impact of the misuse and abuse of drugs and/or alcohol presents with many concerns, the compounded effect of mental health issues and substance use problems proves to be a growing concern worldwide (Whiteford et al., 2013).

International studies report that 25.1% of people with schizophrenia, 20.1% of people with bipolar disorder, and 10.9% of people with depressive symptoms also engaged in problematic use of drugs and/or alcohol (Nesvag et al., 2015). Among these people with mental health issues, middle-aged men with bipolar disorder showed the highest prevalence of problematic alcohol use, whereas young men with schizophrenia showed the highest prevalence of problematic illicit drug use. The research illustrates an alarmingly high prevalence of co-occurring problematic drug and/or alcohol use among people with severe mental health issues.

The burden of mental health and drug and/or alcohol misuse or abuse can be described as years of life lost to premature mortality, years lived with a disability, and disability-adjusted life years (Whiteford et al., 2013). This burden of mental health and substance use was found to have increased 37.6% between 1990 and 2010. Of premature deaths, many are injuries of self-harm and suicide due to mental health disorders and substance use disorders. This poses a major concern for health care systems around the world.

Risk of Suicide

Over 800,000 people die from suicide every year (International Association for Suicide Prevention, 2015). It has been estimated that during 2012 for each adult who died of suicide, there were over 20 others who made suicide attempts. Various risk factors have been found to be

correlated with individuals who have either contemplated suicide, attempted suicide at least

once, or were injured while attempting suicide (Gart & Kelly, 2015). These factors include:

illegal drug use, alcohol use, tobacco use, and depressive symptoms.

It has also been found that there is a strong association between alcohol use disorder and

hospital-treated suicide attempts in both sexes (Morin et al, 2013). Research has also indicates

that there is an elevated risk of suicide attempts among people who inject drugs (Artenie et al.,

2015). Within this sub-population of drug users, chronic or occasional cocaine use, chronic

amphetamine use, and chronic sedative use were most associated with attempted suicide. Thus,

stimulant users appear to be a vulnerable sub-population at risk of attempted suicide. These

findings from the research literature support that illegal drug and/or alcohol use can lead to

suicidal thoughts and actions (Gart & Kelly, 2015).

Statement of the Problem

Drug and/or alcohol misuse or abuse is a very broad topic, where there are many factors

related to the problem and numerous social concerns associated with it. As much as this study

strives to be comprehensive, it is impossible to take into account every aspect and scenario

affecting drug and/or alcohol misuse or abuse. For this reason, parameters will be provided to

narrow the focus of the study. Delineation will be described in terms of: a focus on recovery, the

sample population, and methodological procedures.

Focus on Recovery

Much of the research on drug and/or alcohol misuse or abuse focuses on the negative

health consequences and social burdens of the socially labeled "disease." Drug and/or alcohol

misuse or abuse is related to many negative health and life outcomes, whereby there are, in my

view, just too many to list. Rather than examining the immense amount of negative

consequences of drug and/or alcohol misuse or abuse, there will be a focus on the positive

aspects, specifically on the process of recovery and resilience.

Sample Population

Age. One such boundary involves the age group of the sample population. The study

aims to examine resilience in an adult population. Adults will be categorized as anyone age 19

years or older. The reasoning behind the exclusion of children and youth is reflected in the

current research literature. For example, there is a vast amount of research on resilience focusing

on children and adolescents, yet little information available examining adults (Connor & Zhang,

2006). My intent on studying resilience in adult populations is to add to the body of research

where less attention has been paid.

Geographic region. Another parameter in regard to the sample population reflects

participants' geographic region. My study will is limited to participants who are currently living

in the Delta, BC area. This includes the vicinities of Delta, North Delta, Ladner, and

Tsawwassen. Potential participants from other parts of the Greater Vancouver Region are

excluded due to an affiliation with the agency where the participants will be recruited and this

agency restricts services to residents of the above listed communities only. Specifically,

participants will be recruited from existing clients of Deltassist, an outpatient, non-profit

counselling agency located in Delta, BC.

Methodological Procedures

In determining the research design of this study, many similar methodologies were

considered. Different research methods are used to answer different questions, as each

perspective is based on different assumptions and employs different concepts (Wister &

McPherson, 2014). A qualitative phenomenological methodology was chosen for this study, as it

addresses the key concepts I intend to examine. Specifically, Interpretive Phenomenological

Analysis (IPA) was chosen to examine the topic of drug and/or alcohol misuse or abuse.

IPA is a qualitative research approach committed to the examination of how people make

sense of their major life experiences (Smith, Flower, & Larkin, 2009). The aim of IPA research

is to engage with participants' reflections on the significance of what is happening, as well as to

make sense of their experience.

Purpose of the Study

The purpose of this qualitative phenomenological study will be to further understand the

experience of resilience for adults going through the process of recovery from drugs and/or

alcohol in an outpatient, non-profit counselling agency setting.

Statement of Research Question

With the aim of understanding people's experience of resilience, a semi-structured, open-

ended interview will be conducted with participants. The main research question will be as

follows: What is your experience of resilience throughout your recovery process? The sub-

questions will include: What were the turning points that lead you in this life direction? What in

your environment supported your resilience? What psychological contexts supported your

resilience? And what else or is there anything you would like to share with me today regarding

your recovery?

Importance of the Study

There is a growing concern of the misuse or abuse of drugs and/or alcohol across

genders, age demographics, and cultures as drugs of greater potency are becoming more

available and types of harmful synthetic drugs are increasing in number, from 41 different types

in 2010 to 101 different types in 2014 (Palamar et al., 2015). It is imperative to examine the

impact of the misuse or abuse drugs and/or alcohol on individuals in terms of population health (Lynskey & Strang, 2013; Whiteford et al., 2013). This misuse or abuse of drugs and/or alcohol affects millions of lives worldwide, thus by understanding the elements that allow people to overcome adversity, prevention, harm-reduction, and treatment models can be developed and applied to this population (Granfield & Cloud, 2001; Whiteford et al., 2013). This study will offer implications on developing new prevention and treatment models, addressing the existing service pitfalls, and applying the results to other domains.

Prevention and Treatment Models

Resilience is the gateway to effective prevention and treatment models (Cadet, 2016; Comstock, 2005). There are many determinants of resilience; however, there is a lack of consensus in unveiling the major factors influencing resilience. This voices the concern of the lack of research available in looking at the qualities of resilience. It has been found that resilience can be modifiable on individual and cultural levels; therefore, the application of resilience in prevention and treatment models for the misuse or abuse of drugs and/or alcohol may be possible.

Addressing Service Pitfalls

European research on mental health disorders and alcohol use disorders comprising of a representative sample of 21, 425 adults in Belgium, France, Germany, Italy, the Netherlands, and Spain found that alcohol dependence was frequently correlated with mood and anxiety disorders, while alcohol abuse was associated with major depression (Morisano, Babor, & Robaina, 2014). Research in Australia, New Zealand, and Canada have produced similar results to European studies. In a 2012 US National survey on Drug Use and Health of adults with substance use issues in the past year, it was found that 40.7% (8.4 million) people had a co-occurring mental

health disorder (Morisano et al., 2014). As there is a growing concern of the co-occurrence of

mental health issues with drug and/or alcohol misuse or abuse problems worldwide, there is a

need to design treatment services that address both groups of disorders (Morisano et al., 2014).

Research examining the mechanisms underlying the co-occurance of substance use disorders and

mental health issues reveal a possible bidirectional causal association between the two

conditions. The bidirectional model suggests that a positive feedback loop intertwines the abuse

of substances with mental illness. Co-occuring disorders tend to have a more severe course of

illness, more severe health and social consequences, more difficulties in treatment services, and

worse treatment outcomes than people with a single disorder. Thus it is imperative that there is

research to aid in the development of strategies in order to work with people and their strengths

in order to overcome the course of these disorders.

Applications in Other Domains

In learning more about what makes up resilience, the application of such qualities can

extend beyond work in the field of addictions to drugs and/or alcohol. Resilience has been

associated with the healing of children who have survived abuse and maltreatment (Nasvytiene,

Lazdauskas, & Leonaviviene, 2012), aiding youth to better cope with stress and anxiety (Kenny,

Gallagher, Alvarez-Salvat, & Silsby, 2002), reducing long-term negative outcomes of

delinquency in adolescences (Larm, Hodgins, Tengstrom, & Larsson, 2010), enabling

professionals to cope with demands of the job (Grant & Kinman, 2012), reducing the negative

effects of trauma and post-traumatic stress disorder (Rosenberg et al., 2014), and maintaining

and enhancing the psychosocial, health, and well-being of people as a whole (Robertson, Cooper,

Sarkar, & Curran, 2015).

This study aims to add to the growing body of research examining the factors associated with resilience in terms of drug and/or alcohol misuse or abuse. Resilience allows for people to reach towards new possibilities and, in essence, to improve population health and well-being (Jenkins, 2011).

Definition of Terms

Some terms used throughout this paper do not have a consensus in definition within academic research. The definitions of these terms are examined below. Such terms include: resilience, recovery, substance use/misuse/abuse, addiction, at-risk populations, and marginalized populations.

Resilience

The term resilience often relates to an individual's in/ability to negotiate stressful situations (Burrow-Sanchez, Corrales, Jensen, & Meyers, 2014). It describes a process of adapting successfully in the face of adversity, trauma, tragedy, or other significant sources of stress (Konvisser, 2013). Resilience is the general ability of people to overcome profound difficulties and extreme hardships (Comstock, 2005).

Recovery

Recovery, in terms of drugs and/or alcohol, is a widely used term, one where there is no standard definition among academia and professionals (Laudet, 2007; Schwarzlose, 2007). Recovery is based on two differing definitions coming from the abstinence model of addiction and the wellness model of addiction.

The abstinence model. Under this model, recovery from drugs and/or alcohol is characterized by sobriety (Schwarzlose, 2007). In other words, recovery describes a process which involves total abstinence from drugs and/or alcohol.

The wellness model. This model suggests that recovery is based on a harm-reduction continuum, thus sobriety is not required (Shepherd, Reynolds, & Moran, 2010). Harm-reduction refers to a set of policies and strategies designed to reduce the negative consequences associated with the use of drugs and/or alcohol (Granfield & Cloud, 2001). Although the wellness model does not require that an individual completely abstain from drugs and/or alcohol during the recovery process, abstinence is a part of the continuum in reducing potential harm from drugs and/or alcohol (Shepherd et al., 2010).

Both definitions of recovery will be used. However, to illustrate a simpler definition, recovery will be understood in the sense that is it a process of change whereby individuals work to improve their own health and wellness, while striving to achieve their full potential (Substance Abuse and Mental Health Services Administration, 2015).

Substance Use/Misuse/Abuse

Substance use, misuse, and abuse are used interchangeably. In regard to drugs and/or alcohol, substance use is used to describe problematic drug and/or alcohol use (Frone, 2013). The essential characteristics of substance use include cognitive, behavioural, and physiological symptoms indicating that the individual continues using drugs and/or alcohol despite significant substance-related problems (American Psychiatric Association, 2013).

Addiction

It is important to note that the term addiction can be used to describe positive and negative behaviours in many domains. However, in the scope of this study, addiction will be examined in terms of negative behaviours relating to drugs and/or alcohol. In regard to substances, the term addiction refers to a process whereby behaviour is carried out in a pattern characterized by powerlessness and unmanageability (Goodman, 1990). Powerlessness in this

sense describes a recurrent failure to control the behaviour and unmanageability refers to the

continuation of behaviour despite significant negative consequences.

At-Risk Populations

In relation to drugs and/or alcohol, at-risk populations describe a group of people who are

at greater risk of developing problematic substance use compared to the general population

(Swendsen et al., 2009). At-risk populations reflect socio-demographic factors that affect a

group. Some factors that have been common in at-risk populations include: young age, lower

educational attainment, non-white ethnicity, and lower occupational status. Sex, number of

children, and residential area are also factors affecting at-risk populations, however, it has been

found that they do not have a significant impact compared to the previously stated factors.

