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RESEARCH PAPER

Overcoming the pains of recovery: the management of negative recovery capital during addiction recovery pathways

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ABSTRACT

Recovery is experienced in both positive and negative ways and this paper attempts to integrate the 'pains of desistance' approach into a recovery capital framework. Pains experienced as a result of negative recovery capital are often thought to stimulate motivations for positive behavioral change, usually through a 'rock bottom' type moment. Whilst recovery capital and barriers to recovery have been explored in the literature, conceptualizing these as push and pull factors, and exploring their dynamic interaction, especially at distinct phases of recovery has not. Toward filling these gaps, we use the life-narratives of 30 people in recovery to explore how the pains of recovery (push factors) alongside different forms of recovery capital (pull factors) impact upon and are managed differentially at distinct phases of the recovery journey. Findings indicate the pains of recovery rarely led to positive changes. Rather, a range of pull factors created and promoted positive changes. However, the life narratives reveal that recovery capital cannot be accrued or sustained without managing (eliminating or reducing) the pains of recovery. Overall, this work highlights the need for policy and practice to help reduce the pains of recovery, especially during early recovery to accelerate transition to more stable phases of recovery. As recovery is neither a linear pathway nor a journey without residual challenges for many people, there is much to be learned about effective ongoing management strategies in preventing a return to problematic use that utilize a push and pull framework.

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Introduction

Research into recovery continues to grow each year, however, as Ashford et al. (2019) found in their review of definitions of recovery, there was little consensus, and they contain various operational weaknesses and professional lens-specific limitations. Further, Laudet (2007, p. 243) highlights 'recovery is a ubiquitous concept but remains poorly understood.'

Despite research showing that most people can and do recover (White 2012; Sheedy and Whitter 2009; Kelly et al. 2017), addiction careers average 28 years with an average of 4–5 episodes of treatment over 8 years (Dennis et al. 2007) and so the recovery journey is both long and not a wholly positive or a linear one. The emphasis in recovery research has tended toward the exploration of recovery capital, strengths, and assets as the prime means by which people recover (Best and Hennessy 2021). Research has also explored the notion of hitting a 'rock bottom' moment, or experiencing a series of painful events or crises, or wanting to avoid experiencing a painful event, in order to provide the motivation to make positive change (McIntosh and McKeganey 2000). In contrast, Cloud and Granfield (2008) have highlighted how negative recovery capital act as barriers thwarting the recovery journey.

Recovery is possible and whilst many overcome what we will term in this paper, the pains of recovery, the knowledge base is still in its infancy about when and how barriers and the pains of recovery are eliminated or reduced especially at different phases of the recovery journey (Best et al. 2021; Betty Ford Institute Consensus Panel 2007). This paper seeks to use the life-narratives of those in recovery to explore both the pains of recovery (push factors) alongside different forms of recovery capital (pull factors) at different stages of the recovery journey.

Recovery

The Recovery Science Research Collaborative define recovery as 'an individualized, intentional, dynamic, and relational process involving sustained efforts to improve wellness' (Ashford, et al. 2019: 5). The Betty Ford Institute Consensus Panel (2007), further illuminating the notion of recovery as a dynamic and nuanced journey, identified three phases of recovery: 'early recovery' which they defined as the first year of recovery, 'sustained recovery' referring to years one to five of recovery, and 'stable recovery' referring to five years plus of continuous recovery. The likelihood of relapse changes and is estimated to be very high in early recovery

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(50–70%) but reduces to 15% in stable recovery (Best 2019). Dennis et al. (2014) have found that recovery becomes self-sustaining after five years, and by this time external supports are not required. However, time in treatment or recovery are not the sole factor affecting the rates of relapse (Jason and Ferrari 2010; Cano et al. 2017).

Utilitarian theories of deterrence pervade in the view that some sort of a cost/benefit analysis promotes entry to recovery from addiction when it is deemed that the ongoing pains of addiction and dire life circumstances are greater than the envisioned pains of a life without addiction (Best 2019). Pain is therefore believed to be the motivating 'push' factor for behavior change into recovery and along the recovery journey, especially if a rock bottom moment is experienced or a person is wanting to avoid a specific pain e.g. going to prison or losing custody of a child (McIntosh and McKeganey 2000).

However, recovery research has also identified multiple 'pull' factors and forces for behavior change expressed in the acronym CHIME, community connection, hope, positive identity change, empowerment through discovery of meaning and purpose, and community service (Leamy et al. 2011). Such factors and forces pull a person onwards and upwards into new terrains and spheres on their recovery journey to advance, stabilize and sustain their recovery. Therefore, there is no need for pain as a push factor for motivation or behavior change.

Recovery capital

Recovery capital has evolved to become a strength-based scientific way to map growth and change of those in recovery through research exploring the operationalization and measurement of recovery capital (Best et al. 2016; Jason and Ferrari 2010). Granfield and Cloud (1999) originally coined the term recovery capital to refer to the resources that an individual possesses and can utilize during their recovery journey. Recovery capital was initially perceived as starting on a continuum at zero, that progressed upwards to represent greater amounts of capital being gained (Cloud and Granfield 2008). The underlying assumption here is that as a person progresses in their recovery journey, recovery capital increases, which decreases the chances of relapse and promoting ongoing recovery (Kelly and Hoeppner 2015).

