Processes in Help Seeking Among Amphetamine Users who Experience Problems with Drug Taking

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ABSTRACT

It has been recognised that amphetamine users who experience problems with drug taking rarely initiate or retain contact with services. Reasons for this have been attributed to a stereotyped view that drug services are orientated towards opiate users and therefore have little to offer other drug using populations who may wish to seek formal help. Amphetamine dependency is a growing problem in the United Kingdom and commentators suggest that services will have to begin to acknowledge the diverse clinical needs of this population.

The research undertaken in this study focused on how amphetamine users sought help from a local community drug service. A qualitative research paradigm was used. This facilitated exploration of the process and action involved in help seeking and its associated behaviours. Interviews with amphetamine users were analysed using grounded theory. This was aimed at discovering the principle relationships between help seeking phenomena in the data.

In the resulting account, a three-stage process of help seeking illustrated users' constructions of problematic drug use, help seeking needs and the impact of service contact on these. Related themes were identified around the development of problems, experiences of loss and helping encounters. These emphasised the personal and social sequelae of problematic drug taking. Unexpected hypotheses emerged about the role of personal identity and therapeutic relationships. The analysis focused on the conceptual development of help seeking.

Theoretical, organisational and clinical implications emerged from the analysis. The need to develop a formal theory of help seeking was recognised. Findings suggested that information needs to be targeted at amphetamine users. Therapeutic context rather than content was highlighted by users. This major finding indicated that person-focused approaches informed the general style of preferred engagement for users who sought and retained contact with the service.
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1.0 INTRODUCTION AND BACKGROUND TO THE RESEARCH

The research presented here concerns amphetamine users' experiences both prior to and during their contact with a drug service in which the researcher was undertaking specialist clinical training. Observations made by drug workers indicated that few amphetamine users approached the service. In addition, of those who did, few remained in contact on a regular basis preferring, it was postulated, episodic contact as and when problems arose. Obvious questions emerged as to why it was so difficult to encourage these drug users to initiate and retain contact with the service. Following further discussions with interested parties within and outside local drug services and by examining background literature, a specific area of research interest emerged around the process by which amphetamine users seek and obtain help from the service.

Because of a perception among users that services are orientated towards opiate users it is often contended that there is little to offer amphetamine users who experience problems. This contention is supported by Klee (1992) who has referred to the paucity of research on amphetamine in general and in particular, on the lack of published literature concerning the efficacy of clinical interventions. In addition, Pates et al. (1996) have acknowledged the growing prevalence and incidence of amphetamine use in the UK and advised that it is a problem which many drug services will eventually encounter.

Themes that are current in general dependency research include the nature of problematic drug use and motivation to change. Previous research has addressed diverse areas such
as attribution, personality and behaviour (Orford, 1985). However, consideration of relevant literature in this study will be confined to perspectives which inform the nature of dependency in relation to amphetamine use, help seeking and changes to drug taking. The main literature will be synthesised in such a way that the clinical implications of social, psychological and physical problems associated with drug use can be examined and implications for clinical practice addressed.

1.1 AMPHETAMINE USE AND THE NATURE OF DEPENDENCY

The literature demonstrates that definitions of drug use are often ambiguous and can present value judgements about what constitutes inappropriate use of drugs. A number of different viewpoints on the nature of dependency are offered by commentators and these are summarised briefly.

The term *misuse* implies that a drug is used either excessively or without sanction (Ghodse, 1995). Because it is a value-laden term, its use is likely to reflect the attitudes of the "observer" rather than the "user" of the drug itself. The term *drug abuse* has been used also, but is considered to be equally judgemental. Alternatively, *harmful use* is said to describe a pattern of drug use across all drug classes which causes damage to either physical or mental health (WHO Expert Committee on Drug Dependence, 1993). Debate has taken place about whether people’s drug use should be defined by addiction, habituation or dependence and questions focus on whether these can be considered to be separate entities or not. Because of the importance of emphasising the psychological
components of drug use, dependence is currently the preferred term and will be used here.

Additional viewpoints on the nature of dependency are offered in the literature. For instance, Orford (1985) has conceptualised drug use as a manifestation of "excessive appetite", a view which is allied to the notion of misuse. He suggested that levels of use will vary in relation to preferred drug of choice. Davies (1992) cautioned that definitions of dependency will remain problematic if researcher and clinicians do not take account of the adverse effects produced by different drugs and differentiate reasons for their use.

Davies has further proposed a reconceptualisation of the notion of dependency, "as a motivated species of discourse" (in press). It is argued that drug use becomes "addiction" (his term) only when a person who uses drugs finds him- or herself in a position where it is necessary to assume the mantle of an "addict" in order to survive. The positions referred to might include social, pharmacological, economic or legal situations though he maintains that the state of addiction itself is not necessarily inherent to these situations. In this way dependency is viewed simply as a way of thinking and behaving which is adaptive for drug users who are confronted by a system which places sanctions on such activity.

1.1.1 Amphetamine Use in the United Kingdom

Data concerning the extent of amphetamine use in the UK derive from a number of sources and include prescribed use (Pickering and Stimson, 1994), data on offending (Ghodse, 1995), mortality studies (Home Office, 1994) and demographic factors (Klee,
1992). Its primary use is that of a mood enhancer employed for recreational purposes especially among new, young drug takers who are interested in stimulants rather than depressants (Gilman, 1992). It is also known to be used by some occupational groups (e.g. drivers, night shift workers) to sustain performance over time. Both illicit and controlled use has been reported in these groups. Amphetamine use appears to be increasing at a faster rate than other drugs. In the decade from 1981 to 1991 all seizures trebled, with amphetamine increasing by a factor of 6. It is therefore described as one of the most popular recreational drugs in the UK.

In the UK, Klee (1992) has estimated that three-quarters of amphetamine users are male. Her work indicated that there is added risk for HIV infection because of the increasing tendency to share injecting equipment. The social profile is similar for all stimulant users: a majority are from lower socio-economic groups, are aged 20-35 and most are male. Increases in polydrug use have been noted within amphetamine using populations.

1.1.2 Amphetamine and its Effects
Different drugs can lead to different types of dependence (West and Gossop, 1994). In the case of amphetamine, which is a central nervous system (CNS) stimulant, effects may vary with different dosage levels. These usually result in excitation of the CNS, and sought-after effects include its stimulatory action notably: increased energy, clarity and power of thought, reduced appetite, sustained performance, elation and, for some, increased libido.

Extreme stimulation and depression on withdrawal have been reported in high doses
(Palfai and Jankiewicz, 1991). These may lead to specific disturbances of perception, mood, thinking, behaviour or motor function and produce individual, public health and social problems. Regular use at high doses leads quickly to tolerance and this necessitates increased consumption to achieve the desired effects. Paradoxically, such positive effects are rarely maintained over time. These latter features are the defining elements of amphetamine dependency.

Measures of severity have also been examined as an aspect of dependence. For instance, Gossop et al. (1995) reported on the psychometric properties of the Severity of Dependence Scale (SDS). Their results have given cautious support to the notion of a "dependency construct" which incorporates physical and affective expectancies of amphetamine withdrawal and expectancies regarding withdrawal relief.

1.1.3 Drug Typologies and Amphetamine Use

In describing the characteristics of drug takers themselves Klee (1997) alerts the reader to the danger of stereotyping an already marginalised group. The notion of creating a typology of amphetamine use was not intended to obscure the users' individuality but was designed to "promote understanding of the rich diversity to be found among those who use this particular stimulant" (p. 35). Four basic "types" were identified in Klee's work. Those types which are relevant to the current research are emphasised here.

Recreational Users

These users are characterised by their periodic and social use of amphetamine. They include ravers who are young, low-dose users involved in the weekend club scene. This
type is associated with age, class and preferred drug. Their predecessors, older hippie ravers, emerged from the 1970's club scene, such as Northern Soul all night events. It has been noted that older ravers prefer intravenous routes of administration. A further sub-group includes young mums whose drug taking is largely functional. This group uses amphetamine to get the housework done, deal with childcare pressures and control weight gain.

Controlled and Uncontrolled Users
Controlled use of amphetamine is said to be governed by individual and environmental factors. For the prudent user, dependency can be avoided through a position of informed choice and awareness of the consequences of excess. The user employs strategies to counteract the negative effects of amphetamine and is aware of the disadvantages of different modes of drug administration. Occasional and targeted use of amphetamine occurs.

In contrast, the isolate tends to be a long term user of amphetamine, now experiencing its paradoxical effects brought about by increased tolerance to the drug. The isolate tends to use alone, lacks confidence and has low self esteem and few friends. Drug use tends to be hidden from others and only surfaces when mental health problems or difficulties with aggression emerge. Because of this self imposed isolation, levels of social interaction are low. A majority of isolates are said to be male intravenous users. By comparison, the modified user is usually at a later stage in their drug career and has undergone a progression in drug taking style from recreational to intravenous use. As
a result of emerging health and associated problems this type of user is said to be highly motivated to change.

Two further typologies have been identified: **criminal users** and **self medicators**. For criminal users amphetamine is known to be a functional aspect of property crime and is used to facilitate this activity. Self medicators are, in the majority, women who use amphetamine for physical and mental health symptoms across a range of treatable conditions including obesity and depression.

These typologies or patterns of drug use identify the diversity and progress of drug taking in relation to amphetamine and suggest that adherence to the drug can endure, over time. This is exemplified by the "older hippie ravers" and "the isolate" who, Klee (1997) suggested, is the likeliest candidate within this typology to seek treatment because of a particular vulnerability to the health damaging effects of amphetamine. The use of such profiles may be able to provide services with precise information about who is likely to require help in relation to drug dependency and aid planning and allocation of resources accordingly.

### 1.2 THE DEVELOPMENT OF PROBLEMATIC DRUG USE

#### 1.2.1 Risk Factors for Drug Involvement

Christie *et al.* (in preparation) have identified a range of risk factors from focus group research that help to predict young people's involvement in drug orientated behaviour. These include factors relating to family such as parenting skills and attitudes and family
disharmony. Peer influences and preferences are said to lead young people to emulate others who are similar to them. Conversely, rejection by peers may also be implicated in drug taking. Personality factors found to be involved in early drug taking include anger, depression and low self esteem. A number of environmental issues have been noted in relation to initiating drug use and focus on economic deprivation, unemployment and criminal involvement. Finally, educational factors such as underachievement and truancy present early risks for potential drug taking.

1.2.2 The Drug of Choice Phenomenon

O'Connor and Berry (1990) have examined the influence of the drug of choice phenomenon on the development of problematic drug taking. Reasons for drug taking focused on emotional, physical and social sequelae of use and results indicated that stimulant users chose the drug for its physical effects rather than for social reasons. There were no differences between users of opiates, stimulants and hallucinogens in terms of emotional reasons for use (i.e. either to counteract depression or elevate mood). This broadly concurs with the findings of Erickson et al. (1990) in which a hierarchy of drugs was constructed according to their "dependency potential." This derived from clinical impressions and results showed that CNS stimulants (cocaine and amphetamine) were ranked first followed by opiates. These results appeared to indicate that amphetamine users have a greater potential for developing dependent behaviour and concomitant problems compared to users of other types of drugs.

The interplay of biological and psychological factors may point to reasons for the above findings. For instance, Palfai and Jankiewicz (1991) have indicated that one of the most
sought after effects by amphetamine users is mental alertness and arousal. Such pleasurable effects derive from adrenergic responses at both peripheral and central nervous synapses. These are mediated especially by dopaminergic neurons in the reward system of the brain. At low doses euphoria and elation may occur without the undue danger of psychological dependence. At higher doses a euphoric "rush" has been described (following intravenous injection) either immediately or some minutes following administration. In behavioural terms, the former constitutes a conditioned response to the drugs' effects.

1.2.3 Preferred Routes of Administration

Route of administration is known to have an impact on the development of dependence and drug problems (Strang and Edwards, 1989). Indeed, it may be a primary factor in progressing from occasional use to dependency (Cocores et al. 1991). Based on these findings, Gossop et al. (1992) examined the relationship between route of drug administration and severity of dependence across a range of drug types. Interestingly, their results indicated that many stimulant users reported no difficulties in terms of dependence. This appears to contradict the notion of increased potential for dependence found by Erickson et al. (1990) and may be accounted for by different methods of data collection and analysis. For instance, Erickson et al.'s. findings derived from rankings of clinical impressions whereas Gossop et al used methods of interview and psychometric assessment sensitive to dependence with users themselves.

1.2.4 Patterns of Use

Use of stimulants in general is known to be episodic in nature. When "compulsive"
patterns of use emerge these are carried out in "runs" or "binges" (Murphy et al. 1989). Regular injection, on a daily basis, may increase the risk of developing a severe dependence syndrome and of experiencing an amphetamine induced psychosis (Hall et al. 1993). This has been attributed in part to the fact that preventative education programmes about safe injection practices have focused on opiate drug users thus creating the impression among amphetamine users that this population alone is at risk of contracting viral infections such as HIV or Hepatitis B or C.

1.2.5 Physical Problems

A comparative study of withdrawal symptoms has been undertaken by West and Gossop (1994). They suggested that operational definitions of the factors involved in withdrawal are difficult to determine. This is because multiple determinants of withdrawal mean that its syndromes are not easily demarcated and because complex drug interactions may occur, especially with regard to polydrug users.

Essentially, withdrawal from any drug of dependence will result in mood and sleep disturbance. Physical complications may also occur (e.g. nasal ulcers, IV abscesses) and are associated with route of administration. The effects of stimulant withdrawal remain unclear: somatic symptoms are rarely evident although depression may occur as a result of physiological rebound. A temporal pattern of withdrawal symptoms also appears to be important in maintaining positive withdrawal behaviour. For instance, users who experience severe symptoms at an early stage of withdrawal may be more motivated (and therefore resilient) to continue withdrawal than someone who experiences difficulties in later stages of withdrawal. In a range of withdrawal responses insomnia appears to be
the least well tolerated physical symptom among amphetamine users.

1.2.6 Psychological Problems

Hall et al. (1996) replicated an earlier study on psychological symptoms relating to amphetamine use (Hando and Hall, 1994). Both studies suggested that a high prevalence of psychological morbidity existed among amphetamine users. Severity of symptoms related to frequency of use and route of administration (especially intravenous injection). Symptoms were reported to increase after initiating amphetamine use and consist principally of anxiety, depression, hallucination and paranoia. Such symptoms could not be accounted for by prior use of amphetamine. This raised key questions about whether "more troubled individuals" (their term) were more likely to become involved in intravenous amphetamine use and experience more severe problems than users who chose alternative routes of drug administration.

1.3 THE PSYCHOLOGICAL BASIS OF HELP SEEKING AND BEHAVIOUR CHANGE

The following section considers psychological explanations of help seeking and behaviour change. It demonstrates that decision making and motivational theories provide the principle models which inform our understanding of how drug dependency operates. The strengths and limitations of opposing theories are considered.

1.3.1 Decision Making and the Help Seeking Process

Orford (1985) commented that "it seems intuitively correct to speak of someone with a strong appetite as facing a difficult decision" (p. 271). According to this view, a
person's behaviour reflects decisions which arise out of a position of conflict. Thus, the individual is confronted with a choice between alternative behavioural options when considering seeking help and change. This perspective is reflected in what West (1989) has termed a "commonsense view of motivation" in which potential costs and benefits of courses of action are available to the individual. In West's view, this represents a theory of decision making in relation to dependency. Varney et al. (1995) have interpreted this notion of decision making as the probable occurrence of certain consequences of behaviour change. Decisions are said to arise from positive and negative consequences of changing behaviour based on the likely occurrence of each consequence and the relative value of behaviour change to the individual.

The process of decision making involves assessment of decisional risks and consideration of options which will maximise anticipated change. In the example of drug taking, users' experiences may lead to expectations about the effects of continued use. For this reason, the drug user weighs the possible consequences associated with help seeking and continued use to facilitate change. According to this explanation, help seeking occurs when beneficial gains are perceived to have greater weight than the consequences of seeking help (i.e. relinquishing drug use). Kanfer (1986) demonstrated that identification and evaluation of problems precipitated a "need to change". In drug dependency, negative consequences of events result from appetitive behaviour and lead the person to acknowledge that change is necessary.

It is possible that the constructs referred to by Varney et al. (1995) may not be sufficient in themselves to explain the process of decision making in help seeking. For example,
O'Doherty and Davies (1988) have reported the findings of a study which give credence to this contention. Their study examined memory for events in relation to the consequences of seeking to change problems with substance use. Results were said to reveal the psychological nature of peoples' accounts of their lives. On repeated measurement over an eighteen month period, a "procedural artefact" emerged from the data. This indicated that an intervening procedure led people to report precipitating events for change of progressively decreasing importance once they had exhausted their initial repertoire of major negative events. Over time, events which had limited consequences in terms of seeking change continued to be reported because the research procedure required them to do so.

Davies (1992) commented that the results obtained from such studies cannot be considered independently of the methods used to obtain them. In the example given, the verbal recall of life events was described as a decision theory problem, that is, deciding what to select and for what purpose. In this, the criterion of response had to be differentiated from other factors and depended on participant motivation and its relationship to past experiences and expectations. Only then could perceived costs and benefits of the importance of the event lead to a decision to seek change. This suggests that in most life events' and retrospective research the independent measure of criterion in decision theory remains an uncontrolled variable.

1.3.2 The Health Belief Model
The Health Belief Model (HBM) was developed by Rosenstock (1974) and Becker (1974) and has been commented on recently by Sheeran and Abraham (1996). It is described
as a loose set of variables that can predict behaviour, rather than an explanatory model per se. (Connor, 1993). The model accounts for the influence of individual values and expectations on health-related behaviour and identifies those factors which are associated with health changes (including help seeking). A number of distinct constructs have been specified within the HBM including the individual’s perceived susceptibility to illness; beliefs about cues to action that trigger health orientated behaviour; beliefs about enacting health orientated behaviour and the individual’s readiness to be concerned about health matters. These focus on two aspects of health and changes to health behaviour: namely, the perception of threat and evaluation of behaviour.

Despite its breadth of application, Connor and Norman (1996) have pointed to the model’s clear deficits compared to more recent developments in social cognition research. For instance, it does not incorporate what is known about the impact of social pressure or consider a person’s intention to act unlike, for example, the theory of planned behaviour (Connor and Sparks, 1996). It excludes the person’s perception of control over their own behaviour and a lack of causal ordering between its central constructs prohibits a detailed understanding of what contributes to treatment effectiveness. The model is also said to be static which makes it impossible to distinguish between the individual’s stage of motivation (i.e. their readiness to act) and the stage of volition, where action is planned and executed. These represent key limitations to determining its utility as an explanation of help seeking.

1.3.3 Models of Help Seeking in Dependency

Most models of help seeking derive from work carried out in the area of alcohol misuse
as these predominate in dependency research. Beckman and Kocel (1982) have presented a stage model of help seeking based on elements of the HBM (Rosenstock, 1974; Becker, 1974) and on a framework of health service use (Aday and Anderson, 1974). Accordingly, this explanation of help seeking has focused on characteristics of the individual and on structural characteristics of the treatment service. Four elements have been identified in the help seeking process:

- Individual predisposing factors (from demographic data).
- Attitudes and beliefs (from the HBM).
- Personal enabling factors (e.g. mood, self esteem).
- Social enabling factors (e.g. social situations, social networks).

The model operates within an interactive framework in which relationships are established between the different elements. Because elements within the process may be omitted or retraced, it does not represent a linear process of help seeking. According to this model, barriers to help seeking may occur at any of the stages identified, because of personal characteristics and beliefs or because of social factors and characteristics of treatment facilities.

In a separate area of development, Pringle’s (1982) model of help seeking in alcohol misuse has undergone various stages of refinement. Help seeking is seen as a "device" through which peoples' decisions to change can be explained. Change, it is suggested, occurs as a result of slow growth and emerging awareness of the need for help and does not necessarily represent a rational decision making process. It contrasts markedly with
views held by Hartnoll and Power (1989) in their examination of help seekers as "rational beings" and service users (see section 1.4.3). Thom (1984) suggested that help seeking requires:

- A clear definition of the substance misuse problem.
- Active help seeking from significant others.
- Choosing which agency to contact.
- Making contact with the agency.

It should be noted that this model demonstrates structural features of individual help seeking and these are said to conclude with service contact. In contrast, the model presented by Beckman and Kocel (1982) considers social and systemic features of help seeking as integral parts of the overall process which takes place. From this, it could be hypothesised that help seeking is not merely explained by what occurs up to the point of service contact but goes beyond this to include factors which are important within therapeutic interventions. In this sense Beckman and Kocel's model presents a more inclusive representation of help seeking. It has been suggested that models of help seeking need to be developed further in order to consider the different problems experienced by different substance using groups (Jordan and Oei, 1989). For this reason, it could be argued that it is important to establish stage-specific factors relevant to the help seeking process and to describe the relationships between these more fully.

1.3.4 The Transtheoretical Model of Change

Prochaska and DiClemente (1986) contend that a majority of studies in addictive
behaviour have demonstrated that intentional behaviour change can occur both with and without expert assistance. However, relatively little is know about how people change either with psychotherapy or on their own. This lack of understanding about the process of intentional change has promoted interest in whether common principles exist which can explain structures of behaviour modification within and outside the therapeutic setting. It is claimed that the transtheoretical model offers an integrative perspective on the structure of intentional change and can therefore be employed in examining modification to individuals’ drug using behaviours.

In the transtheoretical model of change Prochaska et al. (1992) described a five stage model of change that has been applied to the process of modifying substance-dependent behaviour. It is transtheoretical in the sense that processes of change are derived from a comparative analysis of the leading systems of psychotherapy. It represents a theoretical attempt to integrate systems such as psychoanalysis, behaviourism, cognitive therapy and has also incorporated existentialist theory because "ordinary people in the natural environment can be remarkably effective in finding practical means of synthesising powerful change processes" (p1108).

The five stages of change are defined by precontemplation, a stage at which the individual has no intention of changing their behaviour in the near future. It is characterised by an inability to recognise or modify a problem. At the stage of contemplation the individual becomes aware that a problem exists and begin to think about addressing it but have not yet made a decision to take action. This stage highlights thoughts about resolving the problem. By the stage at which preparation takes place
behaviour and intention are the criteria which help the individual to reach a decision about taking action. **Action** itself is the stage at which individuals modify aspects of self and environment in order to overcome their problems. This stage identifies target behaviours for change and efforts are made to achieve these. When **maintenance** occurs the individual uses tactics to aid relapse prevention and attempts to consolidate gains made during the action stage. Stabilising behaviour change and relapse avoidance characterise this stage.

Treatment implications which arise from the application of this model are dependent upon progress made by individuals in relation to "stage of change." For example, Prochaska *et al.* (1992) suggested that the vast majority of *addicted* people (their term) do not reach the action stage but remain at stages preceding this. (This finding derives from an aggregation across studies and populations of smokers). They hypothesised that if these data hold for other populations and problems (such as drug taking) then reliance on action orientated, standardised programmes of treatment only will be unlikely to serve the majority of a service’s target population. This suggests that the need to match stage of progress to appropriate types of therapeutic intervention is an essential element of service provision. However, Prochaska *et al.* (1992) do not account for how this match can be incorporated into the existing model in a functional manner. A further limitation of the model lies in its potential for misuse in clinical practice either through overly prescriptive or inaccurate application. Therefore, a more explicit (and detailed) model is required to enable the therapist to formulate strategies for intervention.
1.3.5 The Model of Self Efficacy

Social cognition theory has been applied increasingly to the field of dependency research, for example, in the area of self efficacy (Bandura, 1977, 1982; Schwarzer and Fuchs, 1996). Connor and Norman (1996) have suggested that self regulation processes predominate in the areas of health prediction and behaviour change. This view has emerged from a clinical tradition in which psychologists see individuals as active participants in change which is aimed at addressing dysfunctional cognitive or behavioural patterns.

Within the model of self efficacy control mechanisms act on behaviour and are based on three types of outcome expectancy. These are:-

- Situation-outcome expectancy (or environmental contexts of change).
- Action-outcome expectancies (personal contexts of change).
- Perceived self efficacy (the belief that one is able to carry out or succeed with a task).

According to the model, positive outcome expectancies support the decision to change behaviour. Change is said to be bi-phasic and consists of motivational and volitional factors. Deliberation, choice and decision making characterise motivational states while planning and action describe the state of volition. Essentially, these phases describe what individuals do and how they do it (Schwarzer and Fuchs, 1996).

In the motivational phase intention to change risk behaviour has been conceptualised as "decision making". Here, self efficacy and outcome expectancies are seen as key
predictors for intention to change at an individual level. These may be causally related (Bandura, 1988). It has been suggested that social outcome expectancies also need to be considered as part of this since intentions to change are often influenced by social pressure and/or a desire to enhance self esteem (Schwarzer and Fuchs, 1996). Notably, social networks can influence decision making processes positively and change previously harmful behaviour.

The volitional phase of behaviour change is said to be influenced strongly by self efficacy. This represents the types of action plans for change which may have been devised by users. It is suggested that planning takes place within a cognitive domain and is likely to consist of repeated rehearsal of possible behavioural outcomes. Outcome may be dependent on cognitive style (i.e. defensive or functional states) and post-decisional cognitions are necessary to avoid impulsive behaviour which may increase the probability of failure (i.e. through relapse).

Limitations have been described in relation to self efficacy and to social cognition theory in general. Centrally, it does not elaborate fully the way in which individuals make decisions (or demonstrate intention) to change target behaviour. It is possible that cognitive factors are implicated in this and may be related to rehearsal mechanisms which allow transition from motivational to volitional phases of change thereby facilitating action. This explanatory gap therefore requires further elaboration of the model in relation to decision making and behaviour change as these apply to problem drug use.
1.4 STUDIES OF HELP SEEKING AND DEPENDENCY

Little is known about why the types of amphetamine users identified by Klee (1997) failed to present for help or did so only after many years of drug taking. This has implications for providing effective services for particular client groups who may wish to seek help. In raising the issue of provision, Edwards (1980) declared that "there must be a process which leads up to this point [of help seeking], a sequence of events, actions and reactions, self-appraisals and appraisals by others" (p. 312, cited in Jordan and Oei, 1989).

Medical sociology has provided a general guide to our understanding of factors which precipitate the process of help seeking. To date, the majority of research concerning help seeking has been carried out within medical and psychiatric settings (Zola, 1973). Calnan (1983) described help seeking as a social process involving at least one other person and which has formal and informal mechanisms of support. His work suggests that individuals are more likely to utilise services when networks of consultation involve contact with family and friends. Problems with health are initially identified in this informal context. However, formal contacts are sometimes necessary, for instance, in the case of sudden problems, and these can produce a different route into help seeking activity (e.g. through emergency admission). Research has demonstrated that where the individual experiences greater urgency or more severe problems they will tend to accommodate outsiders in their help seeking endeavours (Calnan et al. 1982).
1.4.1 The Role of Significant Life Events in Help Seeking

It has been documented that a relatively small population of drug users present for treatment and are often at an advanced stage problem drug use (Sheehan, 1991). Life events and the users' subjective experience of drugs are known to be important triggers to help seeking (Power et al. 1992). Central problems with drug use focus on interpersonal, social, legal and employment difficulties. Other influences on help seeking include a sense of impaired functioning within psychological or physical domains and positive life expectancies, such as new relationships (Thom, 1987; Oppenheimer et al. 1988). In addition, the user's drug taking history and negative consequences of drug use are said to be strongly associated with the need to seek help (Varney et al. 1995).

A riposte to the significant life events hypothesis is contained in work by Power et al. (1992). It is argued that at an individual level, "concern" and "need for help" differentiate service users who attach different values to the significance of events occurring between self and others. For this reason life events, social circumstances and problems should be considered as descriptions of people's lives and distinguished from their reasons for seeking help. It is noted that while key life events may act as a stimulus for help seeking behaviour there is usually an important co-existence between drug and other problems. It is possible that the relationship between these is reciprocal since negative life events may lead to increased dependency and vice versa. Therefore, it could be contended that seeking help is aimed primarily at establishing a state of equilibrium in which to manage drug taking.
1.4.2 Motivation and Help Seeking

Jordan and Oei's work (1989) with female alcohol users considered the process by which help was sought. It has been suggested that this is influenced by an interplay of intra- and inter-personal factors which impact on the user who makes initial service contact. Characteristics of treatment facilities, personal motivation and early presentation thus affect the potential success of the help seeking process. It is claimed that service providers interpret motivation as a fixed and immutable state, inherent to the individual. Thus, the individual's desire for help is attributed to his/her motivational state. Jordan and Oei argue that the question of motivation in help seeking is an important one for services since there is often a tendency for professional practitioners to remain problem focused rather than person focused in relation to the individual seeking help. This is also reflected in the views of Miller and Rollnick (1991) who consider motivation to be context-specific rather than inherent to the individual and accordingly represents "the probability that a person will enter into, continue and adhere to a particular change strategy" (p. 19).