Marginalized Populations

Marginalization is the process of being excluded from meaningful participation in

mainstream society (Welbel et al., 2013). It is usually linked to a lower social status or some

other marker of social disenfranchisement with concomitant limited access to important social

resources such as: health care services, social services, education, housing, labour market, and

leisure facilities. Thus marginalized populations reflect a peripheral group outside of mainstream

society who have limited access to social resources.

Scope of the Study

This study has a strong focus on the positive experience of recovery and resilience.

Negative outcomes from addiction to drugs and/or alcohol will also be reviewed. Particular

attention will also be given to adults in this population, as there is an overwhelming amount of

research pertaining to youth and adolescents (Morgen et al., 2015).

The limits of this study pertain to the pitfalls resulting from the self-reported measures of participants and potential interviewer bias.

Results from this study are limited by the participants' ability to recall past events. Phenomenological research acknowledges that to learn about an experience, such as resilience, is always dependent on how much participants can remember and in how much detail they remember it. The description of the experience is also bounded by the participants' ability to articulate their thoughts and experiences. Thus, a participant who speaks English as a first language and who is able to described the events in a detailed manner may be able to provide a richer account of the experience of resilience than a participant who speaks English as a second language and who cannot articulate his or her thoughts as eloquently.

Interviewer bias also represents a possible limit to this study. As I will be conducting the interviews, I may illicit a biased reaction with non-verbal behaviours to the responses given by the participants. As a result, I may unconsciously demonstrate approval or disapproval of what they are saying. In order to address this potential limit, it is important that I am cognizant of my expression of non-verbal language and take an objective and non-biased position when interviewing participants.

Self-reported measures illustrate a potential condition that is outside of my control as a researcher; whereas, interviewer bias represents a potential condition that is within my control as a researcher. Although acknowledged, these factors may place restrictions on my results and conclusions.

Summary

The intent of this phenomenological study is to examine the experience of resilience among adults going through the process of recovery from substance misuses. It is important to

study this for its implications on developing future prevention and treatment models, addressing

service pitfalls, and applying the knowledge gained to other domains. Although this study is

limited by the detail of self-reported measures of participants and interviewer bias, it will be an

important addition to an area of research that is lacking. The misuse, abuse, and addictions of

drugs and/or alcohol represent more than just a local concern; more than just a national concern;

but rather, it represents a global concern. In order to address this problem at its core, the study of

human strength and resilience is necessary.

CHAPTER 2: LITERATURE REVIEW

Addictions to drugs and/or alcohol in terms of its social impact has cost Canadian society many millions of dollars and touched many more lives in the process (Veidhuizen et al., 2007). I have not come across any individual or any family that has not been affected by substance misuse or abuse in some form or another.

Understanding the misuse or abuse of drugs and/or alcohol, from now on to be referred to as substance use, is a highly controversial topic. Some believe that there is a genetic marker, predisposing individuals to addictive behaviours (Belcher, Volkow, Moeller, & Ferre, 2014; Srinivasan, Shariff, & Bartlett, 2013), whereas others believe that it is a result from experiencing trauma (Wingo, Ressler, & Bradley, 2014). Regardless of how people look at addictions or substance use to drugs and/or alcohol, it is common that substance use is associated to the term resilience (Khanlou & Wray, 2014; Konvisser, 2013; Wingo et al., 2014).

The international research literature on resilience generally focuses on children and adolescents, while little attention is paid to adults (Connor & Zhang, 2006). There is a need for studies of resilience on adults because the results and interventions found from child and adolescent studies may not be applicable to adult populations (Connor & Zhang, 2006; Ungar et al., 2008). Current studies suggest that resilience can be fostered with at-risk populations, such as street-entrenched youth, people living in poverty, or people who are subjected to violence or abuse (Connor & Zhang, 2006; Grant & Kinman, 2012). Thus there is a growing movement of research suggesting that resilience can be used as an intervention strategy when working with marginalized and at-risk populations (Connor & Zhang, 2006; Ungar et al., 2008).

Working with substance use in terms of recovery is also a well researched topic area (Krentzman, 2013). The term resilience will be examined in regard to substance use and

recovery. Resilience will be further examined by breaking down and exploring the many facets that make up resilience from a bio-psycho-social-spiritual perspective. The factors that will be examined include: individual factors, interpersonal factors, and social/cultural/environmental factors. The interaction of these factors will then be analyzed to illustrate how they can be utilized to promote resilience.

Exploring Resilience and Recovery

Resilience

It is important to understand the phenomenon of resilience because it has many implications for harm-reduction work with at-risk and marginalized populations (Connor & Zhang, 2006; Grant & Kinman, 2012). Much of the research on resilience focuses on children in settings such as family violence, extreme poverty, war, and natural disasters (Connor & Zhang, 2006). However, the beneficial applications can also be applied to adults who have experienced trauma or substance use issues (Belcher et al., 2014).

There are many different ways to define resilience; however, they all share a key theme. Resilience often relates to an individual's in/ability to negotiate stressful situations (Burrow-Sanchez et al., 2014). Thus, resilience describes a process of adapting successfully in the face of adversity, trauma, tragedy, or other significant sources of stress (Konvisser, 2013).

Resilience is a process rather than a single event (Khanlou & Wray, 2014). From this perspective, resilience is also viewed as a continuum instead of a binary outcome. This means that resilience is not an all-or-nothing phenomenon. It can present in varying degrees in many different aspects of life depending on the support systems available and the challenges faced over time. This process of resilience develops over time and depending on the interactions between factors involved, the time period can vary across individuals and settings. In other words,

individuals can show varying levels of resilience depending on the interaction between their

individual factors, interpersonal factors, and social/cultural/environmental factors (Khanlou &

Wray, 2014; Moon, Jackson, & Hecht, 2000).

Recovery

Three phases are often associated and addressed when discussing substance use:

prevention, treatment, and recovery; whereby recovery is considered the most important stage

(Harris, Smock, & Tabor-Wilkes, 2011). Although widely used, there is a lack of standard

definition of the term recovery, which has hindered public understanding and research in this

topic area that might foster more and better recovery-oriented interventions, as well as

developing assessment tools to evaluate treatment effectiveness (Laudet, 2007; Schwarzlose,

2007).

Recovery remains poorly understood and inadequately defined as there are two different

over-arching definitions of recovery (Laudet, 2007; Schwarzlose, 2007). One definition refers to

the abstinence model of recovery (Laudet, 2007), whereas the other refers to the wellness model

of recovery (Maffina, Deane, Lyons, Crowe, & Kelly, 2013).

The abstinence model. Many individuals in recovery refer to their new sober and

productive lifestyle as "recovery" (Schwarzlose, 2007). Recovery in this sense can be understood

as a voluntarily maintained lifestyle, characterized by sobriety, personal health, and citizenship.

Most people who self-identify as "in recovery" define it as total abstinence; however,

some argue that abstinence goes beyond merely abstaining from substances (Laudet, 2007).

Rather, abstinence is described as a new life, an on-going growth of self-change, and a process of

reclaiming the self.

The wellness model. In a broader sense, recovery can be understood from a harm-reduction perspective as over-coming adversity with pivotal moments followed by both short-term and long-term strategies (Shepherd et al., 2010). Short-term strategies offer individuals relief from distress and emotional discomfort, as well as increased clarity about their substance use issues. Whereas long-term strategies act to rebuild relationships and participate in normalizing activities. Thus the definition of recovery in terms of this model does not require abstinence. Rather, it focuses on the global functioning of an individual in society at large.

Regardless of the definition, resilience and recovery are inexplicably linked. For the purpose of this research, recovery will not be defined using one single definition. Rather, recovery will be examined in terms of what the participant describes it to be because recovery can occur with or without professional help, and can occur with or without total abstinence (Vassallo, 1998). Recovery describes a process where an individual works to improve their own health and well-being (Substance Abuse and Mental Health Services Administration, 2015). The common denominator of recovery tends to be the presence of people who believe in and stand by the person in need of recovery (Vassallo, 1998). Recovery involves growth and setbacks, periods of rapid change and little change, and involves more than just overcoming substance use, but rather it encompasses recovery from the consequences of substance use as well: unemployment, poor housing, loss of rights, and loss of meaningful social relationships.

Individual Factors

Resilience is a strengths-based concept that builds on an individual's strengths, rather than her or his deficits (Khanlou & Wray, 2014). One of the basic definitions of resilience, good outcomes despite serious threats to well-being, focuses on an individual's capacities to overcome adversity, such as substance use issues (Ungar et al., 2008).

Some of these individual factors include: temperament, learning strengths, sense of control, self-concept, emotions, positive and proactive personality, adaptive skills, perceived social support, and social skills (Khanlou & Wray, 2014; Sarkar & Fletcher, 2014). It is the combination of these individual factors and a person's experience and opportunities that shape his or her resilience and the success with which stressful situations are negotiated (Khanlou & Wray, 2014).

An individual's way of thinking can have a great influence on his or her outlook on life while facing substance use issues (Khanlou & Wray, 2014; Konvisser, 2013). Realistic optimism, cognitive, and emotional flexibility, extroversion, and openness to experience are effective for dealing with stress and trauma (Konvisser, 2013). These factors have also been associated with the development of resilience.

One of the most significant individual factors associated with resilience in the face of substance use issues is hope (Konvisser, 2013; McCrea, 2014; Stajduhar, Funk, Shaw, Bottorff, & Johnson, 2009). Hope theory, in terms of resiliency, describes hope as the ability to conceptualize pathways towards goals and conviction of competence in goal attainment (McCrea, 2014). Hope influences how a person copes with life challenges (Larsen & Stege, 2012). In awakening a person's sense of hope and self-determination, resilience can be enhanced (McCrea, 2014). Increases of hope have shown to have increases in resiliency and decreased substance use cravings from pre- to post-treatment (Shumway, Bradshaw, Harris, & Baker, 2013). It has also been found that higher levels of hope are virtually always related to better outcomes in psychological health and wellness (Larsen & Stege, 2012; Yalom & Leszcz, 2005). As the literature on resilience indicates, feelings of hope have a great impact on an individual in terms of recovery from substance use.

Interpersonal Factors

Interpersonal factors also play a role in developing resilience in terms of substance use (Khanlou & Wray, 2014; Moon et al., 2000). Interpersonal relationships, such as those from family, school, and peers, have a large impact on an individual's ability to develop resilience (Moon et al., 2000).

How this occurs can be summed up by the interaction of individual factors and social/cultural/environmental factors (Khanlou & Wray, 2014). In essence, interpersonal factors interact with individual factors and are influenced by environmental factors. This interaction impacts the resilience of each member in the interpersonal relationship. Some of these interpersonal factors include family, school, and peers (Moon et al., 2000) and entail attachment, communication, parent relations, parenting style and peer support (Khanlou & Wray, 2014).

Family, school, and peers can be a major influence of risk or protective factors for an individual regarding substance use outcomes (Abadi, Shamblen, Thompson, Collins, & Johnson, 2011). It has been found that family has a greater influence on substance use among children and young adolescents, whereas school and peer factors have a greater influence on older adolescents. This may be attributed by the fact that as adolescents get older, they have more independence from their parents and less direct supervision from them and are more influenced by their peers and immediate environment.

In terms of family factors, having positive family relations and low parental permissiveness had significant protective effects on the number of substances used in a lifetime, the age of initiation, substance use in the last month, and acceptance of the most recent substance offer (Liebschutz et al., 2015; Moon et al., 2000). Resilience is also promoted within families when there is supportive, responsive, positive parenting, experience of positive activities and

interactions, and exposure to positive adult models of problem solving and interpersonal

behaviour (Riley et al., 2008).

