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Exploring Lived Experiences and Perceptions of Individuals with Substance-use Disorder Recovery Management from a Biopsychosocial Perspective

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This is to certify that the doctoral dissertation by

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2025

Abstract

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MS, Walden University, 2009

BS, Boise State University, 2006

Dissertation Submitted in Partial Fulfillment

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Abstract

Substance-use disorder (SUD) poses significant biological, psychological, and sociological impacts that negatively affect areas of employment, health, family systems, and interactions with social welfare and legal agencies. Although there has been research on SUD treatment, relapse rates remain high at approximately 40%–75%, demonstrating a gap in the literature involving individuals who completed SUD treatment and continuation or management of recovery. Grounded in phenomenological theory and through a biopsychosocial lens, this qualitative study explored the lived experiences and perceptions of individuals with substance-use disorder managing their recovery. Data were collected from 8 individuals who completed partial hospitalization or intensive-outpatient levels of care and who remained substance-free for a minimum of the last 12 consecutive months, through semi-structured interviews. Three core themes emerged: biological, psychological, and social. Substance-use disorder professionals can use these findings to emphasize the significant role that positive and engaging support systems have in the continuation and management of recovery and to expand recovery resources that promote positive social change for individuals who are managing recovery.

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Dedication

I dedicate this work to every individual, parent, sibling, child, and friend of those individuals who suffer daily from substance-use disorder and the challenges you face. Like many diseases, SUD cannot be cured, but we can learn to live with it through successful management of recovery. This work is a small gift that I hope brings you some peace.

Acknowledgments

I would not have been able to complete this journey without the endless support, redirection, sound advice, and expertise of my committee chair, Dr. Sandra Rasmussen, and SCM Dr. Patricia Loun. I sincerely appreciate every email, phone call, and text that kept me moving. I would also like to thank the presenters throughout the residencies who assisted me in understanding the responsibility a person has when writing a dissertation.

I would like to acknowledge and thank my family for the craziness that has been my life for so long. I love every one of you more than I could ever say. This journey was not only for me, but for you, my loves, Stephanie, David, and Robert, and for my granddaughters Lexi, Emma, Renee, Deli, and Aria, to know you can be anything you want to be, but first, they must want it!

Finally, I would like to thank the eight individuals for their willingness to share the most intimate details of their lives with me. Your experiences proved to be what most would consider the worst and best times of their lives. You permitted me to share your experiences with the hope that others may suffer a little less.

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Chapter 1: Introduction to the Study

Introduction

Substance-use disorder (SUD) is a significant social and individual problem that affects individuals in every class, race, and gender. Over 46.3 million individuals who are 12 or older suffered from SUD in 2021 (U.S. Department of Health and Human Services [HHS], 2023). Additionally, 4.1 million individuals obtained some form of treatment for SUD in 2021 (Substance Abuse and Mental Health Services Administration [SAMHSA], 2022). Relapse affects between 40% and 75% of individuals between 3 weeks and 6 months following treatment (Kabisa et al., 2021). Management of recovery for substance-use is a significant daily challenge for millions of individuals. Sobriety is the absence of substances in the body. Recovery management involves the use of learned skills and techniques to maintain sobriety through the successful trigger identification, stress management, setting and maintaining boundaries, self-care, and peer support. Successful navigation of recovery management skills is essential for achieving and sustaining long-term recovery. According to Witkiewitz (2020), the process of behavior changes through improvements in biopsychosocial functioning and purpose in life is the working definition of recovery, inclusive of changes from which individuals improve life wellness through self-direction, striving to reach their full potential in health, home, self-purpose, and their community. Individual efforts are person-driven and holistically based and may occur through many pathways to achieve a better life. The difference between achieving sobriety versus recovery management relies on the utilization of these techniques and skills to address daily living stressors that oftentimes initiate substance use or relapse

(Hystad & Wangensteen, 2021). As a significant contributor, a positive association between support and recovery management has been noted to provide an avenue for individuals to develop strength in the utilization of the techniques and skills to support recovery management (Hoffman et al., 2021).

Background

Substance-use disorder (SUD) has been present for nearly as long as recorded history; however, the Diagnostic and Statistical Manual of Mental Disorders (DSM) only recently (within the last half century) categorized SUD as a primary disorder (Robinson and Adinoff, 2016). Earlier versions of the DSM, before 1980, categorized substance-use disorders as subcategories under sociopathic, personality, nonpsychotic, and mental disturbances or mental disorders, and severity specifiers and duration information were absent. The DSM-III included independent classification, severity specifiers, and duration. Since then, the DSM has evolved to include more inclusive criteria associated with substance-use and dependence, and with the most recent revision, DSM-5-TR, where substance-use and dependence were combined as a single category, which suggested severity is measured on a continuous scale between mild, moderate, and severe for specific symptomology endorsement. The term *addiction* was also removed due to a lack of a concrete definition and its negative connotation (Robinson & Adinoff, 2016; Facts About DSM-5-TR, 2022). Addiction is a chronic condition and a lifelong disease that may affect many areas of life, including but not limited to physical, health, mental, psychological, social relationships, educational, and professional (Cleveland Clinic,

2023). The term addiction is used interchangeably with SUD and involves compulsive seeking and use of substances or behaviors despite harmful consequences.

An important aspect to note is the neurobiological changes caused by SUD. Three main areas of the brain are affected by SUD and experience disruptions. These areas included the basal ganglia, extended amygdala, and prefrontal cortex (DHHS, 2016). These disruptions were responsible for the effect on substance-seeking triggers, the heightened activation involved in pleasure/reward experience, and the reduction of control systems in the brain that are directly responsible for the ability to make decisions involving action, emotion, and impulse regulation. According to the DHHS (2016), there was scientific evidence that these neurobiological changes exist long after an individual stops abusing substances, and they were uncertain how much of these changes may be reversed or how much time this process may take, thus emphasizing the focus on prevention and treatment for SUD. Volkow (2020) stated that addiction is a chronic disease that can be viewed as being managed successfully and compared the management of addiction to other chronic diseases such as heart disease or asthma. SUD treatment involves providing the skills and techniques that are designed to foster long-term recovery.

Since 2005, reported rates of substance-use disorder (SUD) for individuals who are 12 years of age and older have grown to more than 20.4 million in the United States in 2022 (SAMHSA, 2022). Although research shows SUD treatment offered skills and tools to support abstinence, there was a lack of sufficient representation in the literature that described the experiences and perceptions of individuals who were successfully

managing their recovery. The ability to interpret positive and negative impacts during recovery management may lead to a better understanding and assist in forming more inclusive interventions, tools, and skills, proactively removing barriers for those seeking long-term recovery.

Substance-use disorder treatment involves helping individuals stop the use of alcohol or drugs and remain sober and drug-free (Colon-Rivera & Balasanova, 2020). Unfortunately, the definition was vague in concept and application, which required a deeper dive to explain SUD treatment historically. The earliest SUD treatment, in the United States, began with alcohol in the late 18th and early 19th centuries, which resulted mainly in individuals being housed in some form of institution, such as jails, almshouses, asylums, and hospitals, although not offering any treatment (Henninger & Sung, 2014). Sober houses offered alcohol addiction treatment through a medical approach that included religious and moral instruction, proposed by Benjamin Rush in the late 18th century. The proposed medical interventions included cold baths, vomiting, aversion therapy, bleeding, blistering, and sweating patients. In the late 1800s, several inebriate homes and asylum managers collaborated to form the American Association for the Cure of Inebriation (AACI) for housing alcoholics; however, they provided addiction treatment services to the wealthy, usually in the form of referrals from local physicians for isolation from society, for the removal of temptation, followed by cold turkey detoxification. Later, psychotropic substances, including cannabis, coca, and belladonna, were used during detoxification, followed by healthy meals, fluids, vitamins, sunlight, and electrotherapy to assist with recovery. The Temperance Movement portrayed alcohol

abuse as a moral affliction rather than a disease and focused on removing consumption as well as requiring public admission of addiction and a commitment to abstinence. There was a growing recognition that alcoholism could not be cured through mere willpower.

The use of psychotropic substances was legal in the United States until the enactment of the Harrison Act in 1914. Availability of substances, including opiates and cocaine, was rampant and of epidemic proportions, and was often being used to treat other physical and psychological ailments. Before the 20th century, treatment involved lessening withdrawal symptoms during detoxification with other highly addictive psychotropic substances, which largely sustained the cycle of addiction.

Shifting the view of substance addiction from a public health model to a criminal justice model changed the course of potential approaches for treatment. The Harrison Act criminalized the possession of illicit substances and removed access for physicians to use them during detoxification or maintenance of those who suffered from substance-use addiction, thus removing the opportunity for individuals to receive any treatment at all (Musto, 1996). Once again, those who suffered from SUD were housed in jails and narcotics farms and often received experimental treatments such as insulin-induced comas, electroconvulsive therapy (ECT), aversion therapy, and psychosurgery (lobotomy; Henninger & Sung, 2014). The early 19th century resulted in alcohol and substance addiction treatments that involved psychological and psychoanalytic approaches. In 2000, the Drug Addiction Treatment Act (DATA 2000) was enacted to allow for providers to administer controlled substances (Schedules III-V) for purposes of

narcotic addiction treatment outside of opioid treatment practices (Yale School of Medicine, 2018).

Most professional views and opinions of SUD have changed, mostly because the American Medical Association (AMA) defined SUD as a chronic and lifelong brain disease (National Institute on Drug Abuse [NIDA], 2024). This differed from past conceptions of lack of morality, lack of character or self-control, personality deficits, possessing mental disorders, and being dangerous, which would often lead to institutionalization within jails, asylums, and almshouses to a focus on therapeutic interventions focused on staying drug-free through behavioral therapy-individual, group, and family therapy, understanding addiction and preventing relapse, addressing physical and/or mental health issues that may compound substance-use, potential medications to aid with recovery, learn and develop coping skills and strategies, identify triggers for real-life situations and action plans to address stressors, and identify support systems for ongoing support (Mayo Clinic Staff, 2022). Recovery management involves skills and techniques that are learned during treatment episodes and used following treatment.

Problem Statement

Substance-use disorder (SUD) was a significant social and individual problem affecting every class, race, and gender. In 2021, over 46.3 million individuals aged 12 years of age or older suffered from SUD (U.S. Dept. of Health and Human Services, 2023). Additionally, 4.1 million individuals obtained some form of treatment (SAMHSA, 2022). Single and even multiple treatment episodes are often not enough to prepare individuals for living substance-free. Negative impacts caused by SUD significantly

affect individuals, families, and communities in terms of employment, mental and physical health issues, reduced quality of life, and potentially increased participation or contact with social welfare programs such as legal/justice departments and agencies. Substance-use disorder, treatment, and recovery management are not the same for every individual. Each individual lives and experiences life issues differently. Individuals with SUD often face comparable challenges when they strive for long-term recovery. There was a lack of sufficient representation in the literature describing the experiences and perceptions of individuals who are successfully managing their recovery. By conducting this research project, I anticipated gaining a better understanding of participants' experiences and perceptions involving successful recovery management.

Purpose of the Study

The purpose of this qualitative phenomenological study, guided by Merleau-Ponty's theory of perception, with semi-structured interviews, was to explore the complex nature of successful recovery management through purposeful sampling of eight participants' lived experiences. The biopsychosocial (BPS) model developed by George Engel (1977) guided the development of the interview questionnaire and was used to interpret the individuals' experiences and perceptions. The BPS was chosen due to its design to encompass individuals' experiences and perceptions of recovery management from the biological-physical, psychological-emotional/mental, and social characteristics as they pertain to the disease of SUD. Data were transcribed for analysis. I explored perceptions and experiences of individuals following completion of SUD treatment that included partial hospitalization program (PHP) and intensive outpatient program (IOP)

levels of care. I addressed individuals who participated in social media support groups designed as supportive communities for addiction and recovery management. Data analysis was explored for similarities, differences, frequency, sequence, correspondence, and causation.

It was essential to gain a deeper understanding of how participants successfully managed their SUD recovery in terms of achieving long-term sobriety. I addressed these lived experiences and perceptions about their successes and failures using a biopsychosocial perspective to highlight and support potential best practices for achieving long-term sobriety.

Research Questions

I developed research questions (RQs) to explore experiences and perceptions of individuals who completed SUD PHP or IOP levels of treatment and maintained recovery for a minimum of 12 consecutive months:

RQ1: What are individual lived experiences from a biopsychosocial perspective, contributing to recovery management?

RQ2: What are individual perceptions from a biopsychosocial perspective, contributing to recovery management?

Theoretical Framework for the Study

The phenomenology of perception was founded on Merleau-Ponty's theory of the lived body and the phenomenal world (Merleau-Ponty, 2012). Participant's lived experiences and perceptions were collected through a purposeful sampling of 8 individuals and then coded according to similarities as they were interpreted (Saldaña,

2014). The theory that was used in this research was Merleau-Ponty's idea of perception. The framework was expected to provide a relationship between the lived experiences and perceptions of individuals with SUD who were managing recovery successfully, as interpreted through a Biopsychosocial lens. It was intended to provide a bridge in alignment with the context, theory, and structure of the research study (Bolton & Gillett, 2020).

