The Importance of Empathy and Resiliency Among African American Men in Long-Term Recovery From Substance Use Disorders

by

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Abstract

Substance use disorder (SUD) is one of the most critical public health issues in the United States (Campbell-Sills et al., 2018). Research on factors influencing SUD recovery is lacking, primarily those related to the roles of empathy and resiliency in long-term SUD recovery. Empathy refers to the ability to share emotions and understand what another individual is going through. Resiliency is a process that refers to adaptation and adjustment in the face of adversity, challenges, and hardships. A gap in exploration of these factors in SUD exists for scholars and practitioners. This study aimed to help fill this gap by exploring the roles and importance of empathy and resiliency in African American men in long-term recovery (10+ years). One research question guided the study: How do African American men in long-term recovery from SUD experience empathy and resiliency in their recovery process? The study was grounded in the theoretical frameworks of cognitive empathy, social cognitive theory, resiliency, and narrative constructionism. A qualitative narrative inquiry model was used with open-ended interview questions and a sample of 15 African American men with 10 or more years in recovery from SUD. All participants described their experiences extensively, and representative quotes are presented. The data were analyzed with narrative analysis. The qualitative data analysis and coding yielded four emergent themes: (a) the cycle of relapse and shame makes resiliency very hard to attain; (b) detachment leads to a lack of cognitive empathy; (c) trust, love, and understanding lead to cognitive empathy; and (d) resiliency is influenced by the capacity to understand self and others. It is recommended that future research be conducted with larger, more heterogeneous populations and include clinicians and the families of people with addictions. Quantitative studies could also be conducted to supplement and triangulate the qualitative findings. The current study's findings add to the literature on SUD and recovery, and

the results will inform future treatment approaches and best practices. With clinicians' greater knowledge of the roles, importance, and impact of resiliency and empathy, treatment methods can be designed to emphasize these factors and thus improve substance users' recovery outcomes.

Keywords: empathy, resiliency, recovery, sobriety, substance use disorder

Dedication

On a personal level, I must first acknowledge Mrs. Kennyle Johnson, my soulmate on this educational journey and my partner in life. She simultaneously lifts me up and keeps me grounded, helping me to reach my potential and remain balanced. To her first I dedicate this work.

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Chapter I – Introduction

Overview

This chapter presents an overview of the study, beginning with a background on the topic of interest. The problem raised—including gaps in the literature that the study addressed—the study's purpose, and a brief overview of methods are presented. The theoretical and conceptual foundations of cognitive empathy, social cognitive theory, and resiliency are reviewed. Next, the significance of the study is discussed in the context of its personal, clinical, and social relevance. The research question is defined with definitions that are relevant to the study. These sections are followed by a review of the inherent assumptions, study scope, and delimitations/limitations. The chapter concludes with a summary of the information presented therein.

Background

The phenomenon of interest in this study was substance use disorder (SUD), one of the most critical public health issues in the United States of America (Campbell-Sills et al., 2018). Populations living in marginalized settings have an increased prevalence of SUD because of additional exposure to trauma (Cross et al., 2018), reduced access to treatment resources (Miguel et al., 2019), and stereotypes or stigmas that cause avoidance of asking for help (McKenzie et al., 2016). Individuals with SUD face great difficulty breaking their addictions, with many internal and external factors complicating the recovery process (Jordan & Andersen, 2017; Marel et al., 2019). The complex, multifaceted nature of SUD merits a better understanding of factors that translate to long-term recovery.

Problem Statement

Although there is significant research on the root causes of addiction, elements of SUD treatment are not well understood (Breuninger et al., 2020; Garami et al., 2018). In addition, the

research gap between SUD practitioners and researchers has hindered the application of best practices into treatment settings (Vanderplasschen et al., 2017). Research that is informed by factors influencing SUD recovery, particularly the roles of empathy and resiliency in long-term SUD recovery, is lacking (de Wied et al., 2020; Leal & Silvers, 2020; Maurage et al., 2011). These gaps in research lead to the need to better understand how these factors impact persons in long-term recovery so that treatment methods targeting empathy and resiliency can be evaluated and implemented.

Social determinants of health and other community and system-level issues create inequities in SUD treatment in African American populations (Substance Abuse and Mental Health Services Administration [SAMHSA], 2020). This study aimed to inform SUD treatment by exploration of the roles and importance of empathy and resiliency in African American men in long-term recovery (10+ years). The results will inform future treatment approaches and efforts by leveraging the impact of resiliency and empathy to improve recovery outcomes for this population.

Personal Relevance

Of interest in any study is the researcher's motivation for conducting the research. In this case, the researcher's personal experience as an African American man with over 31 years of experience in long-term recovery was a key driver for the study design and focus. The researcher's life transformation led him to work in the field of SUD, in which he has witnessed countless relapses among African American men. These relapses have resulted in helplessness, hopelessness, and despair affecting their psychological well-being, including jail sentences, institutionalization, overdose deaths, and the loss of loved ones to addiction. Their lived experiences led to the researcher's interest in this area of study, with goals to increase this area of

research and take steps to tailor appropriate treatments for the SUD field that translate to improved outcomes for persons with SUD, especially among SUD marginalized populations.

Nature of the Study

This study used a qualitative narrative inquiry approach to understand African American men's experiences in long-term SUD recovery. As storytelling is used in Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) to encourage members to discuss personal hardships and develop collective understanding, storytelling was used in this study to solicit data from participants (Vederhus & Høie, 2018). Quantitative research focuses on the testing of hypotheses through statistical analysis, and qualitative methods allow the researcher to understand how people experience a specific phenomenon (Ravitch & Carl, 2020; Robert & Shenhav, 2014). Specifically, narrative inquiry enables the researcher to acquire detailed descriptions of a particular experiences and investigate the meanings derived from these experiences (Bell, 2002; Riessman, 2008).

Conceptual Framework

This narrative inquiry research study explored empathy, particularly cognitive empathy, and resiliency as factors related to long-term recovery. Empathy, the ability to share emotions and understand what another individual is going through, has resulted in clinical benefits when integrated into a therapist’s training repertoire (de Wied et al., 2020; Elliot et al., 2018). Although research has identified the clinical value of empathy, limited knowledge exists on the role of empathy in SUD treatment and the long-term recovery process. Likewise, there is a dearth of research on resiliency and SUD; the research conducted has been limited to identifying factors related to resiliency but has not focused on how or why these factors operationalize resiliency in a person (Rudzinski et al., 2017).

Cognitive empathy was the key factor framing the design of this study. Grounded in social cognitive theory, which states that knowledge acquisition takes place through observation and learning from social interactions (Bandura, 1986), cognitive empathy has been defined as the ability to understand another's situation. Cognitive empathy is distinct from affective empathy, which is feeling the emotions of another (Murphy & Lilienfeld, 2019). A crucial gap in the literature is the absence of research using cognitive empathy as a framework to study, analyze, and understand SUD treatment experiences. Thus, social cognitive theory guided this researcher's understanding of how cognitive empathy and resiliency develop and influence recovery from SUD.

Social Relevance

In addition to personal relevance, this study has significant social relevance. SUD is a pervasive and prevalent problem in the United States, impacting approximately 20.3 million people above the age of 12 (Substance Abuse and Mental Health Services Administration [SAMHSA], 2019). In addition, African Americans are disproportionally affected by SUD, with their per-capita rates of alcohol use, cocaine use, and heroin use disorders higher than those of the general U.S. population (National Survey on Drug Use and Health ([NSDUH], 2018; SAMHSA, 2019). In 2018, of the 20.3 million people with SUD, 1.5 million were African Americans over the age of 18 who struggled with an alcohol use disorder, and 1 million were African American adults struggling with an illicit drug use disorder (NSDUH, 2018).

Clinical Relevance

Regarding clinical relevance, previous research has indicated that minority populations, such as African Americans, maintain a higher risk for developing SUD than other populations (Marel et al., 2019). Those who experience SUD also have a great deal of difficulty in ending

their addictions, and internal and external factors complicate the recovery process (Jordan & Andersen, 2017; Marel et al., 2019). Research has shown that intervention success can be enhanced when practitioners use a "holistic approach to recovery that emphasizes spiritual, cultural, and interpersonal harmony and connectedness" that simultaneously targets individuals, families, and communities (McKenzie et al., 2016, p. 74). Development and location of effective methods of treatment rooted in empathy and resiliency can have profound clinical relevance.

Research Question and Meaning

The purpose of this study was to develop an understanding of the importance of cognitive empathy and resiliency in long-term SUD recovery in African American men. Thus, the research question was the following: How do African American men in long-term recovery from SUD experience empathy and resiliency in their recovery process? Firsthand insights expressed by participants who have experienced long-term SUD recovery may reduce the research-to-practice gap in SUD treatment.

Insights gained on the importance that empathy and resiliency play in SUD recovery can be used to inform practitioners' treatment approaches. More successful SUD treatments may yield positive social outcomes as individuals who have recovered will be better positioned to reintegrate into society. The results of this study could have positive implications for research and treatment of SUD in African American men and other populations and pave the way for more effective treatment plans overall.

Interview questions (Appendix A) prompted participants to explore this research question. For example, the participants were asked, “What did you look like before recovery, while you were actively using?" “Please describe your challenges in early recovery. How do you or have you persevered?” Such questions encouraged participants to tell their stories of recovery.

Definition of Terms

The primary terms used in this study are presented and defined with relevant citations.

Substance Use Disorder (SUD)

According to the *DSM-5* (American Psychiatric Association, 2013), SUD is diagnosed when two or more of the following criteria are present: hazardous use; the presence of social/interpersonal problems related to use; the individual having neglected significant roles due to abuse, withdrawal, tolerance; having used larger amounts or for a longer period than was intended; repeated attempts to quit or control use; having spent much time using, physical or psychological problems related to abuse; activities having been given up due to use, or cravings (Hasin et al., 2013).

Empathy

Empathy describes a wide range of experiences. It is generally defined as "the capacity to think and feel oneself into the inner life of another person" (Kaluzeviciute et al., 2020). This study focused on cognitive empathy, the "cognitive ability to recognize and understand the thoughts, perspectives, and feelings of another individual" (Eisenberg & Strayer, 1990, p. 146).

Resiliency

Previous research has indicated no universal definition of resiliency (Aburn et al., 2016). Resiliency is a dynamic process of adapting well in the face of adversity; it is associated with rising above a challenge or hardship and involves individual adaptation and adjustment (Aburn et al., 2016). *Resiliency* is used throughout rather than *resilience.*

Recovery

This is “A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential” (SAMHSA, 2020, para. 2). The National Institute on Drug Abuse (NIDA, 2021) explained,

> Even people with severe and chronic substance use disorders can, with help, overcome their illness and regain health and social function. This is called remission. Being in recovery is when those positive changes and values become part of a voluntarily adopted lifestyle. (para. 1)

Sobriety

A consensus definition of sobriety was not found in the literature; however, sobriety is defined as abstinence from drugs, including alcohol. A group of stakeholders from the Betty Ford Institute (2007) included sobriety in their working definition of recovery: “Recovery is defined . . . as a voluntarily maintained lifestyle composed characterized by sobriety, personal health, and citizenship” (para. 1).

Assumptions

Some fundamental assumptions must be made when narrative inquiry is used as a methodology. These assumptions pertain to the study. The first is that people can make sense of their experiences by imposing them on a story structure (Bell, 2002). Second is that a narrative can provide a remarkable window into an individual's world by representing either the fabric of human existence or an individual's identity and experiences (Robert & Shenhav, 2014). A third assumption is that data collected from interviews will stem from participants' subjective interpretations of their experiences. Finally, a fourth assumption is that the researcher assumes

participants will be honest about their experiences and are willing to disclose their personal experiences with SUD.

Scope, Delimitations, and Limitations

The scope and delimitations of a study involve restrictions that are intentionally decided upon and implemented by the researcher (Theofanidis et al., 2019). First, the scope of this study was limited to how African American men in long-term recovery experienced cognitive empathy and resiliency during their recovery process. Only African American men who were in recovery from SUD for at least 10 years were included as participants, limiting the generalizability. Generalizability is not a major concern in qualitative research; it is a quantitative research concern because of the inferences made to larger populations. However, in qualitative studies, the researcher expects to gain a deeper understanding of the phenomenon in question because of this restriction (Ravitch & Carl, 2020).

Another study limitation is that data collected in a narrative inquiry study are inherently subjective, so the researcher asks follow-up questions to help ensure clarity and correct understanding of the data. Finally, by ensuring confidentiality and anonymity to all participants, the researcher hopes that respondents will respond honestly to all questions, overcoming the potential limitation of social desirability, the inclination of participants to respond for reasons of positive self-image or the belief that others will view them favorably (Bergen & Labonté, 2020).

Summary

This chapter provided an introduction to the study. The problem explored was SUD, with a specific focus on African American men who have been recovering from SUD for at least 10 years. The study purpose was to develop an understanding of how empathy and resiliency impact long-term recovery from SUD. This study is significant because several personal, social, and

clinical areas of relevance could impact SUD treatment and therefore long-term recovery. Chapter II discusses the relevant literature and underlying theory in detail.

Chapter II – Review of the Literature

The chief public health crisis in the United States is substance use disorder (Campbell-Sills et al., 2018). Individuals with SUD generally find it difficult to break their addictions (Jordan & Andersen, 2017; Steinhausen et al., 2017). Internal and external factors can complicate the recovery from SUD (Marel et al., 2019). Accordingly, it is imperative for SUD treatment practitioners and those undergoing SUD recovery to leverage all available resources, knowledge, and best practices to increase the likelihood of a successful long-term recovery.

African Americans' health disparities are disproportionately affected by SUD (Cummings et al., 2016). According to data from the 2018 National Survey on Drug Use and Health, 2.2 million African Americans age 18 or older had SUD (SAMHSA, 2019). Because substance use wreaks havoc on the users, their families, and their communities (James & Jordan, 2018), it is especially important to consider the influence of culture on those who seek to recover and the types of treatments that consider their cultural norms and values. For example, a young African American person might be skeptical about a White counselor having empathy towards the challenges they face in their lives that are directly associated with the color of their skin.

Finding community within a group and connecting with a peer or sponsor who is in long-term recovery can help users change and grow so they can reconcile their past and put it behind them (Breuninger, 2020; Humphreys & Moos, 2007). This approach is effective because the peer knows exactly what the person in recovery has experienced and is going through (Kelly, 2017). The group sessions, in turn, are supportive environments where members can discuss their problems and successes in overcoming addiction (Stone et al., 2017). Members sharing stories, helping new members feel like part of a larger community, and locating role models with whom they can relate are the heart of recovery programs.

Many counselors and parole officers mandate that people suffering from SUD go to AA and NA because they can find people who identify with their addiction and compulsion to use drugs. These individuals then often find hope that, in time, they will be able to obtain long-term recovery (Stone et al., 2017). The identification of a peer or sponsor who can truly empathize with their mentee and demonstrate resiliency is at the root of these community support programs.

Although numerous studies and resources have been devoted to understanding the causes of SUD and other addictions, the problem remains, evidenced by the gaps in the literature (Vanderplasschen et al., 2017). The importance of empathy and resiliency in long-term recovery from SUD is still not well understood, despite the established associations between empathy, resiliency, and addiction (Ferrari et al., 2014). Accordingly, the purpose of this qualitative narrative inquiry was to develop an understanding of the importance of empathy and resiliency in long-term SUD recovery.

This chapter reviews the literature relevant to the topic of the study. The review includes, first, the details of the literature search, a thorough discussion of SUD prevalence, treatment of SUD within marginalized communities, SUD treatment approaches, and the relationship between experiential learning and addiction. Next, a review of the relationships is provided between SUD and mental health, adverse childhood experiences (ACEs), post-traumatic stress disorder (PTSD), and socioeconomic background. A brief review of research on personality traits and characteristics associated with recovery is then provided. Next, the history of empathy as a construct and concepts of cognitive empathy and affective empathy are presented, including applications of cognitive empathy in therapy and counseling. Finally, a review of resiliency and its role in SUD is provided.

Literature Search

The literature search for this review was conducted with EBSCO, Google Scholar and ProQuest databases. The following keywords and phrases were entered into these databases to locate relevant research articles: *addiction counseling, causes of addiction, cognitive empathy theory, culturally relevant addiction treatment, culturally responsive counseling, empathy, experiential learning and addiction. factors that moderate addiction, resiliency, substance abuse, SUD. SUD among marginalized populations, SUD recovery,* and *trauma.* Some seminal and historic literature was included to inform the theoretical foundations of this study, Most of the literature cited was in the past 5 years to ensure its continued relevance.

Prevalence of SUD

SUD is prevalent in the United States, especially in African American communities. Data from the National Survey on Drug Use and Health (2018) revealed that approximately 2.2 million African American adults (7.3%) had an SUD and another 1.1 million (3.6%) had co-occurring SUD and mental illness. Among African Americans with SUD, six in 13 (47.1%) had an illicit drug use disorder, two in three (67.6%) struggled with alcohol use, and one in seven (14.8%) contended with both (NSDUH, 2018). Marijuana, psychotherapeutic drugs (including opioids and other prescription drugs), and cocaine were the most misused drugs. A total of 17.8% of African Americans over the age of 12 used marijuana, 4.6% used psychotherapeutic drugs, and 1.8% used cocaine (NSDUH 2018). An additional 3.7% of the population reported opioid misuse specifically (NSDUH, 2018). These figures indicate that African American communities are disproportionately impacted by substance use disorder when compared to White communities.

Substance Use Disorders

Substance use disorder is dependent on the abuse of one or more of the following drugs: marijuana, cocaine, heroin, hallucinogens, inhalants, methamphetamine, or prescription drugs, including opioids (SAMHSA, 2019). Risk factors for SUD include lack of access to healthcare resources, high levels of communal violence, and a deficiency of social capital (Chen et al., 2019). The most common substances misused among African Americans are cocaine, opioids, heroin, and alcohol. In 2018, 1.2 million African Americans, or 3.7% of the total population, misused opioids, including heroin and prescription pain relievers, such as oxycodone (NSDUH, 2018). In comparison, only 0.7% of the total population reported having opioid use disorder in the same year (SAMHSA, 2019). Although national drug overdose deaths from opioid use disorder (OUD) declined between 2017 and 2018—driven by decreases among White populations—deaths *increased* among non-Hispanic African American and Hispanic populations in the same timeframe (Wilson, 2020).

Similarly, 1.8% of the African American population over 12 years of age had a cocaine use disorder, and 0.4% had a heroin use disorder, compared to 0.4% and 0.2% of the total U.S. population, respectively (NSDUH, 2018; SAMHSA, 2019). These figures indicate that illicit drug use and misuse are significantly more prevalent in African American communities than other communities. The following sections explore drug use—specifically cocaine, heroin, and opioids/non-medical prescription drug use—among African Americans.