<div align="center">**Social/Cultural/Environmental Factors**</div>

As much as individual and interpersonal factors play a part in resilience,

social/cultural/environmental factors also greatly affect the resilience of an individual with

substance use issues (Khanlou & Wray, 2014; Moon et al., 2000).

Social/cultural/environmental factors include physical environments and social

environments (Khanlou & Wray, 2014). There is a growing body of research suggesting the

social determinants of health and how these factors have an influence on resilience. Notions that

come up for social/cultural/environmental factors include: fairness of opportunity, social justice,

mutual respect for all practices, policies, and laws, and issues regarding racial/ethnic minorities

and sexual minorities (Balsam et al., 2015; Khanlou & Wray, 2014).

Social Factors

Social factors play an important role in an individual's resilience (Khanlou & Wray,

2014; Konvisser, 2013). It has been found that resiliency is connected with relationships and

offers of social support (Moon et al., 2000). Having social support and resilient role models are

effective for dealing with stress and trauma, and has also shown to contribute to an individual's

own sense of resilience (Konvisser, 2013).

Cultural Factors

Cultural factors are important to understand as we live in an ever-expanding multicultural

society. Past research has found that people with higher levels of ethnic identity, or positively

identifying with their culture, tend to experience less psychological distress (Burrow-Sanchez et

al., 2014). It has also been found that resilience is positively related to ethnic identity and

appears to buffer the effects of internalized psychological distress. Along similar lines, religion and spirituality have also shown to be effective in dealing with stress and trauma, as well as to promote resilience in an individual (Konvisser, 2013). Racial/ethnic minorities and sexual minorities are also considered in cultural factors (Balsam et al., 2015). Previous North American research suggests that racial/ethnic minorities and sexual minorities are at greater risk for trauma exposure, mental health problems, and substance use. Only recently have studies examined racial/ethnic differences and sexual minorities in terms of health-related behaviours and outcomes. These research results show that there are few differences between mainstream culture groups and racial/ethnic minorities and sexual minorities in terms of their resilience in regards to mental health and health issues. Thus being a part of a sub-culture allows for empowerment, trust, common in-group identities, and social support; all of which can support and improve an individual's resilience (Earnshaw, Bogar, Dovidio, & Williams, 2015).

Environmental Factors

Environmental factors have a key impact on the decision-making behaviour from early to late adolescents; therefore greatly influencing youth substance use (Abadi et al., 2011). One of the major environmental factors influencing resilience and substance use is a person's neighbourhood (Khanlou & Wray, 2014; Moon et al., 2000). In a review of the published peer-reviewed literature since 2000 on resilience promotion, it has been found that the mere perception of an unsafe neighbourhood is associated with greater substance use in youth. In a US study of 452 African American youth at age 19, it was found that youth from more disadvantaged neighbourhoods, those with proportionately greater neighbourhood poverty, were at greater physiologically risk of developing substance use disorders compared to youth from less disadvantaged neighbourhoods (Chen, Miller, Brody, & Lei, 2015).

The Interaction

The interaction of individual, interpersonal, and social/cultural/environmental factors can be described as psychosocial integration (Alexander, 2008). Psychosocial integration can also be understood in terms such as belonging, community, and social cohesion. Psychosocial integration equally addresses people's needs for social belonging and their needs for autonomy. It has been argued that the lack of psychosocial integration, or dislocation, eventually leads to despair, shame, emotional anguish, and addiction. Dislocation or disconnection describes a psychological and social separation from one's society. The research literature suggests that dislocated people are more likely to become addicted to substances and thus use the addictions to adapt to this sustained feeling of dislocation. As in the biopyschosocialspiritual perspective, these factors have bi-directional interactions with each other. Thus psychosocial integration makes recovery from addictions possible. Re-integrating or reconnecting with others in society allows for the opportunity for growth-fostering relationships to develop (Comstock, 2005). This type of relationship allows people to be able to withstand tremendous hardships and trauma, such as the difficulties that arise from addiction to substances.

Implications

Resilience is a well-researched concept in social psychology. There are many implications and applications of these three aspects of resilience. One such implication is that resilience is seen as an important element to maintaining and promoting mental health and is a life-long buffer to potential threats to well-being over time (Khanlou & Wray, 2014). Resilience can develop in response to challenges and a person can become stronger than before as a result. Also, the concept of resilience can be applied in helping people understand cognitive and behavioural change in those with substance use issues (Stajduhar et al., 2009).

The Individual

Research in the field has shown that substance use is related to anxiety and depression (Skrove, Rommunstad, & Indredavik, 2013). Until recently, issues of substance use and mental health have been attributed to as an individual's problem, rather than a problem of society as a whole (Adrian, 2015). Resilience characteristics have been found to be associated with lower symptoms levels of anxiety and depression as well as lower levels of substance use (Skrove et al., 2013). These resilience characteristics seemed to protect against symptoms and influenced the associations between lifestyle factors and symptoms of anxiety and depression.

Individual characteristics such as emotional stability, reflective ability, empathy, social confidence, agreeableness, extroversion, and openness to new experiences were found to be key predictors of resilience (Ghimbulut, Ratiu, & Opre, 2012; Grant & Kinman, 2012).

These individual characteristics allow people to turn potential disasters into opportunities (Fehr, 2008). Individual interventions such as mindfulness, peer coaching, social skills training, cognitive restructuring, and problem solving have proved to be effective in promoting resilience (Fehr, 2008; Grant & Kinman, 2012).

Research on the application of positive psychology has also found effective interventions in working with substance use and recovery (Krentzman, 2013). Positive psychology focuses on strengths, well-being, and optimal functioning. Positive interventions are aimed at increasing positive feelings, positive behaviours, and positive cognitions, as opposed to focusing on fixing negative thoughts or maladaptive behaviour patterns. There is a distinct focus on strengths, which aligns with the core definition of resilience.

Resilience and hope are also highly correlated with positive outcomes in working with substance use issues. Hope enables people to envision a future in which they wish to participate

and is a foundational concept to counselling practice (Larsen & Stege, 2012). From a therapeutic

perspective, hope can be fostered by focusing on subjective or personal meaning and by

exploring goals on the basis of past accomplishments. Being hopeful enables people to maintain

a goal-oriented state, despite their present inability to reach the desired outcome. This has great

implications in terms of working with substance use because more often than not, people

suffering from addiction have a difficult time seeing past their addiction to see the metaphorical

light at the end of the tunnel (Parker, Tiberi, Akhilgova, Toirov, & Almedom, 2013). Hope offers

an individual a glimmer of light, to aid them in a positive direction and it is highlighted as the

key component of meaning making and anchoring human resilience.

Interpersonal

It is important to look into resilience in terms of interpersonal relationships because, as

humans, we generally live in a relational matrix and a person typically exists within this tapestry

of relationships (Yalom & Leszcz, 2005). Lack of interpersonal relationships impairs our ability

to become resilient and more often than not results in psychological problems (Comstock, 2005).

Resilience can be described as an interpersonal process that develops through engagement with

others; therefore, this means that as individuals, we can contribute to the resilience of others.

Research has found that children who have at least one supportive relationship with an

adult can achieve good outcomes despite encounters with adverse conditions (Comstock, 2005).

This sense of connection is the most important factor associated with a reduced risk of substance

abuse. Thus social connectedness is one of the most powerful determinants of our well-being.

Loneliness is related to psychological distress (Perron, Cleverley, & Kidd, 2014). A

Canadian quantitative research study conducted on 47 participants examining loneliness among

homeless youth found that homeless youth who experience high levels of psychological distress

also reported lower levels of resilience. Although addressing the issue of homelessness is a complicated matter involving lack of funding, lack of housing resources, and lack of available services, understanding resilience in terms of homeless youth with substance use issues can begin to be addressed by connecting with individuals to others in order to provide an interpersonal relationship.

Thus specifically addressing the alienation found in dislocated homeless people is healing in and of itself (Bai, 2012). However, healing from interpersonal alienation is a cultural work, where members of society engage with one another collectively for relationship building and community development.

Social/Cultural/Environmental

There are many implications in terms of social/cultural/environmental factors in relation to resilience and substance use. Research has found that resilient street youth have attributed their survival to the socio-cultural aspects that arise from their community (Theron & Malindi, 2010). This sense of community is related to the relational aspects of interpersonal factors, in that communities provide an individual with a sense of connection to mitigate feelings of isolation (Perron et al., 2014).

Relational-Cultural Theory (RCT) describes the complex, multi-layered interpersonal and cultural dynamics that affect the ability to become resilient (Comstock, 2005). RCT states that growth-fostering relationships with individuals in the community are central to developing resilience. These growth-fostering relationships are characterized by mutual empathy and mutual empowerment. Growth-fostering relationships allow people to withstand tremendous hardships and trauma. In order to build these growth-fostering relationships, people must be given the opportunity to connect and reconnect with others in society.

Summary

Past research suggests that resilience is a unique, internal trait that is only possessed by a few fortunate people (Comstock, 2005). Despite the dated findings on how resilience is considered rare, current research suggests that resilience does not come from atypical and special qualities, but rather, from everyday ordinary, normative human resources in the minds and bodies of children, families, relationships, and communities (Boden & McLeod, 2015; Masten, 2001).

The concept of resilience is often synonymous with substance use disorders, addiction and recovery, and trauma experiences (Burrow-Sanchez et al., 2014; Collin-Vezina, Coleman, Milne, Sell, & Daigneault, 2011; Harris et al., 2011). Resiliency refers to the ability to cope adaptively with adversity or trauma (Wingo et al., 2014). Resilience may mitigate risks not only for Post-Traumatic Stress Disorder (PTSD), major depressive, and suicidality, but also for substance use issues (Wingo et al., 2014).

Understanding resilience in terms of individual factors, interpersonal factors, and social/cultural/environmental factors allows people to be able to promote resilience. This has many implications in regard to the helping professions, as it could allow people to better help those with substance use issues.

Substance use or addictions impacts many lives and is a significant concern of many families and of society as a whole. By understanding resilience and it's affects on substance use, more effective interventions can be created.

The purpose of this study is to further understand the experience of resilience for adults who are going through the process of recovery from drugs and/or alcohol. The likelihood of this study to obtain meaningful, relevant, and significant results is high because the experience of

resilience for adults is directly examined. Implications from this research will be directly

applicable to adult populations.

CHAPTER 3: METHODOLOGY

There exists a growing amount of evolving phenomenological research methods; each one used to answer different research questions and each perspective based on different assumptions and employ different concepts (Wister & McPherson, 2014). The methodology for this study will be examined. Descriptions of the research methodology, research design, selection of participants, ethical considerations, instrumentation, data collection and recording, data analysis, methodological assumptions, and limitations to the research design will be discussed.

Research Methodology

The following study will be a qualitative phenomenological examination of the experience of resilience for adults who are going through the process of recovery from drugs and/or alcohol in an outpatient, non-profit counselling agency in Delta, BC. The study will examine adults aged 19 and over and will include males and females from various cultural backgrounds and socioeconomic statuses. Sociodemographic information on sexual orientation, religious or spiritual affiliation, educational attainment and employment status will also be collected; however, individuals will not be excluded from the study based on any of these factors.

Phenomenological studies are generally conducted with a relatively small sample size and with a reasonably homogeneous sample (Smith et al., 2009). The literature on phenomenological studies suggests the inclusion of two to 10 participants to reach data saturation (Groenewald, 2004). This is referring to the data collection from interviews with participants that continue until the topic of research is exhausted and no new information is provided. Data collection usually occurs from semi-structured interviews where the transcripts are analyzed case-by-case through systematic, qualitative analysis. From this information, the

researcher's analytical interpretation is presented in detail and is supported by verbatim transcripts.