The biopsychosocial model developed by George Engel (1977) guided development of the interview questionnaire and was used to interpret participants' experiences and perceptions. The BPS was chosen to address individuals' experiences and perceptions of recovery management in terms of biological, psychological, and social characteristics as they pertained to SUD. PHP and IOP levels of care were used as an anchor between SUD individuals and the attainment of recovery management skills and techniques. According to Fiscella (2005), Dr Engels explained that if you allowed individuals to tell their illness stories, they would include appropriate biopsychosocial context. Social media support groups were utilized as a participant pool to offer ease of participant identification, ease of access, similar backgrounds where SUD was concerned, and cost-effectiveness.

Engel (1977) indicated when individuals are allowed to share their stories about their disease, an appropriate psychosocial context would naturally surface (Fiscella, 2005). Because this model suggested understanding diseases cumulatively, and not merely via one dimension, understanding SUD requires a lens that encompasses the biological, psychological, and social aspects of the individual's life. The biopsychosocial

model involves evaluating the interconnectedness of biology, psychology, and social factors to provide a more thorough and complete understanding of individual conditions (Lacks & Lamson, 2018; Tripathi et al., 2019). The BPS model suggests there are connections between biological (body), psychological (mind), and social (environmental) factors that affect each other, and together, they collectively impact illnesses and health. An additional application of Engel's biopsychosocial model purported that all dimensions "share, from the start, and remain in the same ontological space/time," indicating they "bump into and causally interact as opposed to existing in parallel" (Bolton, 2019). This model suggested a holistic view of individuals that involves focusing on people rather than symptomology, and approaches should address substance-use disorder and recovery management through personal and social processes as ongoing and nonlinear in order to address individual perceptions and experiences regarding health, community belongingness, and identity while focusing on coping with recovery management and how relationships, social interactions, cultural identity, and surroundings are intertwined within the biopsychosocial arena (Wangensteen & Hystad, 2021; Woods, 2019).

Nature of the Study

I used a qualitative phenomenological methodology to explore experiences and perceptions of SUD individuals who were in active recovery management. This approach was used to interpret the complexities of navigating biological, psychological, and social experiences and perceptions at the micro and macro levels (Kirk, 2009). I utilized interpretivism as the theoretical framework that connected the lived experiences and perceptions of SUD individuals based on the phenomenon of successful recovery

management. I chose this qualitative approach for its ability to understand the experiences and perceptions, and to support a deeper dive that offered detailed information from among participants.

Willing participants were interviewed through a series of background and current information concerning demographics, substance-use from onset through SUD treatment completion, abuse, violence, neglect, and biological, psychological, and social life. I identified trends involving experiences and perceptions around biopsychosocial areas that will assist readers in understanding the full scope of recovery management of the "whole" individual. The phenomenological approach was appropriate for this study as it provided meaning to understand lived experiences and perceptions through open-ended questions that offered insight through the BPS lens (Fiscella, 2005).

I collected data for this study through semi-structured interactive interviews with willing and informed participants via social media groups. The social media groups were specifically designed as support groups for those with SUD. The sample for this phenomenological study consisted of eight participants. I explored similarities, differences, frequency, sequence, correspondence, and causation as interpreted using the biopsychosocial lens. Selection of participants was conducted using purposeful sampling and recruitment via social media administrators.

Definitions

The following terms were used within this study:

Abstinence: Refraining from substance/alcohol use (Frimpong et al., 2016). For this research, I required a minimum of 1 year of abstinence from all illicit substances and alcohol after completion of SUD treatment.

Addiction: Chronic condition and lifelong disease that can affect many areas of individual life, including but not limited to biological and physical health, psychological and mental health, social-environmental relationships, and education and professions (Cleveland Clinic, 2023).

Alcoholics Anonymous (AA): Fellowship of individuals who work together collectively to stop or maintain abstinence from drinking (AA, n.d.).

Narcotics Anonymous (NA): A not-for-profit peer-to-peer support group operating with a disease model to achieve and maintain sobriety using a 12-step basis (Hopwood & Treloar, 2013).

Partial-hospitalization (PHP): Level of care that involves provides therapeutic environments that do not require 24-hour observation. Discharge planning and/or step-down care are normal processes as individuals work through treatment goals. Living accommodations are not usually required for this level of care; however, treatment may be offered at hospitals or residential treatment centers and usually require 4 to 8 hours of therapeutic interactions daily. This level of care works for individuals who have employment obligations that require their presence as well as individuals with less extreme substance use histories (SAMHSA, 2004).

Substance-use disorder (SUD): A disease affecting an individual's brain or behavior. These effects can lead to an inability to control the consumption of substances

(drugs or alcohol – prescribed/legal or illegal/illicit) despite physical, emotional, financial, legal, or other negative consequences. (Mayo Clinic, 2017).

(SUD) Treatment: For purposes of this study, this researcher defined SUD treatment as a clinical setting designed to assist individuals in stopping an inability to use or control the consumption of substances. Approaches included one or more of the following: partial hospitalization (PHP) or intensive outpatient (IOP).

Diagnostic Statistical Manual (DSM): The DSM is a handbook considered the authoritative guide for the diagnosis of mental health and substance-use disorders, providing a common language so clinicians may exchange information about patients with consistency and reliability in areas of research and diagnosis. The DSM has been revised multiple times (I, II, III, IV, 5, and 5-TR) and almost certainly will be revised again as the understanding of mental health and substance-use disorders evolves (Professional, 2022).

American Society of Addiction Medicine (ASAM): ASAM developed a set of guidelines used for determining the level of care for patients with substance-use disorders and co-occurring conditions, based on medical necessity (ASAM, n.d.). Levels of care, for this research, included partial hospitalization (PHP) and intensive outpatient (IOP).

Intensive outpatient (IOP): Level of care meets 1-3 times weekly, often in the evening and on weekends, for ease of education, work, and family balance. This level of care was reported to work best for individuals who work, go to school, or have families (Center for Substance Abuse Treatment, 2004).

Recovery Capital: Volume of internal and external resources that are used by individuals to initiate and maintain recovery from SUD (White & Cloud, 2008). For this study, recovery management and recovery capital referred to similar internal and external tools and techniques that are used by individuals with SUD and equivalents.

Recovery Coach (RC): Nonclinical professional support coaches with lived experiences involving addiction who work through educating, engaging, and addressing individual barriers and supporting individuals through SUD recovery management (Boston University School of Medicine, n.d.).

Recovery Management: Skills and techniques that are used to assist in managing abstinence from substance-use. These skills and techniques involve successful trigger identification, stress management, setting and maintaining boundaries, self-care, and the use of peer support.

Relapse: Recurrence of substance-use following a period of abstinence. Relapse is a likely pitfall for approximately 40-60% of individuals within recovery (Parker et al., 2019).

Sobriety: Abstaining from drinking and/or taking substances for a specified amount of time (APA, 2023a).

Substance-use Disorder (SUD): A Disease affecting individual brains and behaviors. These effects can lead to an inability to control consumption of substances despite negative physical, emotional, financial, and legal consequences (Mayo Clinic, 2017).

Assumptions

I assumed that the interviewed participants were honest and forthcoming. I assumed that they answered questions honestly and, to the best of their ability, concerning abstinence from all substance and alcohol use at the time of participation in the study. Participants completed a treatment program at a level of partial hospitalization (PHP) or intensive outpatient (IOP) for SUD within the last 12 months. I assumed participants were active in their management of recovery from SUD and willing to provide in-depth information concerning current and ongoing recovery management efforts, including positive and negative impacts on health, biological, emotional, psychological, environmental, and social aspects of their lives.

Scope and Delimitations

This study included interpretations of SUD individuals' experiences and perceptions of their recovery management and how it impacted their lives through a biopsychosocial lens. Criteria for research participants included SUD individuals who completed PHP or IOP SUD treatment, were currently in sobriety, had sustained sobriety for a minimum of at least 12 consecutive months, and were actively within their recovery management. Research participants volunteered based on information provided, posted, recruited, or identified through social media platform administrators.

This study has the potential to be replicated when using the same methodology and framework to explore experiences and perceptions of SUD individuals in terms of their recovery management through a BPS lens. This study was intended to offer insights, commonalities, and interpretations of reported experiences.

Limitations

My goal was to interpret experiences and perceptions of SUD individuals who were managing their recovery as it pertained to impacts on their lives from a biopsychosocial lens. These experiences and perceptions of the SUD individuals were obtained concerning various areas within their lives that included the impact on their biological, psychological, and social factors. Limitations included restrictions that this researcher may not control and was entirely dependent on reported experiences and perceptions of participants. No information was solicited from SUD treatment programs, family, friends, or other support group members about participants.

Significance

This study will add to scholarly work on recovery management by focusing on the experiences and perceptions of SUD individuals involving recovery management and impacts on their lives from a biopsychosocial perspective. Paterno et al. (2018) indicated that further research was necessary to understand the unique meanings of recovery resulting in success. Interpreting positive and negative impacts during recovery management will lead to a better understanding and assist in forming more inclusive interventions, tools, and skills to be presented within treatments to be proactive in removing barriers for those seeking long-term recovery. Although SUD and treatment options have been the subject of much research, there was a deficit of literature focused on SUD recovery management and continuation of recovery through individual experiences and perceptions from a BPS model.

Summary

Unlike substance-use disorder treatment, recovery management involves additional challenges such as working and living within stressful environments that may cause triggers and relapse. Because there was not a one-size-fits-all approach to recovery, what influenced one individual's ability to navigate recovery management and others to relapse was sought through documented self-reports. Despite substance-use disorder treatment, relapse and overdose continue to occur. There is a need for a more comprehensive approach to understanding SUD individuals' experiences and perceptions during the recovery management process (Wangensteen & Hystad, 2021).

The purpose of this qualitative phenomenological study was to explore experiences and perceptions of SUD individuals involving recovery management. Participants completed PHP or IOP level of SUD treatment, had sustained sobriety for a minimum of the last 12 consecutive months, and were actively within recovery management. Research participants volunteered through social media platforms. For this study, I interviewed eight participants through web-based recovery support programs housed primarily on Facebook and LinkedIn. They responded with positive interest following public notice of the study. All responses were recorded and analyzed for interpretation using a BPS lens and qualitative data analysis.

Chapter 2 includes an extensive review of recovery management skills and techniques for SUD individuals. The literature review addressed current and historical literature concerning recovery management skills and techniques from a biopsychosocial lens and explained through the idea of perception guided by Merleau-Ponty (Merleau-

Ponty, 2012). The framework was expected to provide a relationship between the lived experiences and perceptions of individuals with SUD managing their recovery successfully. My intention was to provide a foundation of knowledge and deepen the understanding of individual experiences and perceptions involving recovery management.

Chapter 2: Literature Review

Introduction

Substance-use relapse occurs more commonly than not, and individuals with SUD experience relapse at similar rates to other chronic illnesses. The U.S. Department of Health and Human Services (2023) reported that when individuals with chronic diseases discontinue adherence to medical treatment plans, relapse is almost a (40-75%) certainty. With such a high potential for relapse, the necessity for a solid plan for the continuation of the management of recovery is essential.

According to recent literature, information that surrounded individuals with substance-use disorder (SUD) was more widely accepted as a chronic disease for which many recommended SUD treatment (Center for Drug Evaluation and Research, 2024; Macmadu et al., 2021; Mayo Clinic, 2017; National Institute on Drug Abuse, 2020a; Parker et al., 2019). SUD treatment levels and interventions through clinical therapy and medical interventions allowed for approaches that treated the whole person to account for physical, psychological, and social areas within one's life.

This chapter includes an extensive review of recovery management skills and techniques for SUD individuals. I addressed current and historical literature involving recovery management skills and techniques from the Biopsychosocial lens and explained the idea of perception guided by Merleau-Ponty (Merleau-Ponty, 2012). The framework was expected to provide a relationship between the lived experiences and perceptions of individuals with SUD and the successful management of their recovery. My intention

was to provide a foundation of knowledge and to deepen the understanding of individual experiences and perceptions regarding recovery management.

Although SUD interventions and treatment options have been widely utilized, there was a notable gap between outcomes of individuals with SUD treatment completion and a scholarly noted model of standards rooted in the individuals' experiences and perceptions based on biopsychosocial areas (biological, psychological, and social) that were submersed in the management of their recovery. U.S. President Biden outlined the importance of his 2022 Presidential Unity Agenda in early 2022, which promoted collaborations between federal, state, tribal, territorial, and local partners to include SAMHSA for support of recovery for individuals with mental health and substance-use disorders (SAMHSA, 2023).