1.4.3 Users' Perceptions of Help Seeking

Users' perceptions of the help seeking process, their reasons for seeking help and fears about treatment were considered by Oppenheimer et al. (1988). The constructs "triggers to action" and "barriers to treatment" underpinned such perceptions (as described in the HBM). Results of their work indicated that early intervention enhances treatment efficacy for users who viewed themselves as drug dependent and were unable to manage their own lives. This acted as a trigger to action. Fears which were expressed about treatment related to two aspects of the help seeking process. Firstly, little knowledge
was made available to users about treatment that might be available and secondly, fear of failure correlated highly with experience of life crises. These, coupled with an underlying mood disturbance, operated as triggers to action (i.e. seeking formal help). A stereotyped view that existing services were available for chaotic users only persisted in Oppenheimer et al.'s. help seeking sample. Therefore it was postulated that regular users who retained some control over their drug use would not seek help and that this acted as a barrier to treatment.

To address these barriers, Oppenheimer et al. (1988) have proposed a solution which would involve prospective research focusing on the drug taker’s career: charting their introduction to drugs, their experience of dependence, their experience of agency treatment and post treatment behaviour. They suggest that this could address gaps in understanding users’ perceptions of help seeking which need to be filled. However, it could be contended that such a study contains a basic assumption that drug taking will progress through each of these stages and that it is inherently problematic, ultimately requiring a late stage intervention. Notwithstanding the practical and ethical problems presented by contemporaneous social research, the multi-stage, lifespan process implied by such a study may be appropriately served through qualitative methods of inquiry since these attempt to uncover the "live" components of the individual’s experience, as it occurs.

In addition to the above findings, Hartnoll and Power (1989) have reported the results of an extensive Drug Indicators Project conducted during 1985-1987. This examined drug users’ views on severity of drug use and social, emotional and interpersonal
functioning as well as perceptions of problems and need for help. Agency and non-agency contact was taken into consideration as a barrier to seeking help. Significant factors associated with service provision included accessibility of services, dissemination of information about services via outreach work and provision of information to significant others. In addition, information about harm reduction was provided and users’ stereotypes that services were only available for opiate users were addressed.

However, major limitations were identified in the study and centred on poor generalisation of findings to non-opiate using groups which were significantly under-represented in the sample. Overall, Hartnoll and Power viewed help seeking drug users as "rational beings" (their term) who were aware of problems and risks associated with their drug use despite evidence of ambivalence about changing drug taking behaviour. They were said to hold realistic perceptions about what agencies could offer and make rational judgements about the potential costs and benefits of making a decision to use them.

1.5 THE CURRENT STUDY

1.5.1 Local Conditions in Relation to Amphetamine Misuse

Leicestershire Community Drug Service (LCDS) comprises a statutory NHS drug team and a non-statutory drug advice centre which work collaboratively to provide a community based service for drug users. The multidisciplinary NHS team consists of psychiatrists, psychologists, community nurses and counsellors.
At the time of the research (1997), there were 19 "open" amphetamine cases of which it was estimated 12 remained in regular contact since commencing their current episode of treatment. Of these, approximately half had received or were receiving a maintenance or reduction script for dexamphetamine. This did not represent a service policy for intervention as advocated by Pates et al. (1996), rather, it reflected the way in which clients received a service based on individual needs’ assessment undertaken by clinical practitioners (after Simeone et al. 1993). This broadly concurs with the Advisory Council for the Misuse of Drugs recommendations (1982) which determine that the immediate goal of drug services is to make contact with users in order to offer harm minimisation advice.

Thus, local conditions indicated that only a small number of amphetamine users had contact with the service in comparison to other types of users (e.g. opiate users). This observation raised questions about why such low rates of contact occur, how contact was effected and managed by users and how service provision was perceived by what may be described as a relatively exclusive group of "consumers." Help seeking has been acknowledged broadly as a way of understanding, describing and explaining a complex social phenomenon but remains largely unexplored from the perspective of specific groups of drug takers who utilise services. For instance, Myles (1997) has argued that the need for services to engage and retain amphetamine users is more important than offering treatment aimed only at abstinence. Therefore, a better understanding of those factors which can influence service provision for this group needs to be developed and, indeed, there may be a specific role for psychologists in "attracting" users into services which do not always offer clinically accepted replacement medication.
1.5.2 The Area of Research Interest and Research Questions

The research undertaken in this study proposes an exploration of how amphetamine users seek help in order to address drug related problems. The guiding assumption which underlies the research is that although this population is not associated with high levels of service contact, contact with services can, nevertheless, lead to changes in patterns of drug taking, beliefs about drug use and drug related problems (Hartnoll, 1992). The research presents an initial study and examines the process involved in help seeking experienced by amphetamine users in contact with LCDS.

Three central questions are posed by the current research:-

1. How are drug taking problems construed by amphetamine users?
2. What is the process by which amphetamine users seek help in order to address drug taking problems?
3. How are drug taking problems modified through the process of seeking help?

These wide ranging questions are examples of suitable statements for exploration via qualitative methods since they are orientated towards thought, process and action (Strauss and Corbin, 1990). In particular, "... qualitative approaches bring to our understanding - insight into the process, hows? and whys? of drug taking behaviours at individual and social level(s) …" (Hartnoll, 1995, p. 763). The questions indicate that the research will examine help seeking from the user’s perspective: what they think and do, as opposed to the actions of service providers within a multidisciplinary team. While it is acknowledged that the service provider’s view is important since it may have an impact on the way that amphetamine users manage change it is not the main issue here. Rather,
the focus is on the drug user and his/her perspective of help seeking within the wider context of their lifestyle.
2.0 METHODOLOGY

2.1 THE QUALITATIVE RESEARCH PARADIGM

The social construction of scientific knowledge is identified as a central tenet of the qualitative paradigm. It has been formed in a climate of continuing debate about what constitutes the most suitable methodological approach for the purpose of human inquiry. Bryman (1988) makes a distinction between the technical and epistemological versions of research paradigms. The first refers to quantitative methods of research which are concerned with objective knowledge and the discovery of universal laws of cause and effect. This occurs within an explanatory framework and assumes that reality is made up of objectively defined facts which are subject to quantification and capable of being replicated and generalised to other data. This version "censors" interpretation in human inquiry. The second, epistemological version, represents the qualitative research paradigm which has been employed in this study. This can be described as a naturalistic or interpretive paradigm and is contained within a constructivist framework. It promotes the search for meaning in human inquiry (Richardson, 1996).

The central characteristics of this latter position demonstrate the researcher's commitment to such constructivist epistemologies. These emphasise the utility of describing and exploring data rather than relying on explanatory structures for its examination. Here, reality is represented through the views of participants themselves and knowledge is generated within networks of social activity. Through these systems of socially constructed meanings the researcher can explore and be sensitive to interpretations placed on behaviour in the context of participants' own phenomenological worlds. In so doing,
the scientific process leads to the generation of fluid, working hypotheses rather than fixed empirical facts. This allows concepts to emerge from data and facilitates the application of qualitative methods in analysis.

Further, the qualitative paradigm allows for variation in relation to the context of its use, for instance, through the application of one of several qualitative methods available. These equip the researcher to discover meanings which are open to reflection and renegotiation and pay special attention to the singularity of human experience. In using the paradigm the researcher must strive not to impose objective systems of meaning on participants' internally structured subjective experiences. Nevertheless, it is acknowledged that representations of data are almost always mediated in some form by the interested researcher as part of a conscious, reflexive process of inquiry. Ultimately, its choice as a method of inquiry and analysis derives from its perceived suitability for answering particular research questions and is based on "the nature of the evidence sought and produced" (Pearson, 1995). Reliance on qualitative methods for research has been justified on the grounds of such pragmatism.

2.1.1 The Qualitative-Quantitative Debate in Research on Dependency

Some commentators have proposed that the constructivist epistemological position outlined here is merely "part of a debate, not a fixed truth" (Banister et al. 1994). In this position the paradigm enables the researcher to attempt to make sense of, and structure, what we say about what we do. It also permits exploration, elaboration and systematisation of the significance of identified phenomena. In this way it elucidates the meaning of delimited problems or issues presented by participants. This does not infer
that qualitative and quantitative methods should be viewed as deriving from an incommensurable paradigm split. Rather, it is proposed that research might be strengthened through a "principled mixture of methods" (Henwood and Pidgeon, 1992). Several possible combinations have been identified: methods can be used separately, in parallel, and prior use of qualitative research can lead to quantitative research or vice versa. A recent debate in dependency research reflects this latter proposition.

McKegany (1995) reported that research on addictive behaviour tends to fall on both sides of a quantitative/qualitative divide. Large-scale survey formats and longitudinal research have placed some emphasis on psychosocial influences on behaviour. However, he suggests that these methods are less able to consider the processes by which social, structural and psychosocial factors are mediated at the level of individual experience.

Pearson (1995) has advocated a position of methodological pluralism to guide research in the area of drug misuse. For instance, localised ethnographic studies are said not to yield universal explanatory statements and this is not seen as their ultimate purpose. Rather, they lead to the production of localised forms of knowledge relevant to a specific group. This implies that qualitative research attempts to create a more grounded form of understanding than can be achieved by survey design. He makes the point that it should not be assumed that quantitative methods alone yield universally applicable knowledge.

Hartnoll (1995) has cautioned against both a divisive methodological stance and an integrative approach in which qualitative research is forced into a quasi-positivistic
paradigm to "mimic" quantitative research (i.e. as in content analysis). He suggests that qualitative approaches add value to our understanding of the processes involved in drug taking behaviour at both individual and social levels and as such, acknowledges the complementary strengths of both approaches. Thus, qualitative research is seen to be part of a broader scientific paradigm which has validity in its own right in dependency research.

2.2 GROUNDED THEORY

The application of grounded theory as a qualitative research method in psychology and social sciences emerged from the seminal work carried out by Glaser and Strauss (1967), and more recently from developments instigated by Henwood and Pigeon (1992) and by Charmaz (1995). It represents one of several methods of qualitative analysis and its aim is twofold: to ground theory in experiences, accounts and local contexts and to implement analytic strategies to structure data, such as transcripts, of participants' accounts. This requires the researcher to engage in close inspection and analysis of material in order to generate the emergent theory while simultaneously retaining an open and flexible stance. Strauss and Corbin (1990) have elaborated on the types of "handling strategies" required to carry out the required analysis and their major components are outlined in the sections which follow.

2.2.1 Grounded Theory Analysis

Strauss (1987) has described a "style" of undertaking qualitative analysis that incorporates a number of distinct features. These include methodological guidelines such as making
comparisons between cases and the use of an indexing and coding paradigm to ensure that conceptual developments and theoretical density are advanced for the purpose of theory building. Social phenomena are seen as complex phenomena therefore grounded theory emphasises the need to develop many concepts and linkages in order to capture a great deal of the variation that characterises the central phenomena studied. It extends this through the strategy of "theoretical sampling". This term denotes the further sampling of new cases which help to build the emerging theory.

2.2.2 Stages of Analysis

Four stages of analysis were employed in the current study. In these the researcher worked systematically through a basic data corpus and generated codes for low level concepts through to more abstract categories and themes. (See Appendix 1 for an example of the following procedures).

- **Open coding.** Coding involves a set of tasks in which data are conceptualised. The researcher raises questions about the data and attempts to give provisional answers (usually in the form of hypotheses) about emerging categories (or "phenomena"). The term "code" denotes any product of this analysis (either the category label itself or relationships among two or more categories). The term "category" comes from the task of identifying key properties attached to phenomena. These are the concrete elements of phenomena that can be conceptualised, and lead to greater specificity in the research. In turn these are "dimensionalised" in order to reveal distinctions in the data. Dimensional labels are given to identified properties and these operate along a continuum.
• **Axial Coding.** This represents a further set of procedures in which two or more categories are linked relationally. This is achieved via application of the "paradigm model" which describes the causal conditions that give rise to a particular phenomenon and clarifies the context in which this occurs. It defines the strategies of action and interaction used by participants and identifies any intervening conditions which might influence outcomes or consequences of behaviour. The function of this stage of analysis is to link subcategories to main categories in a set of clearly defined relationships. In this way grounded theory is concerned with "multivariate" analysis since a multitude of comparisons is made among categories and the properties which connect them.

• **Selective Coding.** This represents the highest level of analysis performed in grounded theory. It involves selecting the core category which is considered to be the central phenomenon around which other categories and subcategories are clustered. It is related systematically to other categories in order to validate identified relationships between phenomena. This process is central to integration of all data and reflects the type of analysis carried out during axial coding but operates at a more abstract level of appraisal.

• **Process.** This term is considered to be somewhat "elusive" in grounded theory analysis since it said not to stand out easily in data (Corbin and Strauss, 1990). It refers to the linking of sequences of action and interaction and relates these to the way in which participants manage, control or respond to a phenomenon. "Process" is said to occur when:

- change in identified conditions influences actions and interactions, over time.
response to change is noted and consequences follow from this for participants.

the influence of such consequences has an impact on subsequent action and interaction sequences carried out by participants.

Change may follow from planned or unplanned action that brings about transformation to conditions which impact on individual experience.

2.2.3 Enhancing Theoretical Sensitivity

An important component of analysis is the degree to which theoretical sensitivity is applied when considering the emerging data. The complexity of data should be explored and theoretical sensitivity addressed, in order to open up the researcher’s receptiveness to thinking about data in theoretical terms. This supports the further development of conceptually dense representations of the data and is guided by generative questions such as who?, what?, when?, and how? This form of questioning stimulates cycles of inductive reasoning, propositional thought and verification and runs throughout the lifetime of the research.

Methods of indexing, coding and sampling data are handled through specific strategies such as the method of constant comparison between cases and categories. Aids to theoretical sensitivity include use of the "flip-flop" technique which might be used when issues suggested by the researchers’ exploratory questions do not emerge from the data (Strauss and Corbin, 1990). The researcher has to imagine the very opposite of the concept under consideration, turning this upside down to make a comparison at the extreme end of one of its dimensions. This exercise is used to help the researcher think
analytically rather than descriptively about the data and raise further, generative questions.

Systematic comparison of phenomena may also take place using "close-in" or "far-out" comparison techniques (Strauss and Corbin, 1990). This involves comparison of similar and non-similar examples from, for example, the researcher's own life experiences and clinical or naturalistic observations. It creates further opportunities for developing theoretically dense explanations through exploration of alternative meanings and results in greater insight into issues covered.

Analysis was facilitated by the researcher's participation in a Qualitative Research Group. This provided a forum in which post-graduate clinical researchers could discuss, analyse and suggest modifications to one another's work. In this way, the exploration of alternative views supported the validation of the account which emerged from the data. These techniques were used to enhance theoretical sensitivity in this study and helped to maintain the balance between science and creativity sanctioned by Strauss and Corbin (1990).

2.2.4 The Use of Memos

Grounded theory analysis was further supported by contemporaneous use of memos. These are aids rather than methodological prescriptions which help the researcher to organise emerging themes/issues for later integration into the grounded theory account. Memos may be produced at the level of coding, to help the researcher generate category labels. They may also be used as aids to theory building or as operational tools, guiding
the researcher towards new areas of questioning for the purpose of further theoretical sampling. As notational aids to personal thinking, they are not subject to the rules of grammar or punctuation unlike texts that might be presented for formal examination.

The following memo provides an extract from a theoretical note to myself as researcher which was produced during the course of the current research. (See Appendix 2 for examples of axial coding notes).


"Effects of drug use are described as having diminished over time with nostalgic remembrance that "it's just not the same feeling anymore." "Just" appears to refer to a singled out preferred effect which is later described as a buzz. Active versus passive effects of amphetamine are outlined and juxtaposed in everyday experience. This points to a paradox in drug use: increased use for a particular effect BUT preferred effect not achievable therefore conscious decision to use amphetamine by excluding (avoiding?) consideration of negative effects when using. Management driven by conditions of need to use. Change driven by differences in need to use (past and current)."

2.2.5 Reasons for Choosing Grounded Theory

Firstly, a qualitative research paradigm was employed because of the strength of its intrinsic exploratory and descriptive structures. This paradigm assumes the value of context or setting in inquiry (which is particularly important in locally based studies) and aims to achieve a deeper understanding of the participant's "lived" experiences of the phenomena under consideration. Thus, providing amphetamine users with a forum through which they could "voice" their own experiences was a central component of the
study. This interest arose from reading Davies' (1992) work in which he determines that progress in understanding the problems of drug taking will continue to be inhibited as long as monolithic ways of viewing drug use are maintained. This, he suggests, needs to be differentiated and take account of the problems produced by different types of drugs and reasons for their use. To date, problems attributed to amphetamine misuse have not been widely explored in the general corpus of research undertaken, whichever paradigm is employed (Klee, 1992). However, it is clear that studies which have used empirical research methods to examine the help seeking process confirm that help seeking research in substance misuse is an early stage endeavour. There is a need to emphasise relevant social and personal factors which act on help seeking behaviour. Therefore, the area requires further exploration for meaningful advancement of the concept of help seeking as it applies to drug taking in general and amphetamine use in particular (Oppenheimer et al. 1988; Jordan and Oei, 1989; Hartnoll and Power, 1989).

Secondly, the process of help seeking and the nature of helping encounters remains open to wider inquiry in substance misuse research (Hartnoll, 1992). Therefore, the purpose of the research is important in determining the type of method and analysis to be employed in a study. This study aims to build further on our knowledge about the process and nature of help seeking in a clinical setting. The research findings are intended to inform and guide clinicians' practices in the engagement and retention of clients who seek to change aspects of their drug taking behaviour.

As indicated earlier, grounded theory is concerned with building theory based on the description, analysis and interpretation of data. Because it is interested in bringing
reality to light and providing a framework for action through exploration of connections between elements of the data, it contrasts markedly with, for example, an alternative qualitative method such as discourse analysis. The latter is primarily concerned with accurate description, selection and interpretation of material in order to create a "descriptive narrative". It constitutes an atheoretical, linguistically orientated approach which does not correspond appropriately with the action orientated focus of the questions which guide this research. Therefore, grounded theory has been selected as the method which is most relevant to exploring process and action and developing theory in help seeking (Miles and Huberman, 1994).

2.3 THE RESEARCH PROCEDURE

The present study seeks to describe amphetamine users' own constructions and views of their drug use in the context of "live" help seeking. The method chosen is congruent with assumptions contained within a contextual perspective: that is, it aims to examine the way in which amphetamine users perceive "helping encounters" in the context of help seeking for "drug taking". The research focuses specifically on a population of drug users which is known not to seek frequent levels of contact with services (Klee, 1997).

The research relies on interviews as the primary method of data collection. The purpose of the interviews is to ask amphetamine users to reflect on their experience of encountering help in relation to drug taking. Interviews allow the researcher to trace the development of help seeking encounters at different stages of service contact and identify any associated change in drug taking behaviour. Attention is paid to individuals' own
accounts of events and their view/interpretation of those events. Consistent with qualitative methodology, semi-structured interviews with participants generate data which enables the researcher to use emerging themes to produce theory about, or explanations for, the participant’s own position. The participants’ answers are provided as evidence for the subjective viewpoint which is taken.

2.3.1 Participants

All participants were amphetamine users in contact with Leicestershire Community Drug Service (LCDS) on a voluntary basis for problems relating to drug misuse. A total of eight participants were interviewed, which represented a significant proportion of amphetamine users in contact with the service during the period in which interviews were carried out. A further three participants failed to respond to a request to participate despite initial verbal agreement.

Four male and four female participants took part in the study. This was not planned but simply reflected those users within the population who were available to participate in the study. The age range of participants was 19 years - 46 years (mean age = 30.86 years).

2.3.2 Selecting Participants

The following inclusion criteria for the study were applied:

1. The use of street amphetamine as a preferred drug of choice preceding contact with the service.
2. Duration of amphetamine use not less than six months prior to contact with the service.

3. Current episode of contact with Leicestershire Community Drug Service not exceeding two years.

In addition, participants may or may not have been receiving a prescription for dexamphetamine from the service. An exclusion criterion for the study was the occurrence of a recent episode of psychosis due to amphetamine misuse not less than three months prior to interview.

The duration of participants’ contact with the service ranged from 3 months to 18 months (mean duration of contact = 8.61 months). Duration of amphetamine misuse ranged from 3 years to 32 years (mean duration of use = 10.63 years). Five participants reported their preferred route of drug taking as intravenous administration, three preferred to use an oral route of administration. Two female and one male participant were known to be parents. None of the participants were currently involved in a long term relationship. One participant was homeless at the time of interview. Three participants were directly casemanaged by the researcher within the clinical NHS team, the remainder by psychiatrists, psychologists, community psychiatric nurses and counsellors.

2.3.3 Gaining Access to Participants

All participants were approached initially via their casemanagers within the drug service and were asked if they would be willing to take part in the research. Written information about the study was provided at this stage and participants were asked to complete a
consent form (see Appendix 3). Appointments were offered by the researcher either by letter, telephone contact or contact via the relevant casemanager who was consulted about their client's suitability for participation. At the time of interview, written consent was sought where this had not been given previously and a full explanation of the reasons for carrying out the study was provided (see Appendix 4). Ethical and practical issues attached to managing the data collection were discussed at this time such as issues regarding confidentiality and security of data. Participants were invited to ask questions, for further clarification about the research, prior to interview.

2.3.4 The Study Location

All interviews were conducted in an environment that was familiar to the participant. Seven interviews took place at Paget House, the city-based facility used by LCDS and one was carried out at a participant's home, at her request. Two participants requested that a significant other was present with them during the interview but did not require them to participate actively in the interview process. In one case, the participant's casemanager was present during the interview. All participants who travelled for interview were reimbursed at the appropriate public transport rate.

2.3.5 The Course of the Study

Preliminary discussions concerning the study occurred in March 1996 with the relevant agency. The focus and feasibility of the research was determined throughout the summer of 1996 and received approval from the Department of Clinical Psychology, Leicester University in October 1996. A research protocol was submitted to Leicestershire Ethics Committee at the end of November 1997 for external approval. This was granted in
January 1997. Data collection began at this time. Because of emerging difficulties with the recruitment of participants into the study broader inclusion criteria were developed to include non-statutory drug services within Leicestershire. Further approval was sought from the Ethics Committee and this was agreed in principle. However, the committee made a request for proof of the researcher’s professional indemnity in carrying out such sensitive research. Further data collection was suspended until the matter was resolved in March 1997. Data collection was completed in April 1997.

Transcriptions and initial readings of texts commenced in March 1997 and continued contemporaneously alongside data collection and analysis. All participants (except one) were drawn from the statutory part of the service since no access to other parts of the service actually occurred during this period due to what were described to the researcher as "political problems". It appeared that because of management decisions in non-statutory parts of the service, service users had decided to boycott drop-in centres for a significant period of time and consequently, were not in contact with outreach workers who had agreed to approach potential participants.

2.3.6 Using Semi-Structured Interviews

The selection and construction of interview material in this study was developed from discussions with interested parties such as clinical practitioners and researchers both within and outside the substance misuse field and relevant background literature was considered. A semi-structured interview schedule was used since it is consistent with a qualitative approach that is concerned with subjective meanings and the complex exploration of issues. The fundamental aims of the semi-structured interview were
targeted at tailoring questions to the position and comments of the interviewee and responding to and following up issues raised by the interviewee. The interview format provides an open and flexible research tool and requires the researcher to confront his/her own perspective within the research process. It is said to be suitable for complex issues and processes whether these are controversial or personal (Smith, 1995).

Development of the preliminary interview schedule used here took place over a period of two months. Three open-ended questions invited participants to explore their encounters with drug-taking and reflect on other, associated experiences. The central questions asked were:-

1. How did you come to have contact with the service?
2. Tell me about your experience at Paget House.
3. How do you see your drug use being in the future?

The above questions represented the core elements of the interview schedule. A number of additional, open ended questions relating to specific issues were developed and used flexibly, in a non-linear fashion. These included items on specific topics such as drug-taking, drug management and help-seeking. For example:-

1. Tell me about your drug use.
2. What is different about your use of drugs now?
3. What kind of support do you think you will need in the future?
In addition, a series of probes were available to the researcher in order to encourage participants to open up issues of interest for further exploration, and were used as necessary. These included:

1. Can you say a bit more about that?
2. What did you think of that?
3. What would that have meant for you?

(See Appendix 4 for full details relating to the interview schedule).

2.3.7 Managing Interviews

All interviews were undertaken by the researcher. The interview was guided primarily by the schedule rather than dictated by it. This enabled the researcher to establish rapport with the participant. Thus, the precise ordering of additional questions became less important and the researcher was free to probe interesting areas and issues that arose, by following the participants' own directions and concerns. As an interviewer, the researcher is required to act as guide and facilitator but also works collaboratively with the participant who is allowed to take a central role in determining how the interview proceeds (Smith, 1995). This necessarily places a number of demands on the researcher who has to focus in parallel on listening to what the participant is saying and reflect on how this relates to the schedule while working out what to say and when to say it.

An important aspect of managing the interview process concerns the pace at which questions are asked. Matching the pace of enquiry with the pace of response is of central importance. Also, asking multiple questions may confuse both interviewer and
respondent since potentially, it could be difficult to determine the question to which an answer relates. Therefore, these were avoided where possible. Conversely, "jumping in" too quickly may result in loss of more meaningful information if the respondent’s train of thought is interrupted. The researcher therefore allowed the participant sufficient time to provide a full answer even though this may have included lengthy pauses. A major ethical responsibility in this respect is the continuous monitoring of the effects of the interview on the respondent and attention was paid to this during the interview process.

2.3.8 Producing Transcripts

With the participant’s permission, all interviews were audio-recorded and subsequently transcribed. This provided a full record of the interview. The duration of interviews ranged from 35 minutes to 60 minutes (mean duration = 48 minutes). The average transcription time for producing fully annotated, type written data was 3.5 hours per transcript. All transcripts produced were subject to standard notation which was structural in format (Banister et al. 1994). The terminology employed in transcription used "R" to denote researcher and "P" for the participant thus identifying interviewer and respondent in the interview process. Numerical codes were used as script identifiers thereby maintaining confidentiality and anonymity for the participant. All pages, and lines were numbered and the following notation applied:—

(...) Brief pause, up to 4 seconds.
(5) 5 second pause (number indicates duration).
xxx Untranscribed word on tape.
xxx xxx Untranscribed section on tape.

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Transcripts were produced in double space format for the purpose of analysis in order to include limited notes. Ordinarily, it is not recommended that the transcript is used for note making, rather, this is the function of memo writing produced during the process of analysis. Although time and labour intensive it should be acknowledged that the data produced from audio recorded material represent an impoverished record of the research encounter since it ultimately reflects only a structural representation of the interview. It is important to be aware that it may also be affected by the researcher’s experience and memory of the interview and is therefore not a completely objective record of events.

2.3.9 Ethical Issues

The issue of confidentiality was an area of major concern on submission of the research protocol to Leicestershire Ethics Committee. Its concern focused on possible legal implications should breaches of client confidentiality occur. Therefore, the committee requested clear evidence of professional indemnity before the study could proceed. Three assurances were provided by the researcher:

1. Evidence of personal indemnity insurance taken out by the researcher.
2. Evidence of professional indemnity provided by the researchers’ employer.
3. Evidence of a formal and legally binding release of information document signed by all service users who wished information relating to their cases to be shared with other parties.

By definition, as existing service users, this latter assurance extended to respondents’
participation in the study. Participants were reassured that taking part in the study did not affect their rights to receive treatment in any way. However, in the event of distressing or problematic issues emerging during the course of the interview, it was suggested that participants should either seek to talk to their individual casemanagers directly or, if they preferred, via the researcher, on condition that a release of information form had been signed prior to contact.

The research procedure required that the conditions of participation were outlined fully. For instance, it was made clear that the interview was completely confidential in nature and would not be discussed with casemanagers or other members of the team without the participant’s prior consent. Participants were free to withdraw at any time during the interview if they so wished. All tapes would be destroyed at a suitable point following transcription and names/personal details could not be traced to tape recordings or subsequent typewritten transcriptions. All information would be stored safely, in a secure environment. It was agreed that, if participants were willing, feedback relating to the research would be provided on an individual basis following completion of the grounded theory account.

2.3.10 Researcher Characteristics

The researcher was a trainee clinical psychologist at Leicester University, undertaking a final year placement within the Leicestershire Community Drug Service. Therefore, the researcher was also a casemanager for amphetamine users seeking help for their drug related problems. Participants selected from her own case load were aware of this background (the dual role of researcher and clinical practitioner in training) and the role
was further clarified for other participants. Generally, the researcher was introduced by other casemanagers to prospective participants as a "psychology student" undertaking research in the team.
3.0 ANALYSIS

3.1 FOCUS OF THE STUDY

The study focuses on questions about how amphetamine users construe problem drug use and its change in relation to the help seeking process (see section 1.5.2). It asks the general question: what is the process by which amphetamine users seek help in order to modify drug-taking problems? This wide-ranging statement is concerned with users' actions and changes that are made to drug taking, over time.