The interview questions presented to participants are typically open-ended and focus on meaning rather than outcome (Smith et al., 2009). The interview is often described as a conversation with a purpose. This allows participants to tell their own stories, in their own words. Participants in these studies generally represent a particular perspective, rather than a certain population. This research methodology allows for an array of answers; there are no right or wrong answers. This commitment to understanding a participant's point of view allows the phenomenon to be the true focus of research.

Research Design

A qualitative phenomenological design, specifically Interpretive Phenomenological Analysis (IPA), was chosen for this study over similar research designs due to the research question being proposed and the essence of the interpretive aspect of the design as a whole. This methodology was chosen over a quantitative design as the goal of the research was not to generate incontestable facts, but rather, to discover and explore the unique and common perspectives of the individuals being studied (Moustakas, 1994). Their responses provide meaning rather than measurement.

In conducting this study, I intend to further understand the experience of resilience for adults who are going through the process of recovery from drugs and/or alcohol. A qualitative research methodology is suitable to research in resilience because it allows for the researcher to gain a deeper understanding of the lived experience of the participants (Moustakas, 1994).

As a type of qualitative design, phenomenological research is a method with its roots in philosophy and psychology in which the researcher describes the lived experience of participants

about a phenomenon as described by the participants (Creswell, 2014; Smith et al., 2009). The aim of qualitative methods is not to confirm a hypothesis, but instead to report and make meanings of experiences being shared (Moustakas, 1994). Qualitative designs are inherently interpretive, as the interpretation of the event being studied is based on the participants' and the researcher's interpretation (Applebaum, 2012). The participants' descriptions form the essence of the experience (Creswell, 2014). The basis behind phenomenological research examines exactly what my research questions aim to gain insight on.

IPA is a type of phenomenological research that is committed to the examination of how people make sense of their major life experiences (Smith et al., 2009). There are three major influences of IPA: idiography, phenomenology, and hermeneutics (Hammond, 2010).

Idiography

Idiography is an approach in which analytic depth is valued over breadth, but generalizations are allowed through comparisons between a study's participants (Hammond, 2010). IPA research invites participants to offer a rich, detailed, first-person account of their experiences (Smith et al., 2009). The research design makes it possible to formulate links between the understandings of participants and the theoretical framework of mainstream psychology.

Phenomenology

IPA is also heavily rooted in phenomenology, which is a practice originally developed to analyze the essences of experiences (Hammond, 2010). The phenomenological method deals with the subjectivity of knowledge in human sciences in light of the objectivity of knowledge projected by the natural sciences (Applebaum, 2012; Sousa, 2014). Natural science, such as physics or biology, describes a branch of science that deals with the physical world, whereas

human science describes the scientific study of human society and social relationships (Applebaum, 2012). Objectivity is a concept belonging to natural science; therefore, human science should not strive for objectivity because this would require "objectifying" the human being. Thus, IPA adopts as subjective approach in understanding human experience, which takes into account the various social relationships involved in examining the experience (Hammond, 2010).

Hermeneutics

Finally, IPA places a strong emphasis on hermeneutics. Hermeneutics describes the nature of the analytic process and of human meaning making in general (Hammond, 2010). IPA places a specific focus on philosophical hermeneutics, which emphasizes the subjectivity of the interpreter (researcher) and denying finality to any one interpretation. Thus, philosophical hermeneutics involves immersing the researcher into the analysis.

IPA is interpretive as its core, as the research aims to engage with participants' reflections on the significance of what has happened (Smith et al., 2009). It recognizes that the study of experience is always dependent on what participants tell researchers about their experience and that the researcher needs to interpret that account from the participant in order to understand it. The term "hermeneutic circle" is used to describe the dialogue between the self and other, or between the researcher and the participant (Hammond, 2010). The hermeneutic circle entails a mingling or sharing of meanings that occurs between the interpreter (researcher) and the interpreted (participant). All hermeneutic acts involve this interaction, thereby indicating interpretation to be an inter-subjective act.

Hermeneutics is also described as a "trialogue" between the past (one's presuppositions), present (one's current interaction with the participant), and the future (one's expectations for

following interactions) (Hammond, 2010). According to this three-way interaction, people rely

on their past interpretations to make sense of their current and future experiences. Therefore, as

we encounter new interpretations, people's assumptions are altered and their experiences change.

How IPA relates to my examination of the essence of resilience is that it allows me, as

the researcher, to give a voice to my interpretation of a participants' experience, rather than be

solely descriptive. IPA allows me to highlight my interaction with each participant without

minimizing my subjective experience as a mere personal opinion. Phenomenological research is

not a prop for personal opinion; rather, it acknowledges the complexities of studying human

experience in a social interactional world (Sousa, 2014).

Selection of Participants

Participants in this study were recruited from Deltassist Family & Community Services

Society, in Delta, BC. These participants were recruited with the assistance of the Counselling

Manager at Deltassist. Current clients in the Alcohol and Drug Program (ADP), soon to be

renamed Substance Use Program (SUP), at Deltassist were contacted in person before the start of

their scheduled session with the counsellor. A verbal recruiting script was read to and provided

to each of the potential participants. Interested participants contacted the researcher directly.

Once a participant has indicated interest in the study, a written or verbal contact script was read

to and provided to the participant.

This study will consist of a small sample size of five qualified individuals. Qualified

participants, including both male and female, took part in the study on a first-come-first-served

volunteer basis until all five spots are filled. Participants did not receive incentives or rewards of

any kind throughout the research process. Participants meeting the following criteria were

considered: must be 19 years or older, must be a current Deltassist client and living in the Delta,

BC area (Delta, North Delta, Ladner, Tsawwassen), must have experienced a problematic use of

drugs and/or alcohol in the past, and must be able to speak English. Participants may come from

any ethnicity or cultural background as long as they meet the above qualifying criteria.

Potential participants were excluded from the study if they are currently engaging in

problematic drug and/or alcohol use. Participants who have been deemed violent and aggressive,

based on prior assessments conducted by Deltassist and other referring agencies, and pose a

physical threat to myself as the researcher were also excluded from the study as it would be a

potential safety concern for me to conduct the interview.

Ethical Considerations

There are many ethical considerations to take into account when working with

participants. The potential concerns of this study include: triggering of painful memories from

the past, consenting to participation, and maintaining confidentiality with the possibility of dual

relationships.

Triggers

In discussing a participant's strengths and resilience in overcoming problematic drug

and/or alcohol use, the memories from those difficult times may trigger physical, psychological,

and/or emotional reactions. In the event that a participant becomes triggered, I will offer the

participant to take a break from the interview, stop the interview and continue another day, or ask

if the participant would like to withdraw from the study. If the participant is triggered, I would

follow a debriefing protocol that would allow the participant to connect with his or her

counsellor at Deltassist and to set up an appointment if necessary. If there is an emergency, I

would call for one of the on-site counsellors trained in suicide prevention to assist in the matter.

In addition to suggesting the participant to contact his or her current counsellor, I also provided a

list of referrals and resources for each participant to be given as additional support. A safety plan

was put in place from the time that the participant is triggered until the participant can see his or

her counsellor.

Consent

Consent is a key component when conducting research. As a part of seeking informed

consent, all possible risks will be clearly made known to all research participants. Failure to

disclose this information raises ethical concerns about the safety and well-being of participants.

Gaining consent will be an on-going process from recruitment, confirmation of participation, the

interview, and even after the interview has been completed.

Confidentiality

In order to address the ethical issue of dual relationships, I excluded potential participants

whom I have a prior relationship with. The city of Delta is a small community in the Greater

Vancouver region. Due to my existing involvement in the community, there may be a chance

that I may know some of the clients of Deltassist who may also be qualified to meet the

participation requirements of the study. Thus, in order to protect participants' confidentiality and

prevent potential conflicts of interests, these participants were excluded.

Instrumentation

A semi-structured, open-ended, verbal interview was used to explore participants'

experiences of resilience. The interview consisted of five questions created by myself. Each

interview took approximately 45 to 60 minutes and extra time was allowed for participants to

express more information if needed, as well as for debriefing to ensure the participants' well-

being and safety.

The main research question was: what is your experience of resilience throughout your recovery process? The sub-questions proposed will include: what were the turning points that lead you in this life direction? What in your environment supported your resilience? What psychological contexts supported your resilience? What else or is there anything else you would like to share with me today regarding your recovery?

The strength of this instrumentation is that it allows for each participant's experience to be highlighted and it also gives a voice to each participant's unique story. Participants are encouraged to talk at length, allowing for a rich and detailed account of their experience. I, in turn, can link these accounts to theoretical frameworks found in other research. By conducting an interview, my analytical interpretation of the phenomenon will be supported by verbatim transcripts and extracts.

The interview questions also pose as a strength to this research methodology. Using open-ended questions as opposed to close-ended questions allows participants to share their thoughts and how they construct their own reality (Cozby, 2004). By having the interview questions be open and exploratory, the answers that follow will reflect a focus on the process of resilience and not the outcome. This focus on process allows for the true essence of a phenomenon to be illustrated.

Although there are many strengths to this type of instrumentation, there are also some weaknesses in regard to the nature of self-reported methods.

This study is limited to the self-reported nature of interview questions that participants' recall in their experience of resilience. IPA is highly dependent on what participants disclose (Smith et al., 2009). Participants' may be limited in how much they can remember about the

experience and also how they remember the experience as events afterwards may have affected their ability to recall the accuracy of the experience.

Data Collection and Recording

Data were collected from a semi-structured, open-ended interview questionnaire consisting of five questions. This interview will be administered to each of the five participants at pre-scheduled times. The interviews will be recorded using a voice recording device and notes will be taken on-site during the interviews to be cross-referenced with the recordings. The audio recording will be used in order to transcribe the dialogue for analysis.

Data Analysis

Data produced from transcribing the audio recordings were interpreted and analyzed on a case-by-case basis using thematic analysis. The identification of emergent patterns or themes will be reviewed in each case and subsequently looked at as a whole when comparing each of the cases. The steps to thematic analysis that I shall employ are as follows: reading and re-reading the transcripts, producing initial notes, developing emergent themes for a single case, searching for connections across themes for a single case, moving to the next case, and looking for patterns across cases (Smith et al., 2009).

Methodological Assumptions

I am assuming that common themes in participants' experience of resilience will emerge. Recurrent themes were identified. Another assumption is that the frequency of themes is one indication of their relative importance (Smith et al., 2009).

Limitations

The limits of this study pertain to the confines resulting from self-reported measures and potential interviewer bias.

Results from this study are limited by the participants' ability to recall past events. IPA acknowledges that to learn about an experience, such as resilience, it is always dependent on how much participants can remember and in how much detail they remember it. The description of the experience is also bounded by the participants' ability to articulate their thoughts and experiences. Thus, a participant who speaks English fluently and who is able to describe the events in a detailed manner may be able to provide a richer account of the experience of resilience than a participant who speaks English as a second language and who cannot articulate his or her thoughts as eloquently.

Interviewer bias is also considered a potential problem in this study. As I interview participants, I may be biased and react with non-verbal behaviours to the responses given by participants. Due to this reaction, I may be demonstrating approval or disapproval of what they are saying. Although IPA acknowledges that dynamic interpretive interaction between the researcher and the participants, I must remain aware of my expression of non-verbal language and take an objective and non-biased position when interviewing participants.

Summary

This qualitative phenomenological study will explore the experience of resilience in adults who are going through recovery from problematic substance use from drugs and/or alcohol. Five participants who are current clients of Deltassist and who meet the requirements had a semi-structured, open-ended interview with the researcher to discuss their experience of resilience. Each interview was recorded and transcribed for thematic analysis using IPA. Emergent themes were identified and patterns between participants noted.

Ethical considerations that were taken into account included: triggering of painful memories from the past, consenting to participation, and maintaining confidentiality with the

possibility of dual relationships. Shortcomings of this research involve issues with participants'

memory recall and verbal explanations, as well as interviewer bias.

Although phenomenological studies typically present with this downfall, it is the best

methodology to conduct the study of experience.