Frone et al. (2022) presented SUD from the workforce and reported that approximately 70% of adults with SUD were employed. More importantly, approximately 9% of these individuals reported being in or having been in recovery from SUD. When a 40-75% potential relapse rate looms near, the importance of recovery management through the experiences and perceptions of those who successfully maintain their recovery becomes more important than ever.

To understand recovery management, we must first understand substance-use disorder and the challenges in defining and assessing recovery management. There is scientific and social controversy around substance-use disorder and addiction as a disease. The controversy concerned with the potential impact in the beginning with a diagnosis and its continuation through prognosis has impacted policy from an ethical

perspective (Farisco et al., 2018). Views concerning substance-use disorder have changed throughout various periods in time, cultural contexts, medical usefulness, moral perception, and finally represented by the American Psychiatric Association (APA) Diagnostic and Statistical Manual of Mental Disorders (DSM) (Robinson & Adinoff, 2016).

SAMHSA Protocol TIP 35 (2019) described increasing congruence between intrinsic and extrinsic motivation through exploring participant non-adherence, reaching out/following up, creating coping plans, assessing and enhancing self-efficacy, identifying new behaviors to reinforce change, identifying recovery capital (social supports), and to identify high-risk situations that were likely to increase risk of relapse (internal and external factors) efforts referred to as relapse management strategies. Although SAMHSA did not use specific biopsychosocial interviewing terminology, they suggested motivational interviewing through contact with participants for gauging and assessing areas where high relapse rates were connected.

This qualitative study explored the experiences and perceptions of individuals in post-substance-use disorder (SUD) treatment to understand participants' recovery management through biological, psychological, and social aspects. I used George Engel's (1977) Biopsychosocial theory to interpret individuals' reported experiences and perceptions concerning their achievements and challenges in recovery management through (biological, psychological, and social) factors cumulatively.

Literature Search Strategy

The following databases were utilized: EBSCOHost, ERIC, PsycINFO, SocINDEX, and Science Direct. Search terms were *substance-use disorder (SUD)*, *addiction*, *Opioid use disorder (OUD)*, *medication-assisted treatment (MAT)*, *opioid treatment program (OTP)*, *relapse prevention*, *long-term recovery*, *recovery management*, *continuation of the recovery*, *lived experience*, *perceptions*, *biopsychosocial theory, and model*.

Due to the complex nature of substance-use disorder, other terms within each major search category were utilized to develop a more complete picture of the nature of recovery management/continuation of the recovery. For substance-use disorder, minor search terms included use/abuse of drugs, alcohol (SUD), Opioid (OUD), and addiction. Treatment search terms also included *traditional SUD treatment care*, *individualized SUD treatment care*, *acute and subacute detoxification*, *residential treatment (RTC)*, *partial hospitalization program (PHP)*, *intensive outpatient program (IOP)*, *individual therapy*, *group therapy*, medication-assisted (MAT), and *Alcoholics Anonymous (AA)*, *Narcotics Anonymous (NA)*, *after/post-treatment*, Finally, recovery management/continuation of recovery search terms included *long-term*, *ongoing*, *abstinence*, *sobriety*, *clean*, and *sustaining recovery*.

Multiple perspectives concerning substance-use disorder, the significant social and individual impact of recovery, and the difficulty involved with achieving and maintaining sobriety were addressed for this study. Sources were published between 2022 and 2025. All sources were peer-reviewed and published in full text in the English

language. Many qualitative and substance-use disorder perspectives focused on collecting information on substance-use disorder participants' use and treatment. As the focus changed, attitudes on recovery management and continuation of recovery became more prominent and required further examination.

Theoretical Foundation

The theories and concepts grounding this study were adopted from Merleau-Ponty's phenomenology of perception, where the aim was to develop new and more accurate objective thought leading to further exploration of experiences and perceptions (Romdenh-Romluc, 2010). The lens through which I explored collected experiences and perceptions was defined through Georg Engel's biopsychosocial theory and its application to substance-use disorder. The connections between this framework and my study included a multidisciplinary approach to viewing and treating individuals' physical and mental health care needs. The biopsychosocial model suggested connections between biology (body), psychiatry (mind), and social (environmental) factors that directly affect one another and, together, collectively, impact illnesses and health. An additional application of Engel's biopsychosocial model purported that all dimensions "share, from the start, and remain in the same ontological space/time," indicating they "bump into and causally interact as opposed to existing in parallel" (Bolton, 2019; Engel, 2001). This model suggested understanding an individual's condition (biological, psychological, or social environment) was most effective when viewed cumulatively and not through one dimension (biology, psychiatry, or social). The biopsychosocial theory proposed consideration by evaluating the interconnectedness of biology, psychiatric, and social

dimensions (or biopsychosocial) to provide a more thorough and complete understanding of individual conditions (Tripathi et al., 2019).

Maurice Merleau-Ponty's Phenomenological Theory

Professionals may argue over how substance-use disorder begins, and although an intriguing topic, this research was concerned with the experiences and perceptions of individuals with SUD surrounding the management of their recovery. Merleau-Ponty's phenomenology of perception sought to understand the relationship the SUD individual possessed within the connectedness of their biological, psychiatric, and social areas, where recovery management is concerned. Merleau-Ponty explained that the body was the primary place from which individuals experience the world and all things within it (Anderson, 2022).

Merleau-Ponty purported perception to be thought of as a form of interaction between the perceiver and what is being perceived or simply understood as that which we perceive comes into the perception of it. A positive perception will positively impact individuals who report successful management of recovery (Anderson, 2022).

George Engel's Biopsychosocial Theory

Mental health and substance-use disorders are believed to be developed through various avenues, including biology (genetics), the concept of self (psychology), relationship (social), or the web of interactions between any or each of these (University of Rochester Medical Center, n.d.). George L. Engel suggested illness (medical and mental) was better understood by reviewing the intertwined interactions of physiological, psychological, and social variables (Fiscella, 2005). Engel, dually appointed in the

departments of medicine and psychiatry at the University of Rochester Medical Center in New York, indicated that psychiatric disorders were complex and multidimensional. He further purported that treatment would likely include some combination of medication (biological), psychotherapy, and case management addressing social factors (Ruffalo, 2021).

Although initially Engel was skeptical concerning psychosomatic medicine, he became involved in and collaborated with Franz Reichsman on The Monica Project, which followed Monica from infancy into adulthood and spanned more than forty years. Monica was born with Oesophageal atresia and fed through a surgically produced gastric fistula for her first two years. The subject exhibited extremely poor bonding with her 19-year-old mother, who also had trouble relating to Monica due to depression and conflict concerning feeding due to the feeding tube requirement. Monica's inability to thrive in her home environment led to a 9-month stay, where she showed considerable improvement following an attachment to Dr. Reichsman and one of the nurses, from which the attachment was reciprocated. Observations by Engel and Reichsman noted "unusual" behaviors, including a lack of crying in response to contact with strangers; alternatively, Monica exhibited an immediate unresponsive, withdrawn state that included loss of muscle tone, extreme immobility, sad facial expressions, and her gastric secretions ceased, becoming unresponsive to histamine stimulation. This condition was called depression-withdrawal reaction (Taylor, 2002). Engel noted this important condition-interaction that the subject's physiology (gastric) and emotional state were impacted by an interpersonal relationship with those with whom attachments had been

formed. Engel's view of humans as psychobiological beings with a constant openness to influence and being influenced by the environment and individuals in it presented the primitive basis that Engel pursued through strong advocacy for the interconnectedness between psychoanalysis and biological medicine when treating illness and diseases. Engel asserted a new approach in research that dove into how psychosocial variables may interfere with an individual's biology, which may create a predisposition to illness and disease.

Dissatisfaction with the sole biomedical treatment model for illnesses and diseases offered Engel an avenue to highlight the interrelatedness between the mind and social contributions (Wade & Halligan, 2017). By mid-1950, Engel led the University of Rochester Medical Center as the leader in psychosomatic theory, and it was later coined the "biopsychosocial model" (George Libman Engel, M.D., n.d.). The proposed Biopsychosocial model revealed insight concerning the influence on disease (biology) and further supported Engel's theory that medicine, psychiatry, and psychoanalysis collectively synchronize the body.

Biopsychosocial Theory Applied to Substance-Use Disorder

The evolutionary framework supported information for the APA theory of substance-use disorder. Though the Evolutionary framework purported significant heritability to include tolerance, the sensitivity of the dopamine system, and life history strategy attachment, it also indicated secondary indicators providing adaptation through areas that included the dopamine system (physical-cellular) and environment. Lastly, the Evolutionary framework assisted in therapeutic and intervention efforts that were

developed based on the potential identification of early-onset substance-use (Lende & Smith, 2000). Recommendations suggested that successful interventions must include addressing an individual's attachment strategy in conjunction with therapeutic efforts. These factors indirectly supported Engel's Biopsychosocial theory as applied to substance-use disorder.

How the Biopsychosocial Theory Related to the Study

Engel's theory of the biopsychosocial approach proposed incorporating psychosocial elements of an individual's life to better assess, understand, and treat ailments and diseases (Smith, 2002). Engel suggested that understanding human health required more than pathophysiology. He recognized that systemically considering biological, psychological, and social factors through their complex intertwining interactions offered a better lens to understand illnesses and health (Morgan & Aldington, 2020). As applied to substance-use disorder, Engel's biopsychosocial model suggested that manifestations required a broader, holistic exploration and that ignoring the nature of intertwinement between biology and psychosocial elements produced a deficient explanation (Wade & Halligan, 2017). Buchman et al. (2010) suggested that integrating biological and psychosocial interactions allowed for a more precise approach to substance-use disorders and interventions for prevention. By holistically understanding substance-use disorder and the individuals with this disease, identifying commonalities between those successfully maintaining recovery management allowed more usable intervention templates for those actively within the disease to strive to achieve.

Literature Review Related to Key Concepts

Brief History of Substance-Use Disorder

Sarvet & Hasin (2016) stated elements of the natural history of substance-use disorders (incidence, remission, persistence, and relapse) were crucial to understanding the course and outcomes of substance-use disorders. Emphasis on identifying the development of recovery management for severe substance-use disorders led to interventions within policy and healthcare. Historically, substance-use disorder was viewed as directly linked to external psychopathology. Incidents were associated with early/young substance-use that accompanied delinquency and mental health conditions such as personality disorders. For later/older substance-use associations, it was believed that prolonged mental health conditions and chronic pain were included. Sarvet & Hasin (2016) added that external psychopathology might have been initiated through childhood maltreatment or stressful life experiences.

Identifying the incidence or the onset of substance-use disorder was rare and was met with challenges concerning sociodemographic elements or known psychiatric conditions at the beginning of substance-use. Elementary models as a causal factor initially included retrospective accounts of the "age of first drink." However, this perception did not remain dominant after controlling for demographics, childhood experiences, and family history (Sarvet & Hasin, 2016). Although "age of first drink" has been designated as one determining factor for the onset of a substance-use disorder, sociodemographics showed parental substance-use disorder was a dominant risk factor

and linked to an increase in child maltreatment frequency, physical abuse, emotional abuse, and neglect (Kepple, 2018).

Remission or point and time of abstinence was widely defined and ranged from no longer meeting full criteria, null of symptoms of substance-use, and no longer using substances (Sarvet & Hasin, 2016). Abstinence was reached more widely for individuals with a history of medical conditions or substance-use lacking dependence. Kelly et al. (2020) purported to achieve full remission; the road to recovery and long-term abstinence was treacherous and often cyclical through periods of relapse, treatment, incarceration, and short-term remissions for those with greater severity of addiction and fewer recovery resources. Persistence and substance-use disorder presented as the most severe cases, where remission was concerned.

Understanding and adequately addressing health, social, and psychopathological issues were instrumental in achieving sustainable remission. McCabe et al. (2018) indicated that when high importance was placed on managing and reducing life stressors, a reduction in the persistence of substance-use disorder was more likely for those individuals who were particularly susceptible to relapse, especially during early remission. MacNicol (2017) indicated that cumulative effects or repeated (persistent) exposure to substances likely suppresses natural biological rewards, causing an inability of brain circuit interruptions, excluding substance-use, in the production of positive rewards, thus supporting physical sense for continued use.

Relapse was described as re-engaging in the use of substances following an attempt at or achievement of abstinence. Relapse often occurred due to overwhelming

stressors (life, health, psychiatric) that complicated recovery and are a common barrier for those who desired to achieve abstinence (Harris, 2019). Sarvet & Hasin (2016) indicated that when controlling for sociodemographic and psychiatric variables, relapse was shorter and most likely to occur during the first 36 months of remission. However, it is important to note that individuals who used substances often were not exclusively substance specific. It was speculated that individuals, although in remission from one substance, may develop a use disorder that involves a different substance (Sarvet & Hasin, 2016).