3.1.1 Relationships between Core Categories and Subcategories

Using methods derived from grounded theory the following analysis describes the principal relationships between core categories identified in the data and shows how these are linked within the overall process of help seeking. Developing drug taking problems, encountering help and preparing for change constitute the three central categories implicated in the process. A number of subcategories are linked to these, over time. Categories also define distinct phases in which the process of help seeking operates. Two points of transition between phases are noted. A process map is provided in which core categories and related subcategories are identified (see pages 52 and 53).

The narrative which follows describes the related phenomena which arose during the process of help seeking. Each category and subcategory was defined according to their central properties and range of dimensions. Then, in accordance with the paradigm model described by Strauss and Corbin (1990), strategies for management, intervening
conditions and consequences of phenomena were explored and associations made between these. It should be acknowledged that the process map presented in this section represents a hypothetical model of principal activities involved in help seeking among amphetamine users. Participants' own words have been used as quotations to illustrate key points. These are labelled according to the participant's number (e.g. 01-08) and the line number of text on which the quotation begins (e.g. 25). Italics are used to denote category and subcategory labels.
Figure 3.1.1

PROCESS MAP

Help Seeking: Relationships between Core Categories and their Subcategories, Over Time.

<table>
<thead>
<tr>
<th>Time Course</th>
<th>Phases</th>
</tr>
</thead>
<tbody>
<tr>
<td>DISTANT PAST</td>
<td>PHASE I</td>
</tr>
<tr>
<td></td>
<td>Developing a Technology of Drug Taking</td>
</tr>
<tr>
<td></td>
<td>Initiating the Drug Taking Experience</td>
</tr>
<tr>
<td></td>
<td>Utilising Drugs</td>
</tr>
<tr>
<td></td>
<td>Developing Problems with Drug Taking</td>
</tr>
<tr>
<td>RECENT PAST</td>
<td>PHASE II</td>
</tr>
<tr>
<td></td>
<td>Developing a Personal Identity as a Drug Taker</td>
</tr>
<tr>
<td></td>
<td>Realising Loss</td>
</tr>
<tr>
<td></td>
<td>Identifying Needs</td>
</tr>
<tr>
<td></td>
<td>Initiating Service Contact</td>
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<tr>
<td></td>
<td>Help Seeking Expectations</td>
</tr>
<tr>
<td>PRESENT</td>
<td>PHASE III</td>
</tr>
<tr>
<td></td>
<td>Encountering Help</td>
</tr>
<tr>
<td></td>
<td>Conditions Facilitating the Possibility of Change</td>
</tr>
<tr>
<td></td>
<td>Preparing for Change</td>
</tr>
<tr>
<td></td>
<td>Engaging in Remedial Activity</td>
</tr>
<tr>
<td>FUTURE</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Conditions Inhibiting the Possibility of Change</td>
</tr>
<tr>
<td></td>
<td>Discengaging from Remedial Activity</td>
</tr>
<tr>
<td></td>
<td>Self Supporting Activity</td>
</tr>
<tr>
<td></td>
<td>Predicting the Future</td>
</tr>
</tbody>
</table>

52
<table>
<thead>
<tr>
<th>Symbol</th>
<th>Label</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Core Category</td>
<td>The central phenomenon around which all other categories are integrated</td>
</tr>
<tr>
<td></td>
<td>Plain Text Sub Category</td>
<td>A subsidiary category relating to the core category</td>
</tr>
<tr>
<td></td>
<td>One Way Relationship Arrow</td>
<td>Arrows show direction of relationship; broad arrow = strong relationship, thin arrow = standard relationship</td>
</tr>
<tr>
<td></td>
<td>Two Way Relationship Arrow</td>
<td>Relationships are bi-directional; broad arrow = strong relationship, thin arrow = standard relationship</td>
</tr>
<tr>
<td></td>
<td>Expectations Arrow</td>
<td>Indicates the points between which help seeking expectations operate</td>
</tr>
<tr>
<td></td>
<td>Transition Arrow</td>
<td>Indicates point of transition within a phase</td>
</tr>
<tr>
<td></td>
<td>Time Course Arrow</td>
<td>Indicates the process of encountering help over time</td>
</tr>
</tbody>
</table>
3.1.2 Terminology

- **User.** This term is used to refer to the participating amphetamine users who were also service users as a result of seeking help to address drug taking problems. It reflects the every day terminology employed by users and professional helpers within the community drug service to describe drug taking.

- **Helper.** This term refers to the expert professional who is linked with the user through help seeking encounters designed to facilitate change in drug taking and associated problems.

- **Significant Other.** This term is used to refer to people in the user’s life who play a central role outside of the formal, help seeking encounter. These may be partners, family, friends or interested professionals outside of the drug service context.

- **Amphetamine.** This is also described as whizz, speed, base, amphet, dexamphet and methamphet by users.

- **Ecstasy.** This is described as E by users.

- **Heroin.** This is described as heroin or smack by users.
3.2 THE GROUNDED THEORY ACCOUNT

The categories which emerged from the data were analysed in three stages. The first looked at conditions surrounding the development of problem drug use. The second examined the impact of problems on users' help seeking needs and the third considered the consequences of help seeking behaviour in a service context. This process was not imposed onto the data but developed progressively by using the combination of methods cited in sections 2.2.2 and 2.2.3. The process is outlined in the account via a sequence of inter-relating events which occurred over time. These are expressed in the context of users' retrospective, current and predicted experiences in relation to seeking help for problems with amphetamine use.

3.3 GUIDE TO PHASE I - DEVELOPING DRUG TAKING PROBLEMS

Phase I of the analysis identified conditions which users associated with developing drug taking problems. These were delineated by drug initiation and learning about what worked (drug technology), with best effect (drug utilisation). It was here that consequences of problematic drug taking began to be acknowledged through developing a compromised personal identity as a drug user and by realising the impact of loss. Only then did thoughts emerge about taking ameliorative action. Accordingly, several events occurred in relation to problem drug taking prior to users embarking on help seeking encounters.
3.3.1 Initiating the Drug Taking Experience

For some users the inauguration of a drug orientated lifestyle centred on early drug taking experiences which commenced during their adolescent years.

"… I never really sort of got into it a lot then but like when, you know, when I was about eighteen, like things changed like, you know, and er, I started going, I started going to powder and er." (05.24).

In addition, it was indicated that getting started on drugs early, tended to endure and led to long term drug taking over an extended period of time in the individual’s life, sometimes for reasons which were unclear to the user.

"Because with amphetamine, I mean I haven’t got a clue what it is about the stuff. I mean I’ve used amphetamine all me life, since I was thirteen. I just never been able to find out, work out what it is about the stuff …" (07.286).

The act of initiation itself was associated with the presentation of drugs rather than actively seeking these out. This was likely to be mediated by other novice users.

"Someone introduced me to speed and had only ever tried it once or twice and gave me a bit of theirs." (01.78).

It appeared that the user’s inquisitive urge propelled him or her into exploring drug taking options.

"And er, and you know er a few people like who I knew well, like injected
and I said I'd never do that but like I suppose it were like, everybody's curiosity, isn't it? Er, so like I tried it." (05.30).

An alternative perspective was offered on the issue of curiosity. Here, getting started on drugs was seen as a matter of personal choice and involved self-directed activity.

"Right, um, I never actually turned to drugs for any other reason than the curiosity side and I basically wanted to do it, without raving all about it, to basically see what it was all about." (04.458).

In contrast, one user intimated how a number of early life problems occurred alongside her initiation to a drug orientated lifestyle.

"Um, 'cos I also quite frequently since the age of 13, 14, 15 ... I can't really remember now, it was sometime around then. Um, but I used to cut my arm up quite frequently and ... stuff like that. Or, I'd end up anorexic again and not, not, deciding not to eat anything." (08.253).

At the initiation stage users who spoke about their early drug use declared that the range of drug taking experienced was limited and tended to be experimental in nature. Experimenting thus delimited the extent to which other drugs became assimilated into the user's developing repertoire of preferred substances or methods of use. For users, the outcome of a period of experimentation marked the establishment of amphetamine as the preferred choice of drug.

"It wasn't just speed I were on, I was doing a lot of smoke ... And I've tried Ecstasy. That scared me so I didn't do it again. That's all the drugs I've tried you know. Even now." (01.77).
"And I used to just drop a few like French blues like you know or back street blues like a few reiter or whatever and er chalkies a few bombers and that." (05.22).

"I'd take drugs if I were doing something. Depends what it was. I mean certain drugs I just wouldn't have, you know." (03.251).

"So I didn't actually go into the drugs to sort of like turning to ... drugs as comfort, like. I did it because I wanted to do it. Everything that I sort of did is what I sort of found out what I was doing first, the safest way to do it." (04.466).

The introduction of drugs into the user's life created conditions under which the individual could begin developing an identity in relation to using amphetamine as part of a group experience. Such an identity was construed as being a typical aspect of involvement with other drug users.

"And, er, I used to go to Northern Soul all-nights and I used to DJ on the Northern Soul scene right and you know like that's a recognised scene for everyone taking amphet and that like and dancing all night and that." (05.19).

"Um, basically ... where I lived before um, I was into a big group of people who were mainly amphetamine users um, it ended up most of the people I knew were either on amphetamines and everybody else was ripping everyone off. We were running out of money and we were seeking new ways of going into crime and everything to get money for things." (08.92).

These views contrasted with the users' later experiences as drug problems slowly emerged.

"The more pressure that I were under, I used. But now if I need it that's it, that's it. It's no, it's not with the pressure. I just need it. That's the difference now. ... I didn't expect it would get like this. If I knew what
I knew now, there's no way I would have took it." (01.71).

Ultimately, what began as recreational use developed into enduring use over time.

"I mean after twelve and a half years, thirteen years of constantly using it, I mean I've only abstained twice and that was once when I first met you and now ..." (06.85).

".... you know. I just carried on." (01.80).

Because of these initiating conditions, which developed over the course of time, the users' preferred style of drug taking began to emerge and was amplified into a sophisticated technology for the employment of amphetamine itself.

3.3.2 Developing a Technology of Drug Taking

Users described how developing a "technology" associated with amphetamine use became directed towards the action of drug taking itself. Central properties attached to the activity of drug taking indicated that there was some variation in the content, context and extent to which the user engages with the drug. This led to the establishment of a personalised technology of use which had a particular purpose for users and might be domestic, occupational or functional.

Researcher: "Would you say you take your speed for a particular purpose?"
Participant: "Yeah. So I can get cleaned up. And so I can cope with the kids. I mean I don't ... (son) and (son) are on the go all the time, they're very hard to keep up with so I just need the energy." (01.97).

"Well, I was um, taking whizz for work, getting, getting up in the morning. I was having, doing a bit in the morning then again at dinner
just to get me through the day. But, you know, I was having it everyday and that’s been like the last two, three years." (03.5).

"It was for my own thinking probably, it would all probably come out differently. But as I said before, my mind works probably two or three times faster than I reckon it should do. … [Amphetamine is] sort of like self medication." (06.24).

At this stage, amphetamine became the first choice drug since it was returned to for primary use. Factors such as the severity, amount or frequency of drug taking were described by users and some individuals alluded to features of their lifestyle that accompanied these aspects of use.

Researcher: "What was your drug use like at that point in time?"
Participant: "Er, pretty intense. Er, I was doing a gram of base speed a day generally. … It wasn’t sort of just an intake of drugs as such it was life, lifestyle as well. Um, I’d got myself to a stage where my whole life was surrounded by drugs." (04.26).

"Very heavy. I was doing something like, mixed, like 1:1 and 1:2 amphetamine with something like between half an ounce to three quarters of an ounce a day … and if I was doing base it was something like a quarter to a half ounce, depending on what sort of day I was having. Solidly, every single day without stop." (06.14).

"Then … well, obviously it was a lot heavier, um. It’s not so heavy now like, um. In fact it’s no where near as heavy now. Like er. It’s less frequent, er." (05.212).

"Well it was quite huge ‘cos I was going out robbing people and I really didn’t care too much about what I done to get it, you know. But I was using a lot of street gear as well as the um, as well as the um, prescribed drug." (07.30).

Sometimes, drug taking was seen as being transitional and intermittent in nature moving
between dimensions of extreme use and moderation. Variation was built purposely into use at key times.

"I mean some days now I still use six, seven grams a day. Which isn’t a great deal really, um. But it isn’t everyday. Then it was more regular. I suppose I’d use five days out of seven. Two days I was just unconscious catching up with sleep. Um, I was using about seven grams a day.” (07.35).

"... like I say I’ve cut down to thirty pound a week. And er, it went down to fifteen you know. I am, I have cut down to fifteen but I’ve gone back up to thirty. I just keep going backwards and forwards." (01.123).

"... and in the weekends I always do a bit more. If I’ve not got the kids there, ’cos they’re ... I feel like I’ve done it all week just to be normal and I wanna enjoy it at least once a week. I don’t wanna be sitting there when the kids are at their dad’s like, coming down. It’s like a waste of time, it’s time again, isn’t it?” (02.127).

Some users perceived the extent of drug taking to be at an extreme dimensional point. Through this, the emerging technology of drug taking was further exemplified by user’s willingness to employ alternative drugs to aid withdrawal ("coming down"). This consequence of excessive drug taking was described by one user as an act of personal combat to counterbalance unwanted effects.

"... I used heroin for like 4, 5, 6 days to combat it, coming down.” (04.29).

Thus, if amphetamine was not available and "coming down" was seen as being a "no-choice" option then adjunctive measures might be taken by users. For some users this involved the employment of different types of drugs in order to alleviate the negative effects of withdrawal.
"... I'll sort of deal with it. Like, I'll get a couple of E's. Yeah, they'll sort of... after you've had a good E like, everybody's different like... the E's, E's amphet anyway like you know. Plus like probably with a bit of smack in... then after your come down you know you sort of straighten out d'you know what I mean. Like things are clear like. And you know, there's no bad feelings. You've got no cravings anymore. Yeah, it's calm like, so calm." (05.196).

"I don't smoke now, you know. Even like if I, were really out me head, um. What I used to do I used to have to take the tablets off the doctors. Like, I'd take a load of sleeping tablets to bring me down." (01.82).

Alternative options were chosen by some users to manage withdrawal and derived from the use of cognitive and behavioural strategies such as delaying drug taking or abstinence.

"You know everyone's tired when they first wake up, you know. I wait till I go work and if my feet are dragging or if, you know, I feel tired well then I, like I'll have a bit." (03.88).

"... I was still turkeying so I couldn't really go out to places and, as I didn't have the energy anyway, find out where to get it from. ... So, as the days went on I just thought well, you know, there's not much point in putting myself through this again so I ended up giving it up." (08.23).

Importantly, users described how preferred routes of administration were developed in relation to drug taking. Although these routes were contextually separate, it seems likely that they were aimed at achieving a particular effect whether by oral, nasal or intravenous routes.

"... but if I've probably necked more than I should've done, it wouldn't help until I've straightened myself out a bit like, with the vodka, like ..." (02.125).
"... and I'd use that [amphetamine] like ... intravenously." (08.15).

"And er, if I put an ounce of powder on that table I'd sit in this room until I'd banged it all up my arm. Whether it was two, three, four days, whatever." (07.293).

"Just after like I'd tried it I mean, I snorted it obviously right and it just seemed you know I just blew, the effects seemed different ..." (05.26).

Users also reflected on how a successful technology was also dependent on external factors such as availability of amphetamine (described above) and the drug's perceived quality.

"But the quality of the gear it varied so much, you know. One day you might only need four grams and another day you'd need eight. That's how much the gear varied, the quality of it." (07.39).

"You know, it's not so enjoyable obviously because I'm not getting the amounts that, you know, I'm used to. You know, and partly, it's a different drug isn't it?" (05.214).

Users who were aware of needing to manage this overall technology of drug taking did so by attempting to regulate either the amount, frequency or source of use in order to maintain personal equilibrium. This seemed to enable users to sustain ongoing drug taking activity, preserve financial stability and provide personal security.

"I could get it on tick, I had it on tick. You know, I hadn't got to pay for it, you know? So ... even though I get it on tick now, it's me brother what deals you know? I limit myself to thirty pound a week." (01.42).

"But you know, like then again like you sing to your pocket, don't you? You know that's why I always sort of bought in ounces. Plus it cuts down the risk of you know, when you want to score." (05.110).
By this stage it was demonstrated that access to a guaranteed source of amphetamine was the primary focus of activity in drug taking endeavours. However, the consequence of developing such a regulated drug taking technology was that particular drug effects began to emerge through over-utilisation. For instance, users told how "scoring" for drugs promoted the expectation of pleasure (the desired effects) but over time delivered disappointment thereby transgressing the promise of earlier, novel utilisation. This provided the first indication in the account that the issue of "loss" was impending (linking with Section 3.3.6, Phase I).

3.3.3 Utilising Drugs

What began as drug utilisation in the user’s relationship with amphetamine - making worthwhile use of the substance - next converged into positive and negative drug effects. Thus, effects combined to produce problematic outcomes. It appeared that at this point in the drug user’s career, attachment to positive effects of amphetamine began to influence the development of identity problems beyond those associated with the drug using culture. Over time, this can be said to define the sort of person the drug user believed him/herself to be (this issue is elaborated on in section 3.3.5, Phase I but may have its origins in the phenomenon of utilisation described here).

3.3.3.1 Getting the Best out of Drug Taking

Users indicated that the essential properties associated with drug utilisation were two-fold, demonstrating both good and bad aspects of using amphetamine as a drug of choice. Here, the optimal effect of amphetamine use was the production of high levels of physical energy.
"If you let your mind go, you're going, and basically if you keep your physical side up with your mind you can go, you know for a long time. A good 4, 5 days before you really feeling absolutely exhausted." (04.67).

"Right if I'd had some good base right? I'd be ok. I'd be happy as a jay bird. Er, and er, you know, energetic, flying about like active like and you know I'd er. I'd be productive. Right." (05.67).

The use of amphetamine as a mood enhancer illustrated its status amongst some users as a "psychological" drug. In this, cognitive processes were said to function at heightened dimensional levels.

"... [You're] definitely aware of thinking. Basically the main thing you do on speed is if you haven't got anything physical to put your energies into it's, you sort of invent sort of things to do. A lot of things are in your head, it's, I dunno whatever, you just invent entertainment for yourself basically." (04.44).

"And other people don't sort of relate to speed being a psychological thing it's more of a, ooh, it makes you do things faster, it makes you stay up longer, this that and the other. They're the very basic things. When you go deeper into the base really, it's very, very psychological." (04.131).

Importantly, users described how, at best, drug taking could produce a euphoric sensation which appeared to be a highly desired effect and a valued experience. This seemed to represent its unique quality.

"When I first got that strong stuff it was absolutely brilliant. It was like I'd never whizzed before. It were like, God, I haven't whizzed for ages because all I've done is like keep it so that I'm on a normal level. I've not done it to get off my head. It felt really weird but really nice." (02.117).
One user indicated that his view on this matter had remained unchanged over time.

"... if the gears right it's like an orgasm. So like anybody who can turn round and say that like you know, you don't like to have an orgasm. Like, is telling porky pies aren't they? Right, so. That's the way I looked at it. And, you know, that's the way I've looked at it ever since." (05.42).

By investing in amphetamine as a lifestyle facilitator, the user has begun to interpret productivity and spontaneous activity as personal assets in everyday life, especially in social domains. This was to become central in understanding the experience of lost effect which ensued.

3.3.3.2 Getting the Worst out of Drug Taking

In contrast to amphetamines' positive effects users described how loss of effect occurred when over-utilisation of the drug became established, over time. This represented the adverse effects of drug taking. "Coming down" was viewed as a negative but universal consequence of amphetamine use due to repeated cycles of drug taking and cessation. Primarily, users talked about experiencing dissipation of physical energy and lowered mood.

"If I'm not on it, speed, I've got no energy. If I'm on it um, it's not like I've got energy but it just keeps me awake. Yeah, 'cos I've been on it for a long time I'm not getting any kicks out of it now. It's just that I need it, you know." (01.19).

"... you get to the stage, and it's roughly sort of 4 or 5 days, where your pupils have been open for perhaps so long. I dunno ... you feel you've been going for so long, you do feel like pulling your eyes out. It really hurts, quite painful. It sort of gives you headaches which in turn makes you ratty, very irate, very snappy and everything ..." (04.115).
"... I was feeling very, very tired, irritable. I felt I had a constant cold that was on the edge of breaking out and I couldn't get rid of it. ... I was getting headaches because I was tired even though I'd had about eight to ten hours sleep at night I'd still be just as tired, like before I went to sleep, um." (08.41).

Users acknowledged that cognitive disruption was part of this experience, and was exemplified by confusional states and memory dysfunction.

"I, I just can't remember things. It's ... I can only just remember what I did yesterday, you know?" (01.16).

"It's like just not knowing, not knowing whether your opinion's right or not in any situation." (02.21).

"Speed, it doesn't ha! do much like for your confidence, it doesn't sort of give you much ability to even, I dunno. Another thing is you could be into something full on a really good thing, and something comes from the side and you veer off straight away. Before you know it you've veered off a thousand times. That can cause a lot, very much confusion for yourself." (04.366).

In addition, it was described how a heightened craving for the drug was encountered and immediate gratification sought.

Participant:  "Your heart beats fast and you sweat like, um. You go a little bit euphoric.
Researcher:  What goes through your head?

Any anger or distress experienced as a result of coming down was said to be directed towards dimensions of self or others.
"I was just, flying off the handle over really silly things and it we had like, a little argument. Well, well even an argument, it was just pathetic really. Stuff like talk now or just answering, answering him back. I'd you know, I'd just flip and start fighting over things, you know getting scissors try an' stab try an' stab him but miss him, you know, try and hurt myself, try and hurt him just, just, fly at him [boyfriend], fly at him with like punches and just go really, really mad." (03.27).

"I, I had problems and you know and things set me off. ... Something silly'd set me off and I'd just go and hit it, hit it hard. ... Well, coming to here. I'd go, go into town and miss the bus or something I'd get really wound up and angry and take it out on the people. Yeah. Anything really I mean, someone said the wrong thing to me and I'd just lay into them." (07.43).

It was acknowledged that drug tolerance may have played a role in this overall loss of positive effect, demonstrating the insight displayed by most users into the types of effect experienced once a drug taking technology has been established.

"Um, well the more I took it, the more I needed it. Less effects from it. I didn't get a rush anymore." (06.22).

"It, used to give me energy you know er ... But now it'd give me energy for about an hour and that's it, you know? Yeah, it's not the same. Even though I'm using the base, you know. Really strong stuff it's just ... not the same feeling anymore." (01.26).

"I'm not getting nothing out of it. I'm not getting no extra buzz or better buzz out of it or nothing. I'm just doing it out of pure habit." (07.318).

In summary, users' drug taking management strategies described throughout section 3.3.3 appeared to be mainly non-adaptive. Strategies served only to establish a maintenance process in drug taking, that is, using more amphetamine or alternative drugs to manage "coming down". Causal effects linked with this were symptoms of withdrawal, (predominantly sensations of extreme fatigue), and increased craving. As before,
availability of good quality amphetamine and personal financial constraints were said to have an impact on the management of alternating effects in drug taking. Consequently, physical and psychological problems ensued as the utility of drug taking itself diminished over time.

3.3.4 Developing Drug Taking Problems

As the utility of drug effects diminished over time, problems with drug taking were accentuated. Initial problems experienced by users were construed as loss of positive effect and unsuccessful management of negative effects. These became the distinguishing markers which would enable significant change to ensue and were embedded in physical, psychological and social domains. These domains are illustrated throughout the section which follows. Key properties of the phenomenon, developing drug taking problems, indicated that physical change had occurred and, in time, this was acknowledged to be an undesirable personal state.

Researcher: "And was there anything else you wanted to change?"
Participant: "Um, ... the way I looked. Um, I was, when I first came up here I was, I'd lost a lot of weight. My hair was falling out in clumps which I didn't like and when I was using speed all the time it didn't occur to me how bad I was getting." (08.166).

"I mean my body's in a pretty bad state as it is at the moment. So, I can imagine if I carry on down this road, in five years time I'm not going to have much of a body left." (06.138).

Allied to this notion of physical deterioration, change was also said to restrict opportunities for engaging in social activities.
"I used to follow motor sports all over the country. Um, but I just can't do it now. My health isn't up to it. I mean I can't, I can't, I can't just pack up and move off again. Take off again because my health won't allow me no more. I'm not strong enough to do it anymore. That's something I've had problems coming to terms with. 'Cos I've always been quite fit and healthy. And the last five years it's just. My health has just gone downhill." (07.336).

Users described how psychological problems began to accelerate and several dimensions of difficulty were experienced as their states of mental health declined significantly. Insight into the phenomenon labelled as "paranoia" appeared to be retained by users.

"... and when I was like, coming out of that [amphetamine psychosis] I was like, ultra paranoid. Um, I thought that everyone was out to get me basically. And then um, it was just like. My memory came back and it was like seeing things like I'd taken an LSD trip." (06.45).

"I do get you know, you might call it paranoia, I do get watched now and again. Like, me flat and that and I know I do, like and there's nothing in this world like can ever change me ideas, like you know." (05.311).

The psychological state of paranoia was seen to have an impact on wider, social domains of activity.

"You know, I get paranoid about going out shopping. I sometimes can't go into a crowded shop. Or I've got off the bus half way into town 'cos I've just got suddenly, just got a feeling about the people around you." (07.235).

"I kept thinking I was hearing things, you know all, all day at work you know from everywhere. You know, people behind me, people. I kept thinking that people on the side of me, you know looking at me, talking about me. I just felt like saying, "I know you're talking about me." You know, "say it to my face" but it's a good job I didn't 'cos I don't think they were." (03.53).
Linked to this, users commented that they experienced the effects of an emerging social isolation and its consequences which were impacting at a personal level. These transformed the users’ familiar self identity in such a way that social separation now predominated their lives. Under these conditions, continuing isolation became related to the emerging personal and social identity developed by the user as a result of problematic drug taking. (This links with section 3.3.5, Phase I).

"I weren't myself anyway, I weren't the (name) that my boyfriend who was, who I first went out with. You know, I went very like sh, not shy really, really, I just got under a shell and you know, wouldn't come out. I wouldn't mingle with other people you know couldn't, you know, I felt paranoid." (03.6).

"... I've always, all the work, all the time always been by myself really in this little box. Never having to actually go out and socialise and communicate and make friends with people." (06.204).

Making adjustments to drug use was seen as an impossible solution for some users. This was attributed to the special relationship they held with amphetamine because of the familiar state it produced for them.

"I'd like to think I could stop but. I've, I honestly couldn't say whether that's possible or not." (07.254).

"There isn't anything, you know, can take its place so. At the moment I'll stick with the drugs that I'm currently on." (01.154).

In turn, users told how they developed increased awareness regarding drug management tactics but that this served only to exacerbate the problems they experienced. For instance, dealing drugs to support a personal habit resulted in greater debt as personal
use expanded thereby increasing the negative effects of drug taking. This began to create a dilemma of recidivism for the user whose life had become devoid of other meaningful activity. It appeared to prohibit personal achievement even in contained domestic environments.

"What money I do have, every penny I get goes on drugs, if I don't get ripped off. Every single penny goes on it. And er, that's it. I usually make money from it so to carry on ...." (06.52).

"Everything really were a problem. You know, got no money, you deal to get a load, make a load of money on it. You just don't know where everything's going and you can't find anything. Can't finish anything because you're distracted, you can't do anything, ha, ha! Just busy doing nothing, getting nothing done." (02.25).

Communication with significant others was compromised over time since this served to promote personal awareness of the undesirable effects of drug taking. Such effects were usually conveyed publicly by others. The user's internalised view of self was thus challenged, opening the way for alternative views to become assimilated into existing views of self.

"People who've obviously known you for an amount of time ... God, you're looking ever so thin, you're looking ill you're not yourself and it really brings it home you think, no I don't. You want to convince yourself you think you're alright still." (04.99).

"Um, well, I couldn't see it. I couldn't really see myself doing things but my boyfriend, he's the one like, that could see me, see what I were doing all the time." (03.25).

"I'm one of these people who generally thinks I'm right when I say something. ... I dunno, looking back on a few things I was wrong. So it gives you a bit of a false impression about a few things." (04.120).
Users' volatile actions associated with drug taking increased the potential for isolation in personal and social domains. It is possible that such actions began to define the user's behaviour as being problematic and aberrant.

"... it was my boyfriend what made me come in the first place, 'cos he, you know, he was gonna like, fall out with me 'cos he couldn't handle, like, he couldn't handle the way you know, flying at him for like silly reasons and that." (03.61).