CHAPTER 4: RESULTS

Conducting research is important to furthering the efficacy of prevention and treatment models (Comstock, 2005). Studies on resilience have contributed to promoting improvements in school, the work place, and in mental health settings (Khanlou & Wray, 2014).

A qualitative phenomenological study was conducted to explore the experience of resilience in adults who are going through the process of recovery from drugs and/or alcohol. A semi-structured, open-ended interview was conducted with five participants who were clients of Deltassist. This methodology was used to explore the following research questions: What is your experience of resilience through your recovery process? What were the turning points that lead you in this life direction? What in your environment supported your resilience? What psychological contexts supported your resilience? Is there anything else you would like to share with me today regarding your recovery?

Data collected from the five participants are described below. The names of the participants and identifying information have been changed in order to protect their confidentiality. The pseudonyms "Lisa," "Sam," "Zack," "Kelly," and "Albert" are used. The demographics of the participants in the study will be described and displayed in Table 1.

Demographics

Five individuals who had experienced problematic use of drugs and/or alcohol participated. The length of time that had passed since the substance use was problematic ranged from two to 10 years. The participants' demographic information is illustrated in Table 1.

Table 1 *Participant Demographic Information*

Gender	
Male	60%
Female	40%

Age
      Range   28-41 years
      Mean   36.4 years

Race
      Caucasian   80%
      Aboriginal   20%

Sexual Orientation
      Heterosexual   100%

Marital Status
      Single   40%
      In a Relationship/Common Law   40%
      Married   20%

Problematic Substance Use
      Single-Drug Use   20%
      Poly-drug Use   80%

Lisa

Lisa is a 41 year old Caucasian female. She is in a heterosexual, common law relationship, and has a 22 year old daughter. Lisa is employed full-time working for the Ministry of Children and Family Development (MCFD) in the care of high risk teens. She uses the abstinence model; however, she is open to and works with the wellness model (Shepherd et al., 2010) on a professional basis with MCFD. Lisa described herself as a poly-drug user, but she mostly incurred problematic use with heroin and crack cocaine. She states that she has not used substances for four and a half years.

Lisa describes having experienced a lot of trauma in her childhood while living in foster care. She states that she internalized many of the negative messages she received when she was young. Lisa was exposed to drugs and alcohol at a very young age, which she states, began her unhealthy relationship with substances at the age of 17. Lisa described being involved in many unhealthy relationships during her period of active addiction. She states that she used drugs as her method to cope because she did not have the right tools at the time. Lisa's substance use led her to live on the Downtown Eastside (DTES) in Vancouver, BC for a period in her life. As a

part of living in this community, known for a large number of drug users who often earn money though difficult means, while living in the DTES Lisa disclosed participating in sex trade work and committing crimes in order to gain money to feed her addiction.

Experience of Resilience

Lisa describes her experience of resilience as a journey of courage and strength. She states that "it's not about stopping using, a lot of people can stop using, it's about staying stopped, it's the daily decision not to pick up or go back to old coping behaviours". Lisa elaborates on this by stating that it took a lot of self-discipline and personal awareness to go thought this difficult journey. Lisa stresses that her experience of resilience also encompassed her choice of not being a victim anymore. She states that it took her to a place where she was no longer compromising her values, where she could be somebody that was dependable, reliable, and live with integrity.

Lisa reports that having a balanced lifestyle also played a major role in her resilience. She states that balancing physical, spiritual, and emotional aspects of her life were integral to her resilience because her previous life was very unbalanced. Acceptance and being honest with herself was also important to Lisa.

Lisa also stresses the importance of having supports and giving back to her community. She states that "it's about giving back to the community and not causing harm, it's about sharing my experience and my strength and the hope that I have today".

Turning Points

The turning points that Lisa describes that led her in this life direction involve meeting a counsellor and changing relationships with her husband, her mother, and her daughter.

Lisa describes meeting a drug and alcohol counsellor while she was living on the DTES that was monumental in leading her in this new life direction. This counsellor played different roles to Lisa throughout her life and is still involved in her life to this day. Lisa described that the counsellor trusted her, and that he showed her what acceptance and love looked like. He advocated for her and was always able to separate Lisa's behaviour from who she really was, even when Lisa did not treat him so well. This counsellor never stopped believing in her.

Lisa described the end of her marriage as devastating and she felt totally crushed by it. She states that one of the things that kept her clean and sober was the focus on being a wife. Another important turning point was the death of her mother. Lisa's mother battled cancer for 10 months until it took her life. Lisa's changing relationship with her daughter also precipitated change. As Lisa's daughter was growing up and becoming a young woman, dating and moving out, the dynamic in Lisa's household also changed.

"When these three things were taken from me, I realized I had no life, I didn't know who I was, I started to use again". Lisa described feeling angry, depressed, and having much emotional pain. She states that for some unknown reason, rather than going back to her old life, she looked up Narcotics Anonymous (NA) online and went to a meeting immediately. Lisa states that, "I just told the truth, the things they read at the beginning of the meeting, it made sense to me, I didn't feel like I was fighting it anymore, I felt like I finally found a place where I might be okay, I haven't used since that day."

Environmental Supports

Lisa describes many things in her environment that supported her resilience. One of the most important was having a safe place to stay. She describes it as "not worrying about going to sleep and being sexually assaulted or robbed, my home has to feel safe for me, when things start

to feel unsafe, that's very hard for me because I had unsafety the majority of my life." Lisa also states that having basic needs, like food, also supported her resilience.

Lisa also notes that having supportive and non-judgemental counsellors and doctors involved in her recovery were also helpful. Family also played a large part in Lisa's recovery. She states that reconnecting with her biological family helped her through this difficult journey. Being a part of NA and going to meetings also gave Lisa the support that she needed.

Lisa also states that her relationship with God was also a major factor in her resilience. She states that she needed to change some of the shame and fear based messages from religion to change her personal relationship with God as that of a loving relationship.

Continually learning about herself for personal growth, through education, and discovering her passions, playing softball, also helped Lisa create a supportive environment to aid her in this journey.

Psychological Contexts

The psychological contexts that support Lisa with her resilience were thoughts about her daughter's well-being. Lisa states that, "if I didn't have my daughter, I don't think I would have kept trying". The thought of her daughter's well-being motivated Lisa to keep trying. Lisa reminisced on the emotional pain that she felt as a child and she knew that she did not want to recreate those experiences for her daughter.

Additional Comments

What Lisa learned throughout her progress was that recovery is a personal journey and that it was different for everyone. She stresses that it is important to meet people where they are at, especially in working with and supporting them. She also emphasized using new coping methods if old ones did not work.

Sam

Sam is a 28 year old male who describes his ethnic background as Italian, Irish, and Aboriginal. He is in a heterosexual, common law relationship and he does not have children. Sam is self-employed, full-time with an exterior house cleaning business. He defines his recovery process using the abstinence model. Sam states that he experienced problematic substance use with alcohol and cocaine. He has not used substances for five years.

Sam describes himself as coming from a long family history dealing with the problematic use of alcohol. He understands that much of the alcoholism stems from the systemic racism and generational trauma experienced by the Aboriginal side of his family. Sam states that he never really felt that he fit in with his family. He described himself as the "black sheep." Sam stated that he struggled in school and was often compared to his brother, who was a successful member of the football team and received good grades. Sam vividly recalls a moment in his childhood where a faculty member of his school stated that "you are nothing like your brother." Sam was drastically affected by this negative comment, as he states that it led him in a new life direction. Sam states that he started smoking marijuana at the age of 12. Sam began experimenting with other drugs until he was introduced to alcohol and cocaine in his late adolescence. From that point on, Sam describes having problematic use with both substances.

Experience of Resilience

Sam describes his experience of resilience as a difficult process, where he experienced many hardships and lows in his life. Sam illustrated the repetition he needed in order to get past this stage in his life by stating that "the walls had to come down in order for me to get it, gotta tell 'em and tell 'em and tell 'em, that's how it is for recovery." Sam also describes having many ended relationships with his friends and his family as a result of his past behaviours and actions.

Sam states that the most important aspect for him and his resilience was the ability to balance his feelings and his moods and to feel comfortable in his own skin. Sam reports that he used alcohol and cocaine to feel comfortable in his own skin.

Turning Points

The major turning point in Sam's life that led him in this life direction was when he was unresponsive on a hospital bed. During a night of partying, Sam overdosed on heroin. He stated that he could feel his heart slowing down and he felt groggy. In his attempt to get home, Sam hit his head on the pavement many times. Sam managed to get home that night, but as he was outside, he fell and just lay in the snow until his parents got home. Sam was covered in snow and his skin was blue when his parents found him. "I was dead for a little while in the hospital, the only people there were my mom and dad by my side, that's where I am now, I haven't used since that day."

Environmental Supports

Sam states that he has many environmental supports that have helped him with his resilience. The most influential supports were his mother and his father. Sam also describes that having a sponsor with over 20 years of sobriety has also aided in his resilience. Sam describes these supportive people in his life as helping him to push himself to go further to opportunities for a better life.

Sam also reports that going to Alcoholics Anonymous (AA) helped to support him in his journey. He described moments where the thought of having a drink begins to consume his mind. In those moments, Sam knows that he can seek support by calling his sponsor or going to a meeting to listen to other people share their stories of strength and hope.

The close friends Sam made through AA have also supported him with his resilience. The friendships he has made through organized sports have also been factor in Sam's resilience. And to a lesser extent, God has played a role in Sam's resilience.

Psychological Contexts

The psychological contexts that support Sam through his resilience varied throughout his journey; however, it involved: going to AA meetings, remaining humble, having humour, staying relaxed, and having goals.

Initially, Sam states that he was heavily focused on going to an AA meeting every night. He wanted to soak up as much information as possible and learn how to stay sober. As time went on, Sam reports that he started to go to fewer meetings. However, he did start setting more personal goals.

Sam states that having life goals is very important to him because without goals, he begins to get depressed. Sam remains focused on building his life, setting goals, reaching them, and continuously better his life.

Sam reports that being able to balance his feelings and moods also helped support his resilience. Sam states that it is a constant internal struggle when dealing with his thoughts of having a drink. He is now able to better self-regulate his feelings and seek support when he needs to.

Additional Comments

In addition to Sam's story, he wanted to add that staying busy and working has always helped him through the tough times in his life. He states that it is important to accept who you are. Another key point in Sam's recovery as he describes it "if I drink, I will die, that's where my bottom was, death, if I drink, am I willing to die today or soon, that's the reality of it." Sam

comments that he does not want to die. He wants to see how far he can get in life, as he has set

goals for himself and he plans to reach those goals.

Zack

Zack is a 37 year old male who describes himself to be of Ukrainian decent. He states

that he is heterosexual and currently single with a 14 year old son. Zack is employed full-time as

a longshoreman. He defines his recovery process to be that of an abstinence model. Zack

describes having problematic poly-drug use; however, he specifies having the most concerns

with cocaine, crack cocaine, speed, and alcohol. Zack states that he has not used substances for

10 years now.

Zack states that he started using drugs when he was about 14 years old. His drug use was

followed by alcohol use. Zack states that his substance use began as a Friday and Saturday event,

as he only used substances in a social setting. He states that everyone he associated with would

also use drugs and alcohol. As high school went on for Zack, his substance use began to increase

gradually. After graduating from high school, Zack began to work in a bar and his substance use

began to escalate until it became an everyday occurrence.

Experience of Resilience

Zack's experience of resilience involved a lot of structure, rules, and responsibilities. He

states that this was his experience of a recovery house that he went to. Zack describes the

structure as "what I needed, it teaches you to start doing things again, like cleaning and looking

after things, everyday things."

Zack also stated that going to AA meetings also helped with his resilience. He states that

he was better able to seek guidance, as there were people with more sobriety compared to other

programs that he has tried in the past. One key factor that Zack pointed out was that AA offered him to live his life in a certain way, a way that he hoped to live his own.

