EXPLORING PSYCHO-SOCIAL DETERMINANTS OF NATURAL RECOVERY PROCESS IN SUBSTANCE DEPENDENCY

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Submitted by

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DEDICATION

To my precious parents, Abdul Khaleque (late) and Rehana Begum (late) whose unconditional love and continuous support have made my present identity, and the person I am.

To my beloved husband who is the blessing of God in my life and without whom my journey in Clinical Psychology and in MPhil research would not have been possible.

APPROVAL SHEET

This is to certify that I have read the thesis entitled "Exploring Psycho-social Determinants of Natural Recovery Process in Substance Dependency" submitted by Zohora Parveen in partial fulfillment of the requirements for the degree of M.Phil in Clinical Psychology and the research was carried out by her under my supervision and guidance.

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ABSTRACT

There is a growing recognition that natural recovery or self propelled change without professional support is an important pathway to recovery from drug addiction. Natural recovery in substance dependence is largely an unexplored domain. Only handful of studies has been conducted in this challenging area. Still many questions regarding its underlying process, contributing factors, and interrelations among these factors need to be explored. The present study was aimed to understand the core process of natural recovery in substance dependence with the major goal to contribute in designing and developing community based interventions to foster natural recovery. There is severe lack of knowledge on this significant issue worldwide especially in our country. In this context, grounded theory approach of qualitative research design was suitable to be used to explore the contributing psychosocial factors associated with natural recovery and to investigate the interrelations among those factors.

In depth interviews were conducted with nine naturally recovered individuals who never sought formal treatment for their addictive behaviors. Average drug using and abstinent period of those adult respondents were 12 and 7 years respectively. Snowball sampling technique was used to find out these hard-to-reach populations. Verbatim transcripts from the recorded interviews were the main source of data for this study. The whole data collection process was guided by theoretical sampling. Using NVivo-8, data analysis was completed through open, axial, and selective coding which revealed three broad sections namely encouraging factors to natural recovery, strategies in natural recovery course and prolonging factors for sustenance of natural recovery, incorporating 20 emerged themes associated with natural recovery process. Nine factors were found to

be causally linked where rest of the factors were revealed as associated with each other. To find out the exclusive factors for natural recovery, present findings were compared with the factors associated with treated recovery as suggested by the experts working in the drug field. Through this process five factors appeared to be the core contributors for natural recovery such as inaccessibility to formal treatment, high self respect, adaptive cognitive structures (normalization, non-stigmatized attitude towards self, internal attribution, and high self esteem), gradual goal approximation, and supplementary drug use.

The present study does not suggest any notion against professional treatment; rather it simply promotes the idea that it is possible to overpower drugs without formal treatment through the significant route of natural recovery. Apart from gaining knowledge about the process, this study will also break the silence regarding natural recovery of drug addiction in our country as this is the first study in Bangladesh. The findings may facilitate the enhancement of current treatment practices through evaluation of the existing interventions and treatment programs for drug addiction. The present study may be a milestone of future works on natural recovery in Bangladesh that may be helpful for people to overcome their drug problems who does not have access to formal treatment.

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Zohora Parveen

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CHAPTER 1

INTRODUCTION

Introduction

Substance dependence is one of the major social problems in Bangladesh. It does not require explaining how a deadly outcome can be produced through this problem of substance dependence. This maladaptive behavior pattern drives an individual into compulsive drug use in such a way that the individual is compelled to drug use despite its harmful consequences to him and people around him. Complete resolution of this bewitching condition is just like a dream. Understanding various pathways to recovery from substance dependence is an important concern for mental health professionals and researchers working in this field. In this regard, natural recovery is the promising pathway which is relatively new area of study.

1.1 Defining Substance Dependence

The term "substance dependence" is a complex phenomenon which is easier to recognize than it is to define. According to the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR; American Psychiatric Association, 2000), substance dependence is defined as "a pattern of repeated self administration that usually result in tolerance, withdrawal and compulsive drug taking behavior." In DSM-IV-TR (American Psychiatric Association, 2000), substance dependence along with substance abuse, is considered as Substance Use Disorders.

It is a pattern of behavioral, physiological, and cognitive symptoms that develop due to substance use or abuse; usually indicated by tolerance to the effects of the substance and withdrawal symptoms that develop when use of the substance is terminated. Here, the mostly important terms are 'tolerance' and 'withdrawal symptom'. Tolerance can be defined as the capacity to endure continued subjection to the drug without adverse

reaction. Withdrawal Symptoms are meant by the unpleasant physical reactions that accompany the process of ceasing to take an addictive drug. Substance dependence can be diagnosed with physiological dependence, evidence of tolerance or withdrawal, or without physiological dependence.