Cocaine Use

Cocaine use has declined slightly in recent years among African Americans but still presents significant challenges. In 2017, the NSDUH (2018) survey reported that 317,000 African Americans used cocaine, and in 2018, 303,000 used cocaine. A study on the pathways to

cocaine use in middle adulthood among African Americans found that adolescent drug and alcohol users were more likely to take up cocaine in mid-adulthood than individuals from other cultural backgrounds (Fothergill et al., 2009). Additionally, low income was also linked to cocaine use in mid-adulthood (Fothergill et al., 2009). Conversely, shyness in elementary school and frequent church attendance in early adulthood were associated with decreased tendencies to use cocaine (Fothergill et al., 2009). These findings suggest that community factors and cultural supports, such as support networks formed at religious institutions, could offset inclinations towards cocaine use by building resiliency in individuals.

Other research (e.g., Miguel et al., 2019) has focused on determining if gender and race influence pathways to cocaine misuse and treatment outcomes. Although the rate of cocaine use among African Americans is like that of the general population, African Americans are less likely to participate in treatment. Most clinical research is based on sample populations in which Whites are overrepresented and African Americans are underrepresented (Miguel et al., 2019). Empirical research on the baseline conditions leading to cocaine abuse and treatment outcomes by gender and race found that these two variables differ across both factors. Pooled data from seven randomized clinical trials indicated that African Americans initiated cocaine use at an older age compared to Whites (Miguel et al., 2019).

Additionally, African American male cocaine users were more likely to have been arrested and incarcerated compared to users from other groups, implying that African American men are disproportionately imprisoned for substance use (Miguel et al., 2019). Importantly, the study also found that the mean number of years of cocaine use was higher among African Americans, suggesting that they experience suboptimal treatment delivery and have less access to resources (Miguel et al., 2019). However, no difference was found in treatment outcomes

regarding gender or race, suggesting that, with appropriate resources, African American cocaine users can respond to treatment as effectively as other groups (Miguel et al., 2019).

Opioids and Prescription Drug Misuse

The misuse of opioids and prescription drugs is a growing problem within African American communities (James & Jordan, 2018). Although prescription drug misuse (including opioids) is more prevalent among Whites, African Americans comprise a growing proportion of prescription drug misusers, with approximately 6% of African American youth misusing opioid prescription drugs (Ford & Rigg, 2015). Moreover, prescription opioid-related deaths have significantly increased among African Americans (Kandel et al., 2017).

Opioid prescriptions are commonly prescribed for patients with chronic pain disorders, but because of the addictive nature of opioids they present an increased risk for misuse. A history of substance abuse, untreated mental health disorders, younger age, and social environments that encourage misuse are all risk factors for opioid misuse and addiction (Webster, 2017). A study on the demographic and psychosocial factors contributing to opioid misuse among racial minorities concluded that residential instability, delinquency, depression, weak parental bonds, and substance use among peers were significantly associated with an increased risk of misuse among African American adolescents (Ford & Rigg, 2015).

Heroin

Heroin addiction has serious consequences for individuals' physical and mental health. Heroin dependency is often accompanied by high mortality rates, blood-borne illnesses, and mental health problems such as depression and increased suicide risk (Lister et al., 2017). Heroin use among African American communities is rising, with 96,000 people using heroin in 2016, and 135,000 people using heroin in 2018 (NSDUH, 2018). Heroin addiction is commonly treated

with methadone maintenance treatment in which a synthetic substitute for heroin is administered to patients to gradually wean them from their heroin dependency (Lister et al., 2017).

Research has demonstrated that African Americans experience poor methadone treatment transition outcomes due to various factors. These include increased prevalence of comorbid cocaine abuse and greater socioeconomic disadvantages (Lister et al., 2017). The study by Lister et al. (2017) also revealed that living farther away from a treatment clinic and economic disadvantage contribute to worse treatment outcomes in African American heroin addicts than in addicts of other ethnicities.

Alcohol Use Disorder

Alcohol use disorder (AUD) is a complex disorder with numerous health and socioeconomic repercussions (Galbicsek, 2020). Approximately 95,000 people in the United States die from alcohol-related causes each year, making alcohol the leading cause of preventable deaths (Centers for Disease Control and Prevention [CDC], 2021). AUD can be affected by various biological, psychological, environmental, and social factors and lead to long-term dependency on alcohol that affects multiple aspects of life (Galbicsek, 2020). Alcohol use disorder has many risk factors, including a history of underage drinking (Horsman, 2018); mental illness, such as major depressive disorder (Sartor et al., 2016); socioeconomic background (Jones-Webb et al., 2016); childhood trauma (Sartor et al. 2017); and family history (Hazarika & Bhagabati, 2017). Although African Americans drink less compared to other ethnic groups, they often experience these risk factors at a higher rate, making them more vulnerable to alcoholism (American Addiction Centers, 2019).

Alcohol-related experiences early in life can contribute to the development of alcohol addiction later. Specifically, men who develop drinking problems before reaching adulthood are

more likely to develop alcoholism later in life (McCarty et al., 2012). It is important to understand that alcohol drinking is a progressive process with several intermediary stages between the first drink and the onset of alcoholism (Morean et al., 2019). Empirical research has demonstrated that the younger the age of individuals at the time of their first drink and first intoxication experience, the more likely they are to progress to binge drinking, alcohol-related problems, and eventually, AUD (Marino & Fromme, 2016; Morean et al., 2019; Sartor et al., 2016).

African Americans are also more susceptible than other groups to developing drinking problems if drinking begins earlier in life. A large study on the effect of early alcohol use found that African Americans with a history of early drinking were four times more likely to develop alcoholism compared to people who did not have a history of underage drinking (Horsman, 2018). The results of this study also suggested that familial relationships might moderate the relationship between underage drinking and the onset of AUD (Horsman, 2018). This study emphasized that early intervention strategies targeting at-risk youth could help curb AUD rates, especially in African American communities.

Treating SUD Among Marginalized Communities

Behavioral healthcare professionals and researchers who attempt to approach communities that have been historically disenfranchised by the larger society to help them overcome addiction confront many challenges (Metzger et al., 2018). Marginalized populations are often less likely to seek help when experiencing SUD or other mental health conditions for multiple reasons (Martinez et al., 2018). Numerous identity factors, such as gender, religion, and culture, can affect whether treatment is sought, how SUD treatment is received, and whether a given treatment approach is suitable for a specific client.

Numerous researchers have emphasized the importance of ensuring that SUD treatment is appropriate for the communities it is designed to help. McKenzie et al. (2016) conducted a systematic review to understand addiction among indigenous people and found that the incorporation of traditional culture into the treatment program significantly influenced their recovery. Because many stereotypes relate to marginalized populations, such as indigenous people and African Americans having a propensity for drug use, it can be even more difficult for these communities to reach out for help. The perception may be that they do not want to contribute to the existing stereotypical and discriminatory views of their communities (Skewes et al., 2019).

Skewes et al. (2019) sought to develop a culturally grounded intervention for treating SUD in marginalized populations at a disproportionate risk of developing SUD. Academic community partnerships were suggested as a means of enacting community-based participatory research to benefit disproportionately affected communities. With 25 members of an indigenous community, researchers emphasized the importance of a "holistic approach to recovery that emphasizes spiritual, cultural, and interpersonal harmony and connectedness," as well as "the need for a multi-level intervention targeting individuals, families, and the community as a whole" (p. 74) to enhance intervention success.

Martinez et al. (2018), McKenzie et al. (2016), and Skewes et al. (2019) highlighted the importance of approaching these communities with tact and providing culturally relevant support to individuals suffering from substance use disorder. Doing so requires awareness and understanding of the role of colonialism in treating indigenous people and others, such as African Americans, who have suffered under colonialist practices resulting in generations of trauma. To promote understanding, trust, and rapport, mentors with similar backgrounds and

experiences can positively affect the recovery of individuals belonging to marginalized and traumatized groups. If mentors come from an entirely different cultural or ethnic context, the group members may feel that their mentors or counselors do not understand them (Cross et al., 2018).

Treatment Approaches to SUD Based on Social Cognitive Theory

Approaches to SUD treatment and long-term recovery vary considerably. The research-practice gap has longitudinally affected the process of developing and improving treatment approaches for SUD (Vanderplasschen et al., 2017). The dissonance between SUD treatment approaches used by practitioners and findings from SUD researchers has led to the slow diffusion of best practices into treatment settings. As Vanderplasschen et al. (2017) explained, many SUD treatment practitioners complain that the findings from SUD studies lack practical relevance and numerous topics related to SUD treatment are ignored. This gap between researcher and practitioner presents a barrier to successful long-term treatment. This section reviews studies on SUD from the standpoint of social cognitive theory.

Distinguishing between cognitive and affective empathy allows therapists to concentrate on helping to restore one or the other type of empathy in patients whose condition affects only one of the two. Ferrari et al. (2014) studied cognitive and affective empathy and social skills among 62 drug addicts and 40 healthy individuals. Of these three categories, only affective empathy was significantly different between addicted and healthy individuals. The researchers suggested that therapists treating substance use disorder patients should focus on rehabilitating their clients' emotional (affective) empathy. This kind of narrow focus can save therapists' time and effort and make the time spent with patients more efficient and effective (Ferrari et al., 2014).

Similarly, Kroll et al. (2018) found that opioid use (nonprescription, abusive) decreased social cognition in patients in the United States. Social cognition is the awareness of the effects of environmental factors on emotions and their causes (Kroll et al., 2018). The researchers administered a series of cognitive tests to opioid-addicted individuals and a control group. They found that while overall cognition of the addicted group was impaired, a particular deficit in social cognition was present. Kroll et al., therefore, recommended targeted therapy that focused on restoring the social cognition of opioid addicts. The researchers also observed that the very nature of opioid addiction causes people to turn their emotional focus inward, impairing their social cognition. Thus, it is essential to carefully evaluate the need to restore cognitive and affective empathy in patients treated for opioid addiction.

Experiential Learning and Treating Addiction

Alcoholics Anonymous and Narcotics Anonymous are useful because they provide a setting for someone suffering from SUD to connect with others about their experiences in recovery, and they also offer support as a person relearns how to enjoy day-to-day life while remaining in long-term recovery (Samuels et al., 2020). As addiction manifests as an experientially learned behavior that takes over the mesolimbic reward center in the brain (Campana et al., 2019), it becomes important to understand how to teach those on the path to recovery to live without using substances. Mentorship and social AA and NA communities provide the ultimate experiential learning environment for people in the early recovery stages (Samuels et al., 2020). They can seek guidance from people to whom they can relate, resulting in new social encounters with individuals who learned experientially how to live without substances. As a result, the addicts can forge their own experiences to relearn healthy living (Stone et al., 2017).

Experiential learning also helps practitioners who provide SUD treatment improve the effectiveness of their treatment approaches (Brown et al., 2020; Dice et al., 2019). Some practitioners, particularly those who also struggled with SUD or other addictions in the past, empathize with their clients' struggles. However, many practitioners cannot relate to their clients' struggles with SUD and process of recovery. Clients in SUD recovery can sense a practitioner's inability to relate to their struggle and may feel misunderstood or be less likely to share their experiences (Yates et al., 2017).

Dice et al. (2019) highlighted the utility of experiential learning in activities enacted by students in an addictions class who were learning to administer SUD treatment effectively. The participants were asked to abstain from something significant and valuable to them for a prolonged period outside of class. Analysis of reflective writing assignments revealed that the experiential learning exercise effectively enhanced participants' ability to empathize with individuals who experience SUD in a way that other forms of classroom learning, such as lectures and textbook worksheets, could not.

Brown et al. (2020) similarly concluded that the experiential learning approach could help medical students understand addiction. As the researchers noted, adults over 50 are the most likely age group to be hospitalized for illicit drug use, although adults over 50 abuse alcohol most frequently. Thus, while many medical students have parents or grandparents who struggle with SUD, the students may be unaware that individuals in their lives may experience addiction and other conditions they learn about in class.

Effects of SUD on Mental Health

Further complicating the rates of SUD in African American populations is the substantial co-occurring of SUD, psychopathology, and adverse childhood experiences. Indeed, some

research suggests that SUD and mental health comorbidities may be higher among African American populations than White groups (Chen et al., 2019; Sartor et al., 2016). Mental health can have a significant effect on the development of alcohol addiction. AUD is commonly comorbid with mental illness, especially major depressive disorder (MDD), which sharply exacerbates the mortality and morbidity of each disorder (Deady et al., 2016; Harnett et al., 2017).

It is difficult to determine the cause-and-effect relationship between MDD and AUD. Alcohol is a central nervous system depressant, and increased consumption may cause depressive symptoms (Pavkovic et al., 2018). Additionally, people may use alcohol to cope with depressive symptoms, with AUD developing as alcohol continues to be used as a coping mechanism (Pavkovic et al., 2018). Either way, depression can predict heavier alcohol use, and relapses in AUD predict poor response to MDD (Gopalakrishnan et al., 2009).

A large study on the link between alcoholism and depression in undiagnosed patients found a positive association between MDD and alcoholism (Pavkovic et al., 2018). The researchers also noted that men were more likely to engage in more harmful alcohol consumption than women (Pavkovic et al., 2018). The high prevalence of comorbid AUD and MDD suggests that the two disorders should be screened simultaneously to help facilitate earlier detection and more effective treatment.

Other mental health issues and AUD also co-occur among African Americans. In 2018, 1.1 million African American adults, or 3.6% of the population, reported a co-occurring mental health illness and a SUD (NSDUH, 2018). Mental health problems such as depression, PTSD, and large amounts of stress are often comorbid with AUD among African Americans. A study on alcohol use among African American homicide survivors found that heavier alcohol use was

associated with depression and PTSD (McDevitt-Murphy et al., 2019). Other empirical research has discovered that higher levels of perceived stress stemming from racial discrimination contribute to increased alcohol use (Metzger et al., 2018). Findings indicate that African Americans face additional challenges, such as racism, that can contribute to the development of comorbid AUD and mental health issues.

Effects of Adverse Childhood Experiences and SUD

The existing evidence suggests that childhood trauma is linked to greater alcohol use (e.g., Pilowsky et al., 2009; Pui Kei Leung et al., 2016). Studies show that people who have experienced adverse childhood experiences and trauma are more likely to initiate alcohol use earlier in life (Oberleitner et al., 2015) and use alcohol more (Dube et al., 2006). However, despite a higher prevalence of childhood trauma among African American children compared to those in other ethnic groups, these children are less likely to use alcohol frequently and earlier in life (Sartor et al., 2017). Although African American families are more likely to live in poorer neighborhoods and have lower household incomes—factors linked to a greater risk of experiencing trauma—the children in these families are less inclined towards alcohol use compared to their White counterparts (Sartor et al., 2017). This finding suggests that the higher levels of community cohesion found in underrepresented communities may act as a protective factor against alcohol use (Korbin et al., 1998).

Another ACE associated with developing AUD is parents or primary caregivers who were alcoholics. The children of alcoholics are more likely to develop psychological problems that make them more susceptible to developing AUD in the future (Mukesh et al., 2017). For example, empirical research on the relationship between alcoholism and attachment style has found that alcoholic fathers and their sons display insecure attachment behaviors associated with

an increased risk of developing AUD (Hazarika & Bhagabati, 2017). Attachment style refers to the type of bond that individuals form with their caregivers early in childhood. Since alcoholism can disrupt a person's ability to respond appropriately to social cues, it follows that the formation of attachment between caregivers with AUD and their infants might be disrupted (Söderström & Skårderud, 2009). This disruption could cause social maladjustment in the child and lead to an increased risk of developing AUD later in life.

Many substance use disorder counselors maintain that trauma and hurt are at the center of addictions and SUD (Cross et al., 2018). Resiliency, which enables a person to carry on in the face of enormous challenges and rise above addiction issues (Shi et al., 2019), is still understudied, but the documentation of the relationship between trauma, PTSD, and addiction is well-established (Cross et al., 2018). Trauma experienced during childhood is particularly relevant to addiction, as it can affect cognitive development (Pilowsky et al., 2009).

Childhood trauma can result in attention-seeking behavior due to withheld affection and lead to the child’s impulsive behavior to gain approval from peers or adults (Cross et al., 2018). Children who are not getting positive attention at home will seek out comforting and friendly sources for attention, which can have devastating consequences (Masten et al., 1990; Mukesh et al., 2017). Adolescents are at a greater risk for SUD than any other group, which poses a major challenge for parents whose children are part of a marginalized community seeking SUD treatment assistance (Cross et al., 2018). Children who cannot trust adults in their communities are even less likely to trust counselors and doctors from outside of the community, making it important for community members who are sober to step in and help (Pilowsky et al., 2009). Addressing and treating childhood trauma early decreases the likelihood of developmental issues and addiction later in life (Cross et al., 2018).

Trauma, particularly childhood trauma, and excessive stress have been linked to a higher risk for SUD (Garam et al., 2019). Hirsh (2020), among other researchers, contended that not enough had been done to address the trauma at the root of many addictions, considering research that has illuminated this association. Although numerous therapies are available for both trauma and SUD, many people who experience both only receive treatment for SUD. Hirsch (2020) attributed this unfavorable pattern to the source of most SUD treatment in the United States. Primary care physicians, most of whom do not have an advanced clinical understanding of trauma management, typically guide the SUD recovery process. Accordingly, treatment approaches that do not address trauma as the root cause of addiction often result in temporary recovery and numerous relapses (Hirsh, 2020).

Trauma Exposure and PTSD

Many African Americans face challenges related to trauma exposure and PTSD. Cross et al. (2018) found that trauma exposure and PTSD increased child abuse potential. Stress, violence, and PTSD increase the risk of experimentation with substances (Garami et al., 2018) as a coping mechanism. It may, therefore, be necessary to address the traumas the African American community endures to effectively design a treatment plan for their recovery and help them locate community members to whom they can relate and who can guide them on their recovery journey (Cross et al., 2018).

If a community is struggling with significant PTSD and unhealed trauma, which places their children at risk of abuse and increased rates of a substance use disorder, it becomes necessary to work with the community members themselves to address the drug use (Cross et al., 2018; Garami et al., 2018). When home culture is affected by generations of trauma, a major solution is for the community to come together to heal and support their suffering community

members (McKenzie et al., 2016). The key should be celebration of their identity and culture in the context of sobriety, especially if individuals associate substance use with their culture. When the home culture is traumatizing or traumatized, it becomes even more important to foster leaders from the community and mental health professionals to step forward and offer their support. Collaboration between the community and mental health treatment resources is critical to improve long-term outcomes (Skewes et al., 2019).

Community leaders, along with clinically and culturally competent mental health professionals, can promote a healthy understanding of home culture. McKenzie's (2016) research demonstrated that incorporating a supportive traditional culture into treatment provided comfort to persons in early recovery, reducing the expectation to conform to mainstream therapies and healthcare. Najavits et al. (2017) examined the relationship between SUD and trauma and posited that when the family structure does not provide a healthy environment with love and affection, self-destructive attention-seeking behavior often emerges. For professionals, addressing how an attention-deprived environment can motivate individuals to seek fulfillment by using substances is a critical part of ensuring that addiction and recovery are managed well (Jordan & Anderson, 2017).

Socioeconomic Background

An individual's socioeconomic background can play a significant role in the development of AUD (Miguel et al., 2019). This is especially true for African Americans, who are more likely than Whites to live below the poverty line, live in disadvantaged urban neighborhoods, and attain a lower level of education (Sartor et al., 2018). People living in poverty and disadvantaged neighborhoods often have fewer support systems and are more likely to engage in substance use disorder than other socioeconomic groups (Alcohol Addiction Centers, 2019). Chen et al. (2019)

conducted a comparative study on the associations of individual-level and area-based socioeconomic status indicators with mental disorders across different racial groups. The researchers found that a less than high school education among African Americans was associated with AUD.