However, research has shown that recovery capital is not accrued in a linear or as a consistently positive progressive journey (Kaskutas et al. 2009; Cano et al. 2017). Cloud and Granfield (2008) refined their initial conceptualization of recovery capital to highlight that recovery capital is not exclusively positive, and that negative forms of recovery capital exist on the minus side of zero which do not act as motivators for positive change but instead act as barriers and thwart progression. Gender, age, health, mental health, and incarceration were found to be barriers to recovery (Cloud and Granfield 2008).

Best and Laudet (2010) have argued that there are three core domains for recovery capital (personal, social and community). Personal capital encompasses personal skills and resources and qualities such as resilience, communication skills, self-esteem, and self-efficacy. Social capital encompasses the relationships, supports, and networks that the person can utilize positively in their recovery journey. Community capital encompasses resources at the local community level including specialist treatment supports. Examples here include, education and training, safe and secure accommodation, meaningful employment opportunities, mutual aid groups, visible recovery champions and recovery-oriented treatment services. These domains provide a framework to understand how capitals are accrued at different phases throughout the recovery journey.

Best and Hennessy (2021) found a lack of systematic attention has been paid to the conceptual and applied development of recovery capital in their extensive review of progress toward a science of recovery capital. Given the gaps identified in their review, they provided several future directions for research to address, for example: what are some of the most important factors driving the growth of capital in each domain? How does recovery capital change over time? How do the three recovery capital domains interact? How can recovery capital be used in different stages? The review highlighted the need for a more rigorous and systematic conceptual and empirical development of recovery capital.

Pains of desistance

This paper attempts to integrate the 'pains of desistance' approach (Nugent and Schinkel 2016; Patton and Farrall 2021) into a recovery capital framework. There is a significant degree of overlap between the populations involved in drug recovery and desistance (Best et al. 2017). Further, the drugs and crime literature suggest a strong relationship between substance use and offending (Bennett and Holloway 2004). Research has discussed some of the similarities between the processes of desistance and drug recovery (Best et al. 2017; Kay and Monaghan 2019). Desistance, akin to recovery, is a journey taken by those engaged in a criminal career who seek to reorient their identity and lifestyle away from crime toward integration, participation and human flourishing (Anderson and McNeill 2019). However, Nugent and Schinkel (2016) have recently highlighted that the process of desistance can be painful and difficult.

The pains of desistance act as barriers that challenge or thwart the desistance process (Nugent and Schinkel 2016; Patton and Farrall 2021). Several specific pains have been highlighted. The pains of isolation lead to a limited life in an attempt to avoid old negative or criminal social relationships and geographic locations (Shapland and Bottoms 2011). The pains of stigma and exclusion from a range of aspects of society e.g. the employment market, housing etc. signify the structural barriers faced whilst trying to desist from crime (Farrall et al. 2014). These often lead to the pains of goal failure when aspirations are not attained (Nugent and Schinkel 2016). Consequently, the pains of hopelessness are experienced (Standing 2011). Therefore, Nugent and Schinkel argue that desistance can be experienced more as '*an endurance test with little to no reward*' (2016, p. 13).

Rationale

The emphasis in the recovery literature has tended toward an exploration of recovery capital (the accrual of positive strengths, resources, and assets), therefore this paper will explore the pains of recovery alongside strengths, resources and assets (pull factors) to permit a more comprehensive insight into the recovery journey.

The recovery journey is experienced in both positive and negative ways and as such this paper attempts to integrate the 'pains of desistance' approach into a recovery capital framework (Nugent and Schinkel 2016). The 'pains' of recovery are defined here as negative factors and forces that act either as barriers that impede a person's capacity to overcome substance misuse problems (or negative factors and forces that are used by the individual as a means or motivation to make positive change).

Therefore, we will firstly identify which pains of recovery (push factors) are present, and which strengths, resources and assets (pull factors) are present, within the three domains (of personal, social and community recovery capital), at two phases of the recovery journey (early and stable recovery). Given that the likelihood of relapse reduces from the early recovery phase to the stable recovery phase (Best 2019), we are keen to observe what recovery capital looks like in these two phases of recovery, by exploring what happens to the number and nature of both the pull factors and the pains of recovery in each phase and how the pains of recovery are managed and overcome from the early phase to the later phase. Secondly, we will explore which push and pull factors and forces either promote the growth of recovery capital in the three domains or impede it. Of interest here will be an exploration of whether the pain of recovery act as a push factor for positive change.

Methodology

The paper utilizes 30 qualitative interviews of people in recovery from the UK. All respondents were part of a broader European study across four countries (England, Scotland, Belgium and the Netherlands) which used mixed methods and explored recovery pathways from addiction. (See Best, et al. 2018 for a full methodological outline of the REC-PATH study). The REC-PATH study builds on this emerging interest in mechanisms of action on the one hand, and an emerging literature on gender differences in recovery pathways on the other (Grella 2008). 28 respondents had participated in a baseline and follow-up assessment survey as part of the REC-PATH study (the remaining two participants completed either the baseline or the follow-up assessment survey) and were invited to participate in a follow up interview. We used stratified sampling to compose a sample of 15 males and 15 females ($n = 30$). The interviews were conducted over the telephone by the second author between September 2019 to March 2020 and lasted between 45 and 75 min. Most of the respondents were White (27 White, 2 Asian and 1 Black) and 29 were regarded to be in the stable recovery phase and 1 respondent was regarded to be in the sustained recovery phase (Betty Ford Institute Consensus Panel 2007). The interviewer typed up their responses during the interview. The aim of the qualitative interviews was to use a life narrative approach to explore in greater depth the participant's journey to recovery and their experiences with different kinds of professional and peer support, and their understanding of the key components that supported their recovery or acted as barriers to achieving their goals.