Research concerning substance-use disorders has occurred for centuries; however, the studies were limited by the time's specific and dominant scientific and social theories. Initially, the research conducted was based on popular and professional attitudes. More recently, since the 1960s, research has increased based on grant funding by the National Institute on Drug Abuse (NIDA) and the National Institute of Mental Health (NIMH) (Musto, 1996). Excluding alcohol, morphine was the first addictive substance developed from a natural product in 1806 by a German pharmacist, F.W.A. Serturner. It had been reported to have "revolutionized pain control," and medical optimism deemed substance-use acceptable. In 1875, the first study by Levinstein identified vital elements of opiate addiction, noting it to be the drug that created a "fixation that made it the highest priority even when the user's life situation had deteriorated and the phenomenon of withdrawal that could be reversed quickly by giving more opiate" (Musto, 1996).

In 1914, the Harrison Anti-Narcotics Act was born out of a growing fear of extensive drug use in the United States, believed to have stemmed from a combination of

the association of opium with Chinese immigrants, cocaine with African Americans, and Morphine addiction following World War I (Musto, 1996). The Harrison Act purported that narcotics used in management through treatment to avoid substance withdrawal were not considered appropriate medical treatment and sought to prosecute physicians who practiced this focus. Five years later, the Supreme Court ratified governmental law interpretation and found the ruling to be "controversial" with the potential of intrusion on medical practices and the theory of permanent physiological changes through antibodies/toxins caused by Opiate use. This hypothesis supported the consideration of addiction as a medical disease; however, further research refuted this hypothesis and concluded there was "no organic basis for addiction" and purported withdrawal to be "functional or psychological," causing controversy concerning support of intervention within the medical model and challenged established government policy (Musto, 1996).

Over the next few decades, attention and research contributions began through organizations including, but not limited to, The Public Health Service (PHS), the Bureau of Social Hygiene, the National Research Council (NRC), the Federal Bureau of Narcotics, The Ford Foundation (family foundation), National Institute of Mental Health (NIMH), Addiction Research Center (ARC), Division of Narcotic Addiction and Drug Abuse (DNADA), National Institute on Drug Abuse and the National Institute on Alcohol Abuse and Alcoholism (NIAAA), the Special Action Office for Drug Abuse Prevention (SAODAP), and the National Institute of Drug Addiction (NIDA). Individually and collaboratively, these organizations focused efforts on dealing with existing or growing substance-use issues and their impact on individuals, families, and

society through funding, research, education, prevention, and treatment. The creation of the NIDA indicated that drug use/abuse issues were not expected to go away, and research that addressed them was a national necessity (Musto, 1996).

Concept of Disease and Basic Disease Models

Similarly, in other diseases such as diabetes or cancer, the first sugar or nicotine consumption may result from an individual's choice. It is important to note that not all individuals who consume sugar or nicotine are diagnosed with diabetes or cancer. Some individuals with diabetes or cancer may have never consumed sugar or nicotine, which were known to cause diseases. Similarly, individuals who chose to consume substances for the first time, similar to diabetes and cancer, not all individuals who consume alcohol or narcotics result in substance-use disorders, suggesting that choice does not always determine disease classification (Is Addiction a Disease, 2022). Chronic disease is a long-lasting condition that may be controlled but not cured (Is Addiction a Disease, 2022). Approximately 25-50% of 1st-time substance users develop a severe long-term problem that meets the definition of chronic. Finally, substance-use disorder was defined as a disease affecting an individual's brain and/or behavior that can lead to an inability to control the consumption of substances despite physical, emotional, financial, legal, or other negative consequences (Mayo Clinic, 2017).

Approaches to treating substance-use disorders stem from experts, scientists, clinicians, and policymakers and are embedded in differing beliefs about where the disorder manifests. SUD treatment may occur in various settings and through various approaches aimed at assisting in the inability to use or consume substances through

detoxification, residential, partial hospitalization, intensive outpatient, behavioral therapy, individual therapy, or a combination of multiple services. Varying models are based on biology, psychodynamic, moral, and social learning theories. Each model views primary manifestations, causes, interactions, and individual participation (Jaffe, 1978; Khantzian, 2012).

Views of Substance-Use Disorder

Choice or disease was a valid debate. Early interventions contended that individual choice explained substance-use disorder. The choice model, non-pathological, indicated that individuals choose to use or to abstain from use where substance-use disorder is concerned (Goldberg, 2019). Leyton (2013) suggested substance-use disorder was unique as a disease; it required an individual to be externally exposed, and it included the etiology of normal functioning as being impacted by signs and symptoms (Leyton, 2013).

Theoretical expansions examining substance-use disorders have evolved. Early theories focused on biological, psychodynamic, moral, social learning, and biopsychosocial factors. Woods (2019) indicated a need to refine the connections between the biopsychosocial factors that contributed to specific effects to capture the full complexity of individual perspectives concerning health and family systems. When biopsychosocial factors were considered, identifying relationships between risk factors and interventions supported preventing adverse events, including relapse and overdose (Ishino et al., 2020).

Normalizing relapse decreased the urgency for interventions designed to prevent them. Guenzel & McChargue (2023) reported that countless individuals lost their jobs and families, experienced legal issues, and sometimes lost their lives because of substance-use disorder and relapse. Interventions such as therapy, skill development, and monitoring were noted as the three most common prevention strategies. Some growing popularity explained relapse in stages rather than a singular event. This occurs at numerous points where interventions and learned skills fail to be implemented. The first stage, emotional relapse, occurs when an individual with SUD fails to remember the risk of relapse is urgent and prevents them from utilizing techniques learned to prevent relapse. Examples of emotional relapse exist when an individual begins to isolate, stops seeking support, and fails to exhibit proper self-care habits. Interventions, at this stage, included reminders of good self-care and recognizing denial to avoid further progression into relapse. The second stage, mental relapse, occurs when the individual with SUD experiences an internal struggle between a return to using and remaining abstinent. Examples of mental relapse exist when individuals begin experiencing cravings, exposure to triggers, idealizing past use, and bargaining for use. Interventions, at this stage, include reminders of mindfulness concerning triggers and implementation of relapse prevention plan techniques and skills to avoid further progression, at this stage. Finally, the third stage, physical relapse, occurs when an individual physically returns to substance-use. Examples of physical use are categorized as lapse or relapse. Lapse was described as an initial return to substance-use, while relapse is described as an uncontrolled return to substance-use. Although some did not recognize differentiations at this stage, it is

important for the success of potential interventions. Therapy, medications, monitoring, and peer support were most commonly associated with best practices for relapse prevention. Each of these was an intricate piece of the recovery management techniques and skills obtained within a SUD treatment setting (Guenzel & McChargue, 2023).

Svendsen et al. (2020) conducted a longitudinal study of 30 participants who had achieved long-term recovery. The focus was on the perception of SUD individuals in long-term recovery, concerning monitoring and feedback to support recovery management. Results yielded three points of interest; a) ongoing short text messaging/monitoring offered achieved milestones and historic reminders, b) results assisted participants by tracking physical and cognitive achievements to include self-acknowledgments such as "I am more like myself," and c) understanding the importance of a functional brain to support long-term retention. They indicated retention rates hovered around 89% at the 12-month assessment and 75% at the 72-month assessment periods, respectively. Instruments used in the study included the Drug Use Disorders Identification Test (DUDIT-C) – to assess drug use, the Alcohol Use Disorders Identification Test (AUDIT-C) – to assess alcohol consumption, the Symptom Checklist 90 Revised (SCL-90-R) – to assess psychological functioning based on the summarized Global Severity Index (GSI), the Behavior Rating Inventory of Executive Function – Adult Version (BRIEF-A) – to assess executive functioning, and the Satisfaction With Life Scale (SWLS) – to assess quality of life. Implications of this study supported SUD experiences and perceptions as useful by SUD individuals during their recovery management, indicating pertinence in designing recovery management techniques and

skills offered to individuals during and after SUD treatment for ongoing success and contributing to recovery processes to motivate recovery.

Substance-use disorder treatment and recovery management impacted a broad range of areas that included the labor force, the criminal justice system, and the community at large. Ashford et al. (2019) suggested the 2016 U.S. Surgeon General's Report on Alcohol and Other Drug Use projected that behavioral health disorders cost the U.S. over 420 billion dollars annually and presented a significant concern across the globe with over 18% of the world's population considered high episodic drinkers and 31 million with SUD, excluding alcohol. The recovery system of care was not a new concept; however, the difficulty it poses is rooted in the individuality of the SUD individuals and the various needs of those individuals. Recovery, SUD treatment, and management of recovery must meet SUD individuals where they are in their recovery to support success. A recovery-oriented system for care was designed so that communities may support the coordination of services specific to SUD; it varies by individual, specific for individual, a continuum of care and support, and support for individual, support, and involvement for family and other components of the recovery process (biological, psychological, and social). The recovery management framework suggested that communities that possess more support services, armed with recovery at the center of its focus, were more likely to provide successful recovery outcomes, improved quality of life, recovery capital, and longer abstinence lengths for their citizens (Ashford et al., 2019).

The importance of the recovery management framework transcended the barriers of SUD to mental health as well as biological illnesses. A study of schizophrenia or other severe mental illnesses included 187 outpatients following 12 months of treatment and six months of follow-up. Illness management and Recovery (IMR) or care as usual (CAU) scales were utilized to investigate group differences over 18 months. Results showed patients who received the IMR reported significant improvement in overall illness management that included improved self-esteem, which was noted as a component of personal recovery. It is important to note that there were no statistical differences between the groups' hospitalizations. However, personal recovery was positively impacted by increased self-esteem, and the researchers suggested additional studies to establish efficacy in personal recovery (Roosenschoon et al., 2021).

The controversy of substance-use disorder/addiction as a physical, psychological disease or choice continues to date. Physical versus psychological addiction remains a highly debated topic among the scientific and general population (Bianco, 2017). As a choice or disease progresses, the question of addiction may be explained by biopsychosocial principles through which a comprehensive theory can be applied.

Recovery Management

Recovery management was defined as skills and techniques used to assist in managing abstinence from substance use. These skills and techniques are specifically focused on successful trigger identification, stress management, setting and maintaining boundaries, self-care, and utilization of peer support. Although recovery management appeared to be a theoretically applicable concept from which individuals sustained

substance use, this research utilized “recovery management” as a label to collectively describe a set of skills and techniques used to maintain current sobriety or abstinence from substance use.

Hennessy et al. (2022) embraced a program designed to support college students in recovery from alcohol or other SUD using recovery capital. Through conducting a quantitative mixed methods model that used secondary analyses of de-identified participating student data, resources, experiences, and outcomes, they found that colleges were not able to provide the same resources to all students across the country. The expectations included more positive participant experiences leading to an increase in short-term outcomes such as learning to have fun while being sober, which would increase engagement in college, produce higher grades, and be more likely to graduate. Hennessy et al. (2022) found a large deficit in this field of study and proposed a need for a systematic approach to the collection and evaluation of data and designed a basic toolkit for such focused attention. Although this research was perceived as off-topic, it was not; the focus of Hennessy et al. (2022) study was based on the need and acquisition of skills and techniques to maintain sobriety by supporting the continuation of education endeavors and ultimately as a positive participant in society. Implementation through vast internal and external resource stimulation was recommended as the next step. Receiving individuals’ experiences and perceptions concerning outcomes was essential.

SUD treatment aims to improve individuals’ lives through resources, tools, and techniques to support their recovery management (Kelly & White, 2011). Various professional roles and training, individual and community resources, cell phone

applications, and peer support groups such as A.A. and N.A. have been created, critiqued, and revamped to provide individualized avenues for managing recovery. Kelly & White (2011) followed a group of approximately 140 female patients who completed SUD treatment and then were assigned a recovery coach, RC. They found that those women who worked with an RC were significantly more likely to engage in addressing barriers such as obtaining employment, improved housing, and seeking community resources when needed. They noted these findings did not account for the agreeability to work with an RC or the initial motivation possessed by individuals. They suggested a randomized design that eliminated these potential intruding factors and indicated more research is needed to thoroughly investigate this intervention based on challenges and barriers to including clinicians' desire for RC to be a community extension of an existing treatment plan, clinicians' desire for regular reporting of participants' activity, clinicians' discontinuance of treatment for those who continued to relapse, clinicians' lack of support for engaging in employment before reaching treatment milestones, and clinicians' lack of support for the participant to engage with family and friends in early stages of treatment (Kelly & White, 2011). Although this specific study was based on participants who were in the initial stages of SUD treatment, it followed the patients well after discharge and their return to the community, work, and home.

The above-noted studies varied slightly in approach and goal; however, they explained the importance of recovery management on the individuals' likelihood of maintaining the ability to achieve long-term sobriety. What was missing? The experiences and perceptions of the individuals living with SUD and managing their

recovery were the missing pieces of this puzzle. This research project worked to connect recovery management from the beginning to ongoing recovery management from the individuals' experiences and perceptions.