The concept 'substance dependence' is a known phenomenon to all. Some other related concepts are also used more or less frequently in a synonymous manner indicating it. The related concept of 'drug addiction' has many different definitions. Some writers give in fact, drug addiction the same meaning as substance dependence; others for example, provide drug addiction a narrower meaning which excludes drugs without evidence of tolerance or withdrawal symptoms. In different literatures, varieties of terms such as 'alcoholism', 'drug addiction', 'drug abuse', 'substance use', 'chemical dependence', 'drug dependence', 'habituation', and 'addictive behaviors' are frequently noticed bearing the similar idea. In this research paper, the terms 'drug addiction', 'drug abuse', 'substance use' have been used interchangeably indicating the same meaning as substance dependence to ensure the convenience of the readers as those terms are more popular and to reduce the monotonous use of the particular term.

In 1963, the World Health Organization Expert Committee on Drug Dependence decided to incorporate all the terms into 'dependence' except alcoholism (WHO Expert Committee on Drug Dependence, 2003). In 1964, the World Health Organization (WHO) recommended the use of the term 'drug dependence' and defined it as "a state, psychic and sometimes also physical resulting from the interaction between a living organism and a drug, characterized by behavioral and other responses that always include a compulsion to take the drugs on a continuous or periodic basis in order to experience its psychic effects, and sometimes to avoid the discomfort of its absence. Tolerance may or may not be

present. A person may be dependent on more than one drug" (WHO Expert Committee on Drug Dependence, 2003)

In 1992, WHO modified the term 'drug dependence' and clarified it as "a cluster of physiological, behavioral, cognitive phenomena of variable intensity, in which the use of a psychoactive drug take on a high priority, the necessary descriptive characteristics are preoccupation with a desire to obtain and take the drug and persistent drug seeking behavior. Determinants and the problematic consequences of drug dependence may be biological, psychological or social and usually interact" (World Health Organization, 1992).

1.2 Criteria for Substance Dependence

In DSM-IV-TR (American Psychiatric Association, 2000), the following symptoms are listed for the diagnosis of an individual with substance dependence. A maladaptive pattern of substance use, leading to clinically significant impairment or distress, as manifested by three (or more) of the following, occurring at any time in the same 12 month period.

1. Tolerance, as defined by either of the following:

   (a) A need for markedly increased amounts of the substance to achieve intoxication or desired effect

   (b) Markedly diminished effect with continued use of the same amount of the substance.

2. Withdrawal, as manifested by either of the following:

   (a) The characteristic withdrawal syndrome for the substance.

(b) The same (or a closely related) substance is taken to relieve or avoid withdrawal symptoms.

3. The substance is often taken in larger amounts or over a longer period than was intended.

4. There is a persistent desire or unsuccessful efforts to cut down or control substance use.

5. A great deal of time is spent in activities necessary to obtain the substance (e.g., visiting multiple doctors or driving long distances), use the substance (e.g., chain smoking), or recover from its effects.

6. Important social, occupational or recreational activities are given up or reduced because of substance use.

7. The substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance (e.g., current cocaine use despite recognition of cocaine-induced depression, or continued drinking despite recognition that an ulcer was made worse by alcohol consumption).

The International Classification of Diseases define dependence syndrome as "a cluster of physiological, behavioral and cognitive phenomena in which the use of alcohol or a substance or a class of substances takes on a much higher priority than other behaviors that once had greater value" (ICD-10; World Health Organization, 1992).

1.3 Factors in Substance Dependence

It can be stated that no single factor is related to the concept of substance dependence, rather it is influenced by multi-factorial components. There are some contributing factors for continued use of substances which can be explained from physical, psychological and sociological point of view. Authors have described several factors contributing to substance dependence which are presented briefly in the following sections (see also Carr & McNulty, 2006).

1.3.1 Physical or biological factors.

Almost all psychoactive substances have certain features that they have physiological effects on the individual. Most of the drugs create physical dependence. The issue of tolerance has been mentioned above which directs the individual to increase the amount of drug intake and associated drug related behavior. Sudden reduction in use or cessation of use can precipitate the withdrawal syndrome which is major obstacle for one to be recovered from substance dependence.

1.3.2 Psychological factors.

There are multiple psychological aspects for which one person can be dependent on substance.

Co-morbidity: There may be strong association between the substance use and other psychological disorders, e.g., a depressed individual can use cocaine to feel energized.