Jones-Webb et al. (2016) also found an association between job loss and AUD in African Americans. When modeling the association between recession-related job loss and AUD in African American, White, and Hispanic populations, Jones-Webb et al. (2016) discovered that distress stemming from job loss was positively associated with AUD only among African American participants. This result suggested that this population experiences heavier stress levels because of job loss than other groups. Interestingly, another study on the association between trauma, socioeconomic factors, and alcohol use initiation in African American girls revealed that those living in single-parent households were less likely to engage in drinking behavior compared to White girls (Sartor et al., 2017). The researchers conjectured that this finding may have resulted because single-parent African American households might develop stronger familial and community parenting strategies compared to single-parent White households.

Personality Traits and Other Characteristics Associated With Recovery

Limited research exists on personality traits or characteristics associated with long-term recovery. Most studies identified negative consequences as a key factor in seeking recovery (e.g., Ford & Rigg, 2015; Lister et al., 2017; Steinhausen et al., 2017). A small study published in 2000 concluded that individuals in recovery who received help, whether formal treatment, Alcoholics Anonymous, or both, were more likely to be sober at 8 years (Timko et al., 2000). However, this study did not consider factors that predicted sustained recovery.

A cross-sectional survey study examined self-reported factors related to long-term recovery (Laudet et al., 2002). A total of 51 survey respondents with an average recovery time of 12 years participated in the study. Factors identified as having positive association with long-term recovery included having help from families and friends (30%) and being involved in a 12-step fellowship (25%).

Some studies examine traits of those with substance use disorder to better understand how to target prevention strategies or treatment approaches. Terracciano et al. (2008) explored personality profiles of drug users using the Five-Factor Model. In this model, personality is characterized by five traits: neuroticism, extraversion, openness to experience, agreeableness, and conscientiousness. The study findings showed too much variability to reach definitive conclusions. In 2014, Flaherty et al. performed a qualitative analysis to explore six pathways to recovery: natural recovery, 12-step recovery (one participant from AA and one from NA), secular recovery, medication-assisted recovery, and faith-based recovery. Semistructured interviews were conducted with respondents in each domain to map the varieties of recovery experiences. The researchers found that a general structure of recovery exists, and significant advancements in the emerging science of recovery could benefit individuals suffering from alcohol and other drug problems

This analysis of the literature on personality traits and other factors associated with recovery revealed that none of the studies explored empathy or resiliency as a characteristic associated with long-term recovery. This deficit remains another identified gap in the literature on SUD and recovery. Thus, the present study was conducted.

Empathy

Empathy is a continual outcome predictor in modern psychotherapy research. Elliot et al. (2018) found in a meta-analysis that a therapist's ability to have empathy or understand and relate to a patient's situation is a key predictor of treatment success. Despite this clear significance, no single, consensual definition of empathy exists (Kaluzeviciute, 2020).

Recent breakthroughs in neuroscience have demonstrated three key brain areas or subprocesses of empathy that clarify its definition (Elliot et al., 2018). The first is an automatic, intuitive, emotional simulation process that mirrors emotional components with activation of the limbic system—amygdala, insula, anterior cingulate cortex (Decety & Lamm, 2009; Goubert et al., 2009). The second process is a perspective-taking process, localized in the medial and ventromedial areas of the temporal and prefrontal cortex (Shamay-Tsoory, 2009). The third process is an emotional regulation that allows a person to self-soothe while experiencing someone else's pain, which allows for compassion and helping behavior. This ability is probably found in the orbitofrontal cortex, as well as in the prefrontal and right inferior parietal cortex (Decety & Lamm, 2009; Eisenberg & Eggum, 2009).

To better understand the definition of empathy, a review of the history of empathy as a psychological construct must be undertaken. The field of psychoanalysis has highlighted the importance of empathy since its inception. Both Freud and Jasper believed in clinical objectivity and viewed empathy as an epistemological tool in the clinical setting (Kaluzeviciute, 2020). Freud viewed psychoanalysis as a relational activity: The process of transference is defined by the patient transferring past interpersonal experiences onto the therapist. The therapist analyzes and interprets these experiences, which are unconscious, early childhood themes. Freud emphasized that therapists needed to have intuitive perception, an understanding of the patient

greater than purely intellectual; however, he believed the therapist should maintain clinical objectivity and maintain non-personal relationships. Because of this clinical objectivity, Freud's psychoanalysis did not engage the patient relationally (Kaluzeviciute, 2020).

Another scientist of the time, Jaspers, was a psychiatrist who challenged Freud's lack of empathy in his approach. Jaspers believed mental symptoms fell into two categories: objective and subjective. Subjective symptoms were those that the patient shared. Jaspers believed that a genuine understanding of the patient required the therapist to have empathy, and he stressed the importance of listening. Jaspers also believed that the therapist's capacity to actualize the patient's self-reported experiences by drawing from their own experiences increased the success of therapy (Monti, 2013). However, the importance of clinical objectivity, demonstrated by both Freud and Jaspers, fell out of favor in postmodern psychology, and multiple models such as relativism, perspectivism, and intersubjectivity emerged (Gabbard, 1997).

The first clear definition of empathy as a clinical tool was described by Rogers (1980), a humanistic psychologist. Rogers viewed empathy as the capability and willingness of the therapist to see the world through the client's eyes. Empathy thus requires the therapist to understand the client 's thoughts, feelings, and struggles in light of the client's frame of reference. Similarly, psychoanalyst Kohut (1984) defined empathy as "the capacity to think and feel oneself into the inner life of another person" (p. 82). Although similar, each practitioner had different constructs of empathy. For Rogers, the role of empathy in clinical practice was similar to that found in other human relationships; acceptance, understanding, and genuine attention are key factors of his person-centered approach (Caspary, 1991). Rogers also believed that empathy, congruence, and unconditional positive regard are sufficient for change.

In contrast, Kohut (1984) viewed empathy as a particular clinical technique in combination with interpretation. He developed the theory of self-psychology, noting that people with greater empathy fare better with interactions in life. Thus, therapists must have empathy when working with patients to explore "self object needs," or developmental needs that are key to stability in life (Banai et al., 2005, p. 224; Kohut, 1984).

Two distinct types of empathy are described in the literature; affective empathy is clearly distinguished from cognitive empathy (Healey & Grossman, 2018). In a similar manner to Jaspers's and Freud's early definitions of empathy, cognitive empathy is defined as "the ability to model others' emotional states" (Kaluzeviciute, 2020, p. 11). Affective and cognitive empathy differ. From an affective empathic stance, one shares another's *feelings* but not necessarily their situation, whereas with cognitive empathy, the person *contextualizes understanding* of another's experience (Kaluzeviciute, 2020). A study simulating adverse events in a cohort of participants showed that having a *shared* experience can enhance a person's empathy towards a situation (Murphy & Lilienfeld, 2019). It noted that cognitive empathy occurs when one person understands another's situation (usually a negative or unfavorable situation), which generates empathy (Murphy & Lilienfeld, 2019).

Thus far, empathy has been discussed as it relates to empathy in treatment providers. However, it is also important to discuss the dynamics of empathy in clients with substance use disorders. In a review published in 2018 by Massey et al., the role of empathic processes in substance use disorders was examined across the literature. It found that persons having alcohol or stimulant use disorder displayed behavior consistent with impairments in both cognitive and affective empathy (Massey et al., 2018). This outcome was measured behaviorally,

neuroanatomically, and by self-report. The researchers suggested multiple pathways that influence empathy across the continuum of substance use.

Empathy is distinct from sympathy in several critical ways. Empathy requires that a person can contextualize an understanding of the experiences the recipient has gone through. It can be enhanced when the empathizer has gone through similar experiences and/or has knowledge of resources and how to offer help. (Cox et al., 2012). Empathy is typically more accepted by the recipient than sympathy, as sympathy about major life issues is potentially expressed by someone who may feel sorry for another person but may not necessarily understand this person (Guerrero, 2019). Essentially, empathy requires an element of perspective taking that sympathy does not.

No single theorist or researcher has been credited with creating cognitive empathy theory. Rather, it is an extension of the social cognitive theory advanced by Bandura (1986), which states that a significant portion of a person's knowledge acquisition occurs as a result of observing others. Furthermore, a behavior is learned by observing the rewards or punishments that accrue to others because of their behaviors.

Existing literature that involves the use of cognitive empathy theory to frame SUD treatment and experience is very limited. However, broader studies of adult behavior conducted from a cognitive empathy perspective have provided insights into associations between addiction and empathy. In a study on empathy and adult behavior, Moore et al. (2015) found that adults who have varying affective and cognitive empathy levels have corresponding differences in areas of the brain responsible for social and emotional processing. Consequently, levels of empathy were found to explain why two adults might respond completely differently to the same situation or stimuli in an emotional and/or social scenario.

In another study, Rosen et al. (2016) used cognitive empathy theory as a framework to study how empathy, age, and gender affect moral decision-making among adults. After analyzing participants' decision-making when faced with theoretical pedestrian scenarios and problems, the researchers found that increased age and female gender were significant predictors of altruistic decisions mediated by emotional empathy. Hence, empathy was found to mediate the effect of identity-related factors (age, gender) on the morality of one's everyday decisions. The results of the studies by Rosen et al. (2016) and Moore et al. (2015) suggest that cognitive empathy theory may provide insights into the influence of empathy on the behaviors and decisions involved in long-term recovery from SUD.

Empathy: Brain Functioning and Gender Treatment

Brain Functioning. The distinction between cognitive and emotional (affective) empathy is significant. Cognitive empathy is a fundamentally different process from emotional empathy and takes place in separate brain regions. Decety and Yoder (2016) found that sensitivity to the injustice suffered by others arises from cognitive empathy, not emotional empathy. A person's sense of justice comes from understanding the situational context, not the emotions experienced by another person. Thus, understanding injustice comes about by understanding another person's situation (Decety & Yoder, 2016). The following paragraphs discuss the mechanism of empathy in the human brain.

Schnell et al. (2011) analyzed MRI brain scans of volunteers, showing that the brain's higher reasoning centers were engaged during cognitive empathy; emotional centers were engaged during affective empathy (Eres et al., 2015). In the former case, the volunteer understood what another was going through, whereas in the latter, the volunteer understood another's emotions by sharing their feelings (Schnell et al., 2011). Cox et al. (2012) described

this outcome as the difference between feeling and knowing another person's emotional state. Both are important constructs when empathy is considered as a factor of long-term recovery.

Gender Treatment. Gender has been found to be a predictor of levels of empathy. For instance, in a study set in Turkey, researchers tried to explain the gender differences in the incidence of both traditional bullying and cyberbullying by adolescents 13-18 years old. The adolescents were administered three previously validated questionnaires about bullying. The researchers found that affective empathy tended to mediate the incidence of cyberbullying more than cognitive empathy and that female adolescents showed greater affective empathy than male adolescents. Cognitive empathy was more prevalent among men (Topcu & Erdur-Baker, 2012). Historically, the traditional stereotyped and socialized view of women as being more empathetic and men being more analytical was supported for this population. Other researchers, such as Farrell et al. (2016) and Barry (2016), highlighted a gap in knowledge of gender differences in empathy levels. These researchers contended that many psychological measures and mental illnesses cannot be well understood and effectively addressed without acknowledgment of the gender differences in empathy

Adhering to the gender script, as described by Seager et al. (2014), may have benefitted men in previous centuries when their role in society was to protect their communities, go to war, and gather food. But this gender script can lead to psychological distress in today's societies in which both men and women enact roles that require more empathy and other forms of emotional connection. In recent studies, researchers have uncovered significant associations between the following three factors about men: (a) they have been conditioned not to discuss their emotions; (b) they show lack of empathy; and (c) they are at heightened risk for suicide, depression, SUD, and other mental health conditions (Barry, 2016; Farrell et al., 2016). As a result of social

conditioning, men might associate seeking help for mental illness with weakness. They are therefore less inclined to seek counseling or treatment when problematic symptoms or behaviors arise (Kulesza et al., 2016; Seager et al., 2014).

Cognitive empathy is a vital social skill that helps individuals connect with others and create community, particularly for individuals unable to function well in society. Brook and Kosson (2013) examined male incarcerated offenders who had exhibited signs of criminal psychopathy, presenting them with a series of vignettes and evaluating their cognitive empathy. The researchers found that human interactions and psychopathy lifestyle were correlated with challenges in expressing positive, empathetic emotions. Participants could readily relate to negative antisocial experiences (Brook & Kosson, 2013). This finding is similar to situations in which people in recovery share their stories from their "using" days and laugh while discussing the outrageously dangerous situations they experienced.

Cognitive and Affective Empathy

Substances hinder a person's ability to react to situations, events, and other people emotionally. Maurage et al. (2011) found that alcoholics had a deficit in affective but not cognitive empathy. In other words, they were able to understand the situations of others but not the emotions the others experienced in those situations. The alcoholics could also understand why people felt the way they did (cognitive empathy) but not their feelings (affective empathy). The researchers stated that their findings supported the view that cognitive and emotional (affective) empathy are two distinct abilities and recommended that therapists concentrate on rehabilitating alcoholics' emotional empathy (Maurage et al., 2011).

Considering the relative newness of the concept of cognitive versus affective empathy, Walter (2012) had a somewhat different view of the two approaches compared to the other

contemporary researchers. He stated that the difference between the two types of empathy lies in understanding emotions versus sharing emotions. However, other researchers have not postulated that one must share the emotional experiences of others to have affective empathy for them. One must simply have experienced those emotions in the past and understand how they came about—that is, the situational context.

Resiliency

The definition of resiliency varies widely in substance use disorder research. The most often cited definition is "a positive adaptation despite adversity," with adversity described as "significant," "extreme," or "severe" for the most egregious forms (Luthar et al., 2000, pp. 543, 546, 551; Masten, 2001, pp. 228, 233, 235; Masten et al., 1990, pp. 425, 426). Resiliency has been defined as a trait, process, or outcome but is commonly defined by outcome measures (Rudzinski et al., 2017). Research on SUD and resiliency most often describes a dichotomous trait: People in recovery are viewed as resilient, whereas those in addiction have a lack of resiliency. Many studies on resiliency and SUD limit their scope to exploring individual traits (e.g., Robertson et al., 2018; Woods-Jaeger et al., 2019). However, such research does not account for other factors, such as external resources or environmental factors that can impact resiliency. Additionally, the lack fails to account for changes over a person's lifetime, which may influence the resiliency level (Rudzinski et al., 2017).

Another way that resiliency is defined in the research is process-based; for example, resiliency is "the process of effectively negotiating, adapting to, or managing significant sources of trauma" (Bowland, 2015, p. 174). In another source, resiliency is "a developmental process wherein the individual is able to utilize resources in and outside the self to negotiate current challenges adaptively and, by extension, to develop a foundation on which to rely when future

challenges occur" (Yates & Grey, 2012, p. 476). A review of these studies and others indicated that many of them, although defining resiliency as a process, nevertheless relied on traits-based or outcome-oriented methods (Rudzinski et al., 2017). Such studies have explored factors associated with resiliency, but most have failed to explore the reasons how or why they occur.

The degree of resiliency an individual possesses develops largely during youth due to interpersonal and contextual factors; however, resiliency can shift over time in adulthood (Masten, 2001). Some evidence suggests a delicate relationship between stress experienced throughout an individual's lifetime and resiliency (Dooley et al., 2017). In a study of cancer survivors, Dooley et al. (2017) found that those who had experienced moderate exposure to stress throughout their lifetimes displayed the highest levels of psychological resiliency. Both too much and too little exposure to acute stress were associated with lower levels of resiliency. Thus, Dooley et al. (2017) suggested that individuals' experience of dealing with moderate but manageable stress throughout their lives can enhance their resiliency when adversity arises.

African Americans possess a unique sense of resiliency due to numerous adversities stemming from systemic racism and inequalities (Woods-Jaeger et al., 2019). Vulnerabilities associated with unemployment, poverty, crime, segregation, and low education attainment make African American communities more susceptible to negative mental health outcomes (Farley & Kim-Spoon, 2017). Researchers aiming to understand the contextual elements of resiliency in African American youth have suggested that resiliency indicators in this group include the ability to adapt, persevere, and self-regulate (Woods-Jaeger et al., 2019). For African Americans who are frequently subjected to challenges such as community violence and oppression, the ability to "bounce back" in the face of adversity is key to resiliency.

Youth in the Woods-Jaeger et al. (2019) study also described interpersonal relationships as the key to developing a strong sense of resiliency and cultural values, such as communalism and self-determination. Communalism and self-determination are based on an Afrocentric worldview linked to resiliency in African Americans, as other studies have shown (Constantine et al., 2006). These values highlight the importance of shared responsibility and the belief that hard work can help overcome adversity. These studies emphasize that the African American community's unique challenges enable the development of a shared sense of resiliency.

Resiliency has been shown to have a protective effect, mitigating some of the negative implications of adversity and trauma (Leal & Silvers, 2020). Cognitively, high levels of resiliency are associated with high levels of functional connectivity in the brain responsible for coping, emotional flexibility, and control of inhibitions (Shi et al., 2019). Thus, a cognitive or psychological perspective is useful for understanding the effects of resiliency on people's responses to high-pressure situations and adversity.

Cousijn et al. (2018) investigated the relationship between resiliency and addiction among adolescents, showing that the resiliency of the teenage brain and socialization patterns lead to profound changes in adolescents seeking help for SUD. Robertson et al. (2018) presented the idea that resiliency may be a protective factor in internet addiction, but more research is required. In another study, Charlet et al. (2018) investigated neurological resiliency and found that substance use greatly changes the brain, rendering individuals less resilient to the chemicals they use. Ersche et al. (2020) discovered that learning self-control and learning to control one's impulses could decrease the risk of SUD.

Summary

In summary, this review highlighted the existing gap in the literature on the importance of empathy and resiliency in long-term SUD recovery, particularly within African American communities. In response to this gap, the purpose of this qualitative narrative inquiry was to present an understanding of the importance of empathy and resiliency in long-term SUD recovery. Very little has been documented in terms of how African Americans in long-term recovery experience resiliency and empathy, and the link between resiliency and recovery has been greatly understudied. Recovery from SUD is a nuanced process that varies considerably. In the present study, the eliciting of narratives from selected participants helped ensure that emergent insights about the importance of empathy and resiliency in long-term SUD recovery are directly relevant to the population this research is intended to help.

Chapter III – Methodology

In the United States, substance use disorders are significant and pervasive problems that frequently result in illness or death (Marel et al., 2019). The purpose of this qualitative narrative inquiry was to develop an understanding of whether and how empathy and resiliency contribute to long-term recovery from SUD. The following research question was explored: How do African American men in long-term recovery from SUD experience empathy and resiliency in their recovery process?

This chapter describes the research model that was used to conduct the study, including a detailed description of the research design, sample population, and the data collection procedures. Information about the data analysis process and the researcher's plan for establishing trustworthiness are also provided. The chapter concludes with a discussion of the ethical considerations of the study.