Turning Points

The turning point in Zack's life involves his desire to be fully present in his son's life. He states that "I needed to change, there was nothing going for me, it broke my heart that I wasn't around for my son, I wanted to be, but I knew I couldn't when I was like that". Zack states that he was tired of letting his son down, tired of the lifestyle he found himself in, tired of not trusting himself, and tired of not trusting the people around him.

Environmental Supports

Zack states that his family was a major factor in supporting his resilience. His parents, siblings, and sister-in-law all helped to take him to AA meetings when he needed it the most. Zack's son played an active role his in resilience as well, as he was often involved in the process and often asked Zack about meetings and recovery.

Being a part of AA has also helped to develop Zack's resiliency. He has made life-long friends as a result of AA and he also described it as a place where he can find guidance. Zack also notes that having a sponsor with 38 years of sobriety was monumental in his resilience. Zack states that his sponsor took him under his wing, helped him, showed him, and taught him how to behave, how to act, how to stay sober, and how to deal with day-to-day things.

Psychological Contexts

The psychological context that supported Zack through his resilience was knowing that there was a better life for him. After going to AA meetings and resonating with the messages, he found that the way they lived their lives in AA was the way he hoped to live his as well.

Zack reported that he was tired of feeling helpless and hopeless. He states that as he was gaining clean time, he started to feel better about himself and began thinking clearer. He states that his whole thinking pattern changed. Zack states that as he was beginning to think more clearly, he realized more and more that he did not want his old lifestyle back.

Additional Comments

For Zack, it was important that he find people in his life with sobriety; to find positive influences that he could look up to. What keeps Zack going is the desire to live his life the way that he dreams it to be and to be there to see his son grow up.

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Kelly

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Kelly is a 37 year old Caucasian female. She describes herself as heterosexual and single and she does not have any children. Kelly is employed full-time as a Registered Psychiatric Nurse. She describes her recovery process to be based on the abstinence model. She further described experiencing problematic use with opiates, specifically Percocets, Oxycontin, and heroin. Kelly has not used substances for two years.

Kelly was in an abusive relationship for four years. Although she was able to get out of the relationship, Kelly did not fully get over it. About a year later Kelly was involved in a car accident that left her with neck and back injuries, as well as a chronic pain condition. Kelly was prescribed Percocets by her doctor for the pain. Kelly states that the trauma she experienced led to her over usage of pain medication, where at one point she was able to manipulate her doctor to prescribe her the maximum daily dose of Percocets. However, Kelly soon realized that she needed a higher dose, which led to her start buying un-prescribed Oxycontin. This began her addiction with opiates.

Experience of Resilience

Kelly describes her experience of resilience as a difficult journey to begin with. Initially, she felt like she had no strength. She felt discouraged and beaten down. It was not until Kelly started going to NA, that she learned to be resilient. Kelly realized that she did have the strength and that she could overcome this stage in her life with some help. Kelly also states that perseverance and the desire to be better played a major role in her resilience.

Turning Points

The pivotal turning point in Kelly's life that led her in this life direction was her contemplating suicide. "I was contemplating suicide and that seemed like my only option, I think I knew at that point I needed help or I wasn't going to make it". Kelly states that the drugs turned her life upside-down. She no longer wanted to live like that; she wanted her life back to where it had been. "I was only in active addiction for about a year and a half, but it completely destroyed my life, my self-esteem, my self-worth, my everything." Kelly became dishonest and manipulative towards her family and her friends. She knew that she needed to make a change.

Environmental Supports

The environmental supports that helped Kelly gain her resilience include her family, specifically her mother, and her job.

Kelly's family was very supportive through her recovery process; however, her mother was a major influence on her resilience. Her mother offered her emotional support, took her to doctor's appointments, was with her during her periods of withdrawal, and even lived with her when she was feeling suicidal.

Kelly's job also played a factor in her resilience. "All the energy I had left in me, which was not a lot, everything that I had left was going towards work because I care so much about

what I do". Kelly states that her job was keeping her afloat. Her career meant so much to her that she was prepared to do what it needed to take to save it.

Psychological Contexts

The psychological context that supported Kelly with her resilience was the reoccurring thought that she did not want to live her life in addiction. Kelly states that "I didn't spend years and years in addiction, but look at the point I was at by the end, that's the thing about addiction, it doesn't matter how long you've been there, what your drug of choice is, we all kind of end up in the same place, I had been there long enough to know that was no way to live at all." Kelly stated that she did not want to feel controlled by something so awful and that she did not want to keep harming her family and her friends, and most importantly, herself. She states that she just wanted to feel like herself again.

Kelly looked to her mother for guidance. Kelly states that she followed her mother's example on how to be resilient. Even when Kelly felt like she was in her darkest moments, her mother would be there leading the way "into the light."

Additional Comments

Kelly shared a saying that her mother would always say to her, "feel the fear and do it anyways." This saying resonated with Kelly in that she was terrified of her journey at first, but she made that leap of faith and moved forward despite her fears.

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Albert

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Albert is a 39 year old Caucasian male. He is in a heterosexual marriage and does not have children. Albert is employed full-time as a carpenter. He defines his recovery process as a model of moderation, stemming from the wellness model. Albert describes experiencing problematic use with alcohol. He states that it has been eight years since he has considered his

alcohol use to be problematic. During the past eight years, Albert states that he has tried abstinence from alcohol for the first three years and switched to moderate use for the next five years until today. Albert states that he is still able to drink in moderation.

Albert states that many of his family members engage in problematic use with alcohol. He states that he has been drinking all his life. He describes experiencing many physically abusive relationships. Many of those relationships were often with heavy drinkers. Albert states that his alcohol use became progressively worse. He described using alcohol to cope with the abuse, until his consumption became an everyday occurrence, where he would often binge drink daily.

Experience of Resilience

Albert states that his experience of resilience was difficult at first. He describes the most difficult time when he chose abstinence from alcohol. Albert states that it was difficult to be around his family because they were heavy drinkers. He found it difficult to be around anyone who consumed alcohol. Albert states that "I wouldn't put myself in places I wanted to be because I knew it was a bad idea, I found that I just stayed away from everybody." During that time, Albert describes feeling depressed due to having to choose between his personal goal of not drinking and his desire to spend time with his family.

Albert reports that he enjoys drinking and never intended to fully give it up. After three years of abstinence, Albert began drinking in moderation. He described this as "controlled drinking" where he would not drink from Monday to Thursday. Albert states that he was able to do this because he consciously placed a priority on work and other responsibilities.

Turning Points

The major turning points that led Albert in this life direction were the possibility of losing his job and having met his now wife.

Albert has been working with the same company for over 15 years. He did not realize how bad his drinking became until someone at work told him that "you're no good to us anymore." As Albert reflected, he realized that his work must have suffered in a varying degree due to his drinking. Albert recalls that he would be missing days or calling in sick and lying to his coworkers. Albert recognized that this was the beginning of a bad habit and decided that he needed to make a change. "That flicked a switch, I was scared that I was going to lose my job, when I started going through the process, I realized this was a good thing, not only for my health, but just in general."

Albert also attributes his change to coincide with the time he met his wife. Albert states that "if I was the way I was before, she wouldn't be here, she was also a turning point in the sense that she gave me strength".

Environmental Supports

The pivotal moment in Albert's environment that supported his resilience was having multiple debt collectors call him for repayment. Albert states that his threat of job loss came at the same time when debt collectors started to pursue him for money. Albert reports that "I was in debt to three credit cards, Revenue Canada, and GST, not drinking, not partying, put me in a position where I could pay back all my credit cards."

Albert states that it was very empowering to be able to be in good financial standing again. He reports that it helped him stop drinking. He states that fixing his financial problems

were a priority; responsibilities, bills, paying things off, and saving money are all valued highly by him.

Psychological Contexts

Albert states that the psychological contexts that supported his resilience stem from a financial responsibility perspective. Albert states that he wanted to succeed financially and to make a life for himself and keeping his job was a very important aspect of being able to succeed.

Albert was also motivated by the future he envision for him and his wife. "When you meet somebody and you want to look down the line, having a destructive lifestyle, you don't see anything at the end of the tunnel."

Additional Comments

Albert recognizes that he still binge drinks; however, he limits himself to the weekends when he does not have work obligations to attend to. Albert remembers how bad things became for him when he used to drink on a daily basis. He states that he has more energy now and is not running into problems at work and that is his incentive to keep drinking in moderation.

Albert also states that he has tried going to AA in the past; however, it did not fit with him. He states that people should do what works for them and for him, it means drinking in moderation.

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Common Themes

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These five stories illustrate the many different aspects involved in resilience in the process of recovery from drugs and/or alcohol. The stories of Lisa, Sam, Zack, Kelly, and Albert are all unique; however, they are linked by some common themes. These common themes will be explored below: hope/goals, role model/guidance, children/significant other, family, and passions.

Hope/Goals

Being hopeful enables people to maintain a goal-oriented state, despite their present

inability to reach the desired outcome (Larsen & Stege, 2012). Hope and having goals played an

influential role in all five participants' stories of resilience. They all spoke about making a better

life for themselves or setting goals to point themselves in that life direction. The common

phrases used include: "building my life," "wanting a better life," "how I hope to live," "better

way to live," "knowing there is a better life," "desire to be better," "want to have a future," "the

feeling inside of me that I wasn't going to give up no matter what".

Role Model/Guidance

A positive role model presence is an important predictor of health-related behaviours

(Yancey, Grant, Kurosky, Kravitz-Wirtz, & Mistry, 2011). Having a role model to seek guidance

presented itself as a common theme for four of the five participants. What these participants

shared was the ideal of having someone to look up to; someone who could help guide them on

the right path. Phrases that illustrate this include: "showed me the way," "taught me," "example

to look up to," "someone's gone through it already," and "I can learn from that."

Children/Significant Other

Having children or a significant other also proved to be a source of resilience for three of

the five participants. In these cases, the participants stated that they continued through their

difficult recovery journey because they were thinking of providing a better life for their child or

significant other. Phrases used to describe this include: "I wasn't around for my son, but I wanted

to be," "if I didn't have my daughter I don't think I would have kept trying," and "when you

meet somebody and you want to look down the line."

Family

Social connectedness is one of the most powerful determinants of our well-being (Comstock, 2005; Straussner & Fewell, 2011). Family was found to be a major source of support in all five of the participants' stories of resilience. Family support ranged from emotional support, physical presence, instrumental assistance, to financial support. Mentions of family include: "family," "my parents," "sister, brother, sister-in-law," "big support from my mom," "she saved me," "family connections," "support from my parents," and "parents helped me a lot".

Passions

Finding meaningful purpose or passion in life is a factor in many resilient individuals (Hall & Webster, 2007). Having a passion or finding a passion presented in four of the five participants. Although these passions differed from participant to participant, it helped to give participants a positive direction to move towards. These passions range from career pursuits to discovering a new sport. Some phrases used include: "I care so much about what I do," "finding something you're passionate about, for me that was softball," "have a successful business," and "responsibilities in my life are very important to me".

Summary

Upon examining the stories of Lisa, Sam, Zack, Kelly, and Albert, it is clear that resilience is highly individual and influenced by many aspects. Among the many factors, hope/goals, role model/guidance, children/significant other, family, and passions stood out as the most frequently mentioned topics.

These five categories of themes were present in the participants' stories of resilience and represent the common topics that link their stories together. In uncovering these common

themes, it is important to be able to take the research one step further by examining how these

themes can be fostered within an individual from marginalized or at-risk populations.

CHAPTER 5: DISCUSSION

The aim of this qualitative phenomenological research was to provide a deeper understanding of the experience of resilience for adults who are going through the process of recovery from drugs and/or alcohol. The findings of this research address the gap in the current research literature involving resilience and the adult population. This study builds on a growing body of work that also addresses this gap. It is my hope to stimulate interest in an area of research that is lacking.