Belief structure: Concepts and beliefs about substance use and the effects of the substances are one of the significant psychological factors. Higher positive expectancies about the effects of any substance make an individual serious user compared to light or

non-users. The dependent individuals may believe that they have no control over their use. At the same time, their attribution may focus on external and contextual factors. If the persons with such beliefs reach their goal of complete abstinence, they may be vulnerable to the abstinence violation effect (Marlatt & Gordon, 1986).

Self efficacy: Substance users also may have low self efficacy thinking that they are unable to cope with high risk situations if they do not use substances. Higher self efficacy has been associated with better treatment outcomes (Vielva & Iraugi, 2001) although very high self efficacy may be associated with poor outcomes as the persons having such attitude often have an unrealistic appraisal of the challenges related to abstinence.

Affect regulation: Control on emotion and also its processing is an important part of substance use. The individuals who use substances both to ease negative affect and to increase positive experiences, have the highest vulnerability to develop substance use disorders (Labouvie & Bates, 2002), and relapses occur in response to negative and positive emotions (Marlatt & Gordon, 1986).

Motivation: Motivation is a key psychological variable which determine whether an individual will dwell in the world of addiction or go for resolution. Miller and Rollnick (2002) viewed motivation as a state that is influenced by life experiences and therapeutic influence. No matter whether the individual is influenced by the critical life experiences or therapy process, motivation may be the hallmark for the process of being abstinent from substance dependence because it is the core factor for which one can engage and fix oneself in the fight against drug.

Personality characteristics: It depends greatly on the individuality of the person whether s/he will be vulnerable to drug addiction as well as the continuation of use such

as, pattern of cognitive structure, style of interpretation, orientation for problem solution, way of perceiving anything, and style of attribution etc.

Learning orientation: The process of learning may also play an important role for continuation of use of substances. At this very point the controversy arises between the two notion; the widely held belief "once an addict always an addict" i.e., it is impossible to be recovered from drug addiction and the other idea that addiction is a learned behavior which can be unlearned following the established learning principles. According to Marlatt and Gordon (1985), like any other habits, addictive behaviors are over learned which can be analyzed and modified in the same manner.

1.3.3. Family and other interpersonal factors.

It is well agreed that family environment is responsible for the development of substance dependence, and with similar importance it can be said that successful resolution of drug problems also may occur within the umbrella of family support. The problematic interaction pattern/family dynamic and conflicting interpersonal relationships in a family environment may serve as a background to drug use. Similarly, it is the family who can also play a central role in the maintenance of use. Having the same influential power, family helps a lot a dependent individual to stop drug related behavior by giving inspiration and warm acceptance, normalizing to be stigma free, providing technical support for alternative engagement and so many other ways.

1.3.4 Sociological factors.

Social network and peer pressure: Variation of country, subculture, and proximal social group usually determine the societal norms about substance use. Individual's tendency to use alcohol and drugs in patterns greatly influenced by the member of their

proximal social and family group. McCrady (2004) found that serious drinkers have a focus on such individuals in their social networks who drink intensively. The young drug users and also teen-aged adolescents are typically part of peer groups with similar patterns of use. The peer groups directly pressurize an individual to be engaged into the world of addiction, to continue drug use with switching one from another, to prevent the effort of drug cessation and also act like a strong barrier when the person struggles much to maintain the abstinent life by provoking him/her for lapse.

In a review article, McCrady (2004) claimed the alteration of the individual's social network during the resolution of substance dependence, as an important aspect of recovery. It is well agreed that successful recovery from drug addiction is greatly depends on the changes in the social network so that there are more drug free individuals in the network.

Availability of drugs: It is the strong environmental or sociological factor that drug is easily accessible almost in any culture, let alone for Bangladesh. It can be assumed that if drugs would not be so available and cheap, then it would be possible for the individuals to make them enter into the world of addiction and also to make them abstinent forever.

1.4 Prevalence of Substance Dependence

Since public health is the focal point of the international drug control system, the prevalence of illicit drug use is considered a central indicator of the status of problem. But the record on prevalence is not perfect. However, illicit drug use is a multifaceted issue for which it is not easy enough to decide a fix criterion to record for prevalence measurement. Generally, it is done based on the production, prices, consumption, and seizure rates of the drugs. On the other hand, there are also some realistic barriers to measure global record on drug problem. There is no nationwide survey on drug problem for many countries in the

world for which it is not possible to have a standard and reliable world report on this issue. Therefore, there is no single measure of year-on-year evolution of world drug problem. Prevalence of substance dependence is integrated with crime statistics, medical records, drug production, and seizure rates etc. (United Nations Office on Drugs & Crime, 2010).