Research Model

The rationale for the narrative inquiry model for this study was to provide an opportunity to increase awareness, insights, and storytelling of the lived experiences of African American men in long-term recovery. A narrative approach creates an opportunity to better understand how these men sustained their long-term recovery for 10+ years and the role that empathy and resiliency played. Holstein and Gubrium (1995) indicated that a narrative methodology is necessary to construct stories, narratives, and subjective meanings in marginalized communities to address behavioral health disparities.

In past years, narrative techniques of inquiry and depictions of outcomes have become more common in North American conference proposal presentations. The narrative technique was utilized to collect and convey data in this dissertation research; in addition, the researcher

and participants mutually agreed to edits and refinements of the narrative. The research endeavor and findings focused on the storied experiences of people in recovery, represented in their life narratives. With these, the researcher reached a deeper insight into the conscious experience of recovery and built a framework for these voices to be heard.

Wang and Geale (2015) used a contemporary social constructionist epistemological lens in their study to reveal changes in meaning-making via the procedure of narrative restoration. People define and communicate their perspectives of themselves, other individuals, and the world they live in when they tell stories. Chaos and chaotic events may be organized and arranged through narrative, and the pieces can then be molded into a cohesive whole. Narratives, therefore, help to structure memory and experience (Wang, 2017; Wang & Geale, 2015).

Narrative inquiry presents knowledge as constructable and uncertain and suggests it is composed of psychosocial phenomena that are dependent upon human conceptions and interpretations (Smith, 2016). The exploration of the experiences of the participants necessitates a method that will capture their own interpretations of their experiences within the setting. Narrative inquiry was selected as the research model for this study to gather narrative data from participants who have perspectives and experiences that are directly relevant to the research problem and research question of the study. As the participants' experiences with SUD and recovery spanned a minimum of 10 years, this method elicited relevant personal stories from participants (Caine et al., 2013). With this method, the researcher aimed to understand how individuals construct stories, or narratives, about their experiences. Effectively addressing the research question and refining the results required insight into the complete journey participants experienced from addiction to long-term recovery, making narrative inquiry the ideal approach (Caine et al., 2013).

Smith (2016) discusseed the assumptions inherent in the narrative analysis method, as well as how it differs from other forms of qualitative analysis. Other forms of qualitative research, such as phenomenology and discourse analysis, aim to capture the lived experiences of the participants. However, such methods do not center the stories of the participants in a way that allows the researcher to posture narrative as a tool to analyze these experiences (Clandinin, 2006).

Theoretical, Historical, and Philosophical Underpinnings

The theoretical and historical foundation of narrative studies is based in literary and linguistic theory of the 20th century (Gudmundsdottir, 1997). Cultural anthropologists were the first and best-known qualitative researchers. Other qualitative narrative methods were used by renowned psychologists, such as Freud, who studied and published case studies from his patients. Rogers was known for utilizing transcripts of therapy, and Piaget's clinical method examined clinical interviews (Fritz & Kantonsschule, 1983; Gudmundsdottir, 1997; Mayer, 2005; Miller & Moyers, 2017).

The narrative method is intrinsically interdisciplinary, and it is a natural extension of social science analytical methodologies. For example, when a researcher collects information within stories, the description lends itself to a qualitative inquiry. Surveys, questionnaires, and quantitative assessments of behavior are insufficient to convey the diversity of meaning inherent within histories. The conventional scientific theory uses a rational and empirical methodology to arrive at an objective account of the world's forces, with scientists attempting to observe outside the subject area. Denzin and Lincoln (2018) observed, "All qualitative researchers are philosophers" (p. 19).

The philosophical underpinnings originated during the 1600s and were influenced by modernism. Modernist concepts of logic, universal truth, and scientific models to problem solve predate modernity (Wang & Geale, 2015). Postmodernism, a term coined in the late 20th century, calls into question earlier empiricist and idealist conceptions of the concept of "objective fact." This ideology emphasizes the legitimacy of different viewpoints and situational understanding of issues. According to postmodernism, some individuals and groups of individuals create knowledge. This view suggests that reality is multiperspectival, and truth is rooted in daily people's experiences and personal relations. Life is a text to a postmodernist, but thought is a process of a conceptual act; facts and principles are inextricably linked, and scientific research and all other human activities are intertwined (Wang & Geale, 2015).

People live storied lives, and their lived experience tells the tale of stories that often shape society and create numerous elucidations and viewpoints. Personal experiences can inform, make sense of shared experiences, and lay the groundwork for new truths that are revealed; these stories represent a way of knowing. Denzin and Lincoln (2018) noted,"It is in the study of the unique and the contextual that narratives have succeeded where other methods have failed" (p. 343).

Narrative analysis consists of a method of engaging in storied data, with the assumption that stories are not simply a record of experience but instead provide an important role to individuals (Smith, 2016). Other assumptions inherent in the method include that of ontological relativism and epistemological constructionism. Ontological relativism views psychosocial phenomena as dependent on the people that create it as opposed to entities that exist independently. Epistemological constructionism views knowledge as constructed by individuals and associated with a likelihood of error (Smith, 2016).

Narrative analysis can be conducted in different ways, one of which is narrative constructivism (Smith, 2016). Narrative constructivism is individualistic and views narrative "as a cognitive structure or process that is to be found inside the mind" (Smith, 2016, p. 204). Narrative, in this case, is viewed as both something possessed by individuals as well as a process that serves to help provide them with structure to experience their identities, and how they view others and the world. Within this approach, narrative is then viewed as being internalized, with the process of narrative allowing individuals to present an illustration of what exists in their minds, to impart an experience, and to provide the listener with a sense of their identity (Smith, 2016).

Smith (2016) concluded with a discussion of narrative constructionism that focuses on the sociocultural, conceptualizing people as "meaning-makers who use narratives to interpret, direct and communicate life and to configure and constitute their experience and their sense of who they are" (p. 204). The narratives themselves are derived from the social and cultural arenas in which individuals exist. This approach views narratives as a means of understanding others' stories and is utilized by researchers to develop participants' personal stories.

Thus, a distinction exists between narrative and story, with a story consisting of a tale told by people and narrative viewed as an available, personal resource that is used to help develop stories. In this view, although stories are told, narratives are used as a tool that helps the researcher to create and understand stories. This viewpoint leads to several implications: Stories are constructed from narratives as opposed to simply being composed by individuals, and stories do not perfectly reflect people's experiences or their minds. Additionally, stories are seen as something that can evolve, as opposed to something that is constant and unchanging. Stories then are never "final" and can continue to change as long as the storyteller still has the capacity to tell

the story. Finally, narratives are also viewed as embodied, in that the body and bodily processes are inherently connected with stories and the telling of stories (Smith, 2016).

Participants and Recruitment

Participants

The participants in this study were 15 African American men, ages 38-72, with 10 or more years in long-term recovery from SUD. There is no universally accepted number for what constitutes an adequate sample size in qualitative research, and a recent review of qualitative literature suggests that the range of participants for narrative inquiry is quite large, with as few as one participant and as large as several hundred participants (Lal et al., 2012; Patton, 2015).

This study used purposive sampling. In purposive sampling, the researcher selects participants who are likely to provide information relevant to the study based on the participants' experiences or demographics (Plinks et al., 2015). Purposeful sampling was appropriate to this study because it helped achieve representativeness of the participants selected, captured homogeneity in the population, and was useful for establishing comparisons to explain differences between individual responses (Maxwell, 2005). Random sampling is important in quantitative research to ensure that the sample accurately represents the larger population to make inferences and generalize findings. However, these are not the purposes or goals of qualitative research (Maxwell, 2005). In qualitative research, rather than a random sample, participants are selected purposefully to provide information-rich cases for inclusion in the study (Crouch & McKenzie, 2006; Plinks et al., 2015).

Recruitment

The researcher received approval from the Michigan School of Psychology's Institutional Review Board (IRB; Appendix B) to conduct the study. Participants were recruited through the

SUD treatment provider network throughout Michigan, via Facebook, and by Alcoholics Anonymous and Narcotics Anonymous facilitators. The SUD treatment provider network posted research recruitment fliers throughout their facilities, and the flyers stated the criteria for selection, a summary of the research purpose and intended outcomes, and the researcher's contact information (Appendix C). Participants were given a $25 gift card for full participation.

In addition, the AA/NA facilitators were asked to distribute research recruitment fliers outside of 12-step meetings to individuals who might be interested in participating. This method of recruitment was utilized successfully by DePue et al. (2014) in their study. The method had the benefit of protecting potential study participants' anonymity, which is a central tenet of AA and NA membership.

People interested in participating contacted the researcher via phone or email as indicated on the flyer. During this initial contact, the researcher screened individuals for their eligibility to participate in the study. To participate, individuals were required to meet five inclusion criteria: (a) identify as African American, (b) identify as male, (c) be at least 28 years of age, (d) identify as having substance use disorder, and (e) have been in continuous recovery from SUD for at least 10 years. If all the inclusion criteria were met, the participants were scheduled for individual semistructured interviews with the researcher. Participants were excluded if they had a personal relationship with the researcher or were currently receiving services at Detroit Recovery Project, which this researcher directs. A total of 15 individuals responded and met the inclusion criteria.

Informed Consent

Prospective participants were given the choice of face-to-face or Zoom interviews. If they preferred face-to-face, they met the researcher in a conveniently located private room. If they preferred Zoom, they met with the researcher through an online conferencing platform on Zoom.

Prior to beginning the interview, the researcher gave the individuals a copy of the consent form (paper copy for face-to-face interviews, electronic copy for Zoom interviews; Appendix D). The researcher formally engaged in the informed consent process by reading the consent form to the participants. The individuals then had the opportunity to ask questions and obtain further clarification as needed. After the individuals were fully informed about the study and if they decided to proceed with participation, they gave their consent by signing the consent form (face-to-face interviews). If the interview was conducted via Zoom, they gave consent by verbally indicating they would like to participate (consent was audio recorded in lieu of a signature).

Data Collection

Following the informed consent process, the researcher con ducted the interview. One interview was completed using Zoom as a form of computer-mediated communication. Fourteen interviews were completed face-to-face. The researcher began the interview process by asking questions from the demographic questionnaire (Appendix E). The demographic questionnaire was used to ensure that potential participants met the inclusion criteria of the study as well as to gather important descriptive information to help the researcher maximize variation in the sample. After gathering the demographic data, the researcher and participant engaged in a semistructured interview containing 10 questions (Appendix A). The researcher also asked clarifying questions, as needed, in an effort to follow the participant's train of thought. This approach helped the researcher capture the full story of each participant (Flick, 2019). Each interview lasted approximately 1 hour, and the follow-up interview another hour.

The researcher transcribed each interview verbatim at the conclusion of the interviews. All transcripts were deidentified. Participants' names were removed, and each participant was given a code name, such as P1, P2, P3. In a follow-up interview, the researcher asked all

participants to review their interview transcripts to ensure the transcriptions were accurate so they could clarify any statements made during the interviews. This was the process of member checking (Butina, 2015; Patton, 2015). Participants were given the option of having their interview transcript emailed to them, mailed to them, or hand-delivered by the researcher at a public place if they did not feel comfortable sharing their personal home address or email address. The 15 interviews took place over 3 months, February, March, and April 2022.

Data Analysis

Narrative analysis consists of a series of methods that focus on stories (Reissman, 2008). Specific methods include thematic narrative analysis, rhetorical narrative analysis, autoethnography, and other methods that contribute to understanding the layers of meaning in the data (Smith, 2016). For this study, thematic narrative analysis was most appropriate to analyze the data in consideration of the study aim and research question. This method focuses on the story's content—what is said by the storyteller—with the specific topics and themes present within the story deemed to be particularly relevant.

In addition, when using this method, the researcher conducts the analysis more as a story analyst rather than that of a storyteller, with results taking the form of a "realist tale" (Smith, 2016, p. 209). This realist tale is characterized by the absence of the researcher, an extensive presentation of the qualitative data to sufficiently illustrate the viewpoint of the storyteller, and a knowledge of a theoretical account of the story using qualitative data to explain the data. Instead of rehashings or summaries of the stories themselves, this type of analysis can produce an abstract account of the storyteller's narratives (Smith, 2016).

Other methods and approaches to qualitative analysis can be used for all types of qualitative data, but narrative analysis focuses specifically on the participants' experiences

through storytelling (Smith, 2016). In addition, although other methods of analysis may strongly focus on deconstruction of the data with coding, these methods are less intense in narrative analysis. One important tenet of narrative analysis is avoiding the use of "overcoded" analysis (Childers, 2014, p. 824). Instead, the goal is to maintain and preserve the story during the analytical process, examining all the detail contained within it but falling short of pulling it apart.

Narrative inquiry also strongly views a person's life and experience as being constructed culturally and relationally and differs from some other forms of qualitative analysis in this way. Further, narrative inquiry focuses more sharply on the structure of the story, as well as what is not said. These emphases differ from other methods, such as first method and second method, that maintain a stronger focus on the story itself (Smith, 2016).

Narrative inquiry was selected for use in this study for several reasons. First, it allows for a deep understanding and insight into respondents' stories by analyzing data that contains, in rich detail, the experiences of individuals, their emotions, and the meanings inherent in their relationships with other people (Smith, 2016). In addition, narrative analysis can produce a great deal of theoretical information from the stories analyzed, provide results that may be better understood by the public, and allow for easier knowledge translation (Smith, 2016).

The first step in analysis involves reading and rereading transcripts to identify points of potential analytical interest. In this step, the researcher reads through the transcript several times and identifies areas of preliminary interest in the interview (Braun et al., 2014). The second step involves arranging related phrases or groups of phrases into codes, and these are labeled with descriptive words or phrases. The descriptive labels include preliminary or emergent codes that arise from the interviews (Braun et al., 2014). In the third step, similar codes are grouped into larger themes, which are also labeled with descriptive phrases. Larger themes consist of a

combination of smaller emergent codes that were identified in the second step (Braun et al., 2014).

The fourth step involves reviewing and revising themes to identify relationships and organize the analysis (Braun et al., 2014). In the fifth step, the researcher engages in a detailed analysis of the data to verify themes and refine the organization. Finally, in the sixth step, a final refinement of the analysis is completed with themes representing the data, and a presentation of the results is prepared and presented (Braun et al., 2014).

Efforts were made by the researcher to validate these data. These efforts included member checking, procuring an expert audit review, and clarifying researcher bias (Butina, 2015). As noted above, member checking involved presenting interview transcripts to the participants, as well as the researcher's thoughts pertaining to the analysis, with drafts of the completed results. The respondents reviewed these items to ensure that their thoughts were represented accurately and any corrections they specified were made (Butina, 2015).

The researcher's dissertation committee members served as the dedicated experts to evaluate the data analysis and provide critical insight on the quality of the analysis conducted. Finally, biases that the researcher believed the committee members had were openly discussed to provide an illustration of how this research and the results found may have been shaped by researcher biases (Butina, 2015).

Issues of Trustworthiness

Trustworthiness is the degree to which the researcher can ensure confidence in the study's procedures and results (Guba, 1981). In qualitative research, trustworthiness is shown by the establishment of credibility, transferability, dependability, and confirmability (Connelly, 2016). Each of these components is discussed next.

Credibility

Credibility is defined by Guba (1981) as how well a study's findings accurately represented the experiences of the participants. In the current study, three steps were taken to show credibility. First, triangulation was utilized, which involves testing information through multiple sources (Patton, 1999). Triangulation improves the credibility of research by reducing the probability that the conclusions made are affected by a particular source or method (Maxwell, 2005). Responses were checked against other sources, such as the follow-up interviews, other interviews conducted by the researcher, and other empirical research.

Second, member checking was utilized. Member checking assisted in confirming that the findings were consistent with the experiences of participants and increased the credibility of the results (Creswell & Miller, 2000; Lincoln & Guba, 1985). Member checking also facilitated the comparison of responses to enable richer analysis. During the follow-up interviews, participants were asked to review their narratives and provide any information that they missed.

Finally, the researcher utilized reflexivity throughout the data collection and data analysis process. This method allows researchers to identify the lens through which they viewed their work and how their own background influenced data collection and analysis (Lincoln & Guba, 1985). Through reflexivity, the researcher identified ontological and epistemological position and biases. The researcher noted the ontological and epistemological position in the description of the methodology of the current study as well as any biases that emerged during the study.

Transferability

Transferability refers to the generalizability of a study's results (Maxwell, 2005). Two steps were taken to show transferability. First, rich descriptions of the findings are provided to the reader in Chapter IV. These findings are supported by verbatim participant quotations. As a

part of these descriptions, negative cases and rival explanations are included. Both descriptions and rival explanations provide evidence to the reader about the depth of analyses and fit of codes and themes identified (Creswell & Miller, 2000; Patton, 1999). Providing rich descriptions of the findings enables readers to understand if the findings are applicable in other contexts or not (Lincoln & Guba, 1985). Second, the researcher maximized the demographic variation of participants through purposeful sampling, consistent with recommendations (Connelly, 2016; Guetterman, 2015).

Dependability

Dependability is the measure of how consistent and reliable study results are and the extent to which the research process has been documented (Moon et al., 2016). Threats to dependability include insufficient descriptions of the methodology (Lincoln & Guba, 1985). For this study, methodological memos were used to detail the methods used and decisions made during data collection and analyses. The memos enabled the researcher to provide a detailed methodological description of the data collection and analyses before reporting the findings (Birks et al., 2007). The methodological description detailed the alignment between the problem statement, research questions, and research design. Providing this detailed methodological description allows the readers to scrutinize the procedures used in the current study (Lincoln & Guba, 1985).

Confirmability

Confirmability is the ability for others to confirm or corroborate the findings of a study (Moon et al., 2016). Threats to confirmability include insufficient descriptions of data collection and analysis, insufficient evidence provided to support findings, and researcher bias (Lincoln & Guba, 1985). The researcher ensured confirmability through the processes of providing a detailed

description of data collection and analysis, rich descriptions of the findings, and reflexivity as outlined above.

Ethical Considerations

Before beginning data collection, the researcher received IRB approval for this study from the Michigan School of Psychology's Institutional Review Board (Appendix B). During data collection, the researcher ensured that informed consent was obtained from all participants by inviting questions and supplying explanations as needed. The researcher also informed them that participation was voluntary, they could decline to answer any questions they were not comfortable answering, and they could discontinue the interview at any time. Participants were encouraged to inform the researcher if they felt uncomfortable during the interviews.

Once participants approved their interview transcripts all identifying information was removed from the transcripts to ensure that participants could not be identified in the final presentation of the data. All interview transcripts and audio recordings will be kept in a secure location (a locked desk and password protected computer) for 5 years before being destroyed. Participants were offered copies of the final study if they wished to receive it via mail, email, or in-person delivery.

Finally, this researcher adhered to the tenets of the Belmont Report, which was written by the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research in 1976. The Belmont Report outlined several key principles that should guide all research studies. These tenets include maintaining respect for participants, beneficence, and justice (U.S. Department of Health and Human Services, 2021). In keeping with the first principle, the researcher treated each participant with dignity and respect. The researcher did this by approaching participants with courtesy, answering their questions honestly, and following

through on all promises made to participants, such as keeping their data confidential and representing their experiences accurately (U.S. Department of Health and Human Services, 2021).