In this final chapter, a summary of the study will be provided. Next, the implications of the research will be discussed in terms of the impact on counsellors, at-risk or marginalized populations, program development, and applications in other domains. Recommendations for future research will be reviewed and my concluding remarks will be stated.

Summary of Study

Resilience describes an individual's in/ability to manage stressful situations (Burrow-Sanchez et al., 2014). Research involving resilience is an important facet informing the initial steps in developing effective prevention and treatment models (Comstock, 2005). Drug and/or alcohol addiction is a growing concern around the world, as drugs of greater potency are becoming more available and the types of harmful synthetic drugs are increasing in number (Palamar et al., 2015).There is a need to generate more detailed research within this topic area. The intent of this phenomenological study was to examine the experience of resilience among adults going through the process of recovery from drugs and/or alcohol. Although this study is limited by the self-reported measures of participants and interviewer bias, it is an important contribution to a research area to which little attention has been paid.

In reviewing the research, there exists a distinct past and present outlook on resilience. Previous research suggests that resilience is not a common trait; whereas current findings suggest that resilience is a normative human process (Boden & McLeod, 2015; Comstock, 2005; Masten, 2001). Resiliency refers to the ability to cope adaptively with adversity or trauma (Wingo et al., 2014). Resilience characteristics mitigate risks for many mental health issues and also for substance use issues (Wingo et al., 2014). Understanding resilience in terms of individual factors, interpersonal factors, and social/cultural/environmental factors provides greater scope for people to be able to promote resilience. There are many implications in regard to the helping professions. By understanding resilience and its effects on substance use, more effective interventions can be created.

In this qualitative phenomenological study five participants who are clients are Deltassist were recruited and interviewed using a semi-structured, open-ended interview questionnaire. The ethical considerations that were taken into account include: potential triggering of painful memories, consent to participate, and maintaining confidentiality with the possibility of dual relationships.

The results from the five participants indicate that resilience is highly individual and influenced by many aspects. The common themes that presented themselves throughout the participants' experiences include: hope/goals, role model/guidance, children/significant other, family, and passions.

Implications of the Research

As stated earlier, there is a growing concern for the misuse or abuse of drugs and/or alcohol across genders, age demographics, and cultures (Palamar et al., 2015). It is imperative to examine the impact of the misuse or abuse drugs and/or alcohol on individuals in terms of

population health (Lynskey & Strang, 2013; Whiteford et al., 2013). This misuse or abuse of

substances affects millions of lives worldwide, thus by understanding the elements that allow

people to overcome adversity, harm-reduction, prevention, and treatment models can be

developed and applied to this population (Granfield & Cloud, 2001; Whiteford et al., 2013).

This study aimed to add to the growing body of research examining the factors associated

with resilience in terms of substance use. Resilience allows for people to reach for new

possibilities and, in essence, to improve population health and well-being (Jenkins, 2011). The

implications of research will be reviewed by addressing its impact to counsellors, at-risk or

marginalized populations, program development, and applications in other domains.

Counsellors

The counselling profession and the resulting therapeutic implications are affected by the

research on resilience (Cadet, 2016). Generally, those who seek counselling are experiencing

struggles in various areas of their lives or they seek counselling to better these and other areas of

their lives. Resilience addresses both the struggles and self-improvement. Research states that

resilience is a process rather than a single event and a continuum rather than a binary outcome

(Khanlou & Wray, 2014). Viewing resilience in these terms allows for therapeutic intervention

during the process of resilience and along the continuum or resilience.

It has been found that individual, interpersonal, and social/cultural/environmental factors

can influence resilience (Khanlou & Wray, 2014). This information is essential to counsellors, as

they can direct therapeutic interventions to strengthen areas of resilience that need attention.

The research on resilience also indicates that activities that promote self-expression, self-

confidence, emotion regulation, coping skills, and communication skills also help to facilitate

change in resilience (Giocoechea, Wagner, Yahalom, & Medina, 2014). The aim of counselling

can be to help develop people as individuals and to promote growth-fostering relationships that

enhance resilience.

To further enhance resilience, counsellors can also help to develop self-monitoring skills

and relaxation skills (Hall & Webster, 2007). These techniques help to create a new environment

that makes new learning possible, such as the learning of healthy coping strategies, healthy

interpersonal skills, and healthy relationships. Counsellors can help to create a sense of mastery

among these skills, thus learned optimism and a realistic sense of hope, which are both key

aspects in resilience.

At-Risk or Marginalized Populations

Research on resilience has major implications for at-risk or marginalized populations as

well. There is evidence that early stressful life events and adversities experienced in adulthood

are risk factors for the development of substance use issues (Cadet, 2016). It is important to

acknowledge that not all individuals who face traumatic events develop an addiction to

substances. This suggests that there is the existence of individual and/or familial resilient factors

that protect these mentally healthy individuals. Thus, the methods involved in working with at-

risk or marginalized populations should involve approaches that enhance resilience in these

populations.

A key point in understanding resilience among at-risk or marginalized populations is that

it may guide public policy decisions and the future of program development (Liebschutz et al.,

2015). Research examining potential risk factors and protective factors among the development

of resilience indicate that it is affected by interpersonal factors and environmental factors. Future

interventions can work to enhance these areas of concern as a way to mitigate the effects of

adversity on at-risk or marginalized populations. In uncovering the environmental factors of at-

risk or marginalized populations, we gain a greater understanding of the impact of systematic oppression on the structures that we live in.

Program Development

By understanding the structural oppression of the systems that are involved in the social services industry, we can tailor programs to better fit the individuals who use it. Thus program development can also be affected by the research on resilience. Prevention and treatment models, and addressing service pitfalls will be described below in regard to program development.

Prevention and treatment models. Examining resilience is the gateway to developing effective prevention and treatment models (Comstock, 2005). Research literature states that there are many determinants of resilience; however, there is a lack of consensus in unveiling the major factors influencing resilience. This voices the concern of the lack of research available in looking at the qualities of resilience. It has been found that resilience can be modifiable on individual and cultural levels; therefore, the application of resilience in prevention and treatment models for the misuse or abuse of substances may be possible.

Research on resilience training indicates that these prevention and treatment models are just as effective as cognitive therapies (Zamirinejad, Hojjat, Golzari, Borjali, & Akaberi, 2014). The effect of resilience training has been shown to be effective for depression and work with drug and/or alcohol addiction.

Interventions designed to enhance resilience by supporting the development of social skills has shown to reduce mental health problems (Campbell-Heider, Tuttle, & Knapp, 2009). Thus preventions of substance use issues should target not only individual characteristics, but also the possible risk or protective factors of the social environment (Veselska et al., 2009).

Addressing service pitfalls. As there is a concern of the co-occurrence of mental health issues with substance misuse or abuse problems as it is affecting millions of people worldwide, there is also a need to design treatment services that address both groups of disorders (Morisano et al., 2014). Co-occuring disorders tend to have a more severe course of illness, more severe health and social consequences, more difficulties in treatment services, and diminished treatment outcomes when compared to people with a single disorder. Thus it is imperative that there is research to aid in the development of strategies in order to work with people and their strengths in order to overcome the course of these disorders.

Another gap in services addresses the disconnect between the research on resilience and the actual mental health services provided. It has been noted that much of the research on resilience is focused on children and adolescents; however, there are few services geared to working with these populations (Staussner & Fewell, 2011). In American research literature, it was observed that children and adolescents who abuse drugs and/or alcohol remain underserved by the system of care. Although there is a vast amount of research highlighting the lifetime risk of mental health problems, related psychosocial issues, and the potential misuse of substances among children and adolescents who experience trauma, the research data indicates that the service delivery of health care professionals does not adequately address the concerns of young people.

Applications in Other Domains

In learning more about what makes up resilience, the application of such qualities can extend beyond work in the field of addictions to drugs and/or alcohol. Resilience has been associated with the healing of children who have survived abuse and maltreatment (Nasvytiene et al., 2012), aiding youth to better cope with stress, depression, and anxiety (Kenny et al., 2002),

reducing long-term negative outcomes of delinquency in adolescences (Larm et al., 2010),

enabling professionals to cope with demands of the job (Grant & Kinman, 2012), reducing the

negative effects of trauma and post-traumatic stress disorder (Rosenberg et al., 2014), and

maintaining and enhancing the psychosocial, health, and well-being of people as a whole

(Robertson, Cooper, Sarkar, & Curran, 2015).

Recommendations

The findings of my research indicate that resilience is affected by many factors and that

these factors differ from person to person. Although my research provided an in-depth review of

five participants, it may be beneficial to the study of resilience if research with a greater number

of participants was conducted in order to further the understanding of resilience.

Understanding resilience outside of the realm of substance use may also be beneficial.

Although my study only examined the experience of resilience of adults going through the

process of recovery from drugs and/or alcohol, it would be interesting to see if there was a

difference in the common themes of resilience in other domains, such as in abuse survivors or

those suffering from other mental health issues.

Furthermore, to direct future research it is important to examine possible cultural

differences related to resilience and substance use. My research was limited in that the majority

of the participants were Caucasian. Future research comprising of a more diverse cultural

background of participants may be useful in discovering potential cultural differences involved

in the process of resilience.

The demographic population of the participants in study also allows for future expansion.

It has been stated that much of the research on resilience is geared towards children and

adolescents, thus my research aimed to address the research gap among adults and resilience.

However, there exists another gap in the research and it involves the aging population. As we grow as a society, we also age as a society. Population aging is becoming a growing concern in many countries around the world, specifically in developed countries, as the proportion of older people in these countries increases (Wister & McPherson, 2014). Trauma and substance use issues are also increasing among this population, thus it may be important to direct research in examining the resilience of older adults.

Concluding Remarks

In taking into account the above implications and recommendations, it is clear that we can draw lines of connection to the research of resilience with social policy, public health, and the counselling profession (Straussner & Fewell, 2011).

I am passionate about enacting social change and addressing systemic issues that mitigate the rise of at-risk and marginalized populations. Conducting this research and interviewing participants was a very moving experience for me. It illustrated to me the true testament of the human spirit and what we can accomplish as individuals, and as a community as a whole.

My aim with this research is to develop a platform to base my future research on, which is to be able to develop a resilience-based harm-reduction, prevention, and treatment program for at-risk or marginalized populations. I believe that programs and interventions in promoting resilience should be complimentary to public health measures in addressing the social determinants of health.

Summary

The study of resilience has many implications regarding the counselling profession, the individuals seeking support, and also among program development and program expansion. It is

important to acknowledge the above recommendations; however, it is more imperative that

future research be conducted in order to address those recommendations to produce change.

Substance use is a growing concern around the world and it contributes to global

mortality and affects global health (Lynskey & Strang, 2013; Palamar et al., 2015).

 Although it would be advantageous to globally eliminate the problematic use of drugs and/or

alcohol, it may be more realistic to develop a means to be able to better cope with adverse

situations.

In this sense, coping is related to resilience and by examining resilience we can develop

effective prevention and treatment models that address the needs of people experiencing difficult

situations. In a conference I attended on building resilience, it was stated that people need to

breakdown in order to breakthrough to break free (M. Sangster, personal communication,

November 6, 2014). This statement describes resilience in such a way that gives strengths to

individuals experiencing stressful situations. Much like the Eastern philosophy of Yin and Yang,

the development of resilience requires love and adversity, care, and challenges (Grotberg, 2003).

Without adversity and challenges, strength and resilience would not exist. Thus experiencing

hardships is essential in the development of resilience. And in order to develop resilience in

individuals, it must be further examined to identify the common themes and patterns to be able to

replicate aspects of resilience in those who are experiencing adversities.

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college students. *Issues in Mental Health Nursing, 35*(6), 480-488.