1.4.1 Global scenario.

In the world drug report 2010, UNODC (United Nations Office on Drugs & Crime, 2010) estimated the number of illicit drug users in the past year in 2008 aged 15-64, by regions and sub regions. It was mentioned there that global estimate of Cannabis users are 190,750,000; Opiate users are 21,880,000; Cocaine users are 19,380,000 and so forth. The consumption of illegal drugs was also estimated that approximately 200 million people, nearly 5 % of the world population aged 15 to 64, use it (United Nations Office on Drugs & Crime, 2010). This measurement is consistent with the much higher prevalence of tobacco use causing 5.4 million deaths per year. They also stated that one in every twenty people aged 15-64 (which is less than 5 % of all adults), had tried drugs at least once in the past 12 months. 26 million people (which are about 0.6 % of the world's adult population) are severely drug dependent. Afghanistan produced huge opium in 2007 for which it can be assumed that illegitimate opium production of the world had been almost doubled since 2005. 80 % opium of world's supply is cultivated in five southern provinces. They also reported that marijuana is produced in 172 of the 198 countries and it has almost 160 million customers per year, or 3.8 % of the population aged 15 to 64. In the same report it can be seen that the proportion of HIV infections had been increased in many parts of the world including East and South East Asia while injecting drug use (21 million injecting drug users) was identified as its causal factor.

1.4.2 Current scenario in Bangladesh.

The geographical location of Bangladesh is in such a position that international drug supply can be done without much difficulty. International Narcotics Control Strategy (US Dept. of State–Bureau for International Narcotics & Law Enforcement Affairs, 2005) identified Bangladesh as a transit point because it is located in the midst of major drug-producing and exporting countries. Drugs are not produced or cultivated in our country except some locally made alcohol but the consumption of both illicit drugs (few in numbers) and alcohol (foreign and locally made) had been spread out all over the country since the birth of Bangladesh or before her birth. Approximately in 1980, people came to know that narcotic drugs were using only in some parts of the country, but over three decades it has engulfed the entire society and the people of whole country irrespective of age, sex, occupational and socio-economical classifications.

To declare the current situation in Bangladesh regarding substance dependence, the Department of Narcotics Control (DNC) usually conducts the national epidemiological survey. In recent surveys it is shown that approximately 2 million people are dependent on different kind of substances where 85% are between the ages of 15 to 29, 20% are illiterate, 99% is male, 55% are unmarried, 36% are unemployed, 12% students and rest of them are occupied with different kind of professions (Islam, 2006). The drug users were observed in this survey report to spend almost 4,000 taka per month in average for their choice of drugs.

In a recent nationwide survey, jointly conducted by the National Institute of Mental Health (NIMH) and World Health Organization (WHO), the prevalence of substance dependence among Bangladeshi people was found as 0.6 (Firoz, Karim, Alam, Rahman, & Zaman, 2007). Among those people, 20 to 40 thousands were found creating serious threat

to public health like STI along with HIV and AIDS by using injecting drugs and being engaged into associated high risk behaviors (Reddy, Hoque, & Kelly, 2008).

1.5 Impact of Substance Dependence

As substance dependence is a complex phenomenon that can involve almost every aspect of an individual's functioning, it has its impact at individual level as well as at social level. This maladaptive behavior pattern causes significant impairment to one's physical and mental health along with his/her social, occupational, educational functioning. Moreover, it also has a strong impact on society and public health, which include family disintegration, loss of employment, domestic violence, child abuse and trafficking, transmission of life-threatening infectious diseases (HIV/Hepatitis-c etc), and increased rate of different crimes. Drugs have engulfed our society so deeply that it does not require explaining the pervasive harmful consequences in details while most of the people can understand its deadly outcome with their direct and indirect personal experience.

1.6 Necessity of Treatment for Substance Dependence

For the wide range of detrimental effects of substance dependence, treatment of this devastating condition is a great concern both for government and non-government sectors. The successful outcome of its treatment can reduce not only the sufferings of the particular individual but also stop the crying of the family as well as society. Because of the multi-factorial components and pervasive consequences, treatment of substance dependence usually involves many components from the multi-dimensional approach. Some techniques in the treatment package directly deal the individual's substance ingestion; others, like social skill training, help the dependent individual to play a

productive and adaptive role in the family and society as well as to enable him/her to experience the benefits associated with abstinence.

1.7 Treatment Outcome

If the multiple and costly consequences of active dependence is considered, the center of attention on treatment outcome for substance dependence is essential and reasonable. In all forms of treatment approaches of drug addiction, the nature and length of abstinence is considered as the main indicator of treatment success. The term 'recovery' has