The researcher ensured beneficence by treating all participants equally. Participants were asked the same protocol questions in the same order. Their data and confidentiality were handled in the same way. Finally, the researcher ensured justice was accomplished by sharing the results of the research with each participant and the academic community (U.S. Department of Health and Human Services, 2021).

Summary

The purpose of this qualitative narrative inquiry was to develop an understanding of whether and how empathy and resiliency contribute to long-term recovery from SUD. To fulfill this purpose, the study answered the following research question: How do African American men in long-term recovery from SUD experience empathy and resiliency in their recovery process? Narrative inquiry was selected for this research to gather narrative data from participants who had perspectives and experiences that were directly relevant to the research problem. Recruitment, data collection, and data analysis methods were described.

The findings of the data analysis are presented in Chapter IV. First is provided a biographical sketch of the participants that details the key elements of their life experiences. Following the biographical sketch, the themes generated from the data are presented in response to the research question. Finally, the findings are presented based on the biographical sketches and themes. These two data presentations provide a detailed response to the research question and serve as the results of the study.

Chapter IV – Results

This chapter presents the findings of the data analysis for the study. The following research question was explored: How do African American men in long-term recovery from SUD experience empathy and resiliency in their recovery process? The data were collected from a purposive sample of 15 African American men, ages 38 to 72, with 10 or more years in long-term recovery from SUD. The participants were recruited through the SUD treatment provider network throughout Michigan, via Facebook, and by Alcoholics Anonymous and Narcotics Anonymous facilitators. The semistructured interviews were conducted one-on-one (with one on Zoom) and transcribed verbatim prior to analysis. The timeframe in which this research took place was during February, March, and April, 2022.

All participants were given the opportunity to review their interview transcript to ensure the transcription was accurate and to allow them to clarify any statements made during the interview. The data analysis method used was thematic narrative analysis (Smith, 2016; Sundler et al., 2018), which encompassed iterative coding of transcripts after interviews were transcribed; reviewing the codes from previous interviews; and refining, combining, or splitting codes, followed by combining codes into categories and then categories into themes.

The analysis of the semistructured interview transcripts produced 13 codes. These were embarrassment/shame, role of luck/accidents, cognitive empathy failure, counseling agent dissimilarity, misunderstanding of own motives, trust and responsibility, relapse, understanding dependency, conscious desperation, subjective hopelessness: not a sufficient reason to quit, learning from others, perceived empathy, and lack of attachment/loyalty to co-users. The 13 codes enabled the researcher to uncover a narrative nuance and insight within the main inquiry of this study (i.e., cognitive empathy and resiliency and their roles in SUD recovery).

The codes were combined into four themes: (a) The cycle of relapse and shame makes resiliency very hard to attain; (b) detachment leads to a lack of cognitive empathy; (c) trust, love, and understanding lead to cognitive empathy; and (d) misunderstanding of self and by others leads to low resiliency. The four themes allowed the researcher to organize and interpret rich narratives of SUD and recovery. Each of the themes required two or more codes to support the exploration of the narratives of SUD and recovery. The decision rules for combining codes into categories and categories into themes are discussed in the presentation of the results below.

Participant Demographics

Table 1 shows key demographic characteristics of the research participants. All 15 participants were adult African American males, these characteristics were included in the table.

Table 1

Participant Demographics

Participant	In recovery since	Age	Marital status	Primary occupation	Household income	Highest level of education	Experience in therapy
P1	1987	56	Married	Landscaper	>=$99,000	Some college	Y
P2	1988	61	Married	Education and training	>=$99,000	Master's degree	Y
P3	1980	68	Single	Addiction consultant	$70,000-$80,000	Master's degree	Y
P4	1986	65	Married	Consultant, assistant professor part-time	>=$99,000	PhD	Y

Table 1 (continued)

Participant	In recovery since	Age	Marital status	Primary occupation	Household income	Highest level of education	Experience in therapy
P5	2006	59	Single	Disabled, formerly postal worker	>=$99,000	Associate's degree	Y
P6	1990	54	Single	Real estate	$30,000-49,000	Some college	
P7	1991	61	Married	Therapist	>=$99,000	Master's degree	Y
P8	2010	57	Married	Recovery coach	>=$99,000	Bachelor's degree	Y
P9	1997	53	Single	Auto worker	>=$99,000	Associate's degree	Y
P10	2000	57	Single	NGO program manager	>=49,000	Bachelor's degree	Y
P11	2008	38	Common law married	PhD student	$30,000-$49,000	Master's degree	Y
P12	1990	57	Single	Peer specialist	$30,000-$49,000	Trade school/ Associate's degree	Y
P13	1986	72	Widowed	Retired from city of Detroit	$10,000-$30,000	Some college	Y
P14	2005	43	Married	Counselor	>=$99,000	Bachelor's degree	Y
P15	1992	53	Married	Diesel technician	$50,000-$70,000	High school	Y

Because of the study's emphasis on understanding the experience with empathy and resiliency of individuals in long-term recovery (10 or more years), the sample of participants skewed older. Participants' ages ranged from 38 to 72, with a mean age of 56.93 and a standard deviation of 8.35. The majority of the participants were middle-aged (45-65), one was an older adult (72), and two were younger adults entering middle age (38 and 43, respectively). These statistics were also congruent with the interview accounts, suggesting that most respondents embarked on recovery in their mid- to late-20s. All of the respondents had experience with at least one form of therapy and treatment; however, 13 of 15 reported experience in multiple therapeutic settings (e.g., individual, group therapy, inpatient treatment, intensive outpatient).

Another by-product of the research design (respondents in successful, long-term recovery) was that the research participants had levels of education that were above average: All but one respondent reported some form of higher education, and six out of the 15 reported postgraduate degrees. Accordingly, their reported household incomes were also in the upper percentiles, with eight out of the 15 reporting household incomes of $99,000 or above. The respondents reported a range of occupations, but it was notable that almost half, or seven out of the 15, reported occupations in some form related to addiction recovery and coaching. In sum, the sample of participants met a goal of the study: to select a set of respondents suitable for understanding characteristics of successful long-term recovery.

Narrative Thematic Analysis

The qualitative data were analyzed from the 15 semistructured interviews. The first phase of the analysis was repeated coding until the full set of codes went unchanged for two consecutive rounds of coding the 15 transcripts. Specifically, the repeat coding was stopped upon the second consecutive round of coding. In this round, no new codes were elicited, no reduction

of extant codes into more specific codes took place, and no converging of extant codes into the same code was found (Saldaña, 2015). The coding took three rounds to achieve two consecutive rounds of coding with no changes to any of the codes.

Following the first round of coding, modifications were made in the second round. Between the second round and the third round, no changes were necessary. Thirteen codes were extracted upon the second consecutive round of coding, with no changes in the third round. The codes were generated based on following the respondent narratives without preconceived notions. The only pre-existing aid in grouping the codes was for the researcher to prioritize narratives relevant to the main factors for SUD recovery of interest in this study—resiliency and cognitive empathy.

Once finalized, the codes for the semistructured interview transcripts were combined into themes based on their conceptual similarities. Accordingly, and unlike the coding, categorization of themes was not iterative but rather interpretive. Each theme was required to include at least two codes (Saldaña, 2015), but more were possible as appropriate. For example, the codes *lack of attachment and loyalty to co-users, counseling agent dissimilarity, learning from others,* and *perceived empathy* were grouped under the theme *Detachment leads to lack of cognitive empathy.* The grouping of the 13 codes resulted in four themes.

The decision rule for combining categories into themes was that they contributed to the enunciation of the key narrative themes that emerged across the interviews as related to resiliency and cognitive empathy in SUD and SUD recovery. The four themes identified were the following:

- Theme 1: The cycle of relapse and shame makes resiliency very hard to attain
- Theme 2: Detachment leads to a lack of cognitive empathy

- Theme 3: Trust, love, and understanding lead to cognitive empathy
- Theme 4: Resiliency is influenced by the capacity to understand self and others

General Results on Cognitive Empathy and Resiliency

Before the more nuanced analysis of the narrative data is presented, two more general findings need to be highlighted, namely, the fundamental role of empathy in SUD recovery overall and the meaning and timing of resiliency. With no exception, all respondents emphasized that perceived empathy from different sources (not necessarily a professional but very often so) had been fundamental to their achieving a turning point of committing to recovery. It was almost difficult to select the most illustrative quote among so many, but the words from P5 below describe the sentiment well:

> And I met some people down there that was in the program in NA program, Narcotic Anonymous and that's where I met this one pastor he gave me a card and said, "When you're ready give me a call." And I remember one weekend, because every month, first of the month I get a check. So I'm always thinkin' of how I'm going to stretch this money to the end of the month. And I never could do that right there. I always said that I wasn't going to smoke or wasn't going to get high, I'm going to try to sell this, do that. But the only thing about it, couple hours in or maybe that day I might have been all right, but the next day, a couple hours in, I was up . . . . The whole plan that I had mastermind had already fell through.

Further, it was clear that the lines between empathy and compassion were sometimes blurred. Although empathy and compassion had similar effects on respondents' state of mind, entirely unsurprisingly, compassion was more likely to be manifested by friends, family, and community members. Cognitive empathy was significantly more likely to be manifested by therapists, family, and loved ones.

Especially strong evidence for the latter case was the finding that many of the therapists were not former addicts, and therefore were able, and indeed forced, to provide effective care

based on knowledge and the ability to rationally process respondent circumstances—the very definition of cognitive empathy. In the words of P2:

> I just remember I felt safe and understood and whatever that relationship, well, I can't even tell either person's name or anything about the person, but I just remember the experience and the respect that I had for that professional person that so often sat in front of me doing those experiences. So, I don't know her name or anything. I just remember how they made me, that whole idea, how she made me feel and just like a high-quality person.

P7 had a similar comment:

> He understood what I was going through, he impacted me. You know what I mean? He helped me to battle through those thoughts and feelings in early recovery. Because he was dealing with them himself. He just had the ability to be honest, when a lot of people hide, and hide behind God and hide behind information, but don't really tell the truth. So I'm grateful that I was hanging around him, hearing the truth. Not from experienced people, we were both new in recovery. He just had the ability to be real. A lot of people, when I came in this process, people was quoting a book and talking about God but wasn't talking about themselves very much. This brother was talking about himself, which helped me identify and be able to talk about myself, be able to help me so that I would be the person I am today, that I don't have no secrets.

In summary, a key finding was the fundamental importance of empathy as a contributing, or sometimes sole, factor for respondents to experience a “turning point” and truly commit to recovery. Repeatedly, respondents emphasized that others seeing them as valuable human beings (as opposed to viewing themselves as merely “junkies” or “drunks”) was pivotal in their ability to commit to long-term recovery. The nature and the source of this empathy seems to have been of secondary importance compared to the fact of their experiencing it. Conversely, the inability of community members or caregivers to manifest such empathy and act accordingly have sabotaged some initial attempts to pursue recovery. In the words of P3:

> And I had to explain to him why I was in the church. "I'm seeking the Lord," I remember saying something like that to him. He said, "Sit back here." So he separated me from the rest of the congregation. I was like, "Man, fuck this." So I felt rejected by God, and I remember leaving that Church and walking down the street saying, "Damn, even God don't want shit to do with your ass." You know what I mean?

P12 related a comparable incident:

> One was when the intake specialist looked directly in my eyes, she was doing an intake. She said, "How long did you know you was a dope fiend?" And I never heard it like that. That stung. I was like, "Damn, this bitch just said I was a dope fiend." And it was true. I was mortified in that interview. She was like, "How long did you know you was a dope fiend?"

The importance of empathy also proved to be significantly related to the notions of resiliency and commitment to recovery. Resiliency was manifested by respondents in many different meanings and roles, some unrelated or not conducive to recovery. Indeed, the addiction lifestyle itself and the attendant challenges (e.g., homelessness, social isolation) required a great deal of resiliency, which all of the participants demonstrated.

Thus, instead of "mere resiliency," the resiliency to persist in recovery seemed to be the result of increased self-awareness, the participants' nascent understanding that their lives could be different and better, and their experience of empathetic community support, professional treatment, or both. Once they attained this level of commitment based on self-understanding, knowledge, and empathy, the commitment to stay strong in recovery appeared thoroughly internalized and unshakeable, as well illustrated by the words of P1:

> You start feeling like, man, if that person could go through that and talk about it, you know what I'm saying? I could talk about what I went through. You know what I'm saying? And now, I don't know, each one teach one, you know what I mean? And it's like, once you start talking about it, you see other people okay with you, now you start feeling okay with you.
>
> I think for me, the hopeless piece is that I don't have no hope for me, it ain't that other people don't have hope for me, I don't have no hope for me. But when I see other people having hope for me, I start having some hope for myself, man. I see other people ain't judging me based on that crazy shit that I did, I don't have to judge me no more. Yeah.

P12 corroborated this outlook eloquently:

> My experience now is I feel like I've developed a conscious contact with a higher power. When I say a conscious contact, a relationship, and a communication, an attachment, a dialogue, a closeness with a power that's greater than myself. It's something outside of me. The brotherhood carried me to when I found my own God. And I believe that relationship with that God, through my troubles, and my trials, my tribulations, and my troubles have revealed a message to me. And it's about one of my biggest problems is I'm

> not aware of certain things I do. I do things just because it's a part of my environment and part of my development. And I do certain things, but it is just because I've been conditioned to be that way. And if it don't bring me a lot of trouble, it's hard for me to see them. I got a lot better at it now.

Finally, before the presentation of the analysis of the specific themes, it is worth mentioning that in four cases it appeared that accident and serendipity may have played a significant role in the participants' embarking on—or at a minimum speeding up—the road to recovery. Certainly, it was implausible to argue that pure accidents triggered commitment to recovery alone and could fully account for it. It is more plausible that budding self-understanding reached a point where a minor event may have triggered the process.

Nonetheless when service providers miss cues to act and fail to help addicted persons seeking help, the delay caused in the process will certainly negatively affect individuals who are in the early stages of contemplating recovery. The accounts of P5 and P11 are two of the four instances illustrating the role of serendipity, combined with the role of luck/accidents.

P5 recounted:

> And I remember I was in this hotel, the last time I used was right across the casino, the Viking Hotel, whatever it is. And I was in there with this girl, and something just told me you can't keep doing this. You can't keep doing this. And actually, I was going down to commit suicide to jump in the river, to tell you the truth. So I'm walking down Grand River, I had my stem with me, I threw it against the building. I said, Ah, this is it. Because I just didn't have any motivation, anything at that time. Walking down to the river and had my cell phone, though, I had a cell phone and something told me . . . . I don't know how the call came about, but it came to my hand and said call that number. And it was probably about 7 or 8 o'clock at night, I said, he ain't coming, he isn't going to come.
>
> And I called and he said, Where you at? I said well, I'm almost at Jefferson and he said, What are you doing' I said, I'm just going by the lake, I ain't really telling what I was about to do. He said, Just wait right there, I'll be there to get you. And came and got me and spoke with me and told me you can do something else. First you might want to go into treatment, I said yeah, I need to. That's when I went into treatment and really thought about what I was doing. And he told me after I get out of treatment, I've got a place to stay, which is Emmanuel House.
>
> So I went there for about 3 months that time, cleaned up. Every time I would get clean, my thoughts would get clear and I'll be on the right path as long as I didn't do anything to harm that. Once I got on the right path I went to Emmanuel House. I didn't

> like it at first because it was a strict program, it was a program where you couldn't go nowhere. The door was open though; you could leave anytime you want to. But you just couldn't. I couldn't leave because I knew I needed it. And plus, I was told that I wouldn't make it so I made sure that I was going to do everything that they asked of me during that time.
>
> I stayed with them for 11 months. And I said would never . . . the reason I'm not going to use to date is because I never want to sit in a room. . . . it was four bunk beds and there was a room about six by nine and four guys in it. And I'm going to tell you, I never want to be in that situation again where I have to live like that. And plus, because I had an income they charged me, and I didn't like that.

P11 gave his version of serendipity:

> So realizing there was anybody else like me out there gave me some hope and then starting to just, I guess, I would say internalize the lessons that I was hearing in the meetings and reading the literature and stuff. Reading stuff, paraphrasing here, but basically a program of men and women that have found their way out of active addiction, just reading stuff that gave me a lot of hope. Because it was like, this is possible. And then I think over the years, of course there have been some setbacks, life is full of ups and downs, but I think always remembering that . . . ... I remember this old timer told me a while ago when I was struggling. He's like, "Man, the worst part of your life is over," being, my active addiction was over. And always holding onto that. If I'm able to get through that, I'm able to get through pretty much whatever else.

Results of the Narrative Thematic Analysis: Interview Codes

Thirteen codes were generated based on the 15 interview narratives of respondents' experiences with SUD and their road to recovery, especially regarding cognitive empathy and resiliency. In this section is a presentation of the code label, an illustrative quote, and the number of participants engaging with narrative under this code. Because most participants returned repeatedly to key issues, the description also includes the total number of instances they mentioned the coded issue.

It would be impractical to provide a full set of quotes illustrating a given code or theme; thus, only one representative quote is selected, and the others are counted. The codes address different aspects of the respondent narratives, including experiences while using a substance, key events, and descriptions of situations that contributed to or detracted from their decisions to

commit to recovery. For example, the notion of *shame* was a staple that was explicitly discussed in multiple narratives.

Although shame alone was never the sole impetus to pursue change, it was certainly related to many aspects of the addiction and recovery experience. Many respondents referred to shame. In particular, P10 remarked,

> One of the saddest days of my life was at the end of that year, my mom was in the bathroom and the Father or somebody from Saint Ignatius called my mom and asked her, told her that they didn't want me to come back.

Another notable code was *cognitive empathy failure*. Respondents described multiple instances of different situations in which they felt misunderstood and stigmatized, and in all such cases they became discouraged and as a result recovery was postponed. The scenarios of the discouragement ranged from mere perception and respondent misunderstanding (P1: “People were at the meetings, and I just never could identify with them. They were all older than me, one thing, and a lot of heroin addicts, and I thought heroin addicts were addicts.”), to explicitly feeling misunderstood or disrespected (P3: “And I was like, ‘Man, hell no.’ It was too street for me. The way they were talking—it was disrespectful.”).

While most respondents were able to identify multiple “low points”—instances of hopelessness and desperation—one important finding that emerged is that having reached such a low point alone is often insufficient to prompt a commitment to recovery. The impetus to recovery is always a combination of an addict’s feeling of hopelessness with an instance of empathy or improved self-awareness, or a serendipitous event that may result in a road to recovery. This common pattern is most comprehensively illustrated in this comprehensive quote from P3:

> Ms. [redacted] no matter what, would always dig, man. She always conversed with my innocence, she never talked to me like I was an alcoholic or a druggie. She always talked to me like I was a nice guy, right. I read an article, I ain't read it yet, but I saw it twice.

> And that's all I needed, was to see it. And they were talking about hitting the bottom, a person needs to hit bottom, to lose everything, right? And these two people were calling bullshit. They were saying, "Ah. I ain't, nah. They need support all the way through until you reach their point." And I feel that if the Ms. [redacted], remember I told you about Ms. [redacted] and [redacted], I believe if I have spent more time, or if Ms. [redacted] and [redacted] knew what to do . . . I wouldn't have had to hit the bottom that I did. You see what I mean?