Outlined below is a typology of recovery capital that builds on the Best and Laudet (2010) model using a life narrative approach to recovery pathways. The life narrative approach is a qualitative approach which creates a rich window into the embodied lived experience of the individual who can tell their 'story' and the meanings of events at different stages and phases of their life course (Squire et al. 2014). The narrative approach allows the life trajectory of the individual whilst also understanding the socio-historical and cultural contexts in which the personal life events are occurring (Striano 2012).

A semi-structured interview was used in which participants were asked to describe key events and turning points around key stages of their life:

1. Active addiction career
2. Early attempts at recovery
3. Final and successful change attempt
4. Early recovery
5. Recovery experiences at the time of interview
6. Future directions and plans

A priori qualitative thematic analysis was undertaken with the interview transcripts based upon existing themes identified in the recovery capital, negative recovery, and pains of desistance literature as a starting framework for analysis using NVIVO. NVIVO is a qualitative software package that allows the researcher to organize, store and systematically analyze their data (QSR International 2022). During the coding process two additional themes emerged that are not identified in the literature whilst reading and re-reading the transcripts. The pains of uncovering existing addictions/developing new ones following sobriety and the pains of not knowing how to navigate a new sense of self and the world following sobriety. Table 1 presents the themes by stage of recovery (early and stable) and recovery capital domain (personal, social and community). Pull factors and the pains of recovery are separated into separate columns by stage of recovery.

Once the coding and analysis was complete, the authors presented the findings back to the respondents (as well as to others in recovery) to ensure that the themes used, and the analysis conducted matched the respondents' experiences. Positive feedback was received affirming the validity of the themes and analysis conducted.

Results

Themes are presented using a recovery capital framework broken down into early and stable recovery phases. We were keen to observe the number and nature of both the pull factors and the pains of recovery in both phases of recovery

Table 1. Recovery capital and the pains of recovery.

	Early recovery: recovery capital (pull factors and forces)	Early recovery: the pains of recovery (potential push factors)	Sustained recovery: recovery capital (pull factors and forces)	Sustained recovery: the pains of recovery (potential push factors)
Personal		Uncovering unresolved trauma Low self-esteem Uncovering other addictions Navigating a new self/ world Purposeless/hopelessness	Living a life beyond that which was envisioned Post-recovery identities	Fluctuating levels of self-esteem Mental health Relapse
Social	Mutual aid groups – gaining new friendships and tools for recovery	Family trauma and tensions Cutting off drug using friendships	Stable and supportive romantic relationships Family Reconciliation Social networks (via work, education and recovery groups)	Ongoing family trauma
Community		Unsecure housing Unemployment and menial jobs Negative experiences with professionals Stigma	Stable, secure accommodation Discovery of purpose Fulfilling employment and promotions	

explored, as well as the impact of the factors and forces for initiating and sustaining positive or negative changes in their recovery journey.

1. Early recovery

Personal capital: overcoming and managing adversity

All five themes relating to personal capital in early recovery were identified as pains of recovery.

a. **The pains of uncovering unresolved Trauma**
Trauma was common amongst the respondents which had contributed to the onset of addiction. For many this occurred in their childhoods and continued in their adult lives due to their drug addiction and dire life circumstances. Many disclosed childhood traumas as an adult whilst in a mutual aid group, rehab or in therapy, *'I have used drugs since I was about 13 but disclosed for the first time about abuse that had taken place (in childhood and beyond), I was about 35, I think. I found it very helpful*' (Luke). For some, the realization of the connection between their drug addiction and childhood trauma came through enquiries of others in group sessions. When Mark was asked why he had used for 25 years, he explained that he had no response but, '*I came to understand later that I had used opiates not because I was a bad person but because I had had a difficult childhood.*' (Mark). Ray had observed that '*unfortunately we have many people relapsing and dying because they are told alcohol and drugs are the problem, but it is the stuff underneath that is the problem.*' (Ray). Unresolved trauma was highlighted as a key issue for addiction and one that had elongated their addiction career.

b. **The pains of low self-esteem**
Low self-esteem had affected many respondents, stemming from childhood traumas etc. and had negatively affected decisions relating to how several of the pains and capitals discussed throughout this article were navigated. Alice noted, '*I have always struggled with self-esteem.*' For Ray, '*it was always about not being comfortable with who I was, and cocaine papered over the gaps in my confidence, and it allowed me to wear a mask.*' For Abbie, when speaking of her life situation she observed that '*it was about self-esteem, and I didn't care if I lived or died.*' The effects of low self-esteem negatively affected different areas of their lives and pains of recovery, for example, romantic relationships and work as discussed throughout below.