Appendix A: Institutional Review Board Approval

**Institutional Review Board
Review Response Form**

Project Title: **Understanding Resilience: Uncovering the Common Themes**

Researcher's name: **Tracy Tsui**

Advisor's name: **Chris Shelley**

Date of response: **August 24, 2015**

Determination of risk: **Not minimal**

Decision:

Approve

X **Approve with minor revision(s) as noted below** *(Thesis or project advisor takes responsibility that changes have been made; resubmission not required).*

Reviewer Feedback:
10. You need to list your City U research supervisor as having access to the Data. You only mention yourself and the Counselling Manger in this paragraph.

The data are to be stored off-site.

14. City U research supervisor should also have access to data (electronic data storage)

Resubmission required, with attention to the following issues:

Reviewer Feedback:

Reviewer(s): Ellen K. Carruth, PhD, IRB Member
John C. Stager, PhD, IRB Member
Brian Guthrie Ph D, Chair IRB

Appendix B: Organizational Informed Consent Form

City University of Seattle

Organization Informed Consent Form

Name of Organization _____
Address   _____
City, State, Zip   _____
Telephone   _____

By signing this consent form, I understand that Tracy Tsui (the researcher) is a ☒ candidate for an advanced degree, or ☐ a faculty member of City University of Seattle. I understand that the researcher is conducting a study entitled Understanding Resilience: Uncovering the Common Themes. The purpose of this research is to further understand the experience of resilience for adults going through the process of recovery from drugs and/or alcohol.

I understand the findings of this research study are solely the responsibility of the researcher. It is understood that any and all information/data the researcher collects from contacts within and/or about our organization outside the research protocol will not be part of the research findings. I understand the researcher may publish findings following completion of this study. Any information published will be limited to the findings of the research. No research participants will participate in this study without organization and City University of Seattle Institutional Review Board (IRB) knowledge and approval.

☐   I grant the researcher permission to contact members of the organization for the purpose of requesting participation in the study as required by the research design.
☐   I grant the researcher permission to use organizational premises as necessary to conduct the research.
☐   I grant the researcher permission to collect, use, and store documentation related to the project under study. I understand that in granting permission to access program documentation, the researcher may store copies in a secure manner outside of the organization.
☐   The researcher will maintain all documentation and findings regarding this organization in confidence and confine its use to this research study.
☐   On behalf of the organization, I request a final copy of this research report.

_____   _____
Organization Representative and Signature   Date

Print Name and Title _____
Organization _____

Name of Research Supervisor or Advisor Christopher Shelley
Contact Information cshelley@cityu.edu

Appendix C: Letter to Potential Participants

Hello, my name is Tracy Tsui and I am a Master of Counselling student at City University of Seattle in Vancouver, BC. I am conducting a study to further understand the experience of resilience for adults who are going through the process of recovery from drugs and/or alcohol. The purpose of my study is to broaden the research knowledge on adults with resilience for the future purpose of designing interventions to foster resilience with adult at-risk populations. This research has many implications for harm-reduction and prevention work for at-risk and marginalized populations. Participation in this study is voluntary and participants have the right to withdraw at anytime, provided that you meet the criteria below, and no incentives or rewards will be provided. Participants must also consent to an audio recording of the interview for transcribing purposes. Participants will not be identified in the data collection or the final written product from the study. If you are interested in becoming a participant, you may contact me via my Deltassist phone line (604-594-3455 ask for Tracy Tsui) or you may contact me via email (tracytsui@cityuniversity.edu). You may keep this letter for your information if you chose to contact me. Thank you for your time.

Participant Criteria:
- Must me 19 years or older
- Must be a Deltassist client and living in the Delta, BC area (Delta, North Delta, Ladner, Tsawwassen)
- Must have had problematic use of drugs and/or alcohol in the past
- Must be able to speak English
- Participants can be from any ethnicity and cultural background

Appendix D: Letter to Confirmed Participants

Thank you for your interest in participation in this study. The study is being conducted in partial requirements of an advanced degree and your contributions to the research data are greatly appreciated. Over the next two months I would like to schedule a time to meet with you, at your convenience, at the Deltassist North Delta office (9097 120 Street, Delta) to go over and sign the paperwork regarding informed consent and confidentiality and to conduct the interview with you. The interview will be audio recorded and no identifying information will be used in the study. The interview will consist of 5 open-ended questions and will take approximately 45 to 60 minutes. Extra time will be allowed for you to express more information, as well as for debriefing to ensure your well-being and safety. Participation in this study is voluntary and you have the right to withdraw at anytime without negative consequences. The information collected will be kept confidential and secure in a key card access only file room, within a locked file cabinet, where only myself, the Counselling Manager Julie Chadwick and my City University Research Supervisor Christopher Shelley will have access to. Your identity will remain anonymous in the study, as no identifying information will be used in the final report. Thank you again for your interest in participation in my study.

Appendix E: Informed Consent Form (City University)

School/Division of Arts and Sciences

CITYU RESEARCH PARTICIPANT INFORMED CONSENT

I, _____, agree to participate in the following research project to be conducted by Tracy Tsui, ☐ faculty member or ☒ student, in the Master of Counselling Program. I understand this research study has been approved by the City University of Seattle Institutional Review Board.

Title of Project:
Understanding Resilience: Uncovering the Common Themes

Name and Title of Researcher(s):
Tracy Tsui – Student Researcher

For Faculty Researcher(s):
Department: _____
Telephone: _____
Email: _____
Immediate Supervisor: _____

For Student Researcher(s):
Faculty Supervisor: Christopher Shelley, PhD
Department: School of Arts and Sciences
Telephone: 604-254-0044
Email: cshelley@cityu.edu

Program Coordinator (or Program Director):
Colin Sanders, PhD

Sponsor, if any:
N/A

Purpose of Study:
The purpose of this study is to further understand the experience of resilience for adults going through the process of recovery from drugs and/or alcohol.

Research Participation:
I understand I am being asked to participate in this study in one or more of the following ways (the checked options below apply):

☒   Respond to in-person and/or telephone interview questions;
☐   Answer written questionnaire(s);
☒   Participate in other data gathering activities, specifically, audio recording of interview;
☐   Other, specifically, _____.

I further understand that my involvement is voluntary and I may refuse to participate or withdraw my participation at any time without negative consequences. I have been advised that I may request a copy of the final research study report. Should I request a copy, I understand I may be asked to pay the costs of photocopying and mailing.

Confidentiality

I understand that participation is confidential to the limits of applicable privacy laws. No one except the faculty researcher or student researcher, his/her supervisor and Program Coordinator (or Program Director) will be allowed to view any information or data collected whether by questionnaire, interview and/or other means. If the student researcher's cooperating classroom teacher will also have access to raw data, the following box will be checked.☐ All data (questionnaires, audio/videotapes, typed records of the interview, interview notes, informed consent forms, computer discs, any backup of computer discs and any other storage devices) are kept locked and password protected by the researcher. The research data will be stored for 5 years (5 years or more if required by local regulations). At the end of that time all data of whatever nature will be permanently destroyed. The published results of the study will contain data from which no individual participant can be identified.

Signatures

I have carefully reviewed and understand this consent form. I understand the description of the research protocol and consent process provided to be by the researcher. My signature on this form indicates that I understand to my satisfaction the information provided to me about my participation in this research project. My signature also indicates that I have been apprised of the potential risks involved in my participation. Lastly, my signature indicates that I agree to participate as a research subject.

My consent to participate does not waive my legal rights nor release the researchers, sponsors, and/or City University of Seattle from their legal and professional responsibilities with respect to this research. I understand I am free to withdraw from this research project at any time. I further understand that I may ask for clarification or new information throughout my participation at any time during this research.

Participant's Name: _____

Participant's Signature: _____ Date: _____

Researcher's Name: Tracy Tsui

Researcher's Signature: _____ Date: _____

If I have any questions about this research, I have been advised to contact the researcher and/or his/her supervisor, as listed on page one of this consent form.

Should I have any concerns about the way I have been treated as a research participant, I may contact the following individual(s):
Colin Sanders, PhD, Program Coordinator (and/or Program Director), City University of Seattle, at 310 – 789 W. Pender St., Vancouver, BC, 604-689-2489 ext 113,csanders@cityu.edu (address, direct phone line and CityU email address).

Appendix F: Informed Consent Form (Deltassist)

DELTASSIST FAMILY AND COMMUNITY SERVICES SOCIETY

CONSENT FOR RESEARCH PROJECT PARTICIPATION

Name of Research Project: _____

Name of Investigator: _____

Investigator Phone #:   _____

DFCS Research Committee Contact Name and Phone Number:

Deltassist Family and Community Services Research Committee is charged with determining the scientific relevance of research, evaluation the compliance with ethical principles, to modify or reject research proposals, and to monitor approved research proposals through the course of their administration in order to ensure compliance with the terms under which they were approved by the Committee.

Deltassist Family and Community Services utilizes the ethical principles adapted from the Code of Ethics of the British Columbia College of Psychologists to govern the involvement of DFCS clients in research projects conducted or sponsored by the agency.

1. Participation in the research project is on a voluntary basis.

2. Clients have the right not to participate in the research project or withdraw their participation at any time without censure from the agency.

3. Deltassist Family and Community Services will continue to provide services to clients irregardless of their decision to participate in the research project.

4. Clients have the right at any time to express their concerns to the investigator. If speaking with the investigator does not resolve the expressed concerns, clients have the right to contact the DFCS Research Committee who will address the issue and provide a written response within five (5) working days.

5. Explanation of the Nature/Purpose of the Research Project

The investigator will need to insert the following here:

(a) Clarify the nature and purpose of the project (exceptions to this see Policy Area J4.2)

(b) Clarify all obligations and responsibilities of the investigator and the client

(c) Identify any aspects that would reasonably be expected to influence the client's willingness to participate

6. Description of the Possible Risks of Discomfort to the Client

Deltassist Family and Community Services strives to protect clients from any physical or emotional discomfort, harm and/or danger that arises from research procedures

The investigator will need to insert the following here:

(a) List any possible risks or discomfort that could arise due to the client's participation in the research project

(b) Participants are encouraged to contact the investigator after the research should they experience any signs of distress, either emotional, or physical.

(c) The investigator will address and remove/correct any undesirable consequences for clients.

7. Provision of Information Regarding the Research

After the data has been collected, information will be provided to client about the nature of the research and the investigator will attempt to dispel any misconceptions that have arisen.

8. Confidentiality

Any information obtained about clients during the course of the research project is confidential, unless otherwise agreed upon in advance.

If any other persons may obtain access to the research data, this will be discussed in advance, with the client's consent and plans to protect confidentiality will be put in place.

9. Client Consent and Signature

I have read and fully understand the above as it relates to the research project and I consent to participate in this project.

I consent for other persons, _____, to have access to my information for purposes of the research project. Yes   No   N/A

_____   _____
Participant Signature   Date

Appendix G: Demographics Form

Sexual Orientation:

Relationship Status:

Children:

Employed:

Line of Work:

Appendix H: Interview Questions

Age:

Gender:

Ethnicity:

How do you define "recovery"?

Substance of Use:

How long has it been since you last used this substance?

- What is your experience of resilience through your recovery process?

- What were the turning points that lead you in this life direction?

- What in your environment supported your resilience?

- What psychological contexts supported your resilience?

- What else or is there anything else you would like to share with me today regarding your recovery?

Appendix I: Resources for Participants

Resources
- Deltassist Counsellor: 604-594-3455
- Healthlink BC: 811
- BC Mental Health Support Line: 310-6789
- Suicide Help Line: 1-800-SUICIDE (1-800-784-2433)
- The Drug & Alcohol Information and Referral Service: 604-660-9382 (in the Lower Mainland) or 1-800-663-1441 (toll-free in BC)

Online Resources
- www.heretohelp.bc.ca
- www.healthlinkbc.ca
- www.crisislines.bc.ca