It appeared that users' intransigence may also have reduced the likelihood that social interaction would occur. The act of self imposed separation from community and environment subsumed the isolating nature of drug taking and created a barrier to experiencing meaningful encounters outside the domestic context.

"Yeah I don't like going out. Ask (partner), I just like to be shut in. I won't even open the curtains." (01.50).

"... if I were very, quite paranoid as well I, I was in me shell, I'd go work and come back and be like really cabbaged like, just sit in me bedroom and can't be bothered to speak to anyone and ... you know. It just went on like that, and you know, come week, come like at nights if anyone said d'you want to come out for a drink I was always like too knackered, too like ... I'm always uptight anyway when I finish work like but like, having the whizz everyday doesn't help." (03.34).

In summary, it seems likely that the users' existing personal identity was challenged by the emergence of problems and, as a consequence, the construct of a group or social identity eroded over time to be replaced by revised labels of identity. Under such conditions it can be hypothesised that the user began to accumulate losses which acted to isolate him/her further from others but was not in a position to check this as yet, in
part because of failure to locate the source of emerging problems. At this stage, users remained unable to reflect on whether problems were due to self, substance or others.

### 3.3.5 Developing a Personal Identity as a Drug Taker

As seen in section 3.3.1, the user’s early drug-using identity was established via drug initiation, that is, becoming part of a distinct culture with shared values and experiences. This was construed as being a typical part of life and was linked with the need to achieve "desired" effects (as seen in section 3.3.3). Good and bad aspects of self merged over time (due to problems with drug taking effects) and resulted in vacillation regarding self as a drug user. This outcome inclined towards a compromised personal identity as a user: someone who saw that he/she did not conform to socially constructed rules and values outside of the drug scene because of a chosen drug lifestyle. It appeared to occur irrespective of the user’s individual sense of personal worth.

"So I've always felt as if I've been a little bit of an outsider. You know, you feel as if you're a bit of a leper sometimes. Amongst normal people. Um, you shouldn't feel like that really. Those sort of feelings you should just kick out of the window, 'cos I'm as good as anyone else really." (07.158).

The phenomenon of personal identity as a drug user divided between views of self as user, views of other amphetamine users and views from what had been assimilated via (perceived) public opinion of drug users. In this sense it acted as both a self-descriptive and comparative mechanism.
3.3.5.1 The Idealised Personal Identity

Central properties and dimensions of this phenomenon demonstrated that development of an idealised identity elevated the user’s sense of presentational ability (i.e. their social "face") and emphasised personal resourcefulness: the public "achievements" of choosing drug taking as a lifestyle enhancer. It seemed that users regarded non-conformism as an adaptable state which could be subsumed into their chosen way of life in order to create an impression of social integration and personal control. Essentially, the user attempted to "fit in". Paradoxically, in doing this, it was indicated how the individual user nevertheless regarded non-drug users as "outsiders".

"Um I don't know, I'm sort of, I'm quite good at reading people anyway um, I don't know whether that's through the speed or whether I was like that anyway generally, sort of. I can make myself look appealing to an outside person as well." (04.161).

"... you can sort of adapt it to being a reasonably normal sort of life ... if you haven't got a lot of other, a lot of normal things to do basically, yeah! You can sort of, you can invent yourself a lifestyle that fits into society. Quite well." (04.151).

In their self presentation, users attached affirmative labels to personal drug taking and thereby characterised their uniqueness and emphasised the difference between self and others. This statement of personal distinction further promoted the user's social displacement and separation: other users were seen as being dependent on amphetamine to a lesser degree than self thus elevating the participating user's status in terms of his/her own drug taking accomplishments.

"Most people only do an eighth in twenty four hours or, or less so I mean my habit was like heavy." (06.18).
"I had er, one time mixed, I had an eighth shot which is as I say what most people do in twenty four hours rather than in one go."

"... I knew I was very strong in my head and I knew I could take a very, very strong amount of drug abuse. You know I could abuse myself to a point where not many other people could do or would even think of doing so."

3.3.5.2 The Compromised Personal Identity

Users intimated that their "idealised" personal identity was juxtaposed with their "problematic" personal identity. An adjusted view of self had to be constructed so that the misfit between perception and fact could be addressed. This state of dissonance appeared to create conditions for a revised view of the value of drug taking itself.

"... a year had gone by before I even contemplated thinking about stopping or even looked at myself and thought, "hey (name), you're a bit thin." You look in that mirror, you're still the same person as you were when you started. You do have very false impressions of yourself."

Once the synthesis between mind and body had begun to fracture, users showed that they acknowledged physical change and experienced a decline in body image. These were transformations which were unwanted because they emphasised the breach between ideal or valued self and current or de-valued self as a drug user.

"... I like attention and then again you don't get much attention if you're skinny and looking horrible. Down and out type, looking."

"I just feel like an old bag sometimes."

"... I'm a bit fat. So I get paranoid about that you know, I'd like to be}
like thin again. Well I've never been thin like but you know, I'd like to be trimmer. Which like before, I used to be trimmer. Er, I suppose I can accept myself better that way right as well.” (05.349).

Users constructed and imposed critical self labels. Once more these highlighted the portrayal of extreme views of self that users presented and appeared to be dimensionally opposed to the desired, ideal self. Constructed to justify the users' commitment to drug taking, in practice it may have served only to extend separation and isolation within personal and social domains.

"You know, I am a fully fledged speed freak you could say like without a doubt.” (05.199).

"I would classify myself as a social kinda, a social misfit. Like society's like a square, you know, a square jigsaw and all the pieces are square but I'm a round jigsaw. Doesn't matter how much you try and stick me inside, I don't fit. I don't fit anywhere. I've always been a loner.” (06.225).

Users indicated that this compromised view was alleviated somewhat by social comparison with similar others who attracted negative labels. In dimensional terms, other users were seen as being more irresponsible than themselves. It was others who lacked aspiration to seek lifestyle changes and were unable to act independently. Also, by implication, others behaved dangerously in relation to drug taking, unlike the user who had presented to the service for help. These methods of social comparison may have produced movement towards an intermediate view of personal identity in users themselves representing a medial point between ideal and critical views of self.
"It is annoying though when you see idiots who say "uh, I don't wanna work" and some of them are on the sick for the rest of their lives. They, they don't even, they're not bothered. They don't wanna make a life, you know what I mean? I wanna make a life and I haven't got that confidence anymore and I can't do it. I'm too paranoid. But I really want to." (02.167).

"A lot of people, especially round here who are very much like sheep, they look for somebody to go along with or they look for something to follow or this that and the other. And base is the ideal sort of drug to give that sort of feeling, tighter sort of control over others." (04.530).

"Um, like but, er ... as far as other people, I don't have problems with anyone 'cos I'm not dangerous on it, I don't cause any hazards ... I've got a sin bin you know, things get put in the right places ... like I'm not dirty so I'm not a health hazard and er ... So I'm not a danger, I'm not a menace." (05.313).

Thus, participating users demonstrated how degree of dependency, severity of use and low risk to others became the clearest points of difference between self and others and demarcated the emerging conditions which could support future help seeking endeavours. This principle of justification for attempting to seek help accentuated what was seen as exceptional about self as a drug user: that was, someone who had contemplated ameliorative action because of challenges to personal status and identity within wider social domains. Acknowledgement of current rather than ideal self and acceptance of physical decline now steered the user towards closer realisation of personal loss because of drug taking.

The users' views of public opinion were that it provided a source of negative feedback which influenced development of a compromised personal identity. This was said to compound further the polarised view of self as drug user: someone who surpassed other
users in terms of personal values but experienced more severe difficulties because of drug taking. As a result, amphetamine users began to believe that they were regarded as "alien" and "separate" from mainstream society. This view appeared to be assimilated and projected outwards onto other drug users by those methods of social comparison defined previously. In this way users became isolated by others' lack of understanding and knowledge about drug use (including significant others) and social acceptance was seen as an impossible position.

"I'm not a problem to anyone else in society. Except like, on the level that if they know what I do do, like, their acceptance of it. Do you understand me? You know if they can't accept it. That's more their problem than my problem. ... If they don't see me doing what I do. Right, then er, it's got nothing to do with them. ... I suppose like the way like people like accept you like, you know what I mean? People who do know like what you're doing instead of the kind who don't accept, who don't understand about drugs like and can only imagine it in the way they imagine it. They've never actually tried it never, never, you know, wouldn't even know like. What effects like different drugs give you cos like a lot of don't know do they? Like they ain't got a clue." (05.326).

This appeared to be connected with a belief that users posed a risk to others and were therefore unlikely to be included within a wider social arena. In this way, the choice of a drug taking lifestyle created personal and social tensions and resulted in feelings of judgement and isolation. For users, this seemed to create a sense of personal deviancy: the "freakishness" and "separateness" confirmed by their self imposed labels. For this reason, the user's sense of what was different about self and other non-drug users had to be managed by acts of concealment carried out within public domains. Feelings of shame and acts of self blame were therefore contained within the users' private world.
"The fact that nobody understood um, because most of the people there hadn't been on drugs or drug addicts or anything like that. It was all a new world to them so they didn't understand at all and they were all very biased so I kept my mouth shut about who I told about what I was like. Um, and stuff like the experiences I was going through, I kept it very quiet." (08.85).

In summary, drug taking itself began to emerge as a recalcitrant activity once the user had acknowledged the dilemmas that drug-related problems presented. As a consequence, the user began to realise the extent of their loss in terms of personal and emotional expenditure as their social world contracted, and drug taking expanded. By this means, conditions were created in which help seeking could become a justifiable act. This may have had its genesis in the act of valuing rather than renouncing oneself.

3.3.6 Realising Loss

This phenomenon represented the first point of clear transition in embarking on the process of active help seeking and related closely to its preceding causal conditions: drug taking problems and developing a personal identity as a drug taker. Users illustrated how their realisation of loss acted as a condition of further isolation and accentuated the personal, interpersonal and physical damage accrued over time. The main properties and dimensions which were attached to the phenomenon emphasised users' fears of losing intellectual, physical or social skills.

"I was under false impressions towards the end of the speed where I was, you know, if I give everything up I'm gonna forget everything that I know. That was a big, scary thing. Very scary it was. Am I just gonna end up like a cabbage basically, you know, have I worn my brain down, and have I aged myself internally?" (04.142).
"If you abuse something long enough then it’s eventually gonna break down. It’s like a car. If you abuse it, it’s gonna break down. If you look after it, it’ll last you for years." (07.343).

"Um, that’s another thing I’m gonna have to learn. To learn all my social skills because I don’t have any." (06.195).

The experience of environmental displacement was emphasised by the users’ loss of accommodation and personal property.

"I mean I’ve lost everything. I’ve lost me family, homes. So many homes I’ve had I’ve lost. You know, not always nice places. Lots of them have been crap bedsits and things but. I’ve lost so many, so many possessions and belongings where I’ve kept travelling." (07.163).

Conversely, environmental change became a desirable but impossible position influenced by the users’ assimilated view of self as measured against other users.

"Suppose it’s your environment in it? See, where we live, it’s horrible. Even (drug counsellor) said, amphetamine city, (town), and it is. It’s hard to get out. To me, wherever I go that is where I’ll be, one of them sort, where the gear is. D’you know what I mean? It’s like, I say I could move. I wouldn’t move unless I knew where I could get some gear from." (02.231).

Loss of liberty and personal freedom through legal circumstances relating to drug problems was accepted as a likely but undesirable consequence of drug taking. This became a marker of personal change.

"Like, life was a breeze. Things have changed like. Um, it’s mainly since like er, the last bust like you know. Er ... things deteriorate, ’cos
you know you're gonna go inside and that er ... there was no way I couldn't like. " (05.123).

Users commented that reduced contact with others exacerbated the loss experienced in interpersonal relationships. This seemed to be subsumed by fear of exposure and subsequent rejection by significant others (especially family). It conveyed loss of personal contact.

"... I didn't want my family to come round 'cos I was selling the gear and the door was always going. Yeah. I was worried they'd come in or someone would knock at the door or something. It would be like, ooh, 'cos some of them were like scruffy looking and what have you, you know what I mean? It was just, it was like, you know, I didn't want my family to know that part of my life and I lost contact with my family for ages." (02.35).

Losses were attributed to the negative effects of drug taking but not at this stage to aspects of self which may have contributed to actual loss and underlie fears about potential loss. In this way an initial location was given to the source of the problem. At this point in time, the actual and potential sequelae of loss appeared to have been attenuated by restricting access to contacts which might invite personal judgement.

"I had to do things I didn’t want to um, but had to do them. um, I ended up upsetting my whole family, which, most of my family were down there. Um, and I had only one contact with family, um." (08.97).

Under the conditions outlined above, increased environmental pressures, threatened or actual rejection by significant others and reduced physical coping were shown to influence the identification of needs associated with addressing drug taking problems.
By this stage a point of transition was reached and action for help seeking implemented.

3.4 GUIDE TO PHASE II - ENCOUNTERING HELP

In Phase II of the process, active help seeking commenced and was influenced by the causal conditions: identifying needs and initiating service contact. Help seeking itself was seen as more than simply making contact with a service but extended into the area of constructing relationships with professional helpers. Encountering help (and other, preceding conditions described in the subcategories above) was used as a vehicle for facilitating the possibility of change (the transitional link to phase III). Phase II identified the help seeking encounter as the context in which other help seeking endeavours could be operationalised within the treatment setting. It was governed throughout by the enduring effects of help seeking expectations.

3.4.1 Identifying Needs

General properties which users associated with identifying needs located the areas in which need was said to exist. These were personal, interpersonal and environmental domains, all of which had dimensions of greater rather than lesser impact on the user and created conditions which led to activity which was designed to facilitate the prospective help seeking encounter. The experience of facing dangerous circumstances helped some users to focus on immediate needs. This may be construed as help seeking through the imperative of personal crisis.
"... I was sharing a flat down there with a smackhead. ... And her family are very, very heavy um. As far as the drugs game goes and er, I had to get out of it. It was too much for me. 'Cos, 'cos I was in out of my depth. ... Ur, in the fact that if you upset them or upset their daughter. Um, they, they'd get hold of you and bury you. They're that type of people. It was way out of my depth though." (07.4).

Consolidating a position of personal equilibrium and reclaiming a state of "normal" identity seemed to be the needs which emerged for users at this point in time. When unwanted changes were experienced in physical or social domains, users identified getting "help" as the condition which would enable stabilisation to be achieved.

"Because I was living on the road, you'd get one doctor'd give you seven a day another doctor'll give you ten and another doctor'll give you two a day. And I was so up and down with it all by the time I eventually ended up back here, um. I had to come back here to get some help to sort of get me on an even level, you know." (07.24).

Deterioration in living conditions identified the need for dramatic removal, away from difficulties imposed by the users' personal environment, in order to recover a sense of "normality" however mundane this outcome may prove to be.

"I have thought about burning the house down." (01.190).

"I've gotta get out the house. I've never, I've, I've gotta change completely and I want it to change completely. I want a normal, normal, boring life." (02.48).

Self-enforced isolation from immediate social contacts and the broader community was acknowledged as being necessary but this emphasised an emerging paradox in the experience of solitude and problematic drug taking. That is, some users identified the
need to be included in broader social environments once more: "moving back" in order
to be able to "move forward."

"Um, by removing myself from that environment [drug scene]. If I can do
that then I know. I mean, it's like putting yourself in a real cage. You
can't take yourself away from one, you can't just, no matter how much
people were knocking on the cage. They can't get in." (06.130).

Researcher: "... so, what were your reasons for coming here?"
Participant: "To get myself back to normal basically, um ... But I was
thinking, if I could get, I, if I can get off the street stuff therefore it's
gonna help me financially ... Um, also it would, um worries about where
I will get the money from and things like that I don't have to worry about
where I'm gonna get me gear from 'cos it's. All that, all that's gone.
Then, then cut down to nothing so I can get back to work and everything.
Hopefully, eventually. 'Cos I've always been a productive person. I've
always had to be doing something. I want to get back to work." (06.62).

The problem of compromised physical and psychological health emphasised the degree
doing difference between the user and others. This was seen as further influencing the need
to find a pathway for physical or personal recovery.

"I don't know why I decided, [to seek help] just maybe at the time I think
I was desperate ... for something. 'Cos I was so ill. Mainly, I was very
desperate to get on a script um, because I was feeling so bad um, feeling
so sick and everything ..." (08.137).

"To answer a lot of questions that I didn't really know how to answer my
self." (04.126).

For the user, identified needs were either self imposed or imposed externally by
significant others through encouragement to act, directly or indirectly. This highlighted
how users themselves had reached a point in time when they were able to acknowledge
independently that direct action was required.
"I got loads like, [help seeking needs] particularly where my kids are concerned 'cos like you know, I couldn’t carry on like this forever but eventually they’re gonna be asking what’s what. And I used to be sitting there thinking, what if they wrote a story at school, you know, er, my mum was a bit pissed off today because the eighths were all under or, you know what I mean. It’s always like worries like that." (02.43).

"It was my boyfriend that made me come here because he didn’t like what it was doing to me and he said I needed some help but, um and you know, I didn’t realise I needed some kind of help or advice." (03.14).

At this stage, the user’s management solutions seemed to focus on extracting self from inappropriate circumstances and seeking help from an appropriate agency. As a consequence, action was taken to initiate service contact and the active stage of help seeking was initiated.

3.4.2 Initiating Service Contact

The initial point of contact with the drug service became the marker of an active state of help seeking. The properties and dimensions attached to this phenomenon indicated that a number of routes of contact were open to users. For instance, contact might be mediated by seeking advice from significant others and receiving broad encouragement to act.

"Um basically, I was living in a hostel when I first came up here and ... the people at the hostel basically said we’ll make you an appointment to go to the drug, the community drug service so ... I was very, very pleased ... " (08.4).

Contact might also involve a formal referral process negotiated by self or others. This process identified the users’ primary needs for encountering help.
Researcher: "Can I start by asking how did you come to have contact with the drug service?"
Participant: "Through Social Services ... I needed to come off it."

The decision to make contact appeared to depend upon whether or not information was available about the service. This may have predicted users' initial expectations about the nature of help seeking encounters that subsequently followed. The user considered him/herself as being central to the overall process.

"... through knowledge of it anyway through friends who've had problems, who've come to your services. And er, I went to my GP and asked for his advice on whether, on where was the right place to go and what was the best thing to do for my particular problem. Um, he suggested that Paget House was the best place around to, you know advise me on what to do next about what I needed to help get me off it and he did also say to me that I'd have to do it on my own bat, I'm gonna have to sort of get off the drugs and everything." (04.4).

If the user had identified an acute need for taking self protective measures and support has been provided by significant others then contact (either directly or via a third party) was likely to occur.

"My friend came over, I'd been saying for ages that I wanted to sort myself out anyway and, er, I never actually got round to it and em, my friend came over and phoned from here. She said she was here and she rang up to make an appointment and wanted to do it there and then over the phone." (02.4).

In summary, the consequences of making initial service contact focused on emerging help seeking expectations. According to users, many expectations were well formed and some
were underdeveloped at the initial point of contact but both constituted what was anticipated in prospective help seeking encounters.

3.4.3 Help Seeking Expectations

"Expectations" represented what the user hoped to receive and achieve for him/herself in help seeking encounters within the service. Where these had been well formed, expectations emerged about a number of properties relating to help seeking endeavours. To begin, users anticipated that certain types of treatment would be available to them and their effects were considered. "Cleaning up" and "controlling" drug taking became guiding characteristics for personal change which, it was believed, lay ahead.

"I just wanted a substitute. That's all I came for ... I was, I was like, wanting to get ... I thought that if I got the substitute like, perhaps it'd have been cleaner, I don't know. I didn't know much about it but I thought it would be a cleaner way of doing it, a controlled way. D'you know what I mean?" (02.62).

In contrast, an interest was expressed in addressing underlying psychological factors surrounding individual drug taking. This implied that for some users, the expectations of help seeking presented a challenge in achieving personal changes.

"Um, to overcome the, I dunno, the feeling of like oh, it doesn't matter what they say, I know it all already. To overcome that actual feeling and that's probably one of the biggest things ... dropping the pride, dropping the sort of, dunno, self, self, self bit and to actually open yourself up to advice from someone." (04.157).

This act of forecasting the effects of help seeking encounters seemed to allow users to
reflect on the prospect of coming change. Nevertheless their language revealed the conditional nature of potential outcome as illustrated by use of the words "if" and "hopefully".

"I remember thinking that if I got help and got over it, I'd be over that anyway because my stress wouldn't be up. I wouldn't be so stressed." (02.71).

"Well hopefully, I won't have one [drug habit] if like if I can get cured ..." (03.25).

Hopes for ongoing professional help were expressed through the probability of open-ended rather than time-limited contact. This presupposed that a helper of choice would be available for the user, on demand.

"Probably, I'll probably still like to come here just for a visit like once a month or something, just like to speak to (casemanager) or whoever, um." (03.269).

In contrast, reservations about the prospect of ongoing, undetermined contact were outlined. An awareness of the potential consequences of not pursuing help seeking endeavours was acknowledged.

"I could come over here forever couldn't I, really? God, I must be down. But I don't want it to go on that long without something positive happening. But in the end I just sort of think, no point, and then stop coming again and then just get back down the same old track. Because sometimes you just think, oh, I'll leave it as it is, d'you know what I mean? You think, oh, it's not that bad. But it is. I mean it, it is." (02.301).
Users established such predictions about outcome early in their contact but seemed to modify these once the decision to make changes to drug taking was put into action (this links with section 3.5.1, Phase III).

Where expectations were poorly formed, negative information about what the service could offer the amphetamine user had an important impact on initial help seeking expectations and influenced the prediction of personal outcome. Foremost, feelings of uncertainty informed early expectations but nevertheless influenced users’ motivation to continue, because of vicarious learning experiences.

"[I felt] a little bit dubious for a start, sort of, er, didn’t know whether it was what I needed or whatever …” (04.16).

"… generally the chit chat on the drug’s scene about Paget House is, is yeah, if you’re a heroin addict they’ll help you ’cos, I dunno, I’ve had a couple of friends who you know came with various problems and er, had to, in the end fend for themselves, sort of go out. I mean they did it themselves, basically moved away from the drug scene, moved away from the area and set up another life. Completely got themselves away from anything.” (04.10).

Contact with the service was managed by users’ commitment to present with problems which they felt required specialist help and this was enhanced by support from significant others. As demonstrated, this might be influenced by prior knowledge about the service. At this stage a point was reached when the help seeking encounter could take place, noting that the properties attached to users’ help seeking expectations were to be influential throughout the process that followed, to an end point of predicting times that lay ahead, beyond active help seeking endeavours.
3.4.4 Encountering Help

Users demonstrated that embarking on a help seeking encounter was brought about directly by conditions in which needs were identified and initial service contact was made. The encounter was subsumed by expectations (hopeful and doubtful) brought to the encounter by the amphetamine user and influenced strongly by beliefs about pre-existing personal identity and realisation of loss.

3.4.4.1 Desirable Help Seeking Experiences

Desirable help-seeking experiences can be defined as "successful" encounters between the user and an expert other. The encounter itself denoted the context of help seeking. Here, users focused on properties of active communication with professional helpers. Of these "being listened to" was a central requirement for the purpose of "being understood." This became the central marker of the reciprocal relationship that emerged within the helping encounter. In this way receiving information and support assumed prominence.

"To be with someone that actually listens to start with. I mean, when you say listen not let the words, let the words go in and actually think of what's being said not let the words go in and out and ask another question. And understanding as well." (06.120).

"... (casemanager) I dunno, I can talk to her. She listens you know. If I ask her questions she'll give the answer. You know, even though I'm not coming off it she will be there for me." (01.104).

"I didn't know what I was going to say, not very comfortable when I sat down but then the first words that came out your mouth, I thought instantly ah! I've found somebody here that's like, understanding." (04.169).
Foremost, users determined that the professional helper must have particular qualities with regard to paying attention to their needs for personal feedback. This would appear to go some way in supporting the re-establishment of a positive personal identity.

"I had a very bad opinion about myself ... but coming here and talking about it, it's made it a lot easier because I know I have people for positive feedback ... Because they know I've got the ability to do that but I just need someone to tell me sometimes. (08.257).

The helper's perseverance was a valued quality in helping encounters and seemed to facilitate an emerging awareness of the psychological factors implicated in drug taking. Certainty that a helper would be available for the user was an important aspect of encounters.

"I mean I've been through so many different um, systems like this throughout the country, different parts of the country. But this is the only one that's ever I feel has ever been able to reach inside me head and find out what's going on. A lot of people have tried but ... these have been so bloody persistent, yeah. They really have. It's er, it's done some good." (07.217).

Over time, users indicated that disclosure became a central focus in help seeking encounters and commented that this could be supported by reciprocal collaboration: through an alliance between the user and the professional helper who was valued sufficiently.

"I think like um, they're trying to help me, you know. They're putting themselves out. So I've gotta put meself out a little bit as well. I always try to meet them half way if I can." (07.253).
"... you opened me a little bit which I did and I had a very good response from you basically 'cos to open so many floodgates as such. Um ... and the relief of actually just pouring it all out ...." (04.172).

Users suggested that disclosure was assisted by pre-contact groundwork and seemed to be carried out in order to identify initial needs and develop help seeking expectations.

"... I was just happy to think that maybe somebody's gonna be there listening. Um I had a lot of things to talk about, things I sort of wanted to open up to. Um, a lot of things I couldn't open up to with friends and family, things like that. So, coming here was good." (04.17).

Ultimately, personal disclosure of problems associated with drug taking was seen as necessary and valuable when "the right person" was a participant in the encounter.

"You gotta be able to get hold of the right person. 'Cos some people, um, you could see or talk to on the phone that do absolutely nothing for you. It's pointless speaking to them or seeing them. I um, there's no particular member of staff here that I dislike at all. I think they're all very good." (07.213).

The above conditions suggest that qualitative sufficiency becomes a key aspect of the help seeking encounter, that is, finding a "good" helper to support the user in addressing difficulties around drug taking.

3.4.4.2 Undesirable Help Seeking Experiences

Conversely, the undesirable help seeking experience can be defined as unsuccessful encounters between self and expert helpers or significant but non-expert others.
Professional Encounters

Some users spoke of professional encounters that had been less than satisfactory either in their current experience with the drug service or in previous help seeking endeavours. A range of problems were identified by users and centred on the notion that the expert helper had failed to meet their perceived needs.

"And er, I used. I had a psychiatrist er. This woman used to come, I can't relate to her you know." (01.106).

This act of being unable to relate to an expert helper was echoed by another user who identified that the key issue in a successful helping encounter was the helper’s ability to establish rapport. Without this, it seemed that different values and expectations might be imposed on the encounter.

"My first experience um, with (psychiatrist) was, I mean, he might be a good guy but er, we never got like, any type of relationship at all. I've seen him 3 or 4 times. He was more interested about my drawings which I couldn't understand anything about my drawings, drawing, you know. And things like that and writing things down, I just could not see the point of that." (06.107).

The helper’s inability to establish therapeutic congruence by facilitating a satisfactory encounter was alluded to by users who complained that their expectations of help seeking remained unmet. Realising the impact of such unmet needs resulted in expressions of anger or disbelief at their treatment.

Participant: "And when you told me that I was definitely not going to get it [dexamphetamine] ... I thought you'd just wasted my time."
Researcher: "And how did you feel?"
Participant: "Fucking angry right ... and exhausted. I thought ... and the way I got up ... and it's a right effort getting here and everything. And like, what a waste of time." (02.139).

"So, I'd have preferred methamphetamine ... Yeah, but like. This place had never heard of it. You know, like being given out in script. ... Em, well, er, I won't say it shot me head away but like. It changed me ideas like. I knew you know it just knocked me down a bit but. 'Cos I knew what it was I wanted, and it'd keep me what shall I say like, satisfied." (05.162).

These alternative views contrasted with views held by users who described mainly positive experiences in relation to help seeking. It appeared that dissatisfaction was not expressed towards the service as a whole but towards those helpers who were perceived as being unable to relate to their clients and "wasted their time" or "knocked them down" by providing unanticipated forms of intervention.

Encounters with Significant Others/Peers

Users described how this type of encounter might also become problematic when the preferred helper was not available causing the amphetamine user to seek alternative sources of help.

"She [casemanager] understands that I can talk to my mates about the drugs and they think, it's all in me head, d'you know what I mean? Because they've never experienced it and don't know anything about it." (01.110).

"... I can talk to my mate but like I don't really like talking to her about too much because she probably won't understand and you just, it just sort of goes in one ear and out the other and she don't really give much good advice back anyway like, you know." (03.104).
Users perceived such help as being skewed towards assumptions about drug taking on the part of significant others leaving the user feeling judged, to a greater extent.

"(Town) and basically yeah, those areas in general, you have people that will listen but generally they don't know a lot they're just listeners. They're people who wanna hear such and such, this that and the other. Again they don't know what you're going through and they're just categorising you and making assumptions about how they would deal with it but obviously they don't know 'cos they've never done it." (04.267).