This narrative highlights the interrelatedness of issues and the importance of cognitive empathy and related addiction treatment skills, most relevant for caregivers and professionals. No matter how supportive individuals from a respondent's circle were, most often this support was not enough. Significant professional knowledge and skill were also needed to mitigate addiction.

Lack of self-awareness and of understanding addiction was also identified as a notable code (labeled *misunderstanding of own motives* in Table 2). Many substance users, especially those struggling with alcohol and marijuana, acknowledged that they spent a long time under the impression they were simply "having a good time" rather than being addicted. This interpretation highlights the importance of information and education also, as most of the respondents reported spending significant amounts of time in the addiction lifestyle without *understanding the nature of their dependency* (relevant narratives grouped under code with the same name). They attained this understanding only after a difficult personal journey or after the opportunity to be involved in any kind of treatment.

To enhance understanding of the collected narratives, it was also important to connect the codes into broader themes to provide a more coherent and nuanced picture of the SUD recovery experience. Following the coding of interview data, the codes were reviewed for conceptual similarity. The focused factors of this study—cognitive empathy and resiliency—are very general and broad lenses to examine SUD recovery.

Thus, the general logic used for the grouping of codes into themes focused on the researcher's deriving commonalities of how the role of cognitive empathy manifested in the experience of this sample of former addicts, both individually and in relation to one another.

The main finding underpinning the four themes is that in addition to having undeniable direct effects, cognitive empathy and resiliency interact in intriguing and nuanced ways in the experience of former addicts. It is these interrelationships that better account for the role of these factors in recovery rather than their direct effects considered in isolation. With these respondents, it appeared that the presence of cognitive empathy was a fundamentally important factor for the onset of resiliency. A related factor is knowledge—of self, of the nature of addiction, or of others' experience. In the absence of such knowledge, substance users tend to internalize their addiction as purely personal failure, which in turn leads to a sense of hopelessness and surrender (i.e., inability to pursue recovery until the knowledge deficit is rectified via a relevant experience).

Thirteen codes were derived from the narratives of individuals participating in interviews. Each of the 13 codes was applied to multiple interview responses, with many of the codes used numerous times. Table 2 displays the codes with the number of participants' interviews the codes appeared after analysis and the frequencies for each code. The following section presents a discussion of each of the 13 codes applied to participants' responses from the interviews.

Code 1: Embarrassment/Shame

The most frequent code found in the data was embarrassment/shame. The code was applied to 14 participants, and the code was applied 31 times. Like other codes, the code was applied several times to participants. Embarrassment/shame was applied to sections of text from interviews that appeared to describe an emotional experience in which participants felt

humiliated or foolish because of their behavior. In several instances, the code was applied because individuals used it as a descriptor, and the descriptor appeared to be the best single word to summarize their response. An example of the code in use was in P7's response: "I didn't truly experience hopelessness until I started experiencing some of the suicidal ideation, right? Where guilt and shame became unbearable."

Table 2

Codes and Frequencies

Code	Number of participant interviews	Frequency
Embarrassment/shame	14	31
Role of luck/accidents	6	11
Cognitive empathy failure	9	18
Counseling agent dissimilarity	7	11
Trust and responsibility	9	10
Relapse	7	9
Understanding dependency	6	18
Conscious desperation	8	17
Subjective hopelessness: Not a sufficient reason to quit	9	15
Learning from others	4	7
Perceived empathy	12	37
Lack of attachment/loyalty to co-users	6	9

Code 2: Role of Luck/Accidents

Tied with two other codes for the code applied to the second lowest number of participants was the role of luck/accidents. The code was applied to only six of the participants, for a total of 11 times, and more than once in some interviews. The role of luck/accidents was the code selected as the most appropriate code for certain sections of text because the code appeared to describe an incident that occurred in participants' lives where something unexpected, either good or bad, occurred. The event had a notable impact on the narrative of the participant within the scope of the purpose of the study.

Several participants used the words *lucky* and *accident*, but the code was only applied where it appeared to fit within the context of what the participant was saying. P11 discussed the role of luck:

> The magic. I would say to me, the magic is this. This is the magic. It's about three components. One is it's the people you meet. If you lucky enough to meet people that you identify. I'm going to be honest. I just felt I was lucky. I don't think the young people that walk in the door are able to have the kind of relationships I had when I got here. I don't think they are afforded that.

Code 3: Cognitive Empathy Failure

Cognitive empathy failure was tied with four other codes in terms of the participants' use. Cognitive empathy failure was used as a code a total of 18 times by nine participants. The code was used multiple times in some interviews. Cognitive empathy failure was selected as a code after the researcher reflected on the messages individuals appeared to be conveying during interviews. The presence of cognitive empathy failure in their lived experience was a characteristic of their substance use and path to sobriety that could have created a barrier to their acceptance of treatment. Among participants where the code was applied was P10, who stated, "And I was like, 'Man, hell no.' It was too street for me. The way they were talking—it was disrespectful."

Code 4: Counseling Agent Dissimilarity

Counseling agent dissimilarity was used as a code for seven participants. The code was used a total of 11 times among the seven participants and used once for most of the interviews it was applied to. Counseling agent dissimilarity emerged as a code from the process of iterative coding, where two similar codes were combined. The code was formed based on the differences between participants and their counselors' roles in their treatment.

The experience of counseling agent dissimilarity contributed to the participant overcoming substance use. Of the several participants to whom the code was applied, sections of text from P1 were coded with counseling agent dissimilarity. P1 stated, "I'm lucky because if my clinician was not prepared, I probably would've been distracted about who they were instead of who I was."

Code 5: Misunderstanding of Own Motives

Misunderstanding of own motives was applied as a code to nine of the participants. The code was applied a total of 13 times in interviews and only once by each participant to whom the code was applied. Misunderstanding of own motives became a code based on responses in which participants shared experiences of how they coped with their lifestyle by rationalizing decisions made that related to substance use and decisions about recovery. While several participants received misunderstanding of their own motives as a code, some comments appeared to be stronger examples than others. For example, P1 said,

> So you must feed yourself a lot of nontruths just to keep going, just to make sense out of your own life, just to rationalize the life that you have. I couldn't say all right, so I made homelessness some virtue, there was something virtuous about the ability to live outside of a normal.

Code 6: Trust and Responsibility

Trust and responsibility was a code applied to nine participants. However, the code was applied only 10 times in the interviews. All but one of the participants who received the code received it only once in the interview. Trust and responsibility became a code due to responses by participants describing how they experienced trust and responsibility from people within their families and social circles. The code was applied to several participants, but not as frequently as other codes. A strong representative comment was from P7:

> I was conflicted with the real me and the lesser of me running the show and taking over. That side of me who ran from responsibility, and was operating in drug use, and a constant conflict with God's will. It was a constant conflict with my moral compass because I knew better. I was taught by heroin addicts and crack addicts, don't touch drugs. You can sell them, but don't use them. You could sell them, but don't use them.

Code 7: Relapse

Relapse was applied to seven of the total participants in the study. For these seven participants, the code was applied nine times. Relapse was selected as a code because it was an experience that participants had during substance use or recovery. In many cases, a feeling that everything was under control was a precursor to relapse. Relapse was applied only once to most of these participants but is a critical code in understanding the lived experience of participants. A quote from P15 supports understanding the code from the standpoint of participants' specific words of participants: "So I went to jail and I was able to maintain myself, I think, 2 years there. Came out, got in trouble again. Relapsed. I wouldn't even call it relapse. And immediately I was on a train."

Code 8: Understanding Dependency

Understanding dependency was a code applied to six users, but it was applied 18 times overall. The code was applied multiple times for most of the participants. Understanding dependency was selected as a code based on the participants' narratives, including insight

regarding how they perceived the experience of dependency, not just for themselves, but for others in their dependency social circles. For those who discussed understanding dependency, it was often coded several times. For example, understanding dependency was a code applied to the text from P12. Although he talked about sleep, he was struggling with his dependency:

> They mom's getting up to get ready to go to work, and he's like, okay man, look, man, we got to stop. We going to just shut it down, take a nap, you know what I'm saying? Then once she gone to work, we could start back smoking again. And man, I couldn't do it, bro, I couldn't go to sleep. You know what I'm saying? They did, they laid down like it was nothing. I couldn't do it, I was tweaking. And I got up, man, and I walked out there.

Code 9: Conscious Desperation

Conscious desperation was used for eight users and was applied 17 times. Conscious desperation was selected as a code because it described the lived experience of individuals where they understood the dire nature of the situation they were in and that they were at risk of the situation worsening. This code was applied several times by multiple users. A key quote that supports understanding of the application of the code was from P3:

> That's one of those redundant ones, huh? Well, the pain of using it just got too severe. The hopelessness, the despair, the powerlessness, the distant feeling of me wasting my life, blowing my potential. But in the end, it was just the pain, the hopelessness, the despair, the darkness, just the dying, just the dying on the inside. Man, it's just that darkness and that despair, that brokenness, man. And that, just feel like I was just dying, just rotting on the inside, man.

Code 10: Subjective Hopelessness: Not a Sufficient Reason to Quit

Subjective hopelessness was a code applied to nine participants for a total of 15 times. Subjective hopelessness emerged as a code because of how participants described their experience with substance use and not wanting to recover. The code of subjective hopelessness was used for several participants and applied as a code several times. P12's lived experience gave an example of a brief, yet powerful quote as an example of the application of the code. P12

stated “To me, that was that hopeless feeling. Yeah, that was that hopeless feeling, but s’ill weren't ready to quit.”

Code 11: Learning From Others

Learning from others was applied a total of seven times to four participants. The code was used to describe how participants began to learn from other people who were on the same path toward recovery or how they learned that they could recover. The code of learning from others was less-frequently applied. However, while only four participants had a lived experience in their substance use and recovery that involved learning from others, it is a critical code toward understanding the path toward overcoming substance use. P12 stated

> I think with overcoming the hopelessness, it was just hearing other people share stories, right. Because when you in this 12-step thing, you around people, a lot of people talking about different things happen with them, and I would hear people share their stori’s, and it's kind of like, if they went through that and got through it, you know what I'm saying? I could... Oh man, you hear a lot of stories, I'm sorry, man. You hear a lot of stuff. Oh, you hear a lot of stuff, man. And it's like, wow, I thought what I went through was bad. I mean, you hear people that went through some much more worse situations, man

Code 12: Perceived Empathy

Perceived empathy was applied to 12 participants. The code was used a total of 37 times. Perceived empathy was a code that described parts of responses where participants noted experiences where they received what they felt were empathetic responses or treatment from other people regarding their recovery.

This the second-most frequently applied code, but frequency was not what made the code instrumental toward understanding the narratives of participants that had experienced substance use disorder and the difficulty of recovery. It was how data supported understanding the experience of participants. A critical quote clarifying understanding the stigma of addiction and support of the positive was from P10, who stated,

> Ms. [redacted] was a friend of mine's mother, and [redacted] . . . . And [redacted], I put [redacted] on that. [redacted], right? Ms. [redacted] no matter what, would always dig, man. She always conversed with my innocence, she never talked to me like I was an alcoholic or a druggie. She always talked to me like I was a nice guy, right.

Code 13: Lack of Attachment/Loyalty to Co-Users

Lack of attachment and loyalty to co-users also held a role in the experiences of participants. The code was applied to six participants a total of nine times. The code was meant to describe experiences as a substance user where the participant did not feel attachment or loyalty to fellow users. A crucial quote toward understanding the quote was from P12, who stated,

> I mean, you might have two or three people that you get along with or that you get high with or whatever, but ain't no loyalties, you know what I mean? Really ain't no loyalties in there. I could be getting high with these two or three people today and not even be bothered with them the next day. And I could be getting high with somebody else, it's all depending on who got sack, right? But at that family, that feeling of support, you don't feel that no more because you become this lone rider, the lone soul, you know what I'm saying?

Narrative Thematic Analysis: Combining Codes into Narrative Themes

The final stage of the narrative thematic analysis was combining the interview codes into narrative themes. Table 3 identifies the four themes, with the code or codes that emerged and were combined to form the themes. A brief definition of each theme is also provided, with notes that help clarify the theme. In addition, the table shows the number of participants whose interviews revealed each theme and the frequencies with which the themes appeared across all participants.

Table 3

Combining Interview Codes Into Narrative Themes

Theme	Code	Definition/Notes	Participant count	Frequency count
Theme 1: The cycle of relapse and shame makes resiliency very hard to attain	Embarrassment/ shame (code 1) Role of luck/accidents (code 2)	The cycle of shame causes continued use and/or relapse until internal or external influence—sometimes accidental—interferes with the cycle.	14	42
Theme 2: Detachment leads to a lack of cognitive empathy	Counseling agent dissimilarity (code 4) Learning from others (code 11) Perceived empathy (code 12) Lack of attachment/loyalty to co-users (code 13)	Dyadic heterogeneity, i.e., disconnect between user and caregiver, interferes with learning and recovery.	15	64
Theme 3: Trust, love, and understanding lead to cognitive empathy	Trust and responsibility (code 6) Relapse—"feeling good about myself"(code 7) Understanding dependency (code 8)	Empathy, rather than (dyadic) similarity, is the key factor reversing detachment. Empathy is reached via multiple avenues and includes achieving self-compassion.	15	37

Table 3 (continued)

Theme	Code	Definition/Notes	Participant count	Frequency count
Theme 4: Resiliency is influenced by capacity to understand self and others	Cognitive empathy failure (code 3)	Failure to grasp own addiction and attendant behaviors, failure by others to empathize, and associated with profound homelessness and inability to take even simple steps. Conversely, understanding by self and by others builds commitment and resiliency.	15	64

Theme 1: The Cycle of Relapse and Shame Makes Resiliency Very Hard to Attain

Theme 1 tells the common story of addiction: the casual and sometimes even accidental experimentation with substances in childhood or early adolescence, which gradually progresses to physiological and psychological habituation. This habituation often remains unnoticed by the user for an extended period of time. At some point, whether through increased consumption of "lesser" drugs (alcohol, marijuana), or through progression to more serious drugs, negative personal and social consequences start to manifest. At this important milestone, two scenarios were uncovered. The first one is simply failure to grasp that there is a problem. The words of P9 perfectly describe (in retrospect) this situation:

> So I did more smoking and drinking in the military and I became a alcoholic and didn't know it. I didn't realize that I had crossed a threshold into alcoholism until I got home, right. And I still did not see alcoholism, I just saw a guy trying to get a drink. That's all I saw. I didn't see alcoholism, right.

The second scenario, if respondents did notice that the pattern of use was problematic, that was manifested by all the interview respondents (and perhaps all substance users in general) is acknowledging the problematic use but failing to understand the nature and implications of the developing physiological and psychological dependence on a substance. Instead of taking measures to curb or stop consumption, addicts engage in *adaptations* to their predicament. The adaptations can be psychological (e.g., rationalizing use as normal, "a guy trying to get a drink"), but more commonly are demonstrated by a degradation in ability to read social cues.

This degradation can be unconscious (P1: "I ain't see that as being a behavior of an addict. I thought it was hustling."). The degradation can also be consciously seeing the failure to act appropriately (P13: "When I hit that spiritual and emotional bottom, I begin to question whether I was fit to live. And at those times, I just couldn't control myself and got extremely uncontrollable.").

In the latter scenario, the addicted person would then consciously embrace a marginalized life, including homelessness, to be able to continue to use their substance of choice. This scenario was best summarized by P3: "When I began to talk about adaptation . . . . The comfort, and how quick it was, and easy it was to become comfortable homeless."

With regard to the relationship of this narrative theme to resiliency and empathy, perhaps the most important thing to highlight is that this narrative strand exhibits neither resiliency nor (cognitive) empathy. As a result, the cycle of shame and substance use remains undisturbed even in the cases in which addicts have an idea of the extent of their addiction or may have experienced episodes of hopelessness. This narrative strand is characterized by a combination of a cycle of shame and variety of accidents (in positive and negative directions). The common description of the substance user experience is not being in control, and as a result having no

resiliency. Nascent self-awareness or positive accidents may begin to disrupt the cycle. However, the potential for recovery may be further sabotaged by detachment (Theme 2).

Theme 2: Detachment Leads to a Lack of Cognitive Empathy

Theme 2 combines the codes for *counseling agent dissimilarity, perceived empathy, learning,* and *lack of attachment/loyalty to co-users*. These codes are isolated into a separate theme because they describe the narrative strand where *personal acknowledgement of addiction exists.* This theme applies when the respondent, unlike in Theme 1 narratives, has clearly grasped that the substance use is in fact an addiction. The individual has a yearning, although neither a plan nor a commitment, to resolve the problem. Key for this narrative is that the sense of hopelessness and despair alone that many former substance users report in most cases is not sufficient to trigger committed action towards recovery. This insufficiency results primarily from a factor reducing detachment. A wide range of experiences can help start and facilitate this process, or sabotage it if the experience is unfavorable.

A poignant illustrative account of this sense of detachment was provided by P12:

> So I went in the military and this how I first started noticing I was [an] addict, even though I didn't know. . . .Oh, I'm a here making these decisions because my dad wasn't in my life. I just never have connected it like that. So, what I'm starting to see, and I still don't want to blame my parents, because at the end of the day, I still feel like I made those decisions. But I'm starting to see I have a lot of unaddressed trauma. I have a lot of things I haven't healed from. But I don't attach to them. I don't identify it in that way. I look at it as I am making decisions, I need to learn how to fix them.

P15 also admitted detachment coupled with shame:

> I was . . . just didn’t know what I was doing. I knew I was young, and I knew I shouldn’t be doing this shit. Just felt guilty, and shame. I felt shame. I was just, I wasn’t really trying to. I know I was successful at that shit. Lets be honest with you—I wasn’t successful. What I thought was successful wasn’t even successful, at getting high.

A common example of the latter scenario (detachment sabotaging cognitive empathy) stems from the user’s perceptions and level of knowledge. In such cases, even very well meaning

and empathetic helpers—professional and otherwise—may not be immediately successful in guiding the user to solutions. This failure is primarily due to inability of the user to realize the superficiality of some dissimilarities.

Dissimilarity plays a retarding role, however, only in the very early stages of the road to recovery. Once the desire to consider change is strengthened, dissimilarity does not appear to matter as much, and the extent of cognitive empathy becomes supremely important. Accordingly, in the early stages of recovery, information and knowledge may be more effective than empathy, although a baseline level of empathy does need to be a given, as respondents proved to be highly sensitive to its presence or absence.

The importance of knowledge and information is illustrated by the *learning from others* code collapsed under this theme. The learning does not necessarily mean from professionals; it can be from friends and family (e.g., a brother and a friend for P1) or peers in 12-step programs. The key feature is that nascent desire to address addiction results in openness to experience and permits others' experience to be conceptualized in relation to oneself.

The individual thereby begins to address the sense of detachment and disconnect from relatives and the world more generally. The relationship is bidirectional and as such suggests that the main goal for others to strive for is to achieve any engagement with the user to reduce detachment and thereby provide opportunity for cognitive empathy to produce positive effects.