Summary and Conclusions

The study of recovery management of substance-use disorders has varied throughout history, mainly due to the etymologies of substance-use disorder as a choice versus a disease (Leyton, 2013). In response to more than a century of such controversies, George Engel proposed a biopsychosocial model through which considerations of evaluation of the interconnectedness of biology, psychiatric, and social dimensions (biopsychosocial) provided a more thorough and complete understanding of individual conditions such as substance-use disorders (Tripathi et al., 2020).

The theoretical framework of the biopsychosocial model was used to understand individual experiences for substance-use disorder recovery management following SUD treatment. Also, the literature supported examining individuals' experiences of substance-use disorder recovery management; the field needed additional research that included individuals' reported experiences.

Chapter 3 presented the research design and rationale that included the phenomenological approach and its role in addressing the research question. The methodology chapter included a rationale explaining participant selection and the analysis plan for data collection. The chapter ended with procedures for adherence to Institutional Review Board (IRB) requirements and strategies that addressed potential ethical concerns.

Chapter 3: Research Method

Introduction

The acquisition of appropriate skills and techniques for the successful management of SUD recovery offered positive benefits to SUD individuals. The experiences and perceptions of individuals following 12 consecutive months of sobriety, concerning skills and techniques resulting in successful recovery management, allowed for a positive impact on treatment interventions at earlier stages within the treatment-relapse cycle that supported longer lengths of recovery.

This phenomenological research study focused on the experiences and perceptions of SUD individuals in active recovery management to increase the knowledge and understanding of skills and techniques learned during SUD treatment and to be utilized within recovery management. This chapter reviewed the methodology, approach, research assumptions, study setting, sampling plan, ethical considerations, and biopsychosocial (BPS) data interpretation to be used during the study, as well as included an explanation of the research design and rationale, the role of the researcher, instrumentation, procedures for recruitment, participation, data collection, and the data analysis plan. Potential issues with trustworthiness and ethical procedures were also contained in this chapter.

I conducted a qualitative phenomenological study to explore the lived experiences and perceptions of SUD individuals who were in active recovery management. I utilized an interactive questionnaire process with participants to answer the questions, “What are the individuals’ lived experiences, from a biopsychosocial perspective, contributing to

recovery management, and what are the individuals' perceptions, from a biopsychosocial perspective, contributing to recovery management?" And finally, data was interpreted through a BPS lens.

This approach was the best method for this investigation because it offered the opportunity to interpret participant phenomenology through the complexities of navigating biological, psychological, and social experiences and perceptions at the micro and macro levels (Kirk, 2009). I utilized interpretivism as the theoretical approach to connect the lived experiences and perceptions of SUD individuals based on the phenomenon of successful recovery management. By looking for common experiences, I attempted to develop a deeper understanding and interpretation of how participants-maintained SUD recovery through the collection of stories of individual journeys following completed SUD treatment and maintenance of recovery, the role I played, and the credibility of the study.

I chose this qualitative approach for its ability to understand the experiences and perceptions and to support a deeper dive, offering detailed information from SUD individuals who were willing to participate in this research study.

Research Design and Rationale

My research questions were "What are the individuals' lived experiences, from a biopsychosocial perspective, contributing to recovery management, and what are the individuals' perceptions, from a biopsychosocial perspective, contributing to recovery management?" This phenomenological study aimed to explore the complex nature of successful recovery management through a purposeful sampling of 8 individual's lived

experiences. The BPS model developed by George Engel (1977) guided the development of the questionnaire tool and was used to interpret the individuals' experiences and perceptions to increase knowledge, potential resources, and interventions surrounding recovery management and continuation of recovery for individuals who suffer from substance-use disorder (SUD).

What was missing from the literature was a deeper understanding of how individuals with SUD maintained the continuation of recovery following completed SUD treatment. This research needed more information about individuals' recovery management/continuation recovery and completed SUD treatment experiences to emphasize better ways to understand how to support, intervene, and provide resources conducive to recovery maintenance.

There were two main approaches to research: quantitative and qualitative. Quantitative research focuses on collecting, analyzing, and expressing numerical data. Qualitative research focuses on collecting, analyzing, and expressing information through observation or experiences to explain why or how something occurs (Brinkmann et al., 2014; Wienclaw, 2021).

Phenomenology refers to and aims to examine individuals' experiences from the perspective of the individual. Phenomenology allows the researcher to explore awareness or deep understanding of an individual's lived experiences of something (Saldaña, 2011).

The challenge was the ability to understand the deeper meaning within the participants' experience that addressed a specific research question.

Individuals who have completed substance-use disorder treatment and who have maintained sobriety for 12 consecutive months share unique lived experiences that would be best described by them. These individuals can best express how their recovery management/maintenance journey has impacted their lives socially, emotionally, and financially. Relapse, stigma, legal ramifications, family stress, job loss, and mental health are only a few of the multitude of issues that individuals who are managing their recovery struggle with, and this researcher considered what strategies those individuals used to achieve such success. To determine techniques and strategies to help those seeking to maintain sobriety/recovery, it was first necessary to better understand the techniques and strategies utilized by those who have achieved 12 months of sobriety.

Role of the Researcher

In this qualitative phenomenological inquiry, the role of this researcher was to interpret individual's lived experiences through conversations focused on storytelling by providing an organization of events into meaningful patterns while focusing on a specific research question (Bojko, 2021; Leavy, 2015). Since 2012, I have worked in the field of substance-use treatment in one capacity or another. I was employed for more than a decade as a director of the admissions and utilization review departments, where I was responsible for oversight of initiation or continued insurance authorizations for patient treatment coverage through third-party or state-funded insurance companies. When authorizations for treatment were initiated, a biopsychosocial (BPS) summation of biological, social, mental, and health information was required. At the onset of substance-use treatment, a biopsychosocial assessment was conducted with the patient. The goal

was to obtain a detailed interpretation from the patient about their individual experiences and perceptions of their current need for treatment. Upon completion of the biopsychosocial assessment, a narrative summation was written and included recommendations for the level of care and the anticipated length of time the patient was expected to remain in treatment, proposed treatment goals, initial diagnosis, and expected medication protocols.

To provide consistency in this research process, I gathered and analyzed data by recruiting participants, conducting recorded inquiry-based conversations, and transcribing and analyzing data from notes and recordings. Leavy (2015) stated, it's not the events themselves, but the meanings attributed to the events that shape a person. As a researcher who utilized phenomenological inquiry, I interpreted individuals' stories to provide a meaningful account of events that supported confirmation of experience and perception impact. Potentially supporting additional information based on successful recovery management/maintenance will support research on long-term recovery.

Methodology

The use of phenomenological inquiry was to dive into individual experiences and perceptions to better understand and assist in forming more inclusive interventions, tools, and skills by proactively removing barriers for those seeking long-term recovery (Hystad & Wangensteen, 2021). My research questions are "What are the individuals' lived experiences, from a biopsychosocial perspective, contributing to recovery management, and what are the individuals' perceptions, from a biopsychosocial perspective, contributing to recovery management?" The phrase completed SUD treatment refers to

SUD treatment levels of care that have been partial-hospitalization (PHP) or intensive-outpatient (IOP). The phrase substance-use disorder recovery management/maintenance refers to any self-reported path in which the individual with SUD gained/re-gained the desire and ability to remain abstinent from substances, and continuation of recovery refers to a continuation of rehabilitation treatment processes. The phrase individual experiences referred to the research to be conducted through semi-structured and guided conversations for a full accounting of participants concerning their lived experiences and perceptions of their journey.

I used purposive sampling to gather a selection of participants who have completed PHP or IOP levels of care for substance-use disorder and who have remained substance-free for a minimum of the last 12 consecutive months to participate in my research. The goal of purposive sampling, according to Campbell et al. (2020), was to better align participants with the aim of the research and to achieve the objective of improving the trustworthiness of the research study data results.

I anticipated conducting semi-structured and guided conversations where I collected data from participants' stories concerning their experiences and perceptions of their recovery management/maintenance following SUD treatment.

Participant Selection Logic

The phenomenological model was based on the participation of eight individuals who possessed a personal relationship with the research topic (Saldaña, 2011). Research participants were selected using purposive sampling because it allowed for a strategic selection to gather information specific to the purpose of this research. Participants in this

study were active in their recovery management. I recruited participants from social media support groups to share their stories of recovery management. As suggested by Fiscella (2005), when individuals were allowed to share their stories about their disease, an appropriate psychosocial context naturally surfaced.

Instrumentation

I gathered participant information through a semi-structured, interactive questionnaire process in combination with an open-ended question format that allowed for detailed information as well as for the researcher to probe with follow-up questions as needed. The questionnaire guide served as a footprint to solicit detailed historical and current information concerning participants' experiences and perceptions about their lives, substance-use disorder, their substance-use disorder treatment, their recovery management, and how the areas within the biopsychosocial (biological, psychological, and social) realm have been impacted through their continued recovery (See Appendix A). My goal was to interpret participant information based on the biopsychosocial model for consideration through evaluating the interconnectedness of biology, psychology, and social interconnectedness to provide a more thorough and complete understanding of the individual's condition (Lacks & Lamson, 2018; Tripathi et al., 2019).

Procedures for Recruitment, Participation, and Data Collection

I utilized phenomenology to identify participant experiences concerning a phenomenon, as presented by participants, to capture their experiences in his/her own words. Purposive sampling was used to select a sample of 8 participants from social media group platforms designed to be supportive communities for addiction and recovery

management. The sample group will be pulled from a diverse group of individuals with at least one commonality, seeking support for substance use disorder and recovery management.

Recruitment and Participation of Participants

An outline of the research plan included recruiting participants through online social media platforms and applications. I posted a notice of recruitment to seek participants via personal accounts on Facebook, LinkedIn, and X (formerly Twitter). The post briefly explained the research study, criteria, and contact information for the researcher of this study.

The second step of the plan was to post the notice of recruitment within designated support groups related to substance-use disorder, sobriety, relapse prevention, and recovery management. Recruitment was in any allowable support groups targeting substance-use disorder.

The third step of the recruitment process was to respond with a "participant thank you" to all contacts. I responded with an initial thank-you for interest in the study and provided additional, more in-depth information about the research study that included the intended purpose and an informed consent form. I instructed potential participants to respond with a digitally docu-signed consent form to allow for participation in the research study. Participant selection consisted of 8 participants.

The fourth step of the recruitment process was to organize and review individual participants for potential selection. I selected participants who met the criteria set forth and included SUD individuals who had completed SUD treatment (PHP or IOP), were

currently substance free and had sustained sobriety for a minimum of the last 12 consecutive months and were actively managing their recovery. I responded to each participant and scheduled appropriate times for semi-structured, interactive conversations via telephone. All conversations were recorded via audio recording and saved to my computer for transcription. I protected all data through the use of password protection and document locking for all consents, forms, notes, recordings, and transcription documents.

One major advantage of technological interviews in this research study included potential access to a larger number of potential participants from across the country. This approach lessened challenges such as geography, lessened inconvenience to participants, lowered costs, and increased accessibility.

I began participant recruitment upon receipt of Institutional Review Board (IRB) approval, and approval information was added appropriately and as needed.

Data Collection

Data collection for this research study consisted of audio-recorded, semi-structured questionnaires conducted via telephone. The duration for interviews was anticipated to be approximately 90-120 minutes, as dictated by the amount of information and level of detail provided by the participant. Interviews were intended to secure as much detailed information as possible concerning participants' recovery management as interpreted through the biopsychosocial perspectives.

Data Analysis Plan

Data analysis was conducted through a phenomenological approach with coding and patterns (Saldaña, 2014). I reviewed, analyzed, and interpreted participant data

through the biopsychosocial model developed by George Engel (1977). Saldaña (2015) proposed to present data interpretively; one must explore a phenomenon on a higher and deeper analytical plane. By doing so, the interpretation was extended past simple descriptiveness. He suggested as a researcher, the study must extend higher than the data surface and dig deeper as if mining for treasure, presenting a compound, broad metaphorical realm called high-deep. This was not the act of data interpretation but was the result of interpreting the data at a level that allows for transferable meanings to other situations, times, and contexts.

Data coding was conducted through the use of Dedoose qualitative data analysis software to better understand similarities that emerged from recorded and transcribed notes. All information collected will be held at the highest level of privacy for identity protection.

Issues of Trustworthiness

Credibility

Assumptions of participant honesty and forthrightness were made concerning the length of sobriety/clean time and level of treatment participation based on the participant reports concerning sobriety, recovery management, and additional personal and pertinent information.

Transferability

Transferability and generalization were broadly used to describe a research study that can be repeated when using different participants and/or situations, concluding very similar findings (Tuval-Mashiach, 2021). The research question utilized in this study was

centered on the lived experiences and perceptions of individuals with substance-use disorder and recovery management from a biopsychosocial perspective. According to Tuval-Mashiach (2021), the focus of transferability should be considered through the type of replication intended, the researcher's epistemological view and approach, the aim of study replication, and the nature of the study. He suggested thoroughly describing the research context, participants, and method details would provide readers the ability to evaluate similarities within their study and allow them to make sound research judgments for themselves. Saldaña (2015) suggested documenting each step of the research process to ensure transparency and replication of the study, or the ability to assess the transferability by following the same process based on documented decisions of the researcher. This research followed Saldaña's suggestions for transparency. Most importantly, context and study transparency should be present, especially in such a study where individual lived experiences and perceptions were concerned.