This has commonalities with the users' perceptions of public opinion about drug taking and implied that a close relationship does not necessarily guarantee a sympathetic hearing. Overall, users seemed to suggest that neutrality of interest (as in desirable encounters) would promote success in help seeking.

The undesirable encounter with non-expert helpers was thus attributed to lack of expertise and understanding on the part of a significant other. For this reason, understanding difficulties from the users' perspective was viewed as an impossible position in helping encounters outside the service setting. This appeared to represent a tension between the need to communicate actively at a time of need and undertake encounters with a suitable, empathic witness.

**Encounters with Significant Others/Peers - A Negative Case Example**

In contrast to the views expressed by users in relation to their negative encounters with significant others/peers one user delineated the positive aspects of active communication with significant others when expert helpers were not available. In this sense, his account on this issue represented a negative case example and provided a further illustration of
the diversity in users’ views regarding desirable/undesirable sources of help (both expert and non-expert).

"You know, I was saying about getting stressed out and that? I’ve got a couple of good friends who don’t use I mean they’re smokers but they don’t use powders. Um, if I’m having a particularly bad day I can sit and talk to them and um, we try and sort out what we should do for the best to get through it. Um, a bit like I would do with a counsellor here. Um, I have to try and sit down and talk things through otherwise if I let them build up in my head, that’s when I start messing up." (07.267).

In this particular case it appeared that the user was able to select positive elements from his formal contact with the service and utilise these productively in situations which might otherwise result in harmful behaviour towards self. Such a pattern of generalised learning provided the user with an effective safety net strategy and appeared to promote coping which was independent of the formal helping encounter. In this sense, positive communication with significant others assumed a functional status.

"[Talking] it breaks things down. It’s like, you got, you’ve got an item there that’s causing you a problem you break it down and you piece it all back together in a different way till it, till it um, until it doesn’t bother you anymore. Till you can find an answer to whatever it is, just keep breaking it down. It does help most of the time." (07.276).

Under conditions where contact with significant others can occur it is possible that the user had developed a level of self support and autonomy in help seeking endeavours which now extended beyond that encouraged by experts. This was achieved by using problem solving strategies in the context of active communication which appeared to be used with equal facility in expert and non-expert helping situations. As a consequence
it is possible that the user recognised that protective strategies could be added to everyday behaviour and thereby limit the extent of personal damage associated with ongoing drug taking.

3.4.4.3 The Ideal Help Seeking Experience

The undesirable experience contrasts directly with the ideal help seeking experience which can be defined as a successful encounter between the user and a recovered drug taker acting as helper: the "true expert" in users' views.

"I've always said this and er, I think the best drug's counsellor in the world is actually a drug's counsellor who's actually been through it all himself 'cos he knows what it's like. But um, if you haven't gone through it you want the next best thing or the closest thing possible. Somebody who can actually understand as well." (06.123).

Users acknowledged the limitations to help giving within the drug service but were able to engage in help seeking encounters offered by helpers who were allocated to them on request. As a consequence, the user aimed to achieve the best "fit" in the encounter by identifying preferred sources of help.

"Then my habit got worse so I thought I'd come back and see if I could get another counsellor. Hopefully female 'cos I've got more friends who've been female and I feel more comfortable with a female." (06.9).

Idealisation of the help seeking encounter appeared to place the drug-user-expert at the centre of the helping process where, it was believed, identification with the stated problem could enhance understanding and reduce the users' sense of personal isolation.
Linked to this notion of "knowing expert," it was anticipated that the presence of similar others in a group context may help to reduce the sense of social isolation and separateness that help seeking encounters can bring to light in the initial stage of contact.

"You know, I'd like to hear what other people feel, how they cope with it and what reasons they take it for and what um, what problems they get from using it. You know? I'd like to hear other people's versions of, well, their story about whizz really ... you know it would just ... to me it would feel like I'm not the only one that's got this problem you know. There are other people out there that have their problems but take it anyhow. You know? I wanna hear their reasons why they're doing it." (03.116).

Finally, an existing source of help may become idealised over time. Where current experience represented the ideal help seeking encounter the extent to which a professional helper was considered trustworthy assumed importance. Here, the user's view of helpfulness was equated with the predictability of relationships which might be enacted within what is seen as an ideal family system. In doing this, the user may have created a bridge between ideal and actual help seeking encounters and in order to promote a sense of personal inclusion.

"The fact that I know I can pick up the telephone at home, phone here. The fact that, no matter what state I'm in. They'll always help me. I know that somebody's there. It's like having a, it's like having a big brother or sister you know. You know they're gonna be there for you." (07.193).

These processes occurred in parallel as the user was compelled to make adjustments to early expectations in order to achieve an interpretation of the "best fit" encounter for
him/herself whether this was with experts or non-experts or a combination of both. Most
users anticipated that such contact would involve a long term commitment. Notably, the
helper was not always seen as being an enabling partner in further help seeking
endeavours. The consequence of embarking on help seeking encounters, over time,
appeared to allow the user (and his/her helper) to determine conditions which would
facilitate the possibility of change, based on the prior conditions of problems
experienced, concurrent help seeking expectations and identified needs.

3.4.5 Conditions Facilitating the Possibility of Change

Facilitators which might modify the negative effects of drug taking were identified during
the early part of the help seeking encounter (though they may have been available before
this, as part of the phenomenon of drug utilisation, but were not acknowledged). They
were seen as necessary conditions for establishing the possibility of ongoing change in
drug taking. Users described a broad range of properties and associated dimensions to
illustrate conditions which they felt needed to be created for change to proceed. These
showed how the user’s motivation and optimism had an impact on furthering the help
seeking process.

"Oh … I really wanted to come here 'cos like, coming here you see, even
though it, you know, makes me aware of what I'm taking. ... And I also
feel that I'm doing something, so, you know what I mean, at least like,
I'm not just carrying on like that 'cos it would have been the death of me
for sure." (02.100).

Having a pre-determined focus for change was said to assist the direction of the help
seeking encounter.

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"Um, basically, I thought about it a lot and talked to other people um, how I could change things and what would their opinion be of um, if they were in the same position or situation, um. Would they think it's better if I change this way or, you know. Do you think it's better if I do this or do it this way or that way? And then I ended up getting comments from other people and deciding myself what to do. Um, because I was determined to do it." (08.187).

Initial preparation such as personal removal from a drug abundant environment was seen as essential (if not achievable in practice). One users' social environment assumed the metaphorical form of a "cancerous growth" which he believed placed him in mortal danger. Solutions required the excision of others from self in order to implement self-protecting tactics for the purpose of change. Problems associated with drug taking now tended to become located in other users within the participating users' environment and thereby remained outside of self.

"... it's not gonna work if you, don't cut them [drug using acquaintances] away as well. It's a bit like cancer. You have to cut the whole, not just the cancer, but the surrounding area as well and once you've done that, you can start to recover." (06.102).

Users stated their readiness to take the encounter further at a pace which was individually determined. This also enabled the broader process of help seeking to remain linked to proactive and focused endeavours.

"... I just wanted to get straight into it, by doing the groundwork first." (04.248).

"So that's why, that's how I was when I came here. To make it easier in respects of like to get rid, or quickly get rid of the formalities and to get into the actual questions and everything that I wanted answering and the actual things I wanted to talk about." (04.243).
"It's gonna be over a long period of time but hopefully it'll work out like that." (06.99).

The potential for consequences of further engagement was high following the emergence of this phenomenon. Supportive communication by significant others (and by helpers) enabled preparation for change to begin. The consequence of embarking on a help seeking encounter was that conditions which might facilitate the possibility of change in drug taking were formally acknowledged. This provided a context in which transition to the third and final phase of the help seeking process was able to occur.

3.5 GUIDE TO PHASE III - PREPARING FOR CHANGE

The third and final phase of this process demonstrated how changes to drug taking were enacted through help seeking encounters both within and outside the treatment setting. It was shown that the possibility of change may be facilitated by early help seeking encounters and conditions linked to outside support and personal motivation. Where this happened progress continued and the user could begin preparing actively for change and engage in remedial activity. However, the help seeking context and associated conditions could inhibit the possibility of change in which case progress was halted and the user entered a period of abeyance in relation to proactive help seeking. Possible disengagement from remedial activity allowed the user to contemplate self-supporting activity and make predictions about the future. This active phase of help seeking showed that the majority of users did not equate change with the conclusion of help seeking.
encounters but expected to maintain contact by receiving ongoing support or by conferring help on others in a similar position.

3.5.1 Preparing for Change

The phenomenon referred to here translated change from a potential condition and invited the user to "act now". Preparation occurred within the established collaborative framework. This was acknowledged as the preferred inter-relational style by users during the initial stage of encountering help. In preparing for change, the type, extent or range of problems to be worked on were identified and feasible targets for change established. The preparations for change focused on declared aims, some of which may have been contemplated prior to the formation of help seeking expectations. These were then formalised or adjusted when users encountered help within a service setting.

"To try and get on some kind of programme that'll ... 'cos I've got such a big dependency I mean I'm not fooling myself I know I'm not going to (snaps fingers) straight away." (06.62).

"I like to be in control of my life, I like to be in control of things that are around me, you know, in a good way. I want to put everybody in a sort of positive frame of mind, I like to put myself positively and go into things deeply." (04.363).

"To keep me, you know, me head on an even level so that I don't get too confused. ... I just wanna keep things at a certain level where I can get through from day to day." (07.259).

"Well at first I wanted a script ... I eventually got my way around to thinking that I didn't really want a script because of, I didn't want to have to be getting off that as well ..." (08.149).

Users commented that willingness to continue disclosure of personal information was a central strategy for managing further help seeking activities. (This links with section 103)
3.4.4, Phase II). As a result, the interactive nature of the help seeking encounter could be sustained further.

"... coming here ... makes me aware of what I'm taking, I can be totally straight about what I'm taking, d'you know what I mean." (02.100).

"... I've had to be very careful not to get into a situation where I have like, in (housing estate). There was a time last year I started to get into that kinda situation and I had to ... it wasn't easy to do but I had to admit to (casemanager) that I was messing up. And er, it hurts me to have to admit like I've messed up 'cos she's put so much help into helping me you know?" (07.178).

It became apparent that intervening conditions both facilitated and inhibited the function of the phenomenon "preparing for change". Therapeutic congruence was altered when disparity existed between the user's and helper's aims. This occurred especially when expected and preferred treatment options were not available to the user.

"What’s been helpful? Ha! Um, I suppose being able to talk about it right and try and explain but like, er. It’s still no ... it’s been helpful in a way and also like the two day scripts has been helpful like, but like, you know. It's still not adequate really. Right, um. Plus er, you know what’s his name? My counsellors want me to stop like, which you know, more or less said I would stop if I could right but I don't think it's, I don't think I’d manage it, like, you know." (05.255).

If the temporal context of change dominated preparations, users acknowledged that the pace of enacting discernable change could compromise their perceived aims and progress.

"Um, I was trying to push myself at the beginning of thinking, yeah, I can get over this quickly. It'll only take a couple of months and I can get back to work. But eventually found that that wasn't the situation. That wasn't the um, didn't end up what happened. Because I found that I
In consequence, as the user entered a stage of remedial contact and engaged in treatment-focused activity, dual tensions seemed to emerge and were experienced as being either empowering or prohibiting. This served to influence negatively those conditions which were said to inhibit the possibility of further change in drug taking practice (this links with section 3.5.3, Phase III).

3.5.2 Engaging in Remedial Activity

At this stage a key task set by the user was to achieve transition back to a state of perceived "normality" through supported treatment activity (this was identified as an emerging need prior to encountering help, section 3.4.1, Phase II). The content of help seeking encounters was exemplified by tasks carried out during this remedial stage. Users demonstrated how the central property of psychological intervention addressed cognitive and behavioural needs and to what extent this influenced the conduct of ameliorative action.

"What coming here, here, does for me ... at least I'm doing something. It's sort of like, oh, I dunno. 'Cos I feel so bad about what I'm doing. I feel as though I've been controlled by all of it. It means I feel less ashamed of myself because I'm doing something." (02.220).

"Sort of be able to stop every now and then, that's the problem, put things into proportion." (04.356).

This approach also provided the opportunity for deeper exploration of intra-personal
issues, and represented users’ personal reflections on the psychological influences of drug taking.

"... I've opened up and admitted my problem to sort of leave myself there and sort of jump out of myself and have a look ..." (04.352).

"... I still feel there's a fair bit to get through. ... like the psychological reasons why I did it and um, what happened before them." (08.250).

"See, I'll stay at home 'cos I can't see anything to do me head in. I'm trying to get straight, so I know, I can think of all the things that happened and put them right in me head. Make sense of things, d'you know what I mean?" (02.319).

In this way, the psychological approach appeared to complement medical interventions provided by the service. Activities of engagement associated with this sought to reduce the negative effects of drug taking as a primary aim within task-orientated encounters. Thus, perseverance defined the user's key strategy for managing the active content of help seeking encounters. Conditions which intervened in this process included access to a range of tactics which could enable the user to develop control over illicit drug taking. Throughout this part of the process, users thought that the helper's support was a focal point for the implementation of remedial activity provided that regular and accessible contact remained available.

"He [casemanager] makes me think so that I can go away thinking, thinking about what he says about changing my ways in life, really you know, trying. ... I'm not as negative as what I used to be, I think if I go out I don't think a sad thought, d'you know what I mean like. I don't want to go out ... I can see this happening, I can see that happening. You know, I try to think, you know something's gonna happen, it's gonna be a really good night. It has been for the last few times I've been out." (03.230).
Constructive feedback from the helper assisted some users in maintaining a level of motivation and persistence fitted to the tasks of further engagement.

"... the advice you’ve given i.e. don’t punish too much, praise yourself for, you know, positive things that I do do. Keeping myself away from anything that’s gonna grab my attention anything that’s gonna grab my mind and not go for a long time, if I can keep myself away from all that and go for a long time, if I can keep myself away from all that, which I have done then it’s a very big help not putting yourself in situations." (04.328).

The consequences of such content focused work were that modifications to drug taking could be made and maintained over time thus creating a pathway for disengaging from help seeking encounters. However, users indicated that disengagement did not always equate with a desire to leave the encounter. Where this failed to occur, conditions which inhibited the possibility of further change were activated. For this reason, the context of help seeking (i.e. the encounter itself) remained the predominant focus for ongoing contact.

3.5.3 Conditions Inhibiting the Possibility of Change

Users told how help seeking encounters may occur over protracted periods of time and at different rates of progress reaching a level where an interim threshold of change is achieved. In this case, a period of abeyance may be said to occur reducing potential for further change in the short term. Properties which users attached to this phenomenon demonstrated the inter-play of personal and psychological factors. The expectation was that drug taking would endure and abstinence was seen mostly as an impossible position, having a direct impact on how much change the user considered possible.
"You know but er, I can’t turn round and say I’m gonna stop, when I know that I can’t. Like, you know. If, ok like, if suddenly for some reason there was never any amphetamines about or there were never any E’s about right you know, you have to. You were put in a place where there’s no possible way of getting hold of any, right? You, you obviously would. You’d have to by force. But that’s not reality, is it? So like you know er, you know I can’t choose to stop. I’d like to stop because that would, that’d solve a lot of me problems if I could stop if I could just stop the cravings, right. You know, then I wouldn’t have a problem would I? (05.271).

"I always wanted to stop taking drugs. But being realistic it’s, it’s very unlikely that I ever will stop. And that’s something I’ve just had to accept over the years." (07.68).

Users indicated that if the focus of change was one of seeking replacement of an illicit substance with a prescribed substance then entrenchment within the help seeking process may follow from it. It was suggested that over time, such experiences resulted in disappointments which followed unmet expectations. A primary source of inhibition for change lay in the notion that amphetamine use provided a sensatory experience that could not be equalled by any other means and relinquishment of this was seen as unprofitable in personal terms.

Researcher: "Is there anything you could do yourself to make changes?"
Participant: "... Er, finding something like, that’d give me as much pleasure. But er, but like there’s nothing that gives me that pleasure. Like so er, you know. It’s a little bit hard isn’t it?" (05.294).

Drug use was seen as an inevitable and ongoing part of life and ambivalence about changing this was evident.

"My drug use? Well to be quite honest I, I think I’ll always use. I’d like to think I could stop but. I’ve I honestly couldn’t say whether that’s
possible or not. I suppose it is possible for certain things to happen like but, I can't really see me stopping totally. Abstaining totally from drugs." (07.254).

This appeared to indicate that the users' relationship with the drug has become strongly established and motivation to change has diminished. As a consequence, the user is apparently locked into non-rewarding helping encounters because of an over-riding desire for the effects of drug taking itself. This can be defined as the "existential imperative" of drug use in which the user perceived his/her very existence as being intimately attached to the act of illicit drug taking. It may represent a state of personal intransigence.

"I just have to live for speed at the moment." (01.162).

"If I've not got any, perish the thought, it don't happen very often, if I've not got any of it like ... I just wish I were dead." (02.196).

"... it doesn't really matter whether I'm alive or dead, it's just like existing and existing to your best possible existence that you can actually have, if you know what I mean." (06.142).

As a consequence, it could be hypothesised that a terminal point in treatment progress has been reached. At this stage, it appeared that the directly remedial components of drug taking problems needed to be set aside until facilitators for change could be re-activated and the possibility of change considered by users once more. In practice, this may mean that users would have to be "held" within the system in a framework of more general support around reducing risk in drug taking practices rather being invited to focus exclusively on the issue of abandoning drug taking itself.
3.5.4 Disengaging from Remedial Activity

The main properties attached to the phenomenon of disengagement were dependent upon who or what was perceived to hold the balance of control in relation to drug taking. Users felt that developing stable parameters of use played a central role in establishing control over drug taking. This was construed as "cure," the epitome of remediable drug taking and represented a desired target for outcome, as identified in the early stage encounter (section 3.4.4, Phase II).

"The thing I've got running in my head is that I've never been controlled, I've always been a controller and I will not be controlled by a chemical. At the end of the day I can't be controlled by, or I won't be controlled by anything." (04.360).

"I am more controlled, a bit. But then like, I want it gone. I want it gone. I wanna be like one of those people who just goes out at the weekend and gets off her head. Well, not necessarily gets off her head but, you know. I'd just like to go out and have a few drinks like I used to, like when it's somebody's birthday and tend to share a couple of bottle of wine. I'd like to do that. So I'm in control, that's all. It's about being in control." (02.252).

The dimensional range of control was illustrated by high levels of personal management, for instance, "controlled" drug taking occurred along a continuum through to "abstinence" from amphetamine. Therefore, users did not imply that "cure" was equivalent to abstinence only.

"... I don't feel the need to have it everyday, I mean, I'm still not off it completely but, but you know it's less than what even, when I, when I went from the first amount and then I went to half right. And now I'm less than that which is, you it's hard enough for me but that's changing a bit. Yeah, I've reduced and um, I seem to know more about the drug now ..." (03.197).
Retaining such control was seen as being dependent on avoiding conflict in personal and environmental domains.

"... if I lose control, I'll regain control by staying out of trouble." (04.433).

"I feel comfortable. I feel relaxed here. Whereas other places I've lived, I've tended to be more involved in the drug scene than I am now. Of course, you're always looking over your shoulder. You know. Wondering if someone's gonna shoot you in the back or stab you or rob you or grass you up or whatever but. I seem to have escaped from that." (07.116).

It was also associated with introducing a selective style of social interaction which remained self-imposed but amounted to "keeping the door open" for a less isolated, more socially controlled lifestyle with limited inclusion of others, who "fitted" the users new lifestyle.

"You like barrier yourself off from everything. I'm always like that anyway. I'm like that sort of person. I barrier myself off. But to a degree there is a door there to let the right people in, all the people who are right, to come in." (06.133).

By this means, control was established as the marker of transition between a drug orientated and a socially productive lifestyle. It became directed towards personal achievement. The dimension of difficulty in accomplishing this was declared by some users.

"... the rest of it, is a challenge down to myself d'you know so, it's a lot harder to actually come off it than it is to be on it." (04.441).

"I shall carry on. A year ago I'd rather just, just've stuck a gun to me
head and got it over with. But now I feel like I. I feel different now. I feel more at ease with meself." (07.151).

Alternatively, it was suggested that establishing and maintaining control over drug taking would present few problems in the user's future life.

"I don't think it'll be very hard at all actually. I don't think it's gonna be a problem in the, in the future at all you know, if you know. I'll probably forget about it when I'm about late, late 20's I'll probably think you know, oh God, when I were 20, 21 I used to have so much whizz but now I'm so different you know, I'm so different, so confident, all the things that I weren't when I were younger. I'm hoping to be that then." (03.297).

Both engagement and disengagement from the help seeking process become compromised by conditions which inhibited significant change and by the degree of users' optimism and expectations about how beneficial the help seeking encounter has been. This was seen to be influenced by strategy focused action. It was also affected by either limiting or broadening social environments. As a result, some users perceived personal control as unachievable and remained firmly attached to the help seeking context. Achieving a satisfactory level of control may be actual or predicted dependent on the user's position in the help seeking process. Users described how control may be perceived as "sufficient" in which case opportunities for users to exit the help seeking encounter emerged. As a consequence, it was acknowledged that this would require adoption of autonomous behaviour through use of self supporting activity.

3.5.5 Self Supporting Activity

Self supporting activity refers to the user's beliefs about what and how autonomous
activity, outside of the formal help encounter, can be incorporated into a reviewed lifestyle and positively influence personal identity. In part, this stage of the process represented cautious projections about future autonomy. Therefore, caution was firmly established as a pre-requisite in guiding users' decisions about change. The phenomenon contained a key property in which users set parameters thought to be capable of aiding independent control.

"I don't always have it before I go to work. I'll see what the day is, see what the morning's like first. I'll just take it to work and don't even bother. Um, or leave the little bit I've got at home." (03.262).

It was expected that using and adhering to tried and tested methods acquired through help seeking encounters would help the user maintain a degree of autonomy. Users thought that this might be done independently. These methods could be supported by targeting (and limiting) help sought from outside sources.

"It's got to be me." (01.151).

"How do you deal with it? [craving]. Um, different ways actually. Um, you ... depends like what's going on. Like, where you are, like and it's just like preoccupying your mind like. It's hard, you just have to wait for it to like, pass over." (05.187).

Researcher: "So, overall, how do you think that you can help yourself?.
Participant: "By sticking with what I know is working." (07.240).

"... I can sometimes help myself by talking to people if the right person's there." (07.310).

Users determined that increased productiveness or attention to personal relationships
would aid day to day functioning. These were the central properties associated with potential self support.

"Ur, occupy my time. Work or something like that so that I'm not thinking about it or whatever. ... Can't sit down and do nothing. That's why, even when I'm doing drugs I'm always drawing or writing something or whatever." (06.239).

"I want a lot out of my relationship, a lot out of my homelife. Things that, at one stage in my life, for years were very sort of, well, is that all I've sort of got to live for, is the end of like, getting a wife, getting a kid, a house this that and the other. ... Now, that, those things I took for granted or such or looked down on are things that I, now with what I know, I can create a beautiful life for myself and for a family. Definitely, I really can." (04.509).

Declaration of one's changed status as a drug user appeared to be an essential point of independent action and demonstrated the user's capacity to consider the consequences of further drug-orientated activity by concentrating on its wider social impact.

"Um, I think if I was offered any ... I think of the effects and I knew that I, it wouldn't work anyway because I'd end up feeling guilty 'cos I'd let my friends down ... and, because I'd let myself down and they wouldn't want to see me like that again. And ... I'd also let my family down and lots of other people." (08.319).

These constituted the strategies which users predicted would help them to manage progress to the point of intended outcome. This did not imply that therapeutic completion occurred at this stage of the process. Rather, self support appeared to represent a position of prediction about what the user believed would be necessary in terms of future help seeking. Since this mostly promoted feelings of discomfort, it was a position that carried an element of uncertainty about future directions.
3.5.6 Predicting the Future

Predicting times to come denoted what was hoped for and was influenced by the central property of "fatalism." In this, a strong belief was developed about either not wanting to tempt fate by declaring a wish for success and achievement or by feeling disinclined to plan or predict what might happen because of fear of failure.

"I don't really like talking about the future it's um, 'cos I don't really know what it holds though I know what I hope it holds. I hope I keep things at a level where I can get through the day alright and that's all I hope to do for the future. I'm not looking at anymore than that." (07.298).

Therefore the user's emerging personal identity as a "manager" of his/her drug use may represent the possibility rather than the likelihood for independent organisation in the future. Allied to this, users indicated how the prospect of "self help" can serve to promote those core fears about failure and generate feelings of potential disillusionment or ambivalence when faced with the prospect of change.

"This is what I'd like but I've not actually planned it, because it might go wrong and if it goes wrong, it'll get disappointing and disillusioning ..." (06.182).

"I just can't see it getting any less than this. Because like, I'm on the minimum now. But the thought of getting, having to take any less is just like, ridiculous. I couldn't be expected to take any less, I couldn't do it, you know what I mean?" (02.284).

In contrast, fear of sanctions from significant others strengthened the user's need to continue helping him/herself.
"... I think about them more than anything [friends and family]. 'Cos I know that they don’t want to see me like that and they’d just totally ignore me and I couldn’t face it again. 'Cos I know that they won’t give me a second chance." (08.327).

Many users believed that since the drug taking problem was located outside of self initiated activity then ultimate control lay outside of self also, with the drug service providing opportunities for ongoing help seeking encounters. This demonstrated how contact with the service was expected to remain ongoing in some format, fulfilling earlier help seeking expectations.

"... I’d still like to come here and just talk to someone about, not just talk about problems, you know, everything really." (03.28).

"I feel like I’ll need everything doing for me. ‘Cos I just, I ain’t got the energy for anything. It’s like ... especially if I was to stop I’d need my whole life taken over, I’d need like someone there just to do everything for me." (02.309).

Further adherence to the help seeking experience was declared by some users through a stated desire to help similar others. This revealed "self" to be the ideal facilitator of the helping encounter as someone who would ultimately relinquish a drug taking career, as identified in section 3.4.4, Phase II.

"... somebody from the outside telling them about it, they’re not gonna listen to so. Somebody they know, has been there done that, I dunno and can sort of explain things and can do it in such a way so that it’s not necessary for to go oh, "how does he know that?” I would get a lot of pleasure and a lot of things out of sort of helping others." (04.500).
The prospect of "giving back" to others in a similar position appeared to fulfil the notion of providing an ideal help seeking encounter for users. It further supported the principle of justification for seeking help among participating users. Users demonstrated that help seeking encounters promoted the possibility of self supporting activity and were able to envisage the prospect of social participation once more.

"I'd rather be going out doing voluntary work um, or something like that. 'Cos there's more contact with um, society and everything like that. You're more a personal part of society which is what I used to like to be doing." (08.371).

Users distinguished personal control as the central condition for controlling drug taking. In this way, personal identity can be said to form a close link with personal control since this offered opportunities for users to re-label negative views of self and their drug taking actions.

Despite opportunities presented for reviewing compromised personal identity and reducing social isolation through activities carried out during help seeking encounters, users felt strongly that "the future" remained uncertain. Instead, it was "the present" which delimited temporal boundaries of perceived control. As a consequence, "the ideal past" constituted the state to which users ultimately wished to return.
4.0 DISCUSSION

The story which emerged from participants’ descriptions of their help seeking experiences will be considered in terms of structural and contextual findings. This is because the accounts given demonstrated the process, phases and transitions of help seeking and its concomitants, over time. It also identified related themes in help seeking such as developing problems and experiencing loss, encountering help and identifying possibilities for change which set the context of what has been described here as the helping encounter: the central determinant of help seeking activity. Unexpected hypotheses emerged about the nature of personal identity and helping relationships. Accordingly, their meanings are explored in terms of their relationship to other phenomena within the help seeking process. Temporal influences on seeking help are also considered.

4.1 INTERPRETATION OF MAIN FINDINGS

4.1.1 Constructions of Problem Drug Taking

In the account given by users, problematic drug taking occurred in three main areas. These involved personal, inter-personal and social aspects of use. Personal problems were exacerbated by the development of a drug taking technology which, over time, diminished the drug’s perceived usefulness. Negative effects such as withdrawal and cognitive disruption led to undesirable personal change in both physical and psychological domains. For instance, physical health deteriorated and the development of paranoid states was commonly reported by users.
Inter-personal difficulties were acknowledged to be a central aspect of the drug taker's lifestyle. Of these, aggression towards self and others was said to result from the negative effects of amphetamine on behavioural control. Accordingly, a location was given to the source of individual difficulties and this locus of control was attributed to the external effects of the drug itself (Rotter, 1975; Weiner, 1974 cited in Stainton Rogers et al. 1995). External challenges by significant others seemed to have an impact on the user's internalised view of self and thereby compromised opportunities for inter-personal communication. This was because such interactions served only to promote personal awareness of the undesirable effects of drug taking. Overall, lack of behavioural control may account for the difficulties that individual users experienced in accepting personal responsibility for their drug use (Gossop et al. 1982). In relation to this point, problems of personal risk were not mentioned directly by users. This omission may be accounted for by social cognitive variables such as stopping the active processing of information to do with personal threat or risk (Elliot and Marmarosh, 1995).