Detachment itself can characterize both the user and possible helpers or caregivers. Detached caregivers may be exceptionally well-meaning, but their detachment and resulting lack of cognitive empathy may still exacerbate the problem and stall recovery. Detachment of the user is not necessarily resolved at once. However, positive serendipitous encounters over time may provide meaningful leverage to pursue change further. Such encounters are well illustrated by the

words of P3 recounting his confusion that the neighborhood children seem to like him very much, even in his lowest points:

> And then the kids in the neighborhood dug the fuck out of me, man. You know what I mean? You're like, I'm T-Bone the bum [pseudonymized nickname] as far as I'm concerned, up here on Linwood drinking every damn day. But when I would walk down Pasadena, man, all them little kids liked me. "Pork Chop. Pork Chop. Where you goin', Pork Chop?" And I didn't get it.

Finally, detachment has a positive dimension, but only if it is understood in relation to fellow substance users. Respondents reported consistently a very low degree of loyalty or affection to the individuals they consumed substances with, and some even described them in somewhat derogatory terms, e.g., P3:

> And then sometimes I would be on the corner, right, and I would see somebody I went to high school with drive by. You follow? I'm on the corner getting high with all these suckers, and then one of the girls that I went through high school with—"Hi B. B's a bum?"

The only exception to this type of detachment was when the co-users also happened to be family members, in which case natural family affinity seemed to mitigate detachment, although also within limits. That is, respondents would distance themselves from using friends or family members when embarking on recovery or experiencing the detachment of family members attempting to commit to recovery. However, these generalizations also need to be tempered, because in such cases the family members in question often attempted to positively influence the user, albeit often clumsily and ineffectively, mainly due to lack of knowledge.

Ultimately, the most severe form of detachment is the detachment from oneself. If that breach occurs, then recovery becomes much easier and is characterized with the most resiliency. Multiple quotations address this experience. Here is P3:

> Yeah, I'm an alcoholic and drug addict.But I ain't no damn fool. Right. I'm an alcoholic and a drug addict, but I mean, I'm not lazy, right. So, it's like the alcoholism and the drug addiction became a conflict to my true self.

The importance of knowing oneself—and knowing about addiction—manifests not only in the decision to pursue recovery but also to stay in recovery. P6 provided an account of recovery that also meant fundamental change in perspective and the internalizing of locus of control:

> Well, the pain of using it just got too severe. The hopelessness, the despair, the powerlessness, the distant feeling of me wasting my life, blowing my potential. But in the end, it was just the pain, the hopelessness, the despair, the darkness, just the dying, just the dying on the inside Man, it's just that darkness and that despair, that brokenness, man. And that, just feel like I was just dying, just rotting on the inside, man. A good boy, a good boy was dying, like I going to murder this guy. I'm strangling this guy, a good dude, dude ain't did nothing. You know what I mean? And I'm killing him.

P2 made the distinction between treatment and recovery:

> I didn't realize that treatment wasn't recovery, the treatment was treatment. And that's what I had, treatment. I didn't have recovery. I mean, I literally, so I felt like I was myself again. I felt like when I was in treatment, I was changing, that I had changed. Well, this is my first day out of treatment and it's clear thatyou haven't changed.

Theme 3: Trust, Love, and Understanding Lead to Cognitive Empathy

Theme 3 was constructed by combining the codes for *trust and responsibility, relapse,* and *understanding dependency*. These codes combined into a distinct narrative line, helping to further disentangle the mechanisms of how cognitive empathy emerges and operates in recovery. Key findings for this theme were that knowledge about addiction is an important part in experiencing and that cognitive empathy can manifest in multiple ways, including through indirect modes.

The code for trust and responsibility (i.e., individual responsibility) encompasses narratives emphasizing (a) the positive effects of responsibilities addicts are asked to undertake, and (b) the taking of personal responsibility for their future. The scenarios recounted under (a) provide interesting and potentially important modifications of cognitive empathy as a concept,

referring not only to the process of rationally understanding the experiences and feelings of a user but also to ways of manifesting it.

Asking substance users to undertake certain responsibilities was reported as beneficial in multiple contexts. These included being asked to perform tasks for 12-step meetings. P1 said, “And I was the table monitor, that was a big deal for me.” The responsibilities also included being asked, whether with guidance or via the justice system, to perform small tasks that cumulatively lead to reintegration. P4 reported: “And I would say the whole fellowship and my sponsors, uh, gave me a lot of strength and, you know, then my family, you know, commending me and supporting me.” P6 corroborated: “I realized even though I wanted to blame it all, I got the point where I started to blame it on drugs, the truth being, well, I was me, I messed me up, you know what I mean?”

Such small steps served two important purposes in recovery. First, they were one way to demonstrate cognitive empathy. Second, they enabled users to both understand the addiction problem and to personally commit to recovery, rather than “treatment.”

In the absence of empathy, understanding, and responsibility, relapse is common. The most common scenario of relapse is maintainenance of abstinence for a limited period (e.g., 1-3 months), then experiencing better outcomes, and then succumbing to the common addiction trap of thinking, “Oh well, I can use in moderation now.” As important as cognitive empathy is, the role of knowledge—and how it is delivered—should not be underestimated. In the words of P3, “This was the difference between the other two facilities, they never explained alcoholism, right. Sacred Heart explained alcoholism. And once they did, I said to myself, ‘Oh, that's what's wrong with me.’"

Accordingly, it must be emphasized that the importance of empathy and resiliency is likely diminished in the absence of understanding of substance dependency. This understanding has two components: (a) awareness of one's compulsion, accompanied by (b) more general, i.e., professional, understanding of the nature of addiction. This understanding requires a degree of professional help, fundamental for longer term recovery, rather than for initiating the processss.

Once respondents reached a point to truly commit to recovery, they showed an impressive degree of resiliency and ingenuity. One of the more interesting examples (also illustrating the effects of cognitive empathy failure) is from P2, who faked symptoms once he realized he was about to be discharged after seeking addiction help:

> The notion that they would let me go back out in the streets just terrified me. So, I really started, as a matter of fact, I said, I'll blow this fucking place up. I started sniffing the walls. So, you learn to be an actor in addiction too. So, I sort of exaggerated my problem and made it really psychiatric, but it was really more addiction than psychiatric.

Theme 4: Resiliency Is Influenced by the Capacity to Understand Self and Others

Theme 4 organized the narratives showing how crucial are self-understanding and understanding by others (cognitive empathy) for resiliency. Theme 4 is comprised of the codes *cognitive empathy failure*, *misunderstanding of own motives*, *conscious desperation*, and *subjective hopelessness*. While overlap inevitably took place with some of these codes, the overall narrative underpinning them must be articulated to highlight additional mechanisms of how cognitive empathy and resiliency manifest in recovery.

Perhaps most notably, respondents provided ample evidence that they were highly sensitive to cognitive empathy. This sensitivity was present both in absence or failure of cognitive empathy (in which case respondents are discouraged at best, and their journey to recovery is temporarily derailed at worst), and in instances of success (respondents remember

and recount in great detail the help they have received from a cognitively empathetic clinician). An example of the latter is found in the words of P3:

> My clinician was amazing. I absolutely had, I felt again, that was one of my miracles that I was fortunate enough to have what I felt it was high-quality experience, treatment experience, very professional, high quality environment. I'm lucky because if my clinician was not prepared, I probobly would've been distracted about who they were instead of who I was.

Accordingly, when the role of cognitive empathy in recovery is contemplated, it appears necessary to consider it on a continuum from negative to positive. That is, the mere absence of cognitive empathy is not a neutral situation. However, its presence indeed harms resiliency and therefore the prospects for recovery.

The code for *conscious desperation* was also clearly associated with resiliency. The account of desperation does not always necessarily coincide with objective "low points" in the substance user's experience. Desperation may be associated with a particularly unpleasant episode, but it can also manifest during mundane, uneventful days. This is an especially vulnerable stage for any substance user. Although they are primed and receptive to pursuing change, if no understanding or empathy is forthcoming, no resiliency is built, and the cycle of addiction continues until another opportunity to make a change occurs, if it does at all.

The latter is always a real possibility, and clearly many substance users do not succeed in overcoming desperation and remain in a state of *subjective hopelessness*, the last code. A common misconception appears to persist in some areas of addiction research, namely the notion that if substance users "hit rock bottom," the resulting sense of hopelessness will prompt them to take action. This generalization cannot be true—as only a subset of addicts succeeds in long-term recovery.

Whether this subset is large or small, depending on substance, is less relevant than the fact that some substance users "do not make it." This was apparent even in the respondent

sample, which is indeed striking as the sample by definition consisted of individuals in successful long-term recovery. Even so, multiple respondents, in recounting their journey to recovery, reported that the feeling of hopelessness alone was often not sufficient to trigger action. Instead, a feeling of hopelessness, absent factors interfering with it, resulted in a sense of despondence and continued use.

P12 commented, “To me, that was that hopeless feeling. Yeah, that was that hopeless feeling, but still weren’t ready to quit.” P1 recounted an incident where he could not stop using even for half an hour, and he locked himself in a filthy gas station restroom. “And it was bad. I’m talking about, it was bad. It was smelling bad in there. To me, that was feeling hopeless.” When he left the restroom, he immediately returned to his fellow co-users after narrowly escaping an encounter with the police.

In summary, the lesson that can be learned from this theme may be that while hopelessness and desperation may prompt some users to take action, absent other beneficial factors (such as cognitive empathy and understanding of self and by others), no resiliency is built. Relapse is exceedingly likely, if a pause in use is even accomplished at all. This finding has important clinical implications.

First is acknowledgment of the possibility that the objective severity of consequences of substance use lifestyle may not be a sufficient prompt for action, even if the cost of continuing the lifestyle appears extraordinary through a substance user’s eyes. Building resiliency in the commitment to recovery requires exploring the opportunities to puncture the sense of hopelessness and its acceptance. This acceptance includes a the demonstration of cognitive empathy.

Summary

This chapter presented the results of the narrative inquiry analysis of the interview transcripts. The interviews of 15 African American men in long-term recovery were analyzed. First the general characteristics of the respondents were presented, followed by thematic analysis of their narratives and experiences with SUD experience.

Rich narratives elucidating how cognitive empathy and resiliency manifest in recovery were explored. The initial interviews were coded into 13 codes capturing different aspects of both cognitive empathy and resiliency and the relationships between them. Four themes emerged from the 13 codes:

Theme 1: The cycle of relapse and shame makes resiliency very hard to attain;

Theme 2: Detachment leads to a lack of cognitive empathy;

Theme 3: Trust, love, and understanding lead to cognitive empathy;

Theme 4: Resiliency is influenced by the capacity to understand self and others.

Perhaps the most fundamental general finding was that cognitive empathy and resiliency, while undoubtedly having positive effects on recovery, are profoundly related with each other. In particular, cognitive empathy is fundamental for the development of resiliency in substance users embarking on recovery. The themes explored described the different mechanisms through which the absence of cognitive empathy may hurt both the development of resiliency and the undertaking of recovery.

An important breakthrough emerged in examining the relationship between knowledge and understanding—understanding of self generally, but also knowledge about addiction specifically. Cognitive empathy can greatly improve self-understanding and help substance users realize that they are not defined by their use, and self-understanding can be further fortified by

the provision of addiction knowledge. The success of interventions appears greatly diminished in the absence of cognitive empathy; virtually all respondents reported high sensitivity to cognitive empathy failure, resulting in delayed building of resiliency and consequent recovery.

Moreover, the importance of cognitive empathy was further highlighted by multiple accounts of highly appreciated professionals who *did not have addiction experience themselves*. The ability to be compassionate proved to be significant to recovery (especially when compassion is manifested by nonprofessional community or family members). In professional settings, it appears exceptionally important for therapists to combine compassion with psychological knowledge of the nature of addiction and apply this knowledge in a deliberate way to understand what clients are going through—the very definition of cognitive empathy.

Chapter V – Summary, Conclusions, and Recommendations

This chapter presents the results of this qualitative narrative study that addressed the need to develop an understanding of the importance of cognitive empathy and resiliency in African American men in long-term SUD recovery. Resources and past research examined the root causes of addiction, but certain aspects of substance use disorder are not well understood or well presented in extant literature (Breuninger et al., 2020; Garami et al., 2018). For example, aspects related to the role of empathy and resiliency in long-term SUD recovery were practically ignored in current research (de Wied et al., 2020; Leal & Silvers, 2020; Maurage et al., 2011). The identified gaps in the research indicate a need to better understand how these factors impact persons in long-term recovery.

This research aimed to inform SUD treatment by exploring the roles and importance of empathy and resiliency in 15 African American men, all ages 38 to 72, who experienced at least 10 years of long-term recovery. The current project posed the following research question: How do African American men in long-term recovery from SUD experience empathy and resiliency in their recovery process? The findings may be used in the implementation of treatment methods targeting empathy and resiliency as factors in recovery. Insights gained on the importance that empathy and resiliency have in SUD recovery can be used to inform practitioners' treatment approaches.

This chapter synthesizes the study results based on the experiences of African American men who have experienced long-term recovery from a SUD. A discussion of the findings explores each theme extracted from the sample interview responses. Additionally, the researcher aligns the study results with the related literature previously reviewed in Chapter II. Further, the

researcher explains the clinical implications of these findings, with a discussion of the limitations of the research. Finally, recommendations for future research are offered.

Findings

The use of a narrative research design allowed the researcher to observe and examine the perceptions of a sample of African American men intimately experienced with SUD and its facets of recovery. Factors found to influence SUD recovery related primarily to the roles of empathy and resiliency in long-term SUD recovery (de Wied et al., 2020; Leal & Silvers, 2020; Maurage et al., 2011). The questions asked during the interview (Appendix A) were formulated to extract responses to answer the research question, and the participants were encouraged to offer their unique perspectives on such experiences. From the interviews, the researcher coded the interviews and refined them (Table 2). These findings were grouped into four themes (Table 3), all of which answered aspects of the research question. The themes are further discussed below.

Theme 1: The Cycle of Relapse and Shame Makes Resiliency Very Hard to Attain

The first theme was identified based on the narrative explanations of the sample, with the majority of the participants feeling shame related to the potential for relapse. Accepting one's inability to cope and overcome addiction was a typical response from the respondents. They noted they felt degradation, shame in being around family, hiding from friends, or hiding in public so as not to be noticed by others. The participants explained that their embarrassment and shame were accepted by other individuals with SUD who had overcome their addictions.

Nevertheless, most of the participants agreed that their feelings of shame were considered unacceptable. They shared that the shame they felt was one of the hardest things to overcome while in recovery. This theme was also based on the participants' belief that they lacked

resiliency in maintaining their recovery. The participants recognized that they lacked such resiliency and felt shame for not being able to sustain their recovery. These feelings of shame contributed to a cycle of relapse, making resiliency in staying clean very hard to attain. This finding aligns with existing research that posits that to sustain long-term recovery, shame and guilt need to be managed to break the cycle of addiction (Snoek et al., 2021).

Theme 2: Detachment Leads to a Lack of Cognitive Empathy

The second theme was extracted from the interview question responses and suggested that participants' relationships with other people with SUD were influenced by loyalty but produced detachment, leading to a recognized lack of cognitive empathy. The basis for this theme was the participants' claim that they failed to identify with other individuals affected by SUD who went through the same recovery process. Some participants felt a detachment from others in their programs, which created a lack of attachment or loyalty with other individuals, even if they had the same or similar experiences. Participants also believed they were not given support from families and others with a SUD. This lack of cognitive empathy from others created feelings of detachment for participants. While participants found that others faced similar challenges during recovery, the likelihood of connection with these individuals was low.

Existing literature found that commitment in 12-step mutual support groups has historically been instrumental in helping individuals sustain their recovery and or sobriety (Humphreys & Moos, 2007). The participants also considered how compassion, self-compassion, and resiliency were reflected through their experiences. In contrast to their feelings of detachment, a significant number of the participants believed that learning of similar experiences through the stories of other individuals with SUD provided support and helped to increase their

resiliency in persevering with their program. Participants shared also that such feelings of empathy were produced to facilitate self-acceptance and motivate the desire to change.

Theme 3: Trust, Love, and Understanding Leading to Cognitive Empathy

The third theme was extracted from the participants' responses to the interview questions focused on reasons for having cognitive empathy. These reasons included developing trust and responsibility, having positive feelings, and understanding dependency. The participants verbalized that when they were eventually trusted by others, they began to recognize the positive impact of this trust and their perceived self-value grew. Trust and responsibility were earned; however, the participants believed that time and proving oneself were essential in receiving trust and responsibility from those in charge. As they were offered even the smallest amount of trust and minor responsibility, their feelings of pride and accomplishment grew.

However, there was also discussion related to the illusion that everything was under control, which all participants acknowledged would lead to relapse. The incidents that resulted in receiving trust and responsibility often led the participants into an overblown self-confidence that belied the level of their recovery. For example, a lack of understanding of the nature of addiction prompted ease in reactivating the addiction pathways. Clinicians should be aware that this perception was expected and, as the participants claimed, was a pragmatic sentimentality that arose as the substance users were trying to understand their sense of dependency.

These perceptions often lead to a conscious compulsion to keep using substances even against a backdrop of negative social consequences. These findings align with research that has shown that a fear of stigma associated with both substance use disorders and those in recovery can prevent individuals who need help from seeking it (Kulesza et al., 2016). Persons in early

stages of recovery from substance use disorders who do not feel they can seek help without judgment may become resistant to change and struggle to seek recovery.

Theme 4: Resiliency Is Influenced by Capacity to Understand Self and Others

The final theme that emerged from the thematic analysis was focused on individuals' capacity to understand themselves and others and the link to resiliency. The interview questions focused on cognitive empathy produced responses from the participants that emphasized cognitive empathy failure. When another individual was supportive of their treatment and recovery, the respondents often denied that they had a problem and disregarded the overtures of empathy toward them.

Many of the participants spoke about a friend or family member trying to help convince them to get treatment. Still, participants would remain hopeless and consciously negate any positive empathy directed toward them. The subjectiveness of hopelessness was found to be an insufficient reason to stop substance abuse. This feeling was combined with the subjective feelings of hitting the very lowest point, yet it was not sufficient to trigger positive behaviors for treatment.

The participants also claimed they felt degradation in their ability to read and react to social cues associated with cognitive empathy towards them. All participants corroborated that the misunderstanding of motives from others wishing to help was met with negative behaviors, and they pushed away anyone wanting to support them. The negative behaviors initiating a misconception of self and others' motives led to low resiliency in the participants.

African American men who were in long-term recovery from SUD claimed that resiliency was difficult to attain, as the feelings of shame were overwhelming and failed to allow them to retain resiliency in maintaining their recovery. Further, the sample response regarding

empathy was mixed, with some claiming that they felt more detached from others who had the same past experiences. Thus, these participants had no feelings of loyalty. Other participants, however, believed that learning about similar experiences from men who faced the same challenges during recovery allowed for a stronger sense of commitment to themselves and helped to facilitate acceptance. Learning about others' experiences made them feel supportive companionship, which prompted the development of feelings of trust and understanding.