Dependability & Confirmability

Dependability referred to the ability to present findings based on information that was accurate and correctly depicts the intention. Dependability and confirmability were achieved through frequent reviews with my chair and second committee members to ensure coding and findings were documented appropriately (Bates & Martin-Misener, 2021).

Member-checking was another tool used to enhance the trustworthiness of participant's collected data (Birt et al., 2016). Member-checking was recommended for small sample sizes, when data is sensitive, when conducting participatory research, and

when enhanced validity is desired. This process required additional contact with participants following data collection and transcription. Participants were allowed to review their transcripts and were encouraged to check for accuracy, add information, remove information, or, most importantly, clarify information. This step not only builds trust and rapport with the participants but also adds dependability to the research project.

For this study, dependability was achieved through detailed information about how data would be collected, development of research design, analysis, secured notes, and recorded interactive questionnaire conversations, member-checking, and transcription before compilation of results.

Ethical Procedures

A consent form was provided at the onset of the research study. It entailed information about the study, background information, procedures, topics of the questionnaire guide, information on the voluntary nature of the study, risks and benefits of study participation, payment information, privacy, contact, and question information for the university, and gathered consent signatures. This research study was conducted under the oversight, policies, and procedures of Walden University Institutional Review Board (IRB) and the dissertation committee and followed the approval and permission of the same (#11-21-24-0111695). Gathering of data occurred only after IRB approval had been received. Data storage occurred in compliance with the standards set forth by Walden University.

Summary

The purpose of this research study was to compare the lived experiences and perceptions of individuals who have completed substance-use disorder treatment and remained substance-free for a minimum of 12 consecutive months. It was hoped that the study would reveal commonalities experienced and perceived by individuals suffering from a substance-use disorder that supported addressing challenges resulting in the continuation of recovery management. I was seeking to describe the experiences that impacted their lives and interpret recovery management from a biopsychosocial perspective.

Chapter 4 presented the results of the semi-structured, interactive questionnaire conversations conducted to address the research questions, a detailed description of how data were collected, and the procedures used for identifying and tracking the data. Finally, it was anticipated that the results of this study contained suggestions for additional and future research that may be relevant to this topic.

Chapter 4: Results

Introduction

In Chapter 4, I present the research and connected the findings of the study with the phenomenology of perception, founded on Merleau-Ponty's theory of the lived body and the phenomenal world as the conceptual framework to examine relationships between the lived experiences and perceptions of individuals with SUD who are managing recovery successfully as interpreted through a Biopsychosocial lens. Semi-structured questionnaires with eight participants were completed to obtain experiences and perceptions. I discussed the process for data collection, participant responses, data analysis, and a summary of the findings.

Setting

Due to the target population recruitment obtained from web/online recovery support programs typically found on sites such as LinkedIn and Facebook, it was important that the purposeful sampling provided an ease of access for participants to converse at their convenience due to various locations, time zones, and work schedules. After I received informed consent, I scheduled phone calls based on participant availability for semi-structured questionnaire completions. Phone conversations were audio-recorded, transcribed, and provided to participants following phone calls. No other persons were present during the phone calls to ensure participant privacy.

Demographics

Eight participants, six females and two males, ages 40 to 68, who received substance-use disorder treatment, in various levels of care, participated in this study. The

course of treatments ranged from sub-acute detoxification (7-10 days), residential (30-90 days), partial-hospitalization (90-180 days), intensive-out patient (6-12 months), outpatient (1-10 years), and support groups such as Alcohol Anonymous (AA) and/or Narcotics Anonymous (NA), ranging from 2-20+ years. Participants resided across the United States, including Florida, Idaho, Mississippi, South Carolina, and Tennessee. All participants discussed their lives before acknowledgment of substance-use disorder, throughout treatment, and from the beginning of their recovery management through the present day.

Table 1

Participant Demographics

Participant ID	Participant Treatment Level	Occupation	Length of Sobriety in years	Age	Gender
P1	Sub-acute and PHP	Loan Officer	2	50	Female
P2	Residential and PHP	Peer Support Specialist	10	55	Male
P3	Detox and IOP	Client Support Specialist	17	58	Female
P4	Sub-acute and IOP	Semi-retired Utilization Review	20	64	Female
P5	RTC, IOP, OP, and NA/AA	Admissions-UR	10	45	Male
P6	IOP and AA	Hotel Desk Clerk	20	54	Female
P7	Residential, PHP, OP, and AA	Pharmacist	10	68	Female
P8	Sub-acute, PHP, IOP, and OP	Warehouse Worker	5	40	Female

Data Collection

I conducted approximately 1-hour telephone interviews in the privacy of a home office that protected participants' privacy. This setting was chosen to provide the participants with a sense of safety and anonymity. I spoke with the participants for an audio-recorded interview during one session and then spoke with them on a second occasion to provide written transcripts for member-checking. There were no unusual circumstances that occurred or required to be noted during the data collection process.

Data Analysis

This study was conducted to explore the complex nature of successful recovery management through a purposeful sampling of eight individual's lived experiences. I asked the participants a list of questions designed from the Biopsychosocial model developed by George Engel (1977). The BPS was also utilized to guide the interpretation of the individual's experiences and perceptions. Eight individuals agreed to participate in the semi-structured questionnaire call. All participants completed treatment for SUD at partial-hospitalization (PHP) or intensive-outpatient (IOP) levels of care and shared their experiences and perceptions concerning their childhood, onset of SUD, SUD treatment, and recovery management.

The aim of this research was achieved through the central question: What are the individual's lived experiences, from a biopsychosocial perspective, contributing to recovery management? I used Merleau-Ponty's (2012) phenomenological idea of perception as the method for data analysis. Biopsychosocial Theory (BPS) (George Engel, 1977) was the conceptual lens from which data interpretation was conducted. The

analysis process began with the attention that focused on the generalizations reflected within the experiences of the participants and concluded with the identification of similarities in the findings associated with the scientific literature.

Saldaña (2014) suggested transcribing audio-recordings by listening to each recording shortly after the recording had been completed and then using the audio-recording to manually transcribe into written format. I listened to the audio recordings multiple times. I utilized the Dedoose software, a web-based qualitative data analysis application, which assisted in transcribing the audio recordings into a text format. I read through the text transcriptions in their entirety multiple times to obtain an overarching grasp of the interviews and to narrow critical text associated with the research topic and question. Participant's lived experiences concerning the onset of SUD and recovery management began to surface after each participant's transcription was thoroughly examined. I conducted manual coding through first and second-cycle coding. During the first-cycle coding process, codes were created based on data extraction through excerpts from transcribed individual stories. The second-cycle coding process emphasized the identification of codes and presented the grouping of similar concepts into categories. Themes were then identified from the overarching categories' main ideas and patterns from shared experiences that offered insight into the research phenomenon from an interpretive biopsychosocial perspective. Based on their use within participant stories, several codes were identified as belonging to multiple categories. They were noted with shortened acronyms, including biological-Bio, psychological-Psych, and social factors-Soc.

Table 2

Codes, Categories, and Themes

Codes	Categories	Themes
Addictive Behaviors – Bio, Active Addiction – Bio, Family History of SUD, Health, Immaturity, Recovery Management – Bio, Relapse – Bio, Sober-Clean – Bio, and Treatment - Bio	Physical	Biological Influences
Addictive Behaviors – Psych, Determination, Emotional-Mental Health, Recovery Management – Psych, Sober-Clean – Psych, and Treatment - Psych	Mental	Psychological Influences
Connectedness, Employment, External Influences, Family, Homelessness, Origin of Addiction, Recovery Management – Soc, Relapse – Soc, Sober-Clean – Soc, Social Life, and Treatment - Social	External	Social Factors Influences

This process was repeated for each of the participants' semi-structured questionnaire conversations. Interpretation was identified through the researcher's interpretation of the participants' stories, emphasizing the biopsychosocial model to include the biological, psychological, and social connections stated within their stories. Each code was directly related to the BPS model, as explained by Engel (1977), and ensured consistency of coded labels to reflect descriptions as appropriate and accurate.

The analysis provided three main categories of interest. The first focus was lived experiences and perceptions-biological. The participants reported experiences and/or perceptions related to biological factors that contributed to their recovery management.

The second focus was lived experiences and perceptions-psychological. The participants reported experiences and/or perceptions related to psychological factors that contributed to their recovery management. The third focus was on the social aspects of lived experiences and perceptions. The participants reported experiences and/or perceptions related to social factors that contributed to their recovery management.

Table 3

Table of Responses

	Participant Responses		
	Biological (46)	Psychological (176)	Sociological (246)
P1	Yes	Yes	Yes
P2	Yes	Yes	Yes
P3	Yes	Yes	Yes
P4	Yes	Yes	Yes
P5	Yes	Yes	Yes
P6	Yes	Yes	Yes
P7	Yes	Yes	Yes
P8	Yes	Yes	Yes

Emergent Influence 1: Biological Influence on Recovery Management

Understanding the disease of SUD and recovery management requires the evaluation of the interconnectedness of biological, psychological, and social dimensions (BPS) to provide a thorough and complete understanding of individual conditions (Tripathi et al., 2019). This process included a snapshot of the individual's history and treatment and an expansion into the current actions to understand how one achieved and maintained recovery management.

Commonalities found within the influence that biology played in recovery management included immaturity, family history of SUD, health issues, relapse, and treatment. Although all participants reported biology, in some form, as influencing their SUD, particular interest was found in that only one participant reported a relationship between immaturity-young age, and their SUD.

Four participants expressed significant family history, and three reported that at least one parental figure had SUD.

P4 expressed:

> My dad was an alcoholic as we were growing up. We didn't know anything else. Now, my sister drinks daily, and her husband is a functioning alcoholic. I am just glad that I get to see my nieces as much as I can. I often feel a need to remove myself from family holidays or other get-togethers because of the alcohol exposure. I can handle it for a little while, and then I end up feeling like I should join in, or I just get pissed off. I tend to isolate during these times of year to avoid the fight of staying sober. This is what happens when you try to suppress who and what you are. It took me a very long time to figure that out.

P1 reported:

> Me and my sister were raised by our dad. He drank every single day of my childhood. He never drank before going to work, but every evening, every weekend, every holiday, he drank every day. He would never, he didn't ever admit to being an alcoholic. He said that because he worked, he was not an alcoholic. I struggled; I still struggle. Staying clean and feeling the urge to use is

> something I argue with myself about almost every day. Every once in a while, I hear that little voice in my head that tells me that I can handle just a little, and I stop and remind myself that when I was using, I would lie, cheat, and steal even from myself.

One participant reported she felt SUD was genetic.

P8 reported:

> I think we're built in a way that addiction is strong in my family. I think it's genetic, and I believe it's something in the way we're wired. I remind myself that if I give in to my genetic nature for one second, I'll lose my sobriety, and it'd all be for nothing. I'm too close to be getting my girls back. I don't want to lose myself again. I am striving to break the cycle of family addiction in my life. I'm on a mission to ensure my girls know about it, hear about it, and know they can live a full and happy life without having to go through it. I pray the cycle ends with me.

Overall, most participants expressed a link between biology to their SUD explicitly through family or early childhood learned behaviors as well as physiologically through genetics.

Emergent Influence 2: Psychological Influence on Recovery Management

Substance-use disorder as a physical versus psychological addiction remained a highly debated topic among the scientific and general population (Bianco, 2017). To simplify this statement is to argue whether an individual with SUD possessed a physical

addiction to a substance or if the addiction was perceived in a psychological-mental manner by the individual.

Similarly to biological influences, psychological commonalities with influences on recovery management were identified. Once again, all participants attributed psychological influences, in some form, as influential on recovery management. The commonalities included addictive behaviors, determination, emotional and mental health, hope-faith, relapse, sober-clean time, and treatment as most significant. Emotional-mental health, hope-faith/determination, and treatment received the largest in-depth responses, with all participants weighing in with detailed information.

P8 reported:

> My mental health was in shambles when I was using. After getting hooked on Fentanyl and before going into treatment, I realized the mess I had made of my life. I surrendered, I went to treatment for over six months, and in sober living for a year. After having my children back in my custody, I didn't need an outlet anymore. I went back to school and I worked on my psychology every day. I continue to learn and examine myself and the way I look and think about things in my life, every day. I want to break the cycle with my life so my girls don't have to go through the same things I did. I've lowered my stress levels. I go to work and I work hard every day. I give it my all every day. I don't go to a therapist, but I constantly take an inventory of myself to confirm how I'm feeling and if I am ok. Stress is hard for me and can be a trigger, but I am always working to stay on top of it.