The problem of social isolation was associated with users' drug taking. This was based on a number of factors including social restriction, environmental displacement and change and the user's own intransigence. For instance, the impact of personal factors such as poor physical health accounted for reduced opportunities to engage in social activities. Furthermore, loss of accommodation and personal property emphasised the environmental displacement that some users experienced as a result of problematic drug taking. Making changes to their personal environment (i.e. by moving) was seen as an impossible position. Linked to this, the user's intransigence in social environments may
have reduced the likelihood that social interaction would occur. For example, shutting oneself off from the outside world actively created a barrier to experiencing social encounters.

These constructions of problematic drug taking emphasised both the personal and social difficulties experienced by individual users. It became evident that the location of problematic use was perceived to be outside of the user him/herself and was attributed instead to effects of the drug rather than to individual actions. It was only following contact with the drug service that this view was adjusted (by some users) when the locus of control for managing drug taking became internalised and personal causality was ascribed to such behaviour (Heider, 1958).

4.1.2 Help Seeking as a Process

According to Reber (1985) the term *process* has a "rich variety of meanings in psychology". It refers to the way in which the individual moves forward towards some aim or goal and has directionality or focus. Process is an active state and also describes the manner in which some change is brought about over time denoting a set of operations that produces a particular result. In grounded theory Strauss and Corbin (1990) view process as an elusive but powerful analytical concept. They maintain that "... it is the conceptualisation of events captured by the term process that explains why action/interactional routines break down, why problems occur in the course of life events and why, when looking back at life, one sees growth, development, movement ... " (p. 144).
In the account which emerged about participants’ experiences of help seeking, the process of help seeking itself extended beyond the point of initial service contact (in contrast to the model proposed by Pringle, 1982). Rather, help seeking proceeded through three distinct phases in which pivotal actions were defined by the categories: developing drug taking problems, encountering help and preparing for change. The process was not solely linear in terms of its progress but included relational "loops", two-way relationships and different strengths of relationship between the emergent categories (see Process Map, p.52). For example, the experiences of utilising drugs and developing problems with drug taking were seen as being interdependent. This incorporated a two-way movement between drug utilisation and drug problems but only when the negative effects of drug taking began to predominate.

In this sense, the map corresponds with elements of the model proposed by Beckman and Kocel (1982). This emphasised the importance of the relationship between phenomena rather than explication of discrete events within the overall process of help seeking and reflects in part the inclusive and causal properties of the account presented here. In addition to this, the account included the notion of functional and personal change referred to by Reber (1985) as an integral element of the help seeking process. This conforms with aspects of motivation to change, as contained in the transtheoretical model of change and in self efficacy, notably, through preparation for change as part of a personal decision to act.

Points of transition between phases of change were related to facets of both time and situation. Realising loss presented a first point of transition and highlighted cognitive
influences (such as identifying needs) as markers of change which led to behavioural action such as initiating contact with a service. A second point of transition within the process of help seeking occurred when participants identified conditions which might facilitate the possibility of change, within the treatment context. Points of transition were important to the overall process as these highlighted the "action plans" of movement or change in people's experience of help seeking. A parallel process also seemed to occur within these transitions in which the person's help seeking expectations governed the activities of phases II and III in the overall process.

4.1.3 Modifying Drug Taking Behaviour
All participants were in treatment and, by definition, all engaged in activities of intervention which might lead to changes in drug taking. Treatment was interpreted as preparation for self support, this being the outcome of disengaging from remedial activities. While in treatment participants saw the action of self support as a hypothetical state but some were able to generate concrete plans/activities for change. The temporal context of change appeared to be important: this was seen as being "in the future" and the future was mostly a time of uncertainty, governed by fatalism about possible outcomes. Change itself was seen as a means of "getting back" to normal in order to "move forward" and re-establish personal and behavioural control. However, relinquishing a drug taking lifestyle was in itself seen as a risky option as participants did not have an operational construct for what constituted a so called "normal" lifestyle. Self support thus accounted for part of the risk that lay ahead, in making changes.

Findings on self support in the study appeared to confirm the importance of volition in
behaviour change (Schwarzer and Fuchs, 1996). While an individual might confirm their intention to change, readiness and willingness had to precede any action which enabled them to do so. Some evidence of rehearsing or anticipating potential changes was evident (e.g. changing employment) but no one had contemplated the action of disengaging from remedial activity and enacting self supporting activities though many had an idea of what this might entail (e.g. the use of strategies developed by engaging in remedial activities). Regaining control was seen as a central requirement of disengaging from remedial activities in treatment and pursuing self supporting activity. Stuart (1995) considered the impact of loss of control and will in her psychotherapy work with substance users and concluded that "accepting the experience of loss of control addresses the aspects of addiction which are poorly understood and allows us to offer the kind of treatment that we, dynamically oriented therapists, have to offer patients struggling with addiction" (p. 36). This identifies loss of control as an area of importance when considering how to plan clinical interventions.

Considering possibilities for change emerged as a central facet of the helping encounter but linked closely with the quality and style of the encounter as well as pre-existing expectations about the sort of help which was likely to be given as a result of making contact with the service. This demarcates some of the practical aspects of what was considered possible as a result of seeking help once the participant was in active contact with the service. Overall, it appeared that the content or focus of changes to drug taking behaviour identified a need for clinicians to pay attention to the relevance of techniques and strategies used within a therapeutic context.
4.1.4 Effects of Drug Taking on Social Interaction

The problem of isolation emerged as a key theme in the account. This appeared to present a basic dilemma to participants: whether to conceal or disclose drug taking activity in social domains. Disclosure, as demonstrated in the context of helping relationships, exposed the participant to potential risks or consequences in help seeking as this required an acknowledgement that self is different from others, or "aberrant" within the normative dictates of a wider society. The central point of reference for participants was the culture in which drug taking took place. Acknowledging and acting upon the need to seek help thus placed the user in an uncertain position. In this, displacement from a known culture became juxtaposed with a process of integration into a relatively unknown culture described by users as "normal". This appeared to create a basic tension between knowing where to belong for the purpose of social inclusion and highlighted prominent issues in users' lives. These identified the risks of disclosure as being a potential outcome of social stigma (from significant others) versus a position of personal status (being a substance survivor). The participants' compromised personal identity as a drug user may inform this experience of isolation.

4.1.5 Reciprocity in Help Seeking Endeavours

Reciprocity has been identified as a key element in establishing meaningful relationships (Hargie, 1997). The notion of "giving back" to others in a similar position to current self emerged as a strong theme in relation to participants' hopes for the future. In part, this appeared to fulfil the construct which participants developed in relation to ideal helpers: someone like themselves who has survived and recovered from their drug taking experiences and represents what has been termed "the reflected or looking glass self"
(Hargie and Tourish, 1997, p. 363). This may represent the ideal outcome hoped for by service users. However, the drug taking context remained a central focus for future behaviour. In other words participants appeared not to be rejecting the culture, simply the negative aspects of the drug taking behaviour that went with it. In this way it remained a facet of personal identity which could not be rejected but only adjusted to fit the person's new lifestyle (i.e. it becomes a form of impression management). This is an interesting notion given the experience of isolation which users undergo when seeking help. Its significance lies in the fact that the person acknowledges the need to exist within an acceptable social context and not simply in an "ideology of autonomy and individuality [which is] carved deeply in the subjective consciousness of the culture" (Sampson, 1989, p. 5). Individuality, often exalted as the goal of self development takes second place to the social, emotional and relational environment within which the user acts at this point in the process of help seeking. Such reciprocity becomes the centrepiece of acceptance, reward and validation of social relationships and appears to be enacted in help seeking endeavours.

4.1.6 Temporal Influences on Help Seeking

The process map presented on page 52 indicates the proportion of time which participants spent reflecting on past experiences in relation to current experiences in the interview. The future appeared to be largely separate or divorced from these time-linked reflections. Reasons for this may lie in users' needs to concentrate on the "here and now" experiences of help seeking and fears about potential failure in the context of past experiences (Oppenheimer et al. 1988). Thus, understanding the significance of time in relation to peoples' drug taking experiences is an important aspect of appreciating the
exigencies of help seeking itself. It is acknowledged that the process of help seeking is more likely to occur at later stages of problem drug use and can be precipitated by crisis (Sheehan, 1991).

Waiting was an important aspect of seeking help but deemed not to be overly problematic in participant’s experience with LCDS as no waiting list operates. "Waiting" to change (whatever the context of change identified) was dictated by a rate or pace of therapeutic activity largely dictated by the participants themselves. The time course of help seeking expectations governed and extended across all help seeking activity (current and prospective) once contact with the service had been made. It was noted that a period of hiatus may ensue in remedial activity in which progress is stalled but gains can be maintained or regression occur. Taken together, these illustrate the structural components of the help seeking process and the influence of time on behaviour change.

4.1.7 Unexpected Findings from the Research

Personal Identity

The influence of personal identity was an unexpected finding in the research and understanding its importance can only be considered in relation to the general literature concerning the psychology of self. This is because its impact appears not to have been appraised directly in dependency research regarding adults. According to the current account, users constructed an idealised and/or compromised view of themselves as drug users, arising out of problems with drug taking. This was influenced in part by their own view of other drug users and their perceived view of public opinion about drug use. It arose as a result of increased isolation and concealment of drug taking behaviour and
because of loosened ties with social contacts in the users' drug scene.

According to Wilkinson and Coyle (1997) identity theory is a problematic area for inquiry because of a lack of commonality in the way in which terms are used. A distinction is often made between social and personal identity (indeed, the fracturing of these experiences was identified in users' accounts in the current research). However, this dichotomy has been challenged by Breakwell (1986) in her consideration of identity process theory. She proposes a dynamic model of identity which traces the process of change in relation to the impact of events, especially those which may pose so called "threats to identity". Identity is said to provide continuity over time in which change can be understood within the context of the person's own life history. Identity provides a distinctiveness which individuates a person from others and assimilates them into groups providing both uniqueness and similarity. This is as much a function of the context of identity as the person and is said to be a neutral state although it is implied that individuals are motivated to seek positive ways of being distinct.

This appeared to be what was happening in the current account when users who sought help differentiated themselves from other users by emphasising their positive, personal values and acknowledging the severity of their drug taking. Similarities were diminished during the process of help seeking and were possibly intended to heighten the service provider's awareness of the users' special and distinct circumstances. Most helping encounters created an environment in which the user's reduced self esteem could be addressed and restore a positive self view which had been changed by the adverse effects of their drug taking experiences. Maintaining identity was managed by use of strategies
designed to enable the individual to cope with threats or change. On the one hand, it is possible that denial was employed through idealisation of self. This might be construed as "buying time" to adjust to threat caused for example, by negative physical changes. On the other hand, interpersonal strategies were widely employed by isolating self from similar others and through concealment. These may be explained by strategies of reality negotiation which users employed to maintain positive beliefs about the self under conditions of personal threat (Elliot and Marmarosh, 1995). In relation to this point, intergroup strategies were rejected by most users since the focus of social support was likely to be similar others. Such processes of social comparison have been found to moderate personal reactions to the use of illicit drugs (Wills, 1991).

It should be noted that consideration of issues of self and self identity are important for the purpose of intervention since clinicians frequently require their clients to monitor personal thoughts and behaviours. Also, models such as self efficacy promote individual motivation and volition in behaviour change. As indicated by the account given in section 3.2, being understood and accepted as the individuals they considered themselves to be was a key feature of re-establishing a positive personal identity. Therefore, the importance of focusing on the person, their self awareness and developing self esteem was highlighted by users as an important aspect of the helping encounter and their definitions about what was sought from contact with the service.

**Encountering Help**

The nature of helping encounters emerged as a facet of help seeking which was afforded greater rather than lesser importance by participants. This was a further, unexpected
aspect of the account since it was anticipated that tangible components of help giving such as social support or medication would take precedence, based on examination of relevant studies which emphasised these issues (Oppenheimer et al. 1988; Sheehan, 1991; Myles, 1997). The need for active listening and the notion of unconditional positive regard pointed the way to understanding that what was required was a form of non-judgemental, active participation in clients’ decisions to change. Ideal and acceptable helping encounters were revealed.

Hargie and Tourish (1997) have pointed out that much of our communication with others is an attempt to manage the impression we are making with a view to being liked and securing the positive feedback on our own behaviours which we seek. They suggest that the very act of relating to others (a central component of the therapeutic context) impacts on our core self image on which we rely to make sense of the world. This may go some way in explaining the differentiation between self and other users in terms of personal identity and the presentation of self (or recovered users) as ideal therapists. There are some models which support this notion (outreach work is one such example) and Klee and Reid (1995) have undertaken research to assess the viability of peer led group work. However, most users acknowledged the limitations of what was possible within the service and engaged in the therapeutic milieu which was offered.

The type and quality of communication appeared to be central components of participants’ views of successful helping encounters. Sillars and Weisberg (1987) have summarised effective relational communication as that which is clear, consistent, direct, supportive, focused and reciprocal. In the research presented here, disclosure was said
by participants to be a necessary feature of helping encounters but more likely to occur under optimal therapeutic conditions (i.e. where trust had developed between self and helper). For clients, self disclosure may be used strategically and has consequences (Tardy and Dindia, 1997). There is likely to be a need to regulate self disclosures at different stages within the development of helping encounters. This reflects fears about potential consequences such as judgement or imposition of sanctions and may represent the dilemmas faced by participants when wanting to be open but needing also to protect themselves against possible censure. This may limit the range of self disclosure in early encounters.

The issue of control/power in the helping encounter was revealed indirectly through participants’ descriptions of ideal helpers. The overall aim appeared to represent a need to achieve a more symmetrical partnership in therapy where each party had an equal say in the definition of the relationship and in its control. Some participants appeared to say that this could not happen in the context of formal therapy with expert helpers because of the predominance of superior-subordinate relationships. It has been suggested by Tardy and Dindia (1997) that "such dichotomies of power and status often confound attempts at communication between the people concerned" (p. 365). This may account for some participants’ needs to redefine and label the context of their helping experiences (i.e. the service becomes like a family, helpers like siblings) and are aimed at reducing or equalising the dichotomies of therapeutic relationships.

Participants suggested that one of the least helpful contexts for communication of fears/worries was that with peers or friends. Understanding and acceptance were the
desirable outcomes of interpersonal contact but were thought by most users to be unachievable with significant others and therefore inferior to expert help in spite of the cost to informal sources of social support. As indicated in the negative case example (section 3.4.4.2) if peer support was used, it had to be the "right sort of help" and focus on practical aspects of problem solving with others who were capable of supporting this. Explanations for lack of success in helping encounters with significant others may be provided by the peer’s view of help/support. Research suggests that significant others who are overly enmeshed in a relationship with a user may experience the severe role overload associated with carrying excessive relational burdens (Tardy and Dindia, 1997). A state of co-dependency can emerge in which the significant other is tied into a relationship where everything revolves around the user and his or her difficulties. This possibility was not acknowledged by participants and may have led to the relational constriction mentioned by participants (Wilmot, 1995).

4.2 LIMITATIONS OF THE STUDY

4.2.1 Methodological Limitations

A number of limitations were apparent in the study. These derived mainly from the constraints imposed by the methodology and its impact on the brief time course of the research as well as operational difficulties such as recruitment of participants. The issues of reliability, validity, generalisability and reflexivity contribute to the discussion of methodological limitations and will be dealt with in turn.
4.2.2 Reliability

The issue of reliability is important in qualitative work because the objectivity of a piece of research is said to be at stake. In broad terms, qualitative research aims to produce rich descriptions of a social world which occurs under controlled conditions and corresponds to the social world being described. Thus, its objective is to represent rather than reproduce reality (Hammersley, 1992). Kirk and Miller (1986) have described how reliability in qualitative work is defined by the "degree to which a finding is independent of accidental circumstances of the research" (p. 203, quoted by Peräkylä, 1997). In practical terms this refers to the issue of data collection: its range, quality and detail via recording, observation and transcription. Limitations to reliability in the current study may lie not only in the limited range of research questions but in the question of whether a sufficiently large enough collection of cases was made for the purpose of theory building. It should be acknowledged that further theoretical sampling of cases was truncated here for the purpose of producing an initial, first stage study of help seeking in relation to amphetamine use. The fuller implications of this point will be discussed in more detail in section 4.5, "Future Directions".

4.2.3 Validation of the Study

According to Marshall and Rossman (1995) the strength of a qualitative study lies in its ability to demonstrate validity. In broad terms, this refers to the process of determining whether a property is true, correct and in conformity with reality. It is suggested that a qualitative study will confirm its validity in a number of ways. First of all it provides an in-depth description of the complexity of variables and interactions embedded in data which have been derived from the particular research setting. Secondly, in grounded
theory it includes the notion of consensual validation, an informal procedure which was used through the Qualitative Research Group involving other post graduate clinical researchers. This determines that the more people who concur in a proposition the more likely it is to be valid. It characterises the principle that "systematic support of a particular position grants it a greater acceptability to others" (Reber, 1985, p. 808). Consensual validation was further enhanced in this study by a presentation and discussion of the grounded theory approach and main research findings to the research team leader at LCDS.

The contextual validity of a study can also be accounted for by questions which asks whether the emergent story about help seeking experiences is recognisable by participants or others and whether conclusions drawn relate to substance misuse or the wider literature. In this study attempts were made to invite participants for a further interview in which to provide a de-briefing session about the research analysis. A total of six were contacted (two participants’ cases had been closed) and only two participated further. General concurrence with the account was given and some elaboration was made to the issues of ideal helping encounters and the notion of "being understood". However, because of such a low response rate it was decided not to incorporate this into a formal analysis of respondent validity.

4.2.4 Generalisability

Marshall and Rossman (1995) have suggested further that positivist notions of reliability assume that an unchanging universe exists in which inquiry could logically be replicated. Thus, the generalisation of findings provides evidence of external validity in research.
This contrasts with the interpretive assumption that the world is always being constructed and suggests that research must demonstrate dependability and account for changing conditions in the phenomenon chosen for study. However, within qualitative research it is more a question of determining the transferability of findings within a research study. Thus, qualitative research must also demonstrate confirmability which broadly equates with objectivity. This asks whether the findings of one study could be confirmed by another, an evaluation which is based on the data itself. Transferability occurs across two "decision spans" the first allowing the researcher to generalise the findings about a particular sample to the population from which the sample was drawn. The second occurs when the researcher wants to apply findings about the population to a second population sufficiently similar to the first to warrant application. This represents the "relevancy" of the research. It reflects the internal validity of the evolving theory and describes variables under exploration and the degree to which those variables support the theory. Clarke (1995) has contended that these represent merely "rough analogues" of the concepts of reliability and validity which establish the adequacy of evidence as well as its credibility.

While the notions of subjectivity and reflexivity are considered to be important it is suggested that strategies need to be built into qualitative research to balance potential bias in interpretation. Factors which may interfere with validity include the participant's history, the relationship between participant and researcher, differences between those studied and not studied and possible contamination of the researcher by the area under study. In the study presented here such potential bias was accommodated for by the following strategies:-
• Use of research partners via the Qualitative Research Group.

• The method of constant comparison which involved checking and re-checking data and examining alternative hypotheses for emerging phenomena.

• The use of contemporaneous note taking and memos to inform the progress of ideas within the research. These included coding, theoretical and operational memos.

• The use of extensive theoretical sampling did not occur because of the time constraints of the study. However, as can be seen from the description of drug using typologies within the sample (section 1.1.3) the requirement of generality within the sample was broadly met. That is, participants presented a range of experiences in terms of their technology of drug use.

Qualitative research is not intended to be replicable. Rather, it concentrates on recording the complexity of situational contexts and inter-relations as they occur. In this sense it is a unique piece of work that cannot be repeated but only extended by further independent research. However, it is suggested that data and memos should be available for other researchers to inspect procedures, protocols and research decisions. This represents the "value and trustworthiness" of qualitative research.

4.2.5 Reflexivity and the Role of the Researcher

The notion of reflexive or subjective involvement in the research process stands in marked contrast to the position of neutrality and objectivity advocated in positivistic models of research. Wilkinson (1988) has described this process as an explication of the means by which the research material and analysis are produced. Hence, the researcher and the researched become collaborators in the construction of knowledge. This
constitutes what she has termed "disciplined self reflection". Wilkinson is particularly concerned with the notions of personal and functional reflexivity in the validation of research. The first, personal reflexivity, refers to our individuality as a researcher, who we are, and the influence of personal interests and values on the process of research from beginning to end.

### 4.2.6 My Personal Experience as a Researcher

As a trainee clinical psychologist my experience as a researcher was coloured by innumerable factors each adding to or detracting from my sense of personal efficacy at each stage of the research process. The points of origin of this research have been clearly laid out in the introduction and represented a service led demand to which I willingly responded. My experience of fashioning the subsequent study was reflected in the words of one participant in the study when commenting on the therapeutic process. I was told that embarking on a personal journey of change had been " .... an absolute nightmare but it’s been good." (07.106). When re-reading the participants’ reflections I found that these words in particular resonated with my own experiences of engaging in research and in discovering the many vicissitudes of using qualitative research approaches.

My "nightmares" began early in the process and reflected the organisational exigencies presented by clinical research in a sensitive area such as drugs work. Ethical approval for the study was blocked not on the basis of technical aspects of the research proposal but because evidence of personal/professional indemnity had to be provided before the research could proceed. Further administrative delay ensued from this request and
slowed down formal data collection. This, coupled with difficulties in recruiting participants into the study meant that there was a lengthy hiatus before the research got underway and led to some feelings of frustration. I also found that working through other casemanagers in the service actually slowed the process of recruitment rather than enhanced it. This was not due to any obvious obstruction, simply that "ownership" of the research appeared to lie outside of the service's grasp. This was in spite of my personal consultations with casemanagers and other drug workers and advertising details about the research via written information over a period of 4-5 months. Ultimately, it seemed to me that psychological research was not high on the agenda within multidisciplinary settings unlike, for instance, general audit work. Thus, the issue of extended and unpredictable time played its role in both the participants' and the researcher's experience of contact with the organisation.

A favourable aspect of the research was that it both prompted and facilitated my further development as a psychologist in training. It led specifically to me choosing to explore the assertions presented by some of my colleagues that if amphetamine users were not considered suitable for a substitute prescription then "there is nothing further we can offer". This, coupled with the assertion that amphetamine users were very difficult to work with, gave impetus to my personal need to discover what amphetamine users themselves thought about their treatment within the service, particularly where a substitute drug was not sought or offered. In effect, I was concerned to know what would engage people (Myers, 1997). This led to an emerging interest in the idea of marginalisation of subgroups seeking help from an organisation and I became more aware of some user's sense of exclusion despite their contact. Giving a voice to what I saw as
a rather marginalised group became a fundamental aim of my engagement with participants.

In addition to organisational issues of engagement I became increasingly aware of my own interactional skills during the process of recruitment and interviewing. Multi-level skills of engagement were required through consultation, information giving and sharing, listening and reflecting as well as accurate interpretation of material according to the methods of grounded theory. Of these, it seemed to me that the researcher’s (and indeed, the casemanager’s) ability to listen was most sought after by participants. This led subsequently to me paying more attention to actively employing a range of communication skills within my own clinical practice which had been “taken for granted” previously within the context of three years of specialist training. Thus, learning how to communicate reflexively and not simply as a component of research or intervention was reintegrated into my practice (i.e. as opposed to the procedural artefacts noted by O’Doherty and Davies, 1988). This has continued to be supported through clinical supervision and conforms to the notion that "I am part of the matrix of what is known" (Strauss and Corbin, 1990).

4.2.7 Functional Reflexivity in Research

An issue of central concern to me lay in the fact that a number of participants in the research were, in fact, my own clients all at an early stage of intervention but with widely varying drug taking experiences. This reflected the notion of functional reflexivity and required a critical examination and awareness of any personal bias it might introduce and imposition of any assumptions or values that I carried because of my
additional contact with users. This was particularly problematic for two reasons. First, I was aware of individual histories and reasons for drug taking beyond those given in the research interviews. Similarly, my clients' stories emerged and developed beyond the parameters of the research interview as our therapeutic contact continued. This gave me further insight into the account of help seeking provided in the research and elaborating on this had to be resisted in my analysis of material. In this sense, I chose to remain "true" to the principles of the grounded theory approach and worked only with the material presented on that single occasion. However, this issue alerted me to the fact that the view of "reality" presented was a constructed and personal view which was open to change and reconstruction.

Part of the reconstruction alluded to here was contained in the confusions experienced when trying to pull the many strands of the story together. Clarification came when I began to build a visual representation of the account by constructing flashcards with category labels on and arranging these relationally, according to the principles of axial coding (see section 2.2.2 and Appendix 2). Composing the picture led to a realisation that a process of events was occurring rather than a set of discrete events. Theoretical notes and working memos helped to chart this technical progress and integrate the story. At a personal level I was struck by the energy required at this stage of the analytic process to sustain activity and discover relationships in the data. This has been described as a very creative and consuming part of the process by Strauss and Corbin (1990) and at times it seemed to mirror the types of experience described by amphetamine users themselves in relation to their drug use. That is, expenditure of high levels of energy and engagement in an activity followed by satiation and depletion of energy. Like drug...
taking, the activity of axial coding was returned to repeatedly! Such personal experiences provided the context in which the research was shaped.

4.3 A CRITIQUE OF GROUNDED THEORY

Criticisms which have been levelled at grounded theory as a method of qualitative analysis reflect concerns which have been made about qualitative research in general. Charmaz (1995) has suggested that grounded theory methods provide a bridge between interpretive analyses and traditional positivist assumptions. This is because they are used for the purpose of discovering participants' meanings within an quasi-empirical enterprise by following a set of procedures (Henwood and Pidgeon, 1992; Strauss, 1987). In this way Charmaz argues that grounded theory methods can be used by researchers who subscribe to what she terms "objectivist assumptions" as well as those whose interest lies in constructivist perspectives. An extreme interpretation of this notion has been offered by Van Maanen (1988) who determines that grounded theory is essentially a "realist" form of work whether its origins are in interpretive or positivistic assumptions. This is because the author is absent from most of the text itself and portrays research participants and their worlds in an objective manner. For this reason, many postmodernist (i.e. qualitative) researchers will reject the methods of grounded theory in favour of methods which elevate explication of thinking, feeling and acting human beings. Thus a major criticism lies in its adherence to ways of thinking which ally it to empirical methods of investigation.

It should be acknowledged that to date, grounded theory methods have not focused on
individual narratives. Rather, they have been concerned with fracturing data sets in order to define their total analytic properties. This is because the aim of grounded theory is to discover and define processes of action and interaction by identifying patterns. Accordingly, participants' stories are used to illustrate points rather than provide complete portrayals of their lives. This is said to detract from "... the totality of the individual's story ..." (Charmaz, 1995, p. 49). In defence of current practices Charmaz suggests that many individuals do not wish their whole stories to be revealed and will choose to avoid exposure of their identity. Protection from such exposure was necessary in the research carried out with drug users for the purpose of this study. This derived from ethical concerns about the sample population. Nevertheless, grounded theory methods do not exclude the possibility of working with individual narratives if the researcher wishes to take such a focus.

Layder (1982), commenting on Glaser and Strauss's position regarding grounded theory, suggests that their aim was to make a distinction between formal theory (where the theory fits the data) and grand theory (where the data fit the theory) via a process of logical deduction. He views grounded theory as a vehicle which enables theoretical discovery whose function is twofold: first, as what he calls "an insurance against theoretical stagnation" (p. 110) by emphasising empiricist and rationalist tendencies and second, as a means and locus of theoretical discovery which can resolve structural and interactional problems in "field" research. The notion of such discovery is, according to Layder, a limited form of discovery for certain purposes and questions (i.e. the range of explanation required such as situational mechanics of behaviour or also, knowledge of its contextual conditions) as it is based on a limited form of knowledge (i.e.
empiricism). Rather, he advocates the use of multiple theory which removes the restrictions of empirical methods and requires the use of often competing theories to understand the nature of social reality. This concurs with concerns about its limited value expressed by Van Maanen (1988).