The pains of uncovering alternative addictions

For some, cessation of drugs and alcohol, resulted in further pains through the discovery that they had additional existing addictions or the development of alternative addictions during early recovery. Eric observed that he could '*easily give up the heroin and the crack and the Valium, but I don't know if I can go for the rest of my life without a crutch.*' Amy said she '*had no drink or drugs since then, although lots of addictive behaviors.*' The addictive behaviors noted by respondents ranged from, for example, alcohol, '*I had not drunk alcohol whilst I was on the gear, but then I did turn into a bit of alkie.*' (Zoe); relationships: '*I had a few more crazy relationships and that made me realize that they were just as addictive in a different way.*' (Amy); continual self-development, '*I have to better myself all the time. I feel this is a new addiction.*' (Zoe); and fitness, '*Exercise was my other thing, I had a co-dependence with my skipping rope.*' (Laura). Becoming abstinent was not the end point or utopia that

some had hoped, rather it highlighted the need for further steps on their recovery journey.

The unexpected pains of sobriety

As the respondents began recovering from their addictions, they also began to 'awaken' to a new view of the world and themselves. Mark reflected that he *'had no reference point, I had never had anyone in my life who was straight, who worked properly. So that was the hardest bit. How do you live this straight life?*' This new need to navigate life and relationships became a reality for some as they attained periods of sobriety, for example, Mark stated *'I had never had a relationship without Class A drugs.'* Or at the other end of the romance spectrum, for Amy she realized that she, '*had never broken up with someone sober.*' This had a disorientating effect which also made respondents feel quite vulnerable initially. The need to find replacement identities, paradigms, values, beliefs, habits, or routines were paramount here.

Pains of purposeless and hopelessness

A key feature of early recovery was the pains of not having responsibilities or a sense of purpose. This had a profoundly debilitating effect on personal capital. Amy stated unequivocally, *'I wanted to be dead, I didn't have a purpose.'* Similarly, Anne described, '*I had nothing to live for. I felt like it didn't matter what happened to me*.' Their lack of purpose created a sense of hopelessness about themselves and stymied a desire or hope for something better.

Social capital

Two of the three themes relating to social capital in early recovery were identified as pains of recovery and a pull factor was also identified.

The pains of family relationships and dysfunction

The pains of familial discord, dysfunction and alienation was common and another source of trauma. Ellie described how she had not known her family, *'All my life I have been in children's homes and foster care.'* Luke described being rejected by his family '*My family didn't want any contact with me*'. Eric described that, *'Two of my brothers are addicts. My mum stopped talking to me and wouldn't let me into her house, she would be behind the door crying telling me to leave her alone.'* Holly described her traumatic family situation after she moved back in with her parents after fleeing a violent relationship, *'my dad was abusing my daughter… It was just a dysfunctional family and abusive.*' The lack of social capital from loving, stable and supportive family relationships was a key pain of recovery that thwarted progress in recovery.

The pains of leaving old social and friendship networks

A common experience early in recovery was a reassessment of social networks. Amy found the transition to being in recovery quite hard, *'I had to drop a few of my previous friends which was really quite difficult.'* Cutting people and places from their lives created social isolation and a lack of support, Anne observed that she *'had nothing in the way of support because I had left an area where I knew everyone… I had to get to know new people.'* Lily observed how she '*cut a lot of people out and I was very much on my own.'* Yuri shared that *'I changed my networks. I really had no need to mix with the people I had used with unless I bumped into them in meetings*.' Drug using friendships and social networks had to be drastically changed but naturally led to social isolation and loneliness.

Mutual aid groups: gaining new friendships and tools for recovery

The previous pain of recovery was overcome for many by attending mutual aid meetings. These became a key source of social support and connection aiding social capital. Nicholas explained how meetings had bridged the gap following cutting off old using friendships, '*The meetings had replaced the loneliness and isolation… My social world was pretty much Narcotics Anonymous.*' Abbie also found that participation in recovery groups helped her *'start a social life and network through NA, and I am still friends today with some people.'* Yoel also highlighted the importance of connection, *'I started engaging in NA groups… I felt connected and on a level with people.' For* Nathaniel, the support he got *'filled the void of drugs and it was easier to wean myself away from drugs using NA than trying to do it on my own.'* Holly shared that *'after going to NA meetings, I became mentally stronger as I developed a support network.*' Recovery groups not only provided a new social network but also key replacement friendships for those they had cut off from.

Recovery groups also played a key role in helping achieve positive changes for many respondents. Dan highlighted that the benefit of attending groups was that *'my behaviors needed pointing out by other people for me to recognize them.'* Ed shared how meetings allowed him to, '*realize I didn't have to lie anymore. Someone asks outright what the problem is and I could say all of this stuff.'* Eric described '*when people told me how to stay clean it was like dropping bombs… I was done with using drugs and I just needed someone to show me the way'*. Elizabeth described that *'they were offering me something to cope with life. I had always felt that there was a manual for life that I hadn't been given.'* Mutual aid groups were key in providing a sense of empowerment, a range of tools, resources, and practices for recovery. This was a key source that provided replacement paradigms, values, beliefs, and routines to the void felt in the initial stages of navigating life without their old identity and lifestyles.

Community capital

All four themes relating to community capital in early recovery were identified as pains of recovery.