P4 explained:

> My mental health suffered significantly. But I learned over the last 50 years that this is who I am, and I cannot be anything except that.

P7 expressed:

> I thought I was dying when my son was put in prison. He went to prison for stabbing his father. When he went to jail, I couldn't breathe, I couldn't move, I couldn't think. All I knew was that I was dying. My use increased to the point that I could've died every single time I used it. I was hurting mentally and physically so badly that I wished to die, so it would be over. I did not know how to go on, how to function, how to breathe. After I finally got caught diverting drugs from my work, I was forced into treatment if I wanted to maintain my pharmacist licensure.

P5 was hesitant to explain:

> My addiction journey began with my struggle with being gay and anorexia. I struggled with body image, and my family did not accept gays as the Bible forbade such things. When I found Cocaine, it was a wonder drug, and it seemed to solve some of the issues with anorexia since it made me not hungry, and I wouldn't eat for days. Then it made me more brazen in that I didn't care what others thought about my sexuality. So, I left home to live with an older man. This became problematic for me as it allowed me to use more drugs and begin participating in very dangerous behaviors like having unprotected sex, and more drugs, and then more sex. I was having sex for money to buy drugs. It was a

> vicious cycle. I know this sounds crazy, but for a while, I felt better. I felt free. I was allowed to be the real me. But it didn't last long before it started taking a toll on my mental health even more. I became very depressed and even suicidal at times, which required treatment. Had I not gone to treatment, I'd be dead now. I have continued medication management for my mental health issues. I have a counselor that I meet with, but not as often as I used to, though. I still have bad days where I struggle with body image, and I still think about using drugs when I stay away from my group for too long. And I spend a lot of time in nature by myself. Nature is a peaceful place for me, and I go and just sit in the trees and slow down long enough to hear the sounds that seem to remind me to enjoy everything that has been provided.

The psychological impacts reported by participants appeared to be extremely strong and negative before SUD onset, alternating between negative mental health issues and slowly progressing into a more positive mental health direction during SUD treatment. Following treatment, participants reported healthier and more stable mental health, contributing to successful recovery management.

Emergent Influence 3: Sociological Influence on Recovery Management

Social-environmental influences impacted every individual. In 2021, over 46.3 million individuals aged 12 years of age or older suffered from SUD (U.S. Dept. of Health and Human Services, 2023). These impacts were seen across communities in employment, children's services, and the legal/justice system. Although many identified social influences can be found before or at the onset of SUD, many social influences were

sought and managed through the SUD treatment and well into recovery management. Interestingly, all participants reported the removal of almost all individuals who were identified as those social influences before and or during the SUD. This did not include close family members, as they remained within the participants' lives even if in some reduced capacity. Sociological common influences included negative, before and during SUD, growing up in a home with SUD, being kicked out of my house as a teen, and dysfunctional family dynamics. Sociological commonalities influences included during treatment and into recovery management, AA, NA, online support groups, medication management, and continued outpatient therapy. Participants identified both categories of social influences and labeled them appropriately.

When participants were asked what, how, or why they maintain their recovery, the answers were as individual as the participants.

P1 stated:

> I hurt so many people by doing the things that I did when I was using that no one, especially those people in my family, no one believed or trusted me at all. They thought I was trash and rightly so. I can maintain my recovery because I have to show them that I can. It's the only way I know how to live now. I want my family to trust me and believe me when I talk to them. They do now and I would never do anything to mess that up.

P2 shared:

> I have to stay connected. I was homeless and barred from seeing my siblings. I yearned for the love of my mother and she died before I was able to get my shit

> together. I have learned that staying connected leaves no room for disruption. I do not function in disruption. Relapse begins to happen in the mind way before picking up a substance. I must stay connected. Connected to my group, connected to my higher power, connected to myself. It's the only way I will make it from one day to another.

P3 said:

> To maintain my recovery, I can never allow myself to forget that woman that the drug dealers didn't trust and didn't want to hang around. I must always remember how bad it got, how close to death I was, how much I lost…time with my family, my mother, my kids. I lost all that time, and I can never get that back; it is gone forever. But I can make sure that that woman never gets a chance to live again. That she is gone forever. I do that by living my life in a way to serve others. Help others, show others that they can live through what seems to be the darkest part of an eternity, and they can come out the other side a better person.

P4 indicated:

> It is so easy for someone with an addiction to have reasons to use. The hard part is finding the reasons to stay sober and clean. My issues started before I knew what issues really were. I tried to fit in and didn't. I was taken to a hospital because I felt different and gay, and no one understood back then. There was no follow-up care like there is today. I was left with a family that wanted to have the church dispel the demons from within, so to speak. I started college, and the alcoholism was in full force. I struggled with having support, but I learned that I needed it to

> make it out of alcoholism alive. The way I maintain my recovery and my sanity is through the love and support of those individuals who accept me unconditionally. I go to meetings weekly and more if I feel I need it. I reflect, A LOT, and I stay in touch with people who show me it's possible to stay sober.

P5 reflects:

> My recovery management led me to work in the field of addiction. I work with people like me day in and day out. It's a good reminder of where I was and where I am. I focus on helping others get what they need to be ok. When I first started working in the field of addiction treatment, I wondered why we allowed patients to admit over and over again. In my mind, they just weren't going to get it if they had not figured it out by now. My supervisor told me that we never knew if this was the time that it was going to stick. Since then, I feel like that is the motto by which I live and work…maybe this time it'll stick. I remember that for my life as well. Despite the bumps and pitfalls that each of us faces, maybe just maybe, this time it'll stick. I've been ok for a good while now, and I attribute that to the time I spend supporting and caring for others. I volunteer at the food bank at least once a month. I go to NA a couple of times a month.

P6 described:

> As a teen, my life was great. I played sports and enjoyed school and was very close with my family. Then I became an adult. I lived with a man who was a drinker, so I began to drink. I don't remember much of the 25 years that followed, but what I do know is that the last 10 years have been me making up for all the

terrible things I did when I was drinking. I moved to a very rural part of Arkansas to care for my elderly parents until they passed away, both within 10 days. They just passed about less than a month ago. I am grateful that I was able to be there for them when they needed me the most. I am grateful that I am strong enough that drinking has not entered my mind over the last decade. I am very grateful that I was allowed to participate in your research project, as I feel it is my way of giving something very small back to a community of individuals who have offered me so much in my journey to obtain and maintain my sobriety. I can stay sober by remaining humble and knowing that I cannot do this on my own. I owe everything I am and everything I've been able to overcome to my higher power and the individuals who have been there when I needed to be reminded that I can do this thing called sobriety.

P7 worries:

Currently, I am being monitored by my pharmacist licensing board with mandated drug screens through urine and hair tests. I am required to go to weekly meetings and report to my sponsor every week, but all that ends in less than a month. I have no idea what I am going to do when it is not required for me to participate to keep my pharmacist license. I am concerned that access to drugs may be an issue, and with me being a pharmacist, it is my livelihood. I do not know how I am going to feel about going to meetings if I do not have to go, and the drug screens will end as well. I am scared of the unknown, and I am scared when and if left to my own devices that I may relapse. I am really concerned.

P8 feels confident:

> I attribute my ability to maintain my sobriety to continuing to learn more about myself and my addiction. I am going through child custody issues over my two children, and my mom still holds legal custody of them. I have been fighting for custody to be returned to me for the last couple of years. I have gotten to a point where I can see them unsupervised and have them for weekends. I feel like it will not be much longer, but I am exhausted from the fight. I go to meetings because I need the support from the group. I enjoy hearing the stories of how others have similar struggles and what they do to manage the stress of it all. I wonder sometimes if I help any of them as much as they help me. I hope so. I do not know if I will ever use drugs again. I hope not, but for this minute I am good and all I can do is one minute at a time.

Other Significant Participant Responses

Participants of this study shared information that appeared to be critical to understanding how recovery management, through the biopsychosocial lens, although similar, remains very individualized.

Two participants reported family pressures around sexuality that resulted in suicidal attempts in conjunction with SUD. Other participants related family pressures, including homelessness or a family history of substance-use disorder; however, the severity of suicidal attempts was isolated to two individuals who struggled with the essence of their existence within the world. They were shunned in public and privately by those closest to them and were deemed as demonic or unworthy of basic, appropriate

care. Would acceptance of their sexuality have impacted their SUD differently? Was the lack of acceptance the basis on which SUD grew?

Evidence of Trustworthiness

The participants validated the findings via the member-checking process and were given a summary of the transcribed results. I used an interview guide questionnaire to ensure consistency and clarity for questions and meanings when needed. I asked the proposed questions and then allowed the participants to tell their stories that included specific examples. The participants appeared to be genuine through their storytelling of their lived experiences and perceptions about their lives before and at the onset of SUD, during active SUD, and through SUD treatment and recovery management. Precautions were taken to ensure there was no threat to trustworthiness during the study. Participants were encouraged to articulate as much information as they fully felt comfortable sharing to gather as much detailed information through their descriptions of their experiences as possible. Some participant statements were paraphrased so participants could acknowledge them as correct or incorrect to achieve a better understanding of their specific experience.

Results

Eight participants were recruited for this study. They were asked for detailed stories concerning their lived experiences and perceptions about how they maintain their SUD recovery.

They provided detailed biological summaries of their lived experiences before the onset of SUD, experiences throughout their treatment, and experiences and perceptions of

the management of their recovery. Through their stories, commonalities surfaced, offering similarities and vast differences between early childhood experiences from loving and supportive families, average families, and families who denied accepting them as the individuals they were. The onset of SUD offered some similarities in that many described family histories of substance-use, and others described experiences of initial contact through those outside of nuclear family members and extended into significant others. Treatment experiences varied throughout the participants, from experiences of being forced into treatment to maintain employment or contact with their children, as well as others who expressed having nowhere else to turn, as they were homeless or at a point in their lives where drug dealers would not even hang out with them.

Participants provided psychologically detailed summaries of their lived experiences before the onset of SUD, experiences throughout their treatment, and experiences and perceptions of the management of their recovery. Through their detailed stories, a few commonalities were evident. Two of eight participants reported receiving medications for mental health issues. The remaining participants denied the use or need for such medications. All participants reported struggling with depression or anxiety during active use and treatment; however, only two participants reported ongoing use or need of these medications. Other psychological reports included hope-faith and support as necessary aspects for mental stability throughout managing recovery.

Lastly, participants provided sociologically detailed summaries of their lived experiences before the onset of SUD, experiences throughout their treatment, and experiences and perceptions of the management of their recovery. There were numerous

commonalities from a sociological perspective where recovery management was conveyed. All participants indicated that completing education, maintaining employment, issues with child custody, and legal issues were significant parts of their history. Most participants reported severing relationships with old friends and specific family members. All participants discussed the need for ongoing support within the SUD community in one form or another. They indicated that being supported by others is as important as being able to support others within the same settings. Some report listening and or sharing stories with others within the community AA or NA groups that foster manageability of their SUD was achievable. Many suggest a higher power takes control as long as the willingness to give up control is present, and this appeared to be an essential part of recovery for most of the participants.

Summary

The purpose of this research was to explore the experiences and perceptions of individuals with substance-use disorder in recovery management, from a biopsychosocial perspective. This was achieved through semi-structured, interactive conversations with eight participants who were asked to share detailed descriptions of their experiences and perceptions of their journey from early childhood to SUD onset, through treatment, and into recovery management. The stories resulted in a collection of data that was then coded for similarities and differences between participants to systematically organize and interpret information through the identification of recurring patterns leading to deeper meanings concerning recovery management.

Chapter 5 reiterated the purpose and nature of the study, why it was conducted, summarized key findings, described the limitations, offered implications, and made recommendations for future studies.

Chapter 5: Discussions, Conclusions, and Recommendations

Introduction

This phenomenological research study aimed to explore the complex nature of successful recovery management through the reported experiences and perceptions of SUD individuals in recovery management. The exploration allowed data to be interpreted using the biopsychosocial (BPS) model. Potential issues with trustworthiness and ethical procedures were also contained in this chapter. Primary research questions under investigation included:

RQ1: What are individual lived experiences from a Biopsychosocial perspective contributing to recovery management?

RQ2: What are individual perceptions from a Biopsychosocial perspective contributing to recovery management?

The significance of the study's results offered a better understanding of the various backgrounds from which individuals come and may assist in forming more inclusive interventions and resources within treatment settings. Analyzing individual-reported experiences presents a proactive transition to address barriers for those seeking long-term recovery (Scannell, 2021).

This chapter includes an interpretation of the findings of this phenomenological study, which was designed to explore the lived experiences and perceptions of individuals with substance-use disorder recovery management from a biopsychosocial perspective. I explored the experiences of eight individuals who completed substance-use disorder treatment at PHP or IOP levels and have been free from illicit substances for at

least 12 months, living in recovery management. The analyzed information indicated that these individuals experienced and perceived their recovery management through a biopsychosocial model, including biological, psychological, and sociological aspects. Although each individual's lived experiences varied, the participants' overall perception regarding the management of recovery included an internal need for ongoing support that connects them to others who are immersed in the life of sobriety.