In terms of the practice of engaging in grounded theory research commentators from different clinical disciplines (e.g. nursing, social work) have drawn attention to some of the limitations imposed by the need to apply a strict methodology where the prospect of generating large amounts of data requiring exhausting transcriptions and analysis is aversive. For this reason, many researchers will follow a grounded theory approach in spirit only. The technical terms and abstract concepts often seem to be inaccessible to practitioners (Clarke, 1995; Wells, 1995). It is further suggested that in terms of traditional measures such as validity and reliability qualitative researchers have failed to defend their positions very well and are distinguished by their criticisms of quantitative methodology rather than by any clear exposition of their own practice and perception. Finally, qualitative researchers need to be clear that the work they present is more than mere description or accumulation of facts but provides the contextual meaning suggested by Layder (1982). This is where a precise and open explication of the methods and materials used in creating the final account or story has a central role to play. This can enhance theoretical sensitivity and commit the researcher to examining their pre-conceptions, perceptions and ideas before they are presented (Henwood and Pidgeon, 1995).

In the research presented here emphasis has been placed on describing amphetamine
users' experiences in the substantive area of formal help seeking. In order to enhance theoretical sensitivity constant comparisons were made between different stages of the help seeking process and the experiences of users. Variation in the data was illustrated via exceptional or negative case examples. However, further substantive comparisons could have been made between the experiences of other typologies of amphetamine use or, indeed, other types of drug or substance users (including problematic use of alcohol, which is the area that appears to have been most widely considered in the literature in relation to the issue of help seeking). This represents what Henwood and Pidgeon (1995) have termed "focused conceptual development" which refers to the full exploration of the properties of a defined set of categories. Their selection is determined by their particular relevance to the problem under investigation and are said to generate "depth of vision" as opposed to "breadth of coverage".

If the focus had been on generating formal theory, for example, a formal theory of help seeking then a comparative analysis would have to be made between different types of substantive cases and theories without relating the resulting theory to any one particular substantive area (Glaser, 1968). In this, cycles of interpretation are aimed at increasing theoretical scope in the face of limited initial data or the need for further interpretation of key categories. In this sense, the research presented here does not represent a formal or total theory of help seeking but has provided an initial study of key conceptual and contextual elements of help seeking in relation to the substantive area of amphetamine misuse.
4.4 IMPLICATIONS OF THE RESEARCH FINDINGS

4.4.1 Theoretical Implications

As seen in the introductory literature review a plethora of individual studies and explanatory models exist which elucidate some elements of help seeking in relation to dependency. Many studies refer to the discrete components of help seeking such as precipitants to service contact, personal perception and fear of failure (Hartnoll and Power, 1989; Jordan and Oei, 1989). Explanations derive from models which seek to illuminate the concepts of personal motivation and structures such as triggers and barriers to change (West, 1989; Beckman and Kocel, 1982). Such models originate from social cognition theories of behaviour change and emphasise the degree of theoretical generalisation which has occurred in our understanding of substance dependency in general and drug taking in particular.

The aim of the current study was to explore the notion of process in relation to help seeking within a substantive area of research (i.e. among amphetamine users). It has been described how an understanding of process is important to building our psychological knowledge base about behaviour change (sections 4.1.2 and 4.1.3). Accordingly, the account of the process of help seeking offered here demonstrates that the discrete fracturing of elements of a process (i.e. through the use of separate and distinct explanatory models) has little meaning in the overall context of people’s own understanding of their reasons for, and actions in, seeking help. Rather, help seeking is conveyed as a continuous, cyclical and inter-related process of activities occurring at different levels of a conditional matrix (Corbin and Strauss, 1990). That is, people...
engage with personal, interpersonal and organisational structures in order to procure help and to effect behaviour change.

The "process map" which emerged from users’ accounts remains hypothetical at this stage and therefore, is intended to provide an initial guide to the inter-related aspects of help seeking as a career that parallels key aspects of a drug taking career. In this sense, it attempts to integrate the notions of action and change, over time. However, it is acknowledged that its production has required retrospective and prospective activity on the part of participants and may raise questions about validity of content in the map because of its separation from "live" experiences (Davies, 1992). A possible solution may lie in suggestions offered by Oppenheimer et al. (1988) who advocate the contemporaneous study of the career path of substance users over time. Nevertheless, the process map does provide a "depth of vision" over time of the different activities deemed to be mutually important in help seeking. In this way it presents a development of the concept of help seeking which extends beyond those traditional models which advocate closure of the help seeking construct at the point of service contact. It also demonstrates how, for many amphetamine users, help seeking may translate into a reciprocal state of help giving as a function of change.

4.4.2 Organisational Implications

Stereotypical views of LCDS were held by users in relation to how the service was designed to help opiate users and did not consider the needs or interests of amphetamine users to be equally valid. This perception had evolved from both social anecdote and direct experience and was supported by literature concerning access to services by
different groups of drug takers (Hartnoll and Power, 1989). Contact was most likely to be facilitated by a significant other although the decision to seek help lay with the individual users themselves. Participants identified the need for information about the service, amphetamine and implications of changes to drug taking only when they had made contact with the agency.

These conditions highlighted a need for the service to provide information which could be targeted specifically at the amphetamine using population and which identifies pertinent details about what the service can offer in relation to this particular groups’ needs. Dissemination of service information could be facilitated by closer liaison with outreach workers and other agencies such as Turning Point. The production of service literature aimed at wider dissemination is required. It will enable LCDS to communicate the fact that it acknowledges the different needs of different service users and is willing and able to provide specialist help on an individual basis. Clarification of how this differs from what might be offered by other services will be necessary. These are conditions which consider how the service can engage users who may be considering formal contact. It is acknowledged that there may be a need to balance these needs against financial costs for the service.

The establishment of time limited but formal monitoring systems beyond the scope of a basic audit of outcomes may be a route forward into determining the particular needs of this population in treatment. In the context of the current study aspects of managing drug taking, perceptions of self and its impact on social involvement highlighted the key concerns of service users. Thus, an examination of change in personal and social terms
appears to be just as important to amphetamine users as functional changes in drug use. A difficulty presented by the notion of formal monitoring is its accountability (and indeed, its validity) across multidisciplinary modes of practice where clients' needs are met by individual styles of practice (e.g. by emphasising pharmacological, psychological or general counselling and support). The relative value of each modality may only be determined by the individuals concerned rather than its significance at a systemic or structural level. It assumes also that investment in service provision for a rather marginalised and small group of users will be provided equally across disciplines. This, in itself, highlights the exigencies placed on both service providers and users by multidisciplinary methods of working and suggests an area for the development of service policy in relation to amphetamine users.

4.4.3 Clinical Implications

LCDS operates a policy of "matching" clients to casemanagers on the basis of preferred discipline and gender, where this is practical and possible within the constraints of provision. Accordingly, clients may exercise some choice or preference at the point of initial contact/assessment if this is requested. Clinical interventions thus take place within this context of allocation and may be arbitrary or targeted. A number of clinical implications are suggested by users' accounts of their help seeking experiences.

- The process of initial screening needs to clarify that choice is possible in relation to allocation of casemanagers. Furthermore, where a choice is not made by the client a recommendation may be given concerning the options possible for allocation in the assessors view. This will serve to reduce clients' anxieties about contact and inform
more accurately their expectations about subsequent help seeking endeavours. This highlights the importance of continuous and targeted information giving (which, like help seeking itself, does not end with service contact). It may also reduce the potential for developing problems that might inhibit change during more active stages of help seeking.

- The context of the helping encounter appeared to carry more weight for participants than the content of encounters. Aspects of interventions that emphasised active listening, personal acceptance and understanding were valued above other activities. Thus, therapeutic style appears to be an important factor when considering how to work with amphetamine users. This corresponds with general literature on psychotherapy in which joint participation and co-operation have been identified as essential components of exchanges in therapy (Styles and Shapiro, 1995; Shapiro and Firth-Cozens, 1990). Person-centred approaches in the tradition of Rogers (1951) would appear to inform the general style of preferred engagement. This style marks a key element of the therapeutic relationship which is known to have an important impact on the success of what has been termed "therapist and client participation" in adult psychotherapy (Czogalik and Russell, 1995).

- The content of helping encounters received less precedence than their context but were acknowledged as being important aspects of help seeking. The content of interventions was largely delivered via a mechanism of collaborative empiricism which denoted the importance placed by casemanagers on cognitive activities in therapy, especially in relation to self supporting modes of drug management. Content was largely equated with problem management rather than person-focused work. Given the disparity here between
context (person-focused, emphasised by participants) and content (problem-focused, emphasised by casemanagers) it seems that attention needs to be paid to the integration of therapeutic methods and styles to achieve better congruence between the casemanagers' perceived agenda and the clients' expressed needs as these evolve over time. Assessing, reviewing and amending goals and aims collaboratively with clients as well as colleagues should be an integral part of this process. This would also serve to balance the perceived power relations between clients and casemanager.

- The timing of interventions within helping encounters was a significant issue for participants. Readiness to consider or prepare for further change had a number of dimensions. It was either absent, provoked anxiety or was welcomed with caution. This would appear to indicate that there is a need to continue matching a collaborative style of intervention to the individual's state of readiness to change so that he or she might assume greater personal control. This notion informs a theoretical gap in the transtheoretical model of change (Prochaska et al. 1992) where successful outcomes are said to be linked to personal readiness to change and to the content of intervention rather than its context. The latter requirement has been identified here. In general psychotherapy research, this pattern of response to treatment is said to reflect a need for therapists to pace sessions appropriately as part of an overall clinical management strategy (Stiles and Shapiro, 1995). What was clear in this study was that the casemanager's agenda for facilitating change was considered by users to be secondary to their own agenda. Therefore, interventions which emphasise motivational interviewing approaches (Miller and Rollnick, 1991) may have greater utility for clients than confrontational or skills training approaches at early stages of therapeutic contact. This
concurs with Stiles and Shapiro’s findings (1995) that more general activities such as “revealing” and "storytelling" dominate early contacts between client and therapist.

4.5 FUTURE DIRECTIONS

The research undertaken here raises a number of issues regarding future directions for the study of help seeking and amphetamine misuse. As with the implications outlined above, they are concerned with both theory and practice and their significance lies at individual and structural levels.

- Further development of the concept of help seeking needs to take place at a theoretical level. To date, no inclusive or encompassing theory of the concept exists in relation to drug taking. Although the transtheoretical model of change attempts to account for decision making and change in general areas of substance misuse its use reflects researchers’ (and clinicians’) practice of fitting the data to the theory as opposed to fitting the theory to the data (see Layder, section 4.3). While the latter is particularly suited to clinical practice in psychology given its long tradition of formulating an understanding of individual clinical cases, it is based often on a priori use of discrete theoretical approaches. Therefore, the act of formalising the concept of help seeking will add to a more universal understanding of its meaning for service users and providers.

- The research has identified the need to develop a fuller understanding of what is useful to service users in the helping encounters they experience within the overall process of help seeking. Questions raised by this include what does being understood mean in
practical terms (i.e. in ways that might be operationalised via clinical contact)? Also, what forms of communication enhance the success of an encounter and facilitate further help seeking and change? This represents an area for substantive theoretical development.

- The impact of organisational factors emerged from the data (e.g. allocation of "good" casemanagers). Further development in this area might include interviewing service providers within LCDS in order to determine their views of their clinical role in relation to "help giving". This could provide data for the application of a triangulation technique, build on the existing concept of help seeking and add to the reliability and validity of the study (Banister et al. 1994).

- An important area which emerged from the data was the drug user’s personal identity or view of self. This is an issue which has not been considered in any detail within the wider dependency research or with adult users. Given the user’s tendency to be involved with amphetamine over the course of a life time (as identified in the data here), restriction of its consideration with regard to adolescents only seems misplaced. At a clinical level there were some clues in the data that under conditions of compromised personal identity the realisation of loss is accelerated and social isolation is magnified increasing the possibility of psychological difficulties. This observation remains hypothetical and would require further investigation.

In addition to the above points a series of operational memos were made during the analysis of data. These identified specific sub populations considered important in
developing an understanding of the impact of drug taking and the need to seek help.

Issues were raised about users' views of their own parenting competency and drug use and the role played by significant others given that they were not considered, on balance, to be the most suitable source of support. Finally, it seemed that the construct of what constituted an "ideal helper" might be worthy of further consideration in relation to users' views of themselves as prospective "help givers". These may constitute useful research topics in themselves and add to the growing corpus of knowledge regarding amphetamine use.
5.0 CONCLUSIONS

By looking at help seeking as a process rather than a set of discrete events that may or may not influence subsequent behaviour, this study has attempted to build an initial and substantive theory of the process of help seeking among amphetamine users. It does not discount the possibility that significant events are important in, and of, themselves but suggests that these have greatest cogency in relation to one another. The concept of help seeking emerged as a three stage process in which the central issues: developing drug taking problems, encountering help and preparing for change predominated. Personal, inter-personal and social losses were major factors in the user’s transition from problematic use to active help seeking. The decision to take action was supported by significant others in the user’s life and this facilitated changes in drug taking.

Unexpected findings added to the richness of users’ accounts of their problem drug use in which drug taking itself was seen as an "existential imperative" (see section 3.5.3). The user’s compromised personal identity and negative social comparisons highlighted the psychological aspects of problematic use. Also, positive and negative aspects of helping encounters with professionals and peers illustrated the behavioural diversity of problem drug use and exemplified users’ help seeking experiences. Making changes to drug taking behaviour was seen to lay ahead of the user, at some undetermined time in the future and indicated that relatively low levels of self efficacy were operating in the population which was interviewed.

A number of implications arose from the study. Of these, the context of help seeking
was evidently more important to users than its content and indicated that the style of therapeutic intervention had a significant role to play in users' perceptions of successful encounters. Having an active role in the choice of therapist was an important issue in this and highlighted users' needs to be informed about possible choices at an early stage of service contact. This emphasised the importance of providing continued and targeted information throughout therapeutic contact and highlighted an area in which clinical psychology can make a significant contribution, specifically via psychoeducational approaches with clients and staff teams.

Overall, the research generated questions which will require further elaboration if a formal theory of help seeking is to be developed. These include a need to identify styles of communication which facilitate encounters. Future inquiry may demand a clearer indication of how psychological difficulties arise from the notion of compromised personal identity as a result of problem drug use. Together, they will provide a useful basis for further research in the area of formal help seeking among amphetamine users.
REFERENCES


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APPENDIX 1

Examples of Data Conceptualisation
R: When you decided to come to this service what was your drug use like?

P: Um. Well, terrible, terrible really. I was very dependent on it and I got to the stage when you know I, I. It was my boyfriend that made me come here because he didn't like what it was doing to me and he said I needed some help but, um and you know, I didn’t realise I needed some kind of help or advice, I just needed someone to speak to. Someone to see what, ur, to see what they’d offer, or whatever.

R: Could you say a bit about your drug use at that time?

P: Well, I was um, taking whizz for work, getting, getting up in the morning. I was having, doing a bit in the morning then again at dinner just to get me through the day. But, you know, I was having it everyday, and that’s been like

1Dimensions of drug use.
2Encouragement.
3External Negative appraisal.
4Realisation of need.
5Information giving/seeking.
6Help-seeking vs help receiving.
7Explaining drug use.
8Drug management.
the last two, three years. 9

R: What sort of problems were you having because of your drug use?

P: Um, well, I couldn't see it. 10 I couldn't really see myself doing things but my boyfriend, he's the one like, that could see me, see what I were doing all the time. 11 I was just, flying off the handle over really silly things 12 and it we had like, a little argument. Well, well even an argument, it was just pathetic really. 13 Stuff like talk now or just answering, answering him back. 14 I'd you know, I'd just flip and start fighting over things. 15 you know getting scissors try an' try an' stab him but miss him, you know, try and hurt myself, try and hurt him just, just, fly at him. 16 fly at him with like punches and just go really, really mad. Then I'd start crying 17 and um, and if I were very, quite paranoid as well I, I was very in me shell, I'd go work and come back and be like really cabbaged

9 Duration of use.

10 Lack of insight/denial.

11 Observation/third party insight.

12 Volatility.

13 Inadequate communication.

14 Wind up

15 Loss of control.

16 Impulse to harm self and others.

17 Distress.

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like, just sit in me bedroom and can’t be bothered to speak to anyone\textsuperscript{18} and … you know. It just went on like that, and you know, come week, come like at nights if anyone said d’you want to come out for a drink I was always like too knackered, too like … I’m always uptight anyway when I finish work\textsuperscript{19} like but like, having the whizz everyday doesn’t help.\textsuperscript{20}

R: Were there any other problems because of it?

P: Not that, not that I can think of. I weren’t myself anyway, I weren’t the (name) that my boyfriend who was, who I first went out with.\textsuperscript{21} You know, I went very like, sh, not shy really, really I just got under a shell and, you know wouldn’t come out.\textsuperscript{22} I wouldn’t mingle with other people you know couldn’t, you know, I felt paranoid.\textsuperscript{23} I felt as though I was like a lot, a lot of people around me\textsuperscript{24} and I wouldn’t, I didn’t like everything. I didn’t like everyone talking about me. And there was one stage at work I thought everyone, ah, ’cos I don’t speak to that many people.\textsuperscript{25} well I do, but like, I always wait till like

\textsuperscript{18}Social withdrawal.

\textsuperscript{19}Constant tension.

\textsuperscript{20}Problem exacerbation.

\textsuperscript{21}Self-recognition/identification problems.

\textsuperscript{22}Social withdrawal.

\textsuperscript{23}Social fear.

\textsuperscript{24}Crowding of personal space

\textsuperscript{25}Limiting interaction with colleagues.
break or dinner or whatever to wait an’ speak to them but like everybody else is like talking an’ like, having a laugh around me an’ when you see like people laughing I used to think they were laughing at me and you know, you could hear things. I kept thinking I was hearing things, you know all, all day at work you know from everywhere. You know, people behind me, people. I kept thinking that people on the side of me, you know looking at me, talking about me. I just felt like saying, "I know you’re talking about me." You know, "say it to my face" but it’s a good job I didn’t ’cos I don’t think they were.

R: So, what were your reasons for coming here?

P: Well, as I say, it was my boyfriend what made me come in the first place, ’cos he, you know, he was gonna like, fall out with me ’cos he couldn’t handle, like, he couldn’t handle the way you know, flying at him like for, for like silly reasons and that. So, then I um, when I did come here I, I ... the first time

26 Watching others/keeping a distance.
27 Listening to others/keeping a distance.
28 Separate vs belonging.
29 Desire to challenge.
30 Rationalisation.
31 Encouragement to act.
32 Relationship problems.
33 Tolerance compromised by aggression.
I was just like talking. The like, the second time, you know I thought well it. I am doing it for him but, you know I'd like to see what they could do to help me. if not come off it, just not make it into an everyday thing. Just cut down and things.

R: Were there any other reasons?

P: Um, Pause (5s), I was curious about what does go on in these kind of places and what kind of people are in here and how they all act and um, yeah. Pause (5s).

R: Ok. What did you want to change?

Pause, (5s).

R: What did you want to be different?

P: Um, Pause, (5s). I dunno, just to get through everyday without having to rely on

34Compliance.
35Exploration of alternatives to drug taking.
36Changing drug use.
37Managing drug use.
38Reduction - focused/limited.
39Information seeking.

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or, um, and, I dunno, change my ways, in the way I think about em, using it as well.41 Pause, (8s).

R: How did you plan to make those changes?

P: Ur, well, I didn’t. Er, it was like, you know, talking, talking to (casemanager) and he would say like what if this, what if that?42 Why don’t you try giving it a miss ... but.43 Instead of like, like using the amount that I was using in the week, I cut down from half, half of that which was quite a big step44 'cos, you know, half a, half of what I was getting is nothing really, you know. I had to make, I had to make, like a little bit last me, you know, the whole week45 and take it as necessary if I really felt like it,46 you know ... I. Not the first thing in the morning when I’m really tired. You know everyone’s tired when they first wake up,47 you know. I wait till I go work48 and if my feet are dragging or if, you know, I feel tired well then I, like I’ll have a bit. I couldn’t stop just like

40Examining reliance.

41Engagement with drug.

42Communicating advice.

43Suggested abstinence.

44Reduction of drug.

45Delaying gratification.

46Targeting drug use.

47Rationalising causes of symptoms.

48Delaying gratification.
that, you know, um so I asked to do it gradually.\textsuperscript{49} Pause, (6s).

R: Moving on, could you tell me about your experience here at Paget House?

P: It's been quite interesting really 'cos, he's not, he really doesn't talk about um, um what people experience when they're on whizz.\textsuperscript{50} He doesn't say that much about it\textsuperscript{51} but like I've learnt some new things,\textsuperscript{52} not just about whizz, whizz, you know, about other things as well.\textsuperscript{53} You know he tries to make me think positive instead of like negative all the time\textsuperscript{54} 'cos I do that anyway and I think that has worked a bit 'cos some ... you know, I ... I don't think so negative anymore.\textsuperscript{55} Pause, (5s).

R: Right. So what is helpful about coming here?

P: Just, well like some. I do come here for like, 'cos of me drug problem\textsuperscript{56} and that but I, I always like coming here 'cos I can talk to (casemanager) about

\textsuperscript{49}Negotiating change.

\textsuperscript{50}Paradoxical expectations - learning about common experiences of drug use.

\textsuperscript{51}Restriction of information.

\textsuperscript{52}Acquisition of knowledge.

\textsuperscript{53}Generalised learning.

\textsuperscript{54}Cognitive restructuring.

\textsuperscript{55}Sense of achievement.

\textsuperscript{56}Drug management.
anything and when I go away I usually feel a lot clearer about about things. 'Cos like, I can talk to me mate but like, I don't really like talking to her about too much because she probably won't understand and you just, it just sort of goes in one ear and out the other and she don't really give much good advice back anyway like, you know. (Casemanager) always has something positive to say, you know always summat that makes you feel better, you know. I like that.

Pause, (5s).

Um, when I, when I first came here I did think, 'cos you know how you sometimes watch things on TV. You know like the alcohol, people with alcohol problems, when they have a group, you know there's a few of you, you know when you talk about. I did think that was gonna happen. When I, when I come over, 'cos in a way I wouldn't have minded it because so you know at least I wouldn't feel on my own then. You know, I'd like to hear what other people

57Personal disclosure.
58Solution seeking.
59Resistance to communicating with peers.
60Encouragement.
61Confidence in professional helpers.
62Problem comparison.
63Treatment expectations through exposure to media messages.
64Sense of isolation with problem.
feel, how they cope with it and what reasons they take it for and what em, what problems they get from using it. You know? I'd like to hear other people's versions of, well their story about whizz really.
APPENDIX 2

Axial Coding Notes
20.5.97 AXIAL CODE NOTE - MEMO updated from 14.5.97. PHASE I - PAST TIME INTO RECENT PRESENT.

KEY WORDS: Got to the stage where ...
   Got to the point where ...
   Then, now ....

CATEGORY: CONSTRUCTIONS OF PROBLEM DRUG USE (think of this also as definitions of personal drug career).

Amphetamine users' constructions of their own problem drug use is the core category identified during this phase of the study. Related subcategories which link with this represent the transitional (cumulative?) nature of construing problem drug use and progressing onto an actional phase where mediated help is sought. "I reached the stage where..." (04): directs drug taking activity into a new phase. Here, the relationships which are played out are causal and consequential in nature and are thereby interlinked not only through time (i.e. process) but structure (i.e. context, content).

**SUBCATEGORY**

(ND) DRUG INITIATION

**PROPERTIES**

Introduction
Range of drugs
Trajectory
Identity

**DIMENSIONS**

Context  mediated - sought
Context  limited - broad
Type  group - personal
Potential for consequences = high

**Intervening Conditions**

Introduction by others
Fear of effects
Mood/activity enhancement (club scene)
Curiosity
being ripped off by 'friends'

**Management Strategies**

recreational use
Limiting range of drug (experimental)
Being injected vs self injection
(limiting route of admin)
Introduction to crime to support habit

**Consequence** Development of a drug taking technology - establishing the drug "career."

**NOTE:** intervening conditions and management strategies can be either positive or negative (i.e. adaptive Initial or maladaptive). ? do maladaptive strategies result in greater negative consequences during process of drug career.

? influence on subsequent technology of drug taking.
### SUBCATEGORY

**TECHNOLOGY OF DRUG TAKING**  
(what is done and how?)

<table>
<thead>
<tr>
<th>Intervening Conditions</th>
<th>Properties</th>
<th>Dimensions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Availability of drug</td>
<td>Access to drug</td>
<td>easy - difficult</td>
</tr>
<tr>
<td>Regular source of supply</td>
<td>Drug type</td>
<td>limited - broad</td>
</tr>
<tr>
<td>(legal or illegal?)</td>
<td>Typology</td>
<td>recreational - habitual</td>
</tr>
<tr>
<td>(context of use) spans</td>
<td>Amount</td>
<td>high - low</td>
</tr>
<tr>
<td>intervention and management</td>
<td>Route</td>
<td>IV - oral</td>
</tr>
<tr>
<td>Financial constraints</td>
<td>Frequency</td>
<td>regular - intermittent</td>
</tr>
<tr>
<td>Mood</td>
<td>Severity</td>
<td>extreme - slight</td>
</tr>
<tr>
<td></td>
<td>Quality</td>
<td>good - bad</td>
</tr>
<tr>
<td></td>
<td>Context</td>
<td>social - solitary</td>
</tr>
<tr>
<td></td>
<td>Duration</td>
<td>LT - ST</td>
</tr>
</tbody>
</table>

### MANAGMENT CONTEXT

Potential for consequences = high

**Management Strategies**

- Context of use - environment
- Willingness to change drug type when speed not available.
- Regulating frequency of admin. (Links to availability of drug)
- Regulating frequency of use and amount/strength
- Crime to supply habit

NOTE: flip-flopping between drug use prior to contact and now in continual comparison - some confusion in time?

**Consequence** of developing a regular drug taking technology is the establishment of particular drug effects.
## SUBCATEGORY

### DRUG EFFECTS

<table>
<thead>
<tr>
<th>Interacting Conditions</th>
<th>Availability of quality substance</th>
<th>Financial constraints</th>
<th>Mood/cognitive state (+ve)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fatigue</td>
<td>Craving (leads to more drug use)</td>
<td>Mood/cognitive state (-ve)</td>
<td></td>
</tr>
</tbody>
</table>

#### Management Strategies

- IV admin to enhance effect
- Using more amphetamine
- Changing drug type to get similar effect
- Removal from situation (arguing) (+ve)

- Delaying use - respite?
- Using drugs to come down
- Reducing amount used
- Self medication
  (All teleological)

### PROPERTIES

<table>
<thead>
<tr>
<th>+ve Energy</th>
<th>Mood</th>
<th>Cognitive control</th>
<th>Sensation</th>
<th>Creativity/ Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>-ve Physical health</td>
<td>Mood</td>
<td>Energy</td>
<td>Cognitive disruption</td>
<td>Craving</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Volatility</td>
<td>Paranoia</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Social interaction</td>
<td></td>
</tr>
</tbody>
</table>

### DIMENSIONS

<table>
<thead>
<tr>
<th>Amount</th>
<th>high - low</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality</td>
<td>enhanced - depressed</td>
</tr>
<tr>
<td>Type</td>
<td>clarified - confused</td>
</tr>
<tr>
<td>Location</td>
<td>euphoric - fatigued</td>
</tr>
<tr>
<td>Context</td>
<td>spontaneous - planned</td>
</tr>
</tbody>
</table>

Potential for consequences = high

NOTE: +ve and -ve effects linked over time as utility reduces.

Consequences as in previous note. Problems with drug use ensue as the effects/utility diminish over time.
<table>
<thead>
<tr>
<th>SUBCATEGORY</th>
<th>PROPERTIES</th>
<th>DIMENSIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>PROBLEMS WITH DRUG USE</td>
<td>Drug cessation</td>
<td>Course impossible(ST) - possible(LT)</td>
</tr>
<tr>
<td></td>
<td>Risk taking</td>
<td>Amount increased - diminished</td>
</tr>
<tr>
<td></td>
<td>Social isolation</td>
<td>Extent considerable - minimal</td>
</tr>
<tr>
<td></td>
<td>Financial problems</td>
<td>Extent increased - diminished</td>
</tr>
<tr>
<td></td>
<td>Legal involvement</td>
<td>Prob. high - low</td>
</tr>
<tr>
<td></td>
<td>Relationship</td>
<td>Severity marked - minimal</td>
</tr>
<tr>
<td></td>
<td>Difficulties</td>
<td>Amount diminished - increased</td>
</tr>
<tr>
<td></td>
<td>Activity</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Also from -ve effects:-</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Volatility</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Physical health problems</td>
<td></td>
</tr>
</tbody>
</table>

**Management Strategies**
- Deal drugs to support habit
- Extract self from environment (to aid independent cessation)
- Talk to friends (links with peer communication)
- Reduce drug use
- Cease drug use

**NOTE:** Links closely with -ve effects of drug taking.

Time flip-flops between past and present - these merge into present to illustrate management context above.