The pains of housing transitions

Throughout the recovery journey, respondents experienced key instability and transitions in their housing situations. Eric explained that he '*got evicted from a flat*', Holly explained *'I lost my own home because my husband was on heroin.'* Similarly, Amy explained that *'I came back [from rehab] and I was now homeless.'* After leaving her drug using partner, Zoe lived in her friend's spare room for a year and then secured accommodation, *'I got this nasty bedsit, but it was mine.'* Abbie left her parents' home due to increased tensions, *'and ended up living in a squat.'* Accommodation was a significant pain of recovery that contributed to an unsettled phase in their journey, with respondents being evicted from their homes, becoming homeless, having to reside in bedsits, or having to access emergency accommodation. Overlap between social and community capital are evident here as access to or loss of access to accommodation is also closely linked to positive and negative social capital. Supportive friendships provided at least temporary access to accommodation, whereas dysfunctional relationships with partners and family prohibit access to accommodation. The levels of instability with secure accommodation created a chaotic lifestyle prohibiting gains to be established in other areas of their lives.

The pains of securing meaningful employment opportunities and managing their recovery around work

A lot of respondents in this phase struggled in gaining employment or had to access low level employment roles to gain access to employment. Mark explained that in early recovery he had, *'been unemployed for a long time*'. Respondents at times had to work at menial jobs to get back in the labor market during their recovery, Harriet shared, *'I was a janitor at Tesco, I was embarrassed … I did some low-level jobs.'* Alice shared that, *'After about a year in recovery I got a cleaning job … I struggled with money and was on benefits.'* Difficulties accessing the labor market due to their criminal and drug using lifestyle was a key barrier to entry.

Being in recovery also affected respondents' capacity to work. Laura decided to take some time off work, *'After leaving rehab they suggested that I took a month off work, just to be with me.'* Elizabeth changed employment to facilitate her recovery, *'I had to ditch my full-time job. I started working part time instead in a shop, so that I could go to 3-4 meetings a day.'* Managing their recovery journey impacted their capacity to work in terms of number of hours per week or the type of role they felt able to undertake.

The pains of negative professional experiences

Key agencies were instrumental in the recovery journey and the quality of relationships and approaches used were key to their impact. Yoel articulated the differences he experienced with different staff, '*There were certain personalities I connected with and I believe that is because they showed compassion and humility and I didn't feel any lesser than them. Other people reaffirmed the negative feelings inside.'* Luke explained *'I had many doubters, my probation worker, for one.*' Mark shared that *'The substance misuse team want to concentrate on substance use but I have tried that for over 10 years and it only lasts so long and I start to self-medicate again … it is the underlying issues that need to be dealt with.'* Eva also shared her negative experiences, *'The frankly appalling service I received early in my recovery from the local alcohol service. I didn't feel supported.'* Negative experiences as well as negative attitudes or beliefs by key workers had a hugely detrimental impact on the respondents' identity, self-esteem, or sense of hope about themselves or the likelihood for positive change.

The pains of stigma as negative community capital

The effects of stigma permeate all aspects of the recovery journey. Isabel stated that '*there is still stigma, 100% about being in recovery.'* Yosef articulates how his reputation impacted his family, '*There was a lot more stigma around the family … Children's' friends talking about their dad being a skaghead, I didn't have a very good reputation locally'* and Dan explained that *'someone once said to my son 'your dad is a filthy fucking junkie.'* Luke explained that he decided not to disclose his recovery in his workplace, *'there is still a lot of stigma, and it is the stigma (along with trauma) that kept me using for many years. I meet these people day to day who slag drug users off.'*

The stigma of being an addict continued into their recovery journey and one of the ways respondents sought to validate themselves was by attaining qualifications. Yosef explained that he *'did lots of qualifications … I became a bit of a training junkie, some of it was to validate myself as I was at the top table in statutory services, and I felt a bit 'less than' for quite a while.'* Abbie explained, *'Having worked in treatment for so long, I am tired of being patted on the head for being another ex-addict and that is why I am doing a PhD.'* Some had managed to utilize the pains felt by the stigma to become 'qualified' in the eyes of society to gain a sense of validation and respectability but for many and for too long the role of stigma causes harms and barriers to recovery and elongates the addiction career.

The pains of recovery dominated in this phase of recovery. Eleven themes were discussed by the respondents' that were coded as pains of recovery and only one pull factor. Therefore, it is evident that recovery capital is very low at this stage of their journey.

2. Stable recovery: the ongoing successes and challenges

Research shows that the chances of relapse are significantly reduced in the stable recovery phase. What is less clear is what happens to the pains of recovery evident in the early phase of recovery as compared to this phase. Of

interest here also is whether there are more pull factors present in the stable phase to help explain why relapse is so significantly reduced.

Personal capital

There were three pains of recovery and two pull factors for the personal capital domain in stable recovery.

Living a life beyond what was envisioned

When respondents were asked to describe their current life situation, they responded by saying that '*my life is really full, really happy and really purposeful.*' (Elizabeth); '*My life at the moment is something I wouldn't have even dared dream about … I have everything in my life that I could want.*' *(Yuri)*; '*better than I could ever imagined it could be.*' (Sam). Amy contrasted, '*when I talk about things that happened in my life, it is like another version of me … recovery has absolutely changed my life and who I am. It has given me a life that I just did not know was possible.*' Life in this phase strongly exceeds what the respondents could have envisioned in the early phase of recovery.

The ongoing pains of self-esteem

Some shared ongoing pains with self-esteem, Eric shared how he had a positive 'can do' attitude but, often accompanied by '*crumbling self-esteem on any given day.*' For others like Dan, who felt that he had his '*confidence back, self-esteem, and compassion for others.*' Similarly, Isabel felt that she *'had built enough confidence and self-esteem'* during her recovery. Mark, through his success at work, felt that his '*self-esteem had increased.*' Although labeled as a pain of recovery, a noticeable difference in this phase of recovery however is that self-esteem was something that some respondents felt that they had regained as their recovery had stabilized.

The ongoing pains of mental health

Mental health also continued to be a pain of recovery that affected some of the respondents. Holly highlighted the ongoing detrimental impact that mental health had on the recovery journey *'I still struggle with my mental health and occasionally I lapse'* (Holly). For others, practices learned in recovery meant that they were able to manage their mental health and not relapse. Nick reflected that despite ongoing mental health issues that *'I have learned in recovery and through the steps to live without picking up.'* Sam expressed that despite *'still having issues that I have to manage. I have anxiety that is terrible, and I have low points, but I can sit with stuff now that I never could. I can sit with stuff now and live with it. I just feel.'* Although labeled as a pain of recovery, many who still had mental health issues in this phase felt they were now able to manage this due to the tools and practices they had learnt in recovery, without it causing them to use drugs, which is a contrast to their early recovery.

The pains of relapse

For many at this stage abstinence was still the goal, as Eric articulated, *'it has to be abstinence. I can't use, I don't have an off switch.'* The view that often accompanied this was, *'I don't think I will ever be recovered. It is a continuous thing.'* (Holly). For others, such as Emily, who did not subscribe to the view that recovery equated to abstinence, *'am I going to live my life sober and hanging on for grim death or am I going to carry on and occasionally have a drink? I will never be back to the dependency I had.*' However, for Ellie, she shared that she *'relapsed last year, I think it was meant to happen. It was like 3-4 days but thankfully nobody got involved. I picked myself up and I said no, no more. Since then, I don't have an urge, nothing.'*

Post recovery identities: front doors and good exits

For some, they had moved on to embrace society, relationships, roles and a sense of self identity no longer connected to addiction or recovery. Zoe shared that *'I don't class myself as being in recovery, I class myself as being recovered.*' Dan derives meaning from *'feeling a part of my community, I started off in a recovery community, grew into the mutual aid community and now I feel fully integrated into the local community. I really believe, we need front doors, but we also need good exits.'* Laura also shared that '*I belong in society today, not separate from society. I feel like a part of it now'.* Mark also echoed this sentiment when he said, *'I don't think of myself as being in recovery. I used to be, now I am just Mark.'* For these respondents they felt they had become reintegrated into society and were able to participate, contribute to and were connected to society and networks. This would not have been possible in early recovery.

Social capital

Two of the three themes relating to social capital in stable recovery were identified as pains of recovery and two were identified as pull factors. Family provoked mixed responses in that it continued to be a source of dysfunction and therefore a pain of recovery but for many it was now a stabilizing form of recovery capital.

The pains of social events

Being in recovery has resulted in the creation of boundaries around participating in social networks and social events. Respondents shared how they avoided some social events. Laura shared how, '*I would go for birthdays meals for the family in a restaurant but going in a pub for drinks has no place for me.*' Ed described how social events have altered because of his recovery, '*I was invited to a stag-do for one of my oldest friends and I didn't go. I engage with them still but don't drink. We go out every year on good Friday (we call it*

the 'Long Good Friday') and everyone gets shit faced but I don't.' Alice shared that *'I don't really go to Christmas parties or work events. If the work team were going for a lunch, I would do that, but not nights out. I don't drink either now.'* Recovery for some has meant that they avoid certain social events and locales to maintain their recovery.

Romantic relationships

In this phase, most respondents had reflected on their previous experiences in romantic relationships, had accrued social capital, gained increased levels of self-esteem and as a result were now in stable and positive romantic relationships as compared to the early recovery phase. Whilst for some, they were *'divorced'* (Noah), *'still a single mother of 2 children'* (Lily), had recently discovered that a *'partner is cheating on me' (*Liz), for most, their relationships had stabilized and were positive. Emily shared that she now has *'a very happy marriage to my husband who is very supportive'*. For others, their relationships post drug addiction had transformed in nature, Nathaniel had been married for 8 years at the time of interview and said he is *'doing things as a partnership in a way that I never imagined that I would or could.'* Similarly, Eric expressed that, *'It is the first time I have been in a long-term relationship that is not just about me.'*

Family reconciliation and the pains of ongoing trauma

Respondents reported more stable family situations and it was clear that reconciliation had taken place. Dan said that '*I have family back in my life now*.' Similarly, Anne was '*back in contact with my family.'* Ellie had gained *'custody of my child which I didn't have before.'* Luke also shared that, '*I have had a child and I have a family now*.' Mark said that '*I have become a parent, and life is very different to what it once was.'*

However, for a minority, family was still a place of tension or trauma. Elizabeth described that, *'My recovery has isolated me from my family who are still involved in addictions.'* For Holly, since she moved out of her parents' home she has *'cut off contact with my parents and changed my name by deed poll.'* Zoe described the impact of inter-generational transmission of addiction, *'My last six months of my life have been hell as my son has started taking drugs … He is self-harming, and he sent me pictures of his arm saying that "I hate you, you fucking bitch".'* Emily shared that *'I have two wonderful children who are 27 and 29 but they have been through the wringer with me so my relationship with them can be fraught.'*

Community capital

Both themes relating to community capital in stable recovery were identified as pull factors.

Stable and secure accommodation

Almost all respondents reported stable accommodation at the time of the interview. This contrasts very much with the early phase of recovery. Quality stable accommodation provides respondents with a sense of accomplishment, pride, and a legitimate replacement identity of being conventional and a part of everyday society. Abbie provides the following contrast, *'when I was using, I lived in a squat. I now have a chalet house in Poole in Dorset. I have a south facing garden and I have a conservatory.'* Yuri also now has *'a lovely house in a nice bit of Liverpool witha beautiful garden.' Nick* shared he '*owns a two-bedroom house*' and similarly Yosef is also *'a home-owner.'* Anne boasted that she lives *'in a great location, and I get on great with the neighbors. I came third place in the gardening competition.'* It is evident that increases in personal capital in the form of financial resources (primarily through successes in paid employment) have enabled access to stable and secure accommodation types.

Work: seniority and broadening social networks

At the time of interview, just over three quarters (77%) of respondents were in employment unlike in the early phase of recovery. Several had been promoted and gained senior and management roles. Moreover, respondents spoke about being in employment that they found fulfilling, Emily expressed that she has *'a very fulfilling job and that is an incredibly important part of my life.'* Similarly, Harriet said, *'I love my job, it's diverse, and rewarding.'* Respondents have now been able to access employment but moreover employment that is both meaningful and fulfilling whilst also gaining senior roles within an organization. Discovery of purpose and new skill sets was key here for many in feeling fulfilled in their work.

Employment broadening social networks

The world of work provided a vehicle for gaining new friendships and to access and create new social networks. The social capital accrued here was especially important as it allowed the respondents to reduce or negate the pains of isolation felt from cutting off old drug using relationships and networks discussed above. Lily had created a new friendship network, *'The way I socialize now is with work colleagues and work acquaintances.'* Mark explained how his work was key to his social network, *'At one point that weekend service had 60 volunteers and my social life was built around that.'* Eva shared about her supportive work colleagues *'they're the first people to pick me up on a bad day, and the loudest cheerleaders when things go well.'*

The stable recovery phase contrasts very strongly with the early recovery phase. Recovery capital has increased substantially in this phase. The number of pains present in the stable recovery phase had reduced from eleven to five and the number of pull factors had increased from one to six. It has more 'pull' factors that had helped to establish a sense of hope, motivation, the belief that they could or had changed

and that their lifestyle had changed dramatically often beyond recognition as compared to their addiction phase.

Discussion

The two aims of this paper were to explore which pains of recovery and pull factors were present in early and stable phases of the recovery journey within a recovery capital framework. We wanted to explore what recovery capital looked like in the two phases of recovery, and what happened to the number and nature of both the pull factors and the pains of recovery in each phase. Secondly, we aimed to assess which factors (push or pull) resulted in more significant advances along the path of the recovery journey. We were keen to explore whether the pains of recovery acted as a push factor for motivation or positive change. Findings show that there were more pains of recovery present in the early phase of recovery compared to the stable recovery phase. Eleven pains of recovery with one pull factor were found in the early phase of recovery. This concurs with Best and Ivers' (2021) ice cream cone model of recovery that is premised on the assumption that low recovery capital is common amongst those starting recovery, and that social and community supports are needed early in the journey to build overall recovery capital. Most respondents had eliminated many of their earlier pains of recovery by the time they reached the stable recovery phase. Further, for those that had not eliminated a specific pain, in most cases they had managed to reduce the impact of a particular pain of recovery. For example, some respondents described how they still struggled with their mental health and fluctuating low levels of self-esteem, however what was different in this phase was that many had found tools to help them navigate these. Where a setback was experienced, the respondents described how they were now able to re-group quickly and resume their recovery practices to help them get back on track. What is evident in this later phase of recovery, is that the nature of some pains had changed for many of the respondents. Nevertheless, the pains of recovery acted as barriers to the respondents' journeys and consequently stalled or thwarted their recovery and so did not produce positive change, especially in early recovery but, their impact and influence is significantly reduced for the majority in this sample in the stable phase.

Importantly, having lots of pains of recovery, for example in the early phases of recovery, did not act as a push motivation to promote positive behavior change. The two exceptions to this occurred when respondents dealt with unresolved childhood trauma which promoted the creation of a new positive sense of identity and outlook which then fueled new positive decisions and actions, and secondly, where stigma in employment was transformed into a motivation to gain qualifications to validate their role. Rather, the removal or elimination of the pains of recovery provided the basis for the initiation and speed at which strengths, resources and assets may be activated and utilized to promote increased and ongoing human development, well-being, and flourishing. In a sense, their removal and reduction provide the stability and increased 'space' for their new identity and envisioned life to be built and maintained. For example, as the pains of unemployment and menial jobs were removed, and importantly the discovery of purpose and a key skill set was in place, this sparked an ongoing positive series of advances along their journey as the respondents' used advances in their employment, education, and training to access new and positive social networks and gain social capital (Putnam et al. 2004). These new roles were key transformative and communication mechanisms by which they were able to construct a replacement legitimate identity from old forms of negative self-identity based upon drug use and addiction. As such this boosted self-esteem but also helped the respondents to gain legitimacy in the eyes of the 'other' and thereby helped alleviate the stigma of the old drug using identity (Biernacki 1986; Patton and Farrall 2021).

This research shows the impact of 'pull' factors during the recovery journey. Pull factors had the greatest positive impact for accelerating growth of recovery capital and promoting forward motion along the recovery journey and especially for creating stability and sustaining recovery. For example, the hope and belief that recovery is possible via mutual aid social networks and connections, personal identity changes, and finding purpose and key skills expressed within meaningful work activities and roles. The most potent pull factors appear to relate closely to Leamy et al.'s (2011) acronym CHIME. The factors created strengths and assets that had a potency and contagion that spread across different domains of the recovery capital framework (Best and Ivers 2021).

Levels of recovery capital are not static but changed over time between the two phases (Mericle 2014). The substantial reduction in the number of pains of recovery and the increase in pull factors in the stable recovery phase combines to reduce levels of relapse in this phase (Kelly and Hoeppner 2015; Best 2019). Whilst the number of pains or pull factors identified within a given phase of recovery is both important and illuminating, as Best and Hennessy (2021) noted, there is a misplaced assumption that all forms of recovery capital should be weighted equally. The results here demonstrate that some forms of recovery capital provide access to a greater number of resources and provide a much-needed stability for the respondents and vice versa.

The combination of the accrual of strengths, resources, and assets as well as the elimination of the pains of recovery offer the best chances of recovering from a life of addiction. Eliminating or reducing the pains of recovery in the early recovery phase created a shift toward opening the space for pull factors to be established within the lives of the respondents which later allowed them to move into the stable recovery phase. The respondents now had an architecture of recovery capital that meant that the 'building' of their new identity and lifestyle could not be easily demolished or cause relapse, even though some rooms still needed further or ongoing 'repairs' or 'renovations' to further strengthen the gains attained.

This paper provides a much-needed insight into the personal, nuanced and dynamic nature of recovery pathways that are limited within the literature (Laudet 2007; Sheedy and Whitter 2009). In line with previous research, recovery leads to human development, participation and contribution to society after a significant period of time (White 2012; Best et al. 2016), and highlights that whilst various pathways to recovery are evident, the management of several pull factors and forces alongside the pains of recovery are key. The implications of this research, for practice, recovery-oriented treatment, and support services, highlight the need for the creation of strengths-based recovery plans that map the range of pull factors that accelerate growth and positive change whilst also addressing their pains of recovery to fully maximize recovery outcomes (Cano et al. 2017). At the community and societal level more needs to be done to address significant barriers relating to stigma which in turn leads to social exclusion and ongoing social inequality due to their detrimental impact on recovery processes. The implications of this research for policy relate to where barriers can be removed or reduced for example in the labor market, policy has a key structural role to play in providing greater means to recover. Further, drug policies which are influenced by theories based on push factors (behavioral change motivated by pains) alone need to be reviewed as they could be further enhanced by encompassing a more comprehensive dynamic reality to the recovery journey.

Despite the strengths of the project a number of limitations could potentially affect the findings. The respondents defined themselves as being in recovery (or recovered) and therefore volunteered to participate, and as such the sample may be more likely to feel comfortable talking about their recovery as compared to others. This may also in part be due to a belief that their recovery is on some level successful. It is recommended that further research into pull factors and forces alongside the pains of recovery is conducted using a range of methodological approaches to help gain a more extensive picture of the nuanced and dynamic process of the recovery journey with a broad array of people and recovery experiences to highlight the pathways that create an architecture of recovery capital for those in recovery.

This work highlights the need to be cognizant of the desistance literature relating to the pains of desistance, and the resultant conceptualization of push and pull factors, in developing conceptual and practical approaches to addiction recovery. Viewing the pains of recovery as push factors and recovery capital as pull factors, revealed that recovery capital cannot simply be accrued as the pains of recovery must also be managed effectively. Findings suggest that reductions in the pains of recovery in early recovery could accelerate transitions to more stable phases of recovery, provided that strengths-based recovery plans (Best and Hennessy 2021), which incorporate a range of pull factors to maximize the possibility of accelerated growth and positive change are in place. Further, the pains of recovery reveal that recovery is also social and societal (Best and Ivers 2021) and as such transformations must occur at the structural and systems level if we are to better understand recovery and aid in the much-needed reduction in the pains of recovery. As recovery is neither a linear pathway nor a journey without residual challenges for many people, there is much to be learned about effective ongoing management strategies in preventing a return to problematic use that utilize a push and pull framework.

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Ethical statement

The research received full university level ethical approval. Informed consent was gained for all participants including highlighting voluntary participation, the opportunity to ask further questions about the research before participation, the right to withdraw, how the data would be stored and used and how to make a complaint etc.

Disclosure statement

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