Interpretation of the Findings

The focus of this study was to explore the individual's lived experiences and perceptions from a biopsychosocial perspective contributing to recovery. All participants were willing to disclose personal experiences despite the sensitive nature of the study.

Participants were at least the age of 18 and ranged up to age 68, they had completed substance-use disorder treatment of PHP or IOP levels of care, they had been free of illicit substances for a minimum of the last 12 months, and were actively managing their recovery and they gave the impression they were capable of comprehending the questions and expressed a willingness to share their experiences and perceptions about the topic and focus of my study. I began this study through interviews with participants who provided their lived experiences from early through mid-childhood, progressed through the onset of their SUD, and then SUD treatment, followed by managing their recovery. I developed a questionnaire based on the biopsychosocial model (BPS) that included a thorough investigation of the participants' reports concerning the biological, psychological, and social aspects of their lives and recovery management. The

most significant finding reported by participants was that they needed to stay connected to support groups as the primary tool that they used in maintaining their recovery.

While interpreting the findings, participants shared their thoughts on their substance-use disorder journeys. One participant reported that she would be more likely to commit suicide than to allow herself to relapse. Another revealed that she learned that her addiction was partly generational and reported that she would love to stop the generational cycle before her daughters became consumed by the dysfunction. And finally, one participant verbalized the multiple attempts she encountered with treatment and failure. Her suggestion was heartfelt and honest when she indicated how important it is to never give up on those individuals who are struggling with sobriety. She emphasized that substance-use disorder is a disease, not a choice, and reported *it* can be a long process.

Kelly et al. (2024) indicated that participants reported supportive gatherings such as AA or NA, offering a common community to be liked and helpful based on the camaraderie of lived experiences. Florian (2025) indicated that peer support programs such as AA and NA were highlighted as providing a transformative impact among participants in long-term recovery. These findings further support the summation among other participant reports in that they each presented their experiences, which could be interpreted as universal, and yet they were able to project empathy about others with SUD who have struggled with or who were currently in recovery management. Each individual considered their experience as unique and recognized that their journey was a personal one, while understanding that others' experiences were similar to their own. The

participants' perceptions pointed toward the importance of building a strong and accessible support system as the most substantial contributing factor to their ability to maintain their recovery. Wangensteen and Hystad's (2021) indicated that understanding SUD recovery management required being examined through biological, psychological, and social contexts, emphasizing that support was crucial in the recovery process.

Islam et al. (2023) confirmed that successful recovery was exhibited in many forms. They reported that there is a positive correlation between a strong support system within recovery management and subjective well-being, days of abstinence, decreased stress levels, and self-efficacy. Strong support for those in recovery management also discourages previous SUD-using habits, offers rewards for new positive habits, and fostered engagement in coping skills. All of which was highly beneficial to ongoing successful recovery management (Kelly et al., 2024). Conversely, the inability to build or engage in a positive support system may create social isolation, which can increase psychological stressors, potentially leading to relapse.

Another significant finding was that all participants perceived some form of mental health aspect as a contributing factor to the onset of their SUD or a significant role in the continuance of their SUD, ultimately leading to SUD treatment and recovery management.

The findings summarized from participant interviews indicated a difficult childhood that was impacted by the trauma of being raised by an alcoholic single parent. That, despite not experiencing physical abuse herself, witnessing her sister's abuse by her father was traumatic. She also indicated that her sister was her primary caregiver for

emotional support and love. Another participant indicated that losing the support of her mother at the young age of 15 resulted in her living on the streets, which led to self-medicating with drugs when she needed mental health care. One participant reported that her family owned a bar, which normalized her initiation into the drug life. It led to her finding her first husband and the introduction to harder drugs. Upon his demise, she was left with a young child and a slippery slide further into the long life of drug dependence. She indicated years of struggling before realizing that she was suffering from depression and grief. Other participants indicated being hospitalized in early adolescence when she needed care for significant mental health issues and not learning until well into middle age of a life-altering diagnosis that, if treated earlier in life, may have made a significant difference and two others reported an early adolescent mental health issue of body dysmorphia and sexual orientation leading to hospitalization for depression and suicide attempts because being gay was against the family's religion. Finally, a participant reported a situation of family trauma, where her son stabbed his father, causing such grief that she began using Dilaudid to numb herself from the reality of her life, where she reports feelings of failure as daughter, mother, wife, and pharmacist. Her use led to stealing drugs from work and an increase in use to the point of job loss and forced treatment.

These findings are consistent with Binder (2023), who suggested mental health disorders, like SUD, share some unknown predisposing factor that, when left untreated, can cause elevated levels of anxiety and depression. He also indicated these increased levels are almost identical between mental health and SUD, which are likely to lead to

substance-use to reduce or eliminate the uncomfortable emotions that individuals experience.

Limitations of the Study

George Engel proposed that mental health and substance-use disorders were believed to develop through various avenues, including biology (genetics), the concept of self (psychology), relationship (social), or the web of interactions between them (University of Rochester Medical Center, n.d.). George L. Engel suggested that all illnesses (medical and mental) would be better understood by reviewing the intertwined interactions of physiological, psychological, and social variables (Fiscella, 2005).

The most notable limitation of this study, from the biopsychosocial perspective, involves its inclusiveness. The counterclaim of the limitation proposes that there is a lack of testability due to overemphasis on one area within the biopsychosocial realm over another, as well as inconsistencies across individual contexts that fail to consider cultural differences and individual subjectivity (Benning, 2015).

McLaren (2020) reported that the biopsychosocial model served as a valid alternative to reductionism for the biological approach to psychiatry. He perceived Engel's BPS model as one that had gained no support in the broader medical field due to the lack of connection with medically accepted science. He claims the BPS model is not a science of mental disorder but one that is an ideology of mental disorder.

Other and general limitations exist in this study. First, the small sample size means that only the current results can be used to describe the lived experiences of the eight individuals who were obtained through online SUD recovery support group settings

who participated in partial-hospitalization (PHP) or intensive out-patient (IOP) treatment settings and who were in active recovery management. A contributing factor to the sample size was the lack of follow-through of participants who expressed interest in the interview process. Subsequently, they did not respond to emails to schedule call times or to provide consent for this study. Multiple factors may be related to potential participants' decisions to withdraw their interest, including relapse, employment/family responsibilities, or unwillingness to share their experiences. Awareness of the dynamics of participants' experiences is essential for those who may want to research this population in the future, as these factors could impact aspects such as time constraints for specific time requirements.

Another important limitation of the study included my personal experience working with this population of participants. Because of my first-hand knowledge in the field of substance-use disorders, treatment levels, and recovery management, and my personal experience growing up in an alcoholic home, I assumed there would be a larger number of participants who experienced an early childhood stemming from SUD parental figures, and my experience prompted clarification questions when answers were vague to associate responses from a biopsychosocial lens.

Recommendations

This study's results provided a snapshot of the individual experiences of eight individuals. Although broad similarities emerged, generalizing based on these similarities should be avoided, given the small number of participants in the study. Perhaps the most prominent pattern is that mental health issues appeared to precede SUD and recovery

management, and that through SUD treatment and recovery management, participants found appropriate care and support for their mental health.

It is recommended that community organizations, social service and legal agencies, and health and mental health providers offer psychoeducational materials, links, and connections/contacts for individuals who seek resources for support addressing biopsychosocial deficiencies. Providing resources such as these offers substantial access to support resources, including community and neighborhood-level platforms within society, offering an expansion of focus toward understanding individual behavior, highlighting a shift in stigmatic views of harmful toward beneficial and supportive, and vital in promoting positive interaction, building more accessible supports (Witkiewitz & Tucker, 2024).

Implications

SUD recovery management supports positive impacts across society, including but not limited to individual, family, organizational, and societal/policy. At the individual level, it promotes individuals to take control of their lives by providing individualized treatment options to address substance-use disorder, mental health issues, or other personal crises. This process teaches resilience, self-efficacy and provides a renewed sense of purpose, enabling individuals to live healthier lives.

For families, SUD recovery management creates stability and healing, not only supporting the individual in recovery but also offering support and resources for family members to begin rebuilding trust, creating a supportive environment. This fosters the mending of family bonds and promotes well-being.

In organizations/society, SUD recovery management leads to more stable work settings by reducing absenteeism and fostering an environment of inclusiveness, which fosters higher employee morale. Societal contributions focus on public health and equity. When systemic barriers such as stigma and lack of access to appropriate healthcare are removed, more inclusive policies and equitable resources will be accessible. This can lead to a reduction in costs for healthcare, a reduction in crime rates, and stronger community networks.

In principle, SUD recovery management achievements are transformative in that they lay the foundation for potential meaningful social change across multiple levels. Its holistic approach not only supports individuals but also positively impacts society as a whole.

Successful navigation of recovery management is essential for achieving and sustaining long-term recovery. According to Witkiewitz (2020), the process of behavior change through improvements in biopsychosocial functioning and connection is the working definition of recovery from which individuals improve wellness, striving to reach their full potential in health, home, self-purpose, and community. These efforts are person-driven, holistically based, and may occur through varied pathways in achieving a better life. Through this research, I sought to fill a gap in the literature by exploring the lived experiences and perceptions of individuals with substance-use disorder recovery management from a biopsychosocial perspective. I sought to gain a better understanding of how their experiences and perceptions of their SUD and their SUD treatment fostered successful recovery management for them.

Through my study, I addressed a gap in the literature identified by the Substance Abuse and Mental Health Services Administration (SAMHSA, 2023), concerning a connection between recovery management outcomes of individuals with SUD, individuals' SUD treatment completion, and a scholarly model of standards known as the biopsychosocial model. The structure of this model is based on individual experiences and perceptions that include their biology, psychology, and social environments. U.S. President Biden outlined the importance of his 2022 Presidential Unity Agenda in early 2022, prompting a collaboration between federal, state, tribal, territorial, and local partners to include SAMHSA for support of recovery for individuals with mental health and substance-use disorders. Next, the findings from my study adds information about individual experiences and perceptions that lend to successful recovery management of SUD.

Another implication is that the findings can inform and guide community organizations, social service agencies, legal agencies, and healthcare providers in addressing the widespread need for easily accessible resources. These resources will include reference materials to initiate conversations, access to support groups, and easier access to health and mental health services. This approach aims to support individuals in the community seeking assistance for health, mental health, and substance-use disorders and equip the providers with the ability to better serve those in need. The findings of this study can be utilized in oral or written presentations to promote awareness and action in providing access to resources to providers, employers, law enforcement, and heads of

organizations to filter information by fostering collaborative resource provision throughout communities across the country.

The information in this study focused on the importance of increased awareness regarding effective recovery management through relationships with others who have similar conditions, such as disease or other disorders. The connections, as expressed through shared experiences, are reported to improve general well-being, mental health, family relationships, employment opportunities, and overall satisfaction with life.

Conclusion

In conclusion, this phenomenological study aimed to explore the lived experiences and perceptions of individuals with substance-use disorder recovery management from a biopsychosocial perspective. The participants indicated that positive engaging support systems such as attending alcohol anonymous (AA) or narcotics anonymous (NA) meetings were the underlying basis for their successful recovery management; however, they acknowledged that relapse was a true monster that they managed to keep at bay not one day at a time, but by one minute at a time and they attribute their continued success to remaining connected as much and as often as possible.

Participants' experiences confirmed that, regardless of substance-use disorder origin, mental health issues, or social impact, successful recovery management was individually focused yet collectively reported to need a strong connection to ongoing support for success. The findings of this study create a better understanding of the lived experiences of individually identified successful recovery management. It serves as a basis for promoting widespread access to resources to providers, employers, law

enforcement, and heads of organizations for dissemination to create open spaces to foster collaborative resource availability provisions throughout communities.

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Appendix A: Interview Guide

As previously discussed, this study aims to explore, in your own words, your journey with recovery management. This serves as a reminder that anything you reveal will be kept confidential, with the exclusion of information concerning immediate danger to you or others. I will be recording our interview to capture all the information you provide. All interviews will be assigned a number so that confidential information is unidentifiable. Names and other personal information will not be associated with the recordings or any other documentation outside your informed consent form. Do you understand and agree to continue with the interview?

1. In your own words, tell me about your substance-use disorder. What was your life like before substance-use disorder?
    a. Follow-up question: How did it affect your employment, family, health, and social life?
2. Tell me about your experience with substance-use disorder treatment.
3. Tell me about your experience and perceptions concerning relapse.
4. What does recovery management mean to you?
5. How have you managed to remain active in recovery? How important or what role does support mean to you in your recovery management?
6. How would you describe a successful recovery?
    a. Follow-up question: How has it affected your employment, family, health, and social life?
7. Is there anything else you would like to tell me about your recovery journey?