Consequences of becoming aware of **problematic drug use** is that the individual's **personal identity as a drug user** becomes compromised (therefore problem remains internally focused at this stage).
<table>
<thead>
<tr>
<th>Subcategory</th>
<th>Properties</th>
<th>Dimensions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Personal Identity as a Drug User</strong></td>
<td>(Self) Achiever, Conforming, Resourceful, Transformed, Isolated, Body image, Problem user</td>
<td>Amount high - low, un权able - able</td>
</tr>
<tr>
<td><strong>Intervening Conditions</strong></td>
<td>Conforming unable - able, Resourceful Extent a lot - not much, Transformeed unwanted - wanted, Isolated Direction self-imposed-imposed by others, Body image Direction positive - negative, Problem user Direction particular - general, Problem user Direction to self - to others</td>
<td></td>
</tr>
<tr>
<td><strong>Management Strategies</strong></td>
<td>Physical change, Position in drug culture Status, Mind-body Condition, Speed freak Degree</td>
<td></td>
</tr>
<tr>
<td><strong>Messages from others</strong></td>
<td>Physical image Direction positive - negative, Body image Direction positive - negative, Problem user Direction particular - general, Problem user Direction to self - to others</td>
<td></td>
</tr>
<tr>
<td><strong>When things start to go wrong</strong></td>
<td>Physical change, Position in drug culture Status, Mind-body Condition, Speed freak Degree</td>
<td></td>
</tr>
<tr>
<td><strong>Perceived personal status</strong></td>
<td>Physical change, Position in drug culture Status, Mind-body Condition, Speed freak Degree</td>
<td></td>
</tr>
<tr>
<td><strong>Cognitive assimilation</strong></td>
<td>Physical change, Position in drug culture Status, Mind-body Condition, Speed freak Degree</td>
<td></td>
</tr>
<tr>
<td><strong>Ability to self label in a positive way</strong></td>
<td>Physical change, Position in drug culture Status, Mind-body Condition, Speed freak Degree</td>
<td></td>
</tr>
</tbody>
</table>

**Management Strategies**
- Compare self with other users (usually more +ve but seek help because of level of problem)
- Frustrated - sheep Type unskilled - skilled
- Dependent Severity less than self-more than self
- Aspiration Extent lacking - present
- Use - don't use
- Can never be friends because
- Aspiration Extent lacking - present
- Dealers Status powerful - neutral/passive
- Scroungers Extent all - none
- Uncaring Extent all - none
- Irresponsible Extent all - none
- **Others**
- Dependent Severity less than self-more than self
- Aspiration Extent lacking - present
- Use - don't use
- Can never be friends because
- Aspiration Extent lacking - present
- Dealers Status powerful - neutral/passive
- Scroungers Extent all - none
- Uncaring Extent all - none
- Irresponsible Extent all - none
- **Self**
- Angry Duration always - never
- Needing help Amount increasingly - less
- Responsible Direction for others - for self
- Judged Frequency usual - unusual

Consequences become more aware of self compared with others (social comparison) and social stigma attached to drug users through **Public View** of drug use - status in drug using culture compared with perceived non-status in wider social culture (? status in treatment culture).
### SUBCATEGORY

<table>
<thead>
<tr>
<th>PUBLIC PERCEPTION OF links with DRUG USERS</th>
<th>PROPERTIES</th>
<th>DIMENSIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Perception</td>
<td>Direction</td>
<td>positive - negative</td>
</tr>
<tr>
<td>Drug user alien</td>
<td>Context</td>
<td>social - personal</td>
</tr>
<tr>
<td>Lack of understanding</td>
<td></td>
<td>isolates - includes</td>
</tr>
</tbody>
</table>

**Intervening Conditions**
- Feelings of shame
- Drug user
- Feelings of anger
- Fear of discovery through indirect exposure
- Protection of others

**Management Strategies**
- Reduced social interaction
- Social interaction with similar others

**Drug use**
<table>
<thead>
<tr>
<th>Social Comparison</th>
<th>Users</th>
<th>similar - different</th>
</tr>
</thead>
<tbody>
<tr>
<td>Peers</td>
<td></td>
<td>knowledgeable - ignorant</td>
</tr>
<tr>
<td>Colleagues</td>
<td></td>
<td>normal - deviant</td>
</tr>
<tr>
<td>Non-users</td>
<td></td>
<td>normal - deviant</td>
</tr>
</tbody>
</table>

**Results in Concealment**
- Amount considerable - little
- Direction likely - unlikely

**Consequences**
These inter-related subcategories lead to a series of consequences. The net result is one of realisation of LOSS.
### SUBCATEGORY

<table>
<thead>
<tr>
<th>LOSS REALISATION</th>
<th>PROPERTIES</th>
<th>DIMENSIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>(links to fears re changing drug use)</td>
<td>Personal possessions</td>
<td>Amount</td>
</tr>
<tr>
<td></td>
<td>Physical coping</td>
<td>many - few</td>
</tr>
<tr>
<td></td>
<td>Relationships</td>
<td>Extent</td>
</tr>
<tr>
<td></td>
<td>Personal</td>
<td>↓ strength - ↑ strength</td>
</tr>
<tr>
<td>Intervening Conditions</td>
<td>Family contact</td>
<td>Loss - Loss</td>
</tr>
<tr>
<td>Debt</td>
<td>Children</td>
<td>feared - rationalised</td>
</tr>
<tr>
<td>Messages from SO's</td>
<td>Friends</td>
<td>Duration</td>
</tr>
<tr>
<td>Reduced physical coping</td>
<td>Emotional control</td>
<td>LT - ST</td>
</tr>
<tr>
<td>Personal liberty</td>
<td>Spontaneity</td>
<td>State</td>
</tr>
<tr>
<td>Reaching a point of clear transition</td>
<td></td>
<td>rejected - accepted</td>
</tr>
<tr>
<td>Legal involvement (potential/real)</td>
<td></td>
<td>loss - retention</td>
</tr>
</tbody>
</table>

### Management Strategies

- drug contacts/extraction from environment
- Distraction, keeping busy
- ↑ drug use, dealing - valued
- ↑ drug use and dealing to support habit?

Extends into areas covered by -ve drug ↓ isolation from effects and personal identity ↓ loss
= movement away from 'old self' → normal, healthy, active, sociable.
How to regain this and restore losses.

Consequences of realising loss is the identification of certain needs in relation to drug taking lifestyle and the problems which impact on the individual user.
20.5.97 CODE NOTE MEMO (expanded from 13.5.97). PHASE II RECENT PAST IN PRESENT

KEY WORDS: then ... now
at the moment
right now

CORE CATEGORY: HELP SEEKING FOR PROBLEM DRUG USE

Loss realisation presents a transitional point from which the actual help seeking process can begin. (In the transtheoretical model - moving from contemplation to action? Does this hold up?). Two phases of help seeking emerge: preparation and planning to modify drug taking and active modification once through the transitional interface into ongoing therapeutic contact.

SUBCATEGORY PROPERTIES DIMENSIONS

IDENTIFICATION OF NEEDS

Intervening Conditions
(enhancing above)

- Psychological and physical health compromised
- want to get back to normal
- Isolation from family and community
- Messages from SO's
- Physical environment unacceptable

Management Strategies

- Extract self from environment
- Seek help from appropriate agencies

CONDITIONS LEADING TO HELP SEEKING

- include categories outlined previously esp. -ve effects and their effects on personal identity as a drug user but also:
- Legal involvement
- Deterioration in living conditions
- Criminal career looming
- Dangerous circumstances

CONSEQUENCES

The combination of (unplanned) conditions which lead to help seeking and identification of needs results in an action to make service contact.
MAKING INITIAL SERVICE CONTACT

Intervening Conditions

- % of helpfulness service likely to offer
- Mediated contact (encouragement or referral)

Management Strategies

- Contact directly
- Contact indirectly via 3rd party
- Re-contact

Advice from others
Knowledge re: service
Encouragement by others
Referral by others

Action
Extent
Style

sought - not sought
available - unavailable
broad - limited
negotiated - imposed

NOTE: Again, may conditions/strategies and contextual relationships appear to overlap with other subcategories. Is there a difference between categories or would they be better represented by a collapsed category, re-labelled to represent all? Problem presented by this is that the sublety/detail of process might be lost.

Consequences of making initial service contact (before following actual contact with service) are that expectations of help provided/offered begin to emerge. Some expectations are well formed (script and counselling - experienced users?) some embryonic (advice about what to do next) at the point of contact.
## HELP SEEKING EXPECTATIONS

### Intervening Conditions
- *(Casemanager allocation - getting intervention the right person = arbitrary)*
- Non-prescribing of dexamphetamine *(substitute)*  
- Style of contact with service
- Outcome predictions
- Negative feedback from similar others
- Uncertainty about what to expect

### Management Strategies
- Come anyway - Carry on anyway
- Make a specific request for a case manager

### Properties
- **Forecasting**
- **Professional support**
- **Pharmacological**
- **Contact**
- **Cure**

### Dimensions
- **Direction** +ve outcome - -ve outcome
- **Duration** ongoing - time limited
- **Type?** available - unavailable
- **Context** group - individual
- **Extent** complete - partial
- **Potential for consequences** = high

### Consequences
Consequences of having help seeking expectations (which precede contact and continue through the different stages of contact) is that a point in time is reached when encountering help takes place. This represents a commitment to undertake therapeutic work with an allocated worker. (Help receiving - previous label - too passive. Participants clearly active in taking up help).
### Properties and Dimensions of the Helpful Encounter

<table>
<thead>
<tr>
<th>Subcategory</th>
<th>Properties</th>
<th>Dimensions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>The Helpful Encounter</strong></td>
<td>Professional: Listener, Informative, Supportive, Has a particular approach to understanding problems, Establishes rapport, Experience with users, Persistence</td>
<td>Direction: active - passive, Frequency: often - rarely, Style: comforts - challenges (valued) (not valued), Action: able - not able, Extent: considerable - minimal, Duration: LT - ST</td>
</tr>
</tbody>
</table>

**Intervening Conditions**
- Availability of experienced helper
- Communicative style of helper (see properties)
- Regular contact
- Client view of professional (like family)
- Facility of contact with service
- Direction to other agency/support

**Management Strategies**
- Personal disclosure re drug taking reciprocal collaboration
- "alliance"
- Pre-contract groundwork

**Lay/Peer**
- Problem solving discussions
- Problematic/unhelpful: Lay/Peer Make assumptions, Judge, Inexperienced

**Access to Service**
- friends - acquaintances
- always - never
- can't - understand
- easy - difficult

**Consequences**
The professional's communication style facilitates the 'helpful' therapeutic encounter and results in the enablement of personal communications form client → therapist to take place. These are seen as necessary conditions under which the encounter can endure over time in order to progress to therapeutic completion. This is pivotal in determining mechanisms by which drug use might be modified.

**NOTE:** Therapeutic relationship with Casemanager necessary for +ve outcome (e.g.,6) but dependent on finding the right person - mismatch between intentions for change can lead to dissatisfaction.
### THE IDEAL THERAPEUTIC ENCOUNTER

#### Intervening Conditions
- **Availability of helper - possible/not possible**
  - (philosophy of service - multiprofessional approach::individual work)
- **Trustworthiness of helper(s)**

#### Management Strategies
- **Where ideal = current**
- **Where ideal = not current**
  - Next best fit: identifying preferred therapist
  - i.e. getting the best possible fit

#### Consequences
- can be positive and negative. Some identify the ideal encounter (contrast this with *idealised* encounter) as being what is currently available (not just "making do" but enacted through structural components of service via multi-professional contact). Ideal seen as impossible with formal service but possibility of creating it lies with drug users themselves who, through personal experience have the potential to help thereby setting up the ideal mechanism (i.e. encounter) by which to modify drug using behaviour.

---

<table>
<thead>
<tr>
<th>SUBCATEGORY</th>
<th>PROPERTIES</th>
<th>DIMENSIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>THE IDEAL THERAPEUTIC ENCOUNTER</td>
<td>Former user</td>
<td>Style</td>
</tr>
<tr>
<td></td>
<td>Social/interactive</td>
<td>Context</td>
</tr>
<tr>
<td></td>
<td>Current helper</td>
<td>Type</td>
</tr>
</tbody>
</table>

NOTE: This is not entirely the flip side of actual helpful encounters since the interface between ideal/actual becomes blurred because of clients' particular views of individual CM's. Is the situation confused with the persona providing help? Are they indistinguishable? What effect does environment or service structure have on this?
21.5.97 PHASE III: PRESENT INTO UNDETERMINED FUTURE TIME

KEY WORDS: I hope to ...
Now ... but when

CORE CATEGORY: MODIFYING PROBLEM DRUG USE

The helping encounter provides an environment in which the possibility for change can be considered, discussed, planned and executed. The mechanisms of change (whether facilitated or inhibited) may well occur pre-contact but they are clarified and elaborated on during early encounters. It is important to be aware of temporal influences at this stage in the process because of the multi-phasic nature of desired change. "Getting back to" past self and moving on to future self - "moving forward" - and the influence of present self who may be "entrenched" in the therapeutic process - perhaps a situation of abeyance rather than a terminal point in therapy/contact.

SUBCATEGORY

PROPERTIES

FACILITATORS TO DRUG MODIFICATION

Intervening Conditions
Messages from SO's (including helpers, +ve and -ve)
Support outside helping encounter Need to act
Expectations (enduring)
Helping encounters ongoing
Motivation
Environment

Management Strategies
Contact service
Do 'groundwork'
Having a clear focus for change
Rationalising time span

Prediction of change
Options/strategies
Intention
Stated readiness
Support
Job searching
Drug expenditure
Motivation/optimism
Focus for change
Initial preparation
Extraction from environment
Lifestyle
View of self

Course LT
abstinence-ST
abstinence
possible
not possible
Context
planned
unplanned
Context
expressed
unexpressed
Course
proximal
distal
Type
available
unavailable
Course
immediate
far off
Action
proactive
passive
Value
considered
considered
worthless
worthwhile
Amount
high
low
Direction
predetermined-undetermined
Action
accomplished-unaccomplished
Extent
essential
desired
Course
unmaintainable-maintainable
Direction
+ve
-ve

Consequences planning change through construction of therapeutic plan.
### INHIBITORS TO DRUG MODIFICATION

<table>
<thead>
<tr>
<th>Subcategory</th>
<th>Properties</th>
<th>Dimensions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Intervening Conditions</strong></td>
<td>Environment</td>
<td>Type</td>
</tr>
<tr>
<td></td>
<td>Employment</td>
<td>Direction</td>
</tr>
<tr>
<td></td>
<td>Personal aspirations</td>
<td>Extent</td>
</tr>
<tr>
<td></td>
<td>Recipience</td>
<td>Direction</td>
</tr>
<tr>
<td></td>
<td>Entrenchment</td>
<td>Amount</td>
</tr>
<tr>
<td></td>
<td>Expectations</td>
<td>Course</td>
</tr>
<tr>
<td></td>
<td>Focus of change</td>
<td>Type</td>
</tr>
<tr>
<td></td>
<td>Suggestion of abstinence</td>
<td>Style</td>
</tr>
<tr>
<td></td>
<td>Sensation</td>
<td>Type</td>
</tr>
<tr>
<td></td>
<td>Existential imperative</td>
<td>Intensity</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Management Strategies

- Altering environment (minimal impact)
- Continuing contact with service

**TERMINAL POINT?**

NOTE: Contact maintained within system but 'readiness,' 'motivation,' 'determination' for transition to active modification inhibited by context above. 'Entrenchment' results from 'existential imperative.' - transtemporal.

**Consequences:** maintained within the system - held until modification facilitators are activated/contemplated.
<table>
<thead>
<tr>
<th>SUBCATEGORY</th>
<th>PROPERTIES</th>
<th>DIMENSIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>CONSTRUCTING THE INTERVENTION: PLANNING CHANGE</td>
<td>Treatment options</td>
<td>Style</td>
</tr>
<tr>
<td></td>
<td>Goals/aims</td>
<td>consider - consider</td>
</tr>
<tr>
<td></td>
<td>Time span</td>
<td>jointly alone</td>
</tr>
<tr>
<td></td>
<td>Problem identification:</td>
<td>targeted - untargeted</td>
</tr>
<tr>
<td><strong>Intervening Conditions</strong></td>
<td>Extent</td>
<td>LT - ST</td>
</tr>
<tr>
<td>Willingness to work</td>
<td>Type</td>
<td>major - minor</td>
</tr>
<tr>
<td>collaboratively &quot;you learn to listen&quot; (04)</td>
<td>Range</td>
<td>many - few</td>
</tr>
<tr>
<td>Some treatment options may not be available (pharmacological)</td>
<td></td>
<td>practical - personal</td>
</tr>
<tr>
<td>Disparity between goals of client and those of therapist - need to achieve congruence</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Time - urgency to reach point of enacting change</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stage may compromise progress</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- crisis - relapse?</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>NOTE: links with helpful therapeutic encounter and treatment activities, also need identification, modification facilitators and expectations inform this subcategory extensively.</td>
<td></td>
</tr>
<tr>
<td><strong>Management Strategies</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disclosure (willingness)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Identifying problems/needs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Setting manageable targets (type and time)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Subcategory

#### Engaging in Treatment Activities

**Intervening Conditions**
- Access to a range of strategies
- Encouragement from SO's
- Positive feedback
- Therapeutic style/engagement
- Motivation maintained
- Locus of control

**Management Strategies**
- Most as in treatment activities
- but split between psychological and medical - both in some cases
- "Carrying on" - persistence on the part of client and therapist
- Also links with enacting change - keeping overall goals in mind
- Attending/not attending regularly

**Consequences** of engaging in treatment activities are that modifications to drug-taking behavior are activated and maintained over time.

### Properties

<table>
<thead>
<tr>
<th>Support</th>
<th>Background history</th>
<th>Urine checks</th>
<th>Drug education</th>
<th>Psychological treatment:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Problem solving</td>
<td>Cog. style</td>
<td>Relaxation training</td>
<td>Medical treatment:</td>
<td></td>
</tr>
<tr>
<td>Pharmacological</td>
<td>Hosp. admission</td>
<td>Harm reduction</td>
<td>Relapse prevention</td>
<td>Follow up</td>
</tr>
</tbody>
</table>

**Dimensions**

<table>
<thead>
<tr>
<th>Practical - General</th>
<th>Frequency: intermittent - routine</th>
</tr>
</thead>
<tbody>
<tr>
<td>Taken - not taken</td>
<td>Extent: very - not very</td>
</tr>
<tr>
<td>Important - not very</td>
<td>Only experience - other experiences</td>
</tr>
<tr>
<td>Type: task focused-exploratory</td>
<td>Direction: active - passive</td>
</tr>
<tr>
<td>Maintain</td>
<td>Direction: change - maintain</td>
</tr>
<tr>
<td>Not requested</td>
<td>Direction: desirable - undesirable</td>
</tr>
<tr>
<td>Beneficial - unhelpful</td>
<td>Emphasised - de-emphasised</td>
</tr>
<tr>
<td>Considered - not considered</td>
<td>Provided - not provided</td>
</tr>
</tbody>
</table>

**NOTE:** Very difficult to see the distinctions between properties, management strategies and intervening conditions - all seem to be very closely related.
### SUBCATEGORY

#### COMPLETING TREATMENT

**Intervening Conditions**
- Environment
- Personal efficacy
- Outcome expectations
- Skill of helper?
- Compliance with treatment activities (?)
- Motivation/optimism

**Management Strategies**
- Practising strategies suggested by CM
- Broadening some and limiting other environments (physical, social, financial)
- Keeping overall goals in mind re drug taking

#### PROPERTIES

<table>
<thead>
<tr>
<th>Control/management of drug taking</th>
<th>Type</th>
<th>abstinence - reduction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Retaining control</td>
<td>Context</td>
<td>displaced - focused</td>
</tr>
<tr>
<td>Dependent on</td>
<td>Degree</td>
<td>a lot - a little</td>
</tr>
<tr>
<td>Conflicting control</td>
<td>Location</td>
<td>avoiding - facing</td>
</tr>
<tr>
<td>Parameters of control</td>
<td></td>
<td>conflict</td>
</tr>
<tr>
<td>Location</td>
<td></td>
<td>external - internal</td>
</tr>
<tr>
<td>&quot;maintaining equilibrium&quot;</td>
<td></td>
<td>stability - fluctuation</td>
</tr>
</tbody>
</table>

- Location
- Future control
- Cure
- Abstinence

**NOTE:** Treatment management/outcomes are construed mainly in terms of control over self (self image also), environment, drug. This is the marker of change between drug oriented lifestyle and a productively orientated lifestyle.

**Consequences** (Perceived) treatment outcomes result in greater opportunity to engage in **self supporting activity**. This results from the level of control which is gained via the processes involved in help seeking. Where individuals are "held" in the system what degree of personal control is exerted over drug use? Either 1. Feel unable to comment on future likelihood of +ve outcome "can't talk about what I haven't experienced" or 2. Feel that current progress is limited to having more control over their habit than previously. FUTURE = time of uncertainty/anxiety for most.
### SUBCATEGORY

**SELF SUPPORTING ACTIVITY**

<table>
<thead>
<tr>
<th>Intervening Conditions</th>
<th>Properties</th>
<th>Dimensions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Environment - constraints</td>
<td>Setting parameters</td>
<td>Degree</td>
</tr>
<tr>
<td>(money, location etc)</td>
<td>Being productive</td>
<td>limited - broad</td>
</tr>
<tr>
<td>Aspirations</td>
<td>Help seeking</td>
<td>Amount</td>
</tr>
<tr>
<td>Increased physical/psychological</td>
<td>Using tried and</td>
<td>high - low</td>
</tr>
<tr>
<td>coping</td>
<td>tested methods</td>
<td>Extent</td>
</tr>
<tr>
<td>Predicting consequences</td>
<td>Personal care</td>
<td>selective - general</td>
</tr>
<tr>
<td>of relapse</td>
<td></td>
<td>Direction</td>
</tr>
<tr>
<td></td>
<td></td>
<td>adherence - rejection</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Direction</td>
</tr>
<tr>
<td></td>
<td>Aspirations</td>
<td>aids - limits</td>
</tr>
<tr>
<td></td>
<td>Environment</td>
<td>functioning</td>
</tr>
<tr>
<td></td>
<td>Psychological health</td>
<td>Degree</td>
</tr>
<tr>
<td></td>
<td>Retaining control</td>
<td>limited - broad</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Context</td>
</tr>
<tr>
<td></td>
<td></td>
<td>limiting - broadening</td>
</tr>
<tr>
<td></td>
<td></td>
<td>social contacts</td>
</tr>
<tr>
<td></td>
<td></td>
<td>controlled</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Direction</td>
</tr>
<tr>
<td></td>
<td></td>
<td>by self - by substance</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Direction</td>
</tr>
<tr>
<td></td>
<td></td>
<td>avoiding - facing</td>
</tr>
<tr>
<td></td>
<td></td>
<td>conflict</td>
</tr>
</tbody>
</table>

**Management Strategies**

- Developing self-generated strategies for coping
- Limiting help seeking from outside sources or using this selectively
- Stating the position directly

**NOTE:** Linked to future expectations "just take one day at a time" - aspirations 'here and now' therefore linked to current time. Developing independent management skills - actual and projected.

### Consequences

Self-supporting activity is a theme which runs from identification of needs/expectations: to the end point of this help-seeking process. Its inclusion here is necessary since it predicates expectations about the future based on a synthesis of past and current experiences. It points the way to predictions of success/failure in achieving change and its likely outcome.
### SUBCATEGORY

**FUTURE EXPECTATIONS** (predicting the future)

- Helping others
- Service contact
- Helping self
- Thinking about the future
- Drug taking
- Problem management
- View of self

**Intervening Conditions**

- Availability of helper
- Development of self efficacy + problem solving skills
- Dwelling on past failure - not wanting to tempt fate
- Modifying personal identity as drug user

**Management Strategies**

- Focusing more on the present than on the past/future
- Broadening external sources of support
- Continued use of service to assist intermittently BEFORE problems get out of hand → 'stop-start' contact

### PROPERTIES

- Helping others
- Service contact
- Helping self
- Thinking about the future
- Drug taking
- Problem management
- View of self

### DIMENSIONS

- Direction: giving - receiving
- Frequency: intermittent - regular
- Amount: possible - impossible
- Extent: strong - minor
- Direction: manageable-unmanageable
- Direction: +ve - neutral - ve

**NOTE:** Therapeutic completion not identified here. Endings = 'in the future' even for those who are currently abstinent. Not surprising since ceasing contact not contemplated. Post hoc rationalisation 'if I'd known then what I know now ...' 'I blame myself...' (01, 04).

**Consequences**

Contact with service likely to be ongoing in some format: giving back to similar others (i.e. fulfilling the notion of idealised helping); intermittent personal support. Increasing likelihood of self supporting activity results from process of help seeking and not predicated solely on notion of abstinence but control through harm minimisation strategies (i to a manageable level). Self identity then linked intimately to personal control → controlled user vs problem user. BUT future also undeterminable despite aspirations → return to present uncertainties.
APPENDIX 3

Information Sheet and Consent Form
INFORMATION SHEET AND CONSENT FORM

We are interested in looking at the sort of needs that amphetamine users have during their contact with the Community Drugs Service. Your participation in this study would be very much appreciated.

You are being asked to give an informal interview which will last approximately one hour. This will take place at Paget House at a time which is convenient for you. Your travel expenses will be reimbursed. Follow-up interviews will be offered to give feedback about the results of the study.

Please note

* All information obtained will be treated confidentially.
* Your anonymity will be assured.
* The interview is for research purposes only.
* You may withdraw from the study at any point if you wish to do so.
* Withdrawal will not affect your treatment in any way.

A form is provided overleaf for you to respond. I look forward to hearing from you.

Thank you for your time.

Jayne Carruthers (Trainee Clinical Psychologist, Leicester University)
Please complete this form and return it in the envelope provided.

I am / am not (please delete as appropriate) willing to participate in the research project outlined above.

Your name _____________________________

Signature _____________________________ Date __________________________
APPENDIX 4

Research Questions and

Introduction to the Interview
SEMI-STRUCTURED INTERVIEW - AMPHETAMINE RESEARCH
STIMULUS QUESTIONS

1) How did you come to have contact with the service?

PROBES

DRUG TAKING

• Tell me about your drug use.
• How did you see your drug use then?
• What sort of difficulties have you experienced with your drug use?

HELP AND SUPPORT

• What were your reasons for coming here?
• What made you decide to get in touch?
• What sort of help did you hope for?
• Was anyone aware of your drug problems?
• What were your hopes about treatment?

CHANGING

• What did you want to change?
• How did you plan to make those changes?
• How much did you want to change your drug use?
• How motivated did you feel about making changes?

2) Tell me about your experience at Paget House.

PROBES

DRUG TAKING

• Would you say you take your speed for a particular purpose?
• How much are you able to control your drug use?
• What is different about your drug use now?

HELP AND SUPPORT

• What is helpful?
• How does coming here meet your needs?
• How difficult are things at the moment?
CHANGING

- How much do you think your drug use has changed?
- How are those changes being made?
- Do you have an idea of what you want to change?
- Is there anything you are doing yourself to make changes?

3) How do you see your drug use being in the future?

PROBES

DRUG TAKING

- What do you expect will happen with your drug use?
- How will you manage your drug use?
- How do you think you will control your drug use?

HELP AND SUPPORT

- What kind of support do you think you will need?
- How will you look after yourself?
- How will you deal with difficulties in the future?

CHANGING

- How would things be different without your drug?
- What do you think would help you stop?
- How do you see things turning out for you?

GENERAL PROBES

- Can you say a bit more about those feelings you’ve had?
- Could you say a bit more about that?
- Is there anything else you want to say about that?
- Do you have any ideas about …… ?
- What did you think of that?
- What would that have meant for you?
INTRODUCTION TO INTERVIEW

Thank you for agreeing to participate in my research about your personal experience of changing your amphetamine use and your reasons for using the service here in Leicester.

The interview will be very informal, rather like an open ended discussion about how you see things from your own point of view. I will need to record the conversation because I later have to write it out in order to make sense of what we’ve talked about. The tape will be wiped afterwards and the transcription kept in a secure environment. No one except myself will have access to it thereby ensuring strict confidentiality.

The only personal information I need to have about you is your age, sex and duration of contact with the service. If amphetamine is prescribed for you by this service it will be noted. Details of who you are and more personal information contained in your clinical records will not be sought. Although your signature has been requested for consent purposes this cannot be traced to particular interview transcriptions which will coded numerically, assuring your anonymity.

As explained in the information and consent form, and through your case manager, the interview will last approximately one hour. If you wish to withdraw at any point during the interview you are free to do so. Also, if, after our conversation, you wish to follow up any issues that have been raised for you I will be happy for you to discuss these with your case manager. This will have no bearing on the research itself.

My research will be completed in the summer of 1997. If you would like some feedback about the overall research findings I will be happy to talk to you again about the research then.

Do you have any questions before we start?
APPENDIX 5

Transcripts 01 - 08

For Reasons of confidentiality this appendix is removed to a separately bound appendix and is available only to bona fide researchers.