These feelings in turn led the participants to acknowledge cognitive empathy from those with similar circumstances and experiences, which in turn enabled the participants to develop their own feelings of self-empathy. Such beliefs prompted certain positive reactions with empathy. However, some participants also claimed that relapse occurred due to a failure in understanding their own dependency or addiction. Consequently, the sample was found to have a need for high levels of support; they felt a lack of understanding about their addiction and doubted their own capability to maintain recovery, thereby leading to a low resiliency in their own recovery process.

These findings align with the claim by Rudzinski et al. (2017) that it is overly simplistic to assert that those in recovery are resilient and those in addiction lack resiliency. That is, if one is addicted, one is not resilient; conversely, if one is in recovery, one is resilient. Other studies on resiliency and SUD limited their scope to exploring individual traits, failing to account for other factors such as external resources or environmental components that can impact resiliency (Bowland, 2015; Woods-Jaeger et al., 2019). Additionally, Rudzinski et al. (2017) failed to account for changes throughout a person's lifetime; these can also influence the level of resiliency.

Reviewing and Extending the Literature

The existing research reviewed in this study examined themes closely associated with SUD treatment, and some of the research findings from the current study were in alignment. The first theme was associated with the literature reviewed. For example, Samuels et al. (2020) claimed that addiction manifests as learned behavior, and recovery was considered a means of unlearning the behavior, finding how to live without substances, and forging one's own experiences as living a healthy lifestyle and maintaining resiliency against substance use.

Studies also showed that many substance use disorder counselors felt that trauma and hurt were at the center of addictions and SUD (Cross et al., 2018; Moore et al., 2015). Resiliency, which enables an individual to carry on in the face of challenges including addiction issues, was understudied (Cross et al., 2018). Trauma experienced during childhood is particularly relevant to addiction, as it can affect cognitive development. Childhood trauma can result in attention-seeking behavior due to withheld affection and impulsive behavior to gain approval from peers or adults (Cross et al., 2018; Moore et al., 2015; Rosen et al., 2016).

The findings on resiliency as a theme were supported by much of the existing literature; however, the literature regarding shame did not note any association with resiliency. The existing research showed that stress was related to resiliency (Dooley et al., 2017; Woods-Jaeger et al., 2019). Further, studies showed that resiliency had a protective effect, diminishing some of the negative implications of adversity and trauma (Leal & Silvers, 2020; Shi et al., 2019). Cognitively, high levels of resiliency were associated with increased functional connectivity in certain regions of the brain (Shi et al., 2019). Thus, a cognitive or psychological perspective was noted for understanding the effects of resiliency on an individual's response to high-pressure situations and adversity, such as with addiction recovery.

The existing literature discussed two distinct types of empathy: affective and cognitive. The latter was most prevalent among individuals with SUD, as they could understand the situations of others but not the emotional experiences (Maurage et al., 2011). Much of the past research devoted to discussing cognitive empathy was not associated with resiliency but was explained as a factor mediating the effect of certain aspects of identity on the morality of an individual's everyday decisions (Decety & Yoder, 2016; Rosen et al., 2016).

Notably, the research literature has found that cognitive empathy is a predominant social skill helping individuals connect with others and create community. However, there are limitations to the level of empathetic emotions in individuals during recovery. Researchers explained that therapy needs to focus on rehabilitating cognitive and emotional (affective) empathy during recovery (Brook & Kosson, 2013; Maurage et al., 2011; Moyers et al., 2016).

Much of the current research discussing trust and understanding leading to cognitive empathy was focused on the effects of ACEs and SUD, linking these experiences with learning cognitive empathy (Dekkers et al., 2020; Marel et al., 2019). Researchers explained that trauma experienced during childhood was particularly pertinent to addiction and was systematically impactful on cognitive development (Cross et al., 2018; Massey et al., 2018). However, studies associating cognitive empathy as a relearned behavior for individuals with SUD were limited, making the findings of the present study important in filling this gap in the literature.

The reviewed literature contained findings that were relatively dissimilar to the current results, with researchers finding the value in and highlighting the importance of shared responsibility and the belief that hard work can help overcome adversity. The emphasis was that these unique challenges enabled the development of a sense of resiliency (Leal & Silvers, 2020;

Shi et al., 2019). The participants of the current study felt differently, however, claiming that they developed a low sense of resiliency.

Theoretical Foundations and the Study Findings

The participants' responses to the interviews and the analysis that formed the four themes answered the posed research question, How do African American men in long-term recovery from SUD experience empathy and resiliency in their recovery process? The extant research did not provide an answer to this question. It focused chiefly on cognitive empathy and resiliency in African Americans as a population but not within the context of SUD and recovery.

The conceptual foundation of this study, cognitive empathy, was noted in the literature and was reflected in the interview question responses from the current study participants. Further, the application of social cognitive theory grounding this research was examined within the participants' perceptions and was termed an extension of the social cognitive theory advanced by Bandura (1986). Bandura posited that a significant portion of an individual's knowledge acquisition occurs as a result of observing others.

However, with SUD, the acquisition ability is lost during the actual time an individual abuses drugs and alcohol. It is only during recovery that the participants noticed these behaviors could be relearned. The interviews provided further support to what research had shown—that people in recovery need a support system to help them reach and maintain recovery (Perron et al., 2011). Hence, empathy was found to mediate the effect of identity-related factors (age, gender) on the morality of participants' everyday decisions (Moore et al., 2015; Rosen et al., 2016). The results of the current study indicated that cognitive empathy theory might provide insights into the influence of empathy and resiliency on the behaviors and decisions involved in long-term recovery from SUD.

Limitations of the Study and Future Research

Limitations

The limitations noted in Chapter I indicated that the scope of this study was limited to how African American men in long-term recovery experience cognitive empathy and resiliency during their recovery process. Further, the researcher showed that data collected in a narrative inquiry study were inherently subjective. The researcher asked follow-up questions to help ensure clarity and correct understanding and interpretation of the data.

Another limitation was that the results were interpretative rather than largely unambiguous, as in quantitative methods. Further, the purposeful sample means that the results cannot be generalized to larger populations of addicts in recovery. Because of the interpretive nature of the current data analysis, the researcher's bias was considered. Thus, it should be understood that different interpretations and therefore emergent themes may follow from another researcher's findings. It is possible that if another researcher carried out the current study, different themes and subthemes might have been developed, resulting in another presentation of the results.

An addition limitation was that the verifiability of the results was difficult to prove. This limitation is based on the understanding that qualitative research is open-ended, giving participants control over the content of the data collected. As such, the researcher was unable to verify the results objectively against the scenarios described by the participants.

Future Research

This study results showed a need for further research to determine positive approaches to recovery and relearning empathy, as taught by clinicians, social workers, and addiction counselors. Past researchers assessed current trends and best practices; however, little empirical

attention was given to the perceptions regarding attitudes and behaviors of African American men living with long-term SUD recovery. The current study focused on only one population: African American men experiencing long-term SUD recovery.

From this expansive general population, the researcher purposefully selected 15 participants for interviews. The results suggested only a limited represented set of perceptions. Therefore, the results are not representative of the whole population, and thus, further research with an expanded sample is needed. It is also plausible that the researcher would have obtained different results with more participant interviews. A larger sample size would benefit a future study. Samples from different geographical areas could also be drawn for possible comparisons of environment and findings.

Additional research needs to be conducted about SUD among marginalized populations or groups (e.g., African Americans, Hispanics, Native Americans). Populations that lack sufficient research regarding SUD are the LGBTQIA, criminal justice, and homeless populations. Future researchers should explore the experiences of other populations, such as families, African American women, Latinx people, and Asian Americans.

Further, quantifiable studies could be conducted with survey methods, which may enable the research to be extended to broader populations. Statistical tests could then be conducted for statistical significance and relationships among the various factors studied in terms of empathy and resiliency. Qualitative studies do not have the tools for such tests. By quantifying this study, more objective results may be obtained. The researcher further advises the incorporation of data triangulation methods, such as individual interviews, focus groups, and mixed-method research surveys, to increase the strength and trustworthiness of the results.

Professionals, families, and the addicts themselves need to gain more knowledge on the subject of recovery and learn about the struggles and tools used for the educational process regarding cognitive empathy and resiliency. To that end, courses could be designed and made available. Trainings could be provided through neighborhood gatherings, community and online resources, and schools and universities.

Additionally, byproducts of addiction, such as incarceration and increased health risks, merit further research. Future research should also examine other factors beyond cognitive empathy that may sustain long-term recovery, such as mentorship and spiritual/religious practices. This study allowed people's voices to be heard, and future studies could extend these voices by recruiting participants to share stories from a broader set of perspectives.

There is a further need to address the perceptions of clinicians who work with this population to improve the quality of treatment and recovery. Enhanced communication, respect, and appreciation could improve the quality of treatment and recovery.Clinicians' perceptions of the importance that empathy and resiliency play in SUD recovery should be explored and how they can be used to inform practitioner treatment approaches. Especially through the use of qualitative methods, the study of clinicians' perceptions may further provide a more profound understanding of the phenomenon.

Clinical Implications and Recommendations

The study results inform future treatment approaches and efforts by considering the impact of resiliency and empathy on improving recovery outcomes. The findings on cognitive empathy and resiliency in long-term SUD recovery in African American men should influence professionals who work with individuals in recovery from SUD to leverage cognitive empathy

and promote resiliency. Treatment should therefore focus on effective communication of cognitive empathy to this population to enhance their resiliency.

To further encourage resiliency, clinicians could suggest auxiliary methods in addition to traditional therapy for individuals with substance use disorders so that they can discover more about themselves and their experiences through individual mentoring, journaling, and spiritual exploration (Dermatis & Galanter, 2016; Krentzman et al., 2022; Nixon, 2020). Such resiliency is essential for individuals in SUD recovery to maintain their sobriety and/or long-term recovery. Research should continue to benefit from SUD recovery improvement, with clinicians learning how recovery outcomes are impacted by empathy and resiliency.

The results of this research may be applicable within the clinical setting. By answering the research question with the themes extracted from the interview responses, clinicians can develop the ability to implement such findings in their practice. The most vital implication for clinicians who work with SUD that came from this research was the view that clients need insight and awareness on how to maintain their resiliency and cognitive empathy as part of their recovery process.

Those who help clients with SUD can also contribute to the recovery process by focusing on providing the tools for clients to resist the cycle of relapse, detachment, and misunderstanding of self. The findings showed that the chances of intervention success were increased when clinicians provided supportive treatment with a recognizable approach to recovery that emphasized spiritual, cultural, and interpersonal harmony, as well as connectedness and assistance from SUD individuals' families and communities. These elements of treatment were necessary to establish skills in learning empathy and resiliency.

This study adds to the literature on the largely neglected topic of SUD, empathy, and resiliency. The research highlights the point that SUD recovery counselors and clinicans should work with their clients to relearn empathy as well as develop and strengthen their resiliency against future threats to sobriety. It is hoped that these findings will aid therapists to help individuals with substance use disorders to rise above their addictions, continue in recovery, and live productive and happy lives.

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Appendix A: Qualitative Interview Questions

1. Could please share your story about your active addiction/recovery?
2. What did you look like before recovery, while you were actively using?
3. Please describe your first experience with alcohol, cocaine, heroin, marijuana, opioids, or other substances. How did it make you feel? How long was it until you tried it again?
4. Please describe your experiences with hopelessness and helplessness during your active addiction, and your experiences to overcoming those feelings.
5. As you look back on your period of regular use, what kinds of changes did you see spiritually, with your family, friends, support groups?
6. Can you please share why you stopped using substances?
7. Please describe your challenges in early recovery. How do you or have you persevered?
8. Was there anyone who you felt understood what you were going through? Did they have any impact on your recovery?
9. Please describe your experience as it relates to your key motivation for staying in recovery.
10. What is the magic of staying in recovery for 10+ years?

Appendix B: Michigan School of Psychology IRB Approval Letter

11/19/2021

Protocol Title: The Importance of Empathy and Resiliency among African American Men in Long-Term Recovery with 10+ years from substance use disorders

Protocol Number: 211101

This number should appear on all future documents, recruitment materials, and informed consent, etc.

Dear Andre Johnson,

I am writing on behalf of the MSP IRB to inform you that your IRB application has been reviewed. The Board has made the decision to approve your application and authorize the collection of data effective 11/19/2021. This approval is valid until 11/19/2022.

Please remember the following:

- An updated IRB application is required in the event that you change anything in your research methods (e.g. participants, procedures, measures).
- An adverse event report should be filed with the IRB as soon as possible (e.g. 24 hours) in the event that you detect that a participant has experienced any distress during or after the conduct of your research.
- Failure to adhere to your approved research methods, as well as the above caveats, could result in nullification of any data collected and a recommendation for academic sanctions.

We wish you much success as you collect your data, and complete your research project. If you need any further information, please contact me at XXXX@msp.edu

Sincerely,

Georgios Lampropoulos, PhD

IRB reviewer

Appendix C: Recruitment Flyer

I am conducting a dissertation study at Michigan School of Psychology and am seeking research participants who are willing to discuss their experiences of being an African American man in long-term recovery with 10+ years or more.

To be eligible to participate in this study, participants must be:

- 28 years of age or older
- African American Male
- 10+ years in recovery from substance use disorders (alcohol, heroin, cocaine, marijuana, etc.)

If you are interested in participating, you will be asked to complete 2 interviews, either in person or through an online video platform (e.g., Zoom). Each interview will last approximately 1 hour. You will receive a $25 gift card for your full participation.

If you would like to participate, please contact Andre Johnson via email **XXXX@msp.edu** or by cell phone at 313.XXX.XXXX to set up an interview soon!

*****This study has been approved by the Institutional Review Board of the Michigan School of Psychology (**IRB Approval # Protocol Number: 211101).**

Appendix D: Informed Consent

Michigan School of Psychology

INFORMED CONSENT FOR USE WITH IN-PERSON OR ZOOM INTERVIEW

I, _____hereby agree to voluntary participate in the research study on substance use disorder and long-term recovery, conducted by Andre Johnson.

I understand that the purpose of the study is to explore substance use disorder and long-term recovery. To participate in this study, I understand I will do 2 interviews either in person, or by using Zoom, a free software program that allows users to make video or voice calls over the Internet, to answer questions in a two-part interview format. I understand the interviews will take approximately 2 hours in total (1 hour for the initial interview and 1 hour at a later date to confirm that the researcher accurately captures my experience). If I choose to meet via Zoom instead of in person, I am comfortable using computer technology, including Zoom and the Internet, to participate in this interview.

I understand that there are minimal physical, social, and economic risks associated with the study. It is possible that I may experience discomfort in answering some of the researcher's questions. In this situation, I am free to discuss my concerns with the researcher and can choose not to answer questions. Should I determine that I have personal concerns that might benefit from counseling, I understand that the researcher will not be available for counseling sessions but will, at my request provide a referral to a counseling service, which I may choose to pursue at my own expense.

I agree that my participation in this study is completely voluntary, and that I may withdraw from the study at any time without penalty.

In terms of benefits, I understand that participating in the study may contribute to having a better understanding of substance use disorder and recovery in African American men. When participation is complete, I may request the general findings of the research by contacting Andre Johnson at 313.XXX-XXXX.

I understand that the researcher will make an audio recording of the interview. To further ensure the security of the interview, the researcher will use a separate audio recording device and will not utilize the recording features included within Zoom. Later, the interview will be transcribed into a word processing document with no reference to my identity, and the recording will be destroyed after the completion of the project**.** Thus, any data or answers to questions will remain confidential regarding my identity.

I understand that the information I provide will be used for this project but may also be used in future studies. Any information derived from the research project that personally identifies me will not be voluntarily released or disclosed without my separate consent, except as specifically required by law. State law requires appropriate notification of designated others if I reveal that someone, including myself, is in danger of serious harm, including but not limited to abuse,

neglect, or threats of harm to myself or others.

Zoom conversations are encrypted for maximum security. However, I understand that there are security risks and consequences to conducting an interview over the Internet, including, but not limited to, the possibility that despite reasonable efforts on the part of the researcher: the transmission of my personal information could be disrupted or distorted by technical failures, and/or the transmission of my personal information could be interrupted, accessed, or stored by unauthorized persons.

To protect your personal information and confidentiality, security recommendations include: creating a new Zoom account that is solely used for the purpose of this research; deleting the Zoom account after the interview(s); creating a new password that is used only for the Zoom account; participating in the interview alone at a computer in a secure room; participating in the interview at a computer with a wired connection (opposed to a wireless connection); and ensuring that the computer is free of viruses prior to conducting the interview. I understand that the researcher will follow the above security recommendations when conducting my interview and that I am responsible for whatever security is implemented on my end of the Zoom connection.

I understand that if I have any questions related to my participation in this study, I may contact Andre Johnson 313.XXX-XXXX. I may also contact the Institutional Review Board Chair at the Michigan School of Psychology, (248) 476-1122 ext. 115, or **irb@msp.edu** if I have any questions about my rights as a research participant.

My signature below means that I have read and understand the information provided above and that I agree to participate in this study.

Participant's Name: _____

Participant's Signature:_____ Date:____/_____/_____

Researcher's Name: _____

Researcher's Signature: _____ Date:____/_____/ _____

Appendix E: Demographic Questionnaire

1. How long have you been in recovery (defined as absence of substance use)? _____

2. How do you identify your gender? _____

3. What is your age: _____ years?

4. City _____ State _____ Zip Code _____

5. Are you willing to be contacted for a follow up interview? ___Yes ___No

6. Preferred method to contact you? ____Phone Call _____Phone Text _____Email
   Phone: _____
   Email: _____

7. What is your Racial Identity? _____

8. What is your current Marital/Partnership status? _____

9. Employment Status:
___ (1) Work 40 hours or more a week
___ (2) Work fewer than 40 hours a week
___ (3) Homemaker
___ (4) Retired
___ (5) Unemployed
___ (6) Not Working/Disability

10. What is your primary occupation (whether or not you are currently employed)?
What is your major occupation or skill? _____

11. What is your total family income (including your spouse's income, if applicable):
Pay Range:
___ (1) Under $10,000
___ (2) $10,000-$29,999
___ (3) $30,000-$49,999
___ (4) $50,000-$69,999
___ (5) $70,000-$89,999
___ (5) $90,000-$99,999
___ (5) $100,000 or more

12. What is the highest education level you obtained?

Elementary _____
Some High School _____
High School Diploma _____
GED _____
Some College _____
Community College Associates degree _____
University Bachelor's degree _____
Graduate degree_____
Trade school_____
Professional school_____
Other _____

13. Previous substance use disorder treatment experiences (Describe all):

____ (1) Individual therapy
____ (2) Group therapy (outpatient)
____ (3) Intensive Outpatient (group, family, individual)
____ (4) Residential based treatment
____ (5) Hospitalization (including partial/detoxification)
____ (6) Psychiatric residential treatment

14. Previous attempts at Recovery (Describe all):

____ (1) 12 Step meetings
____ (2) Medically based strategies (suboxone/methadone)
____ (3) Cold turkey (no other support system)
____ (4) Harm reduction strategies (use only certain amounts/certain times)
____ (5) Behavioral replacement strategies (replacement of behavior)
____ (6) Other pathways to recovery non-traditional treatment (for e.g., church, spiritual healing)
____ (7) Community groups (refuge recovery, smart recovery groups)
____ (8) Any other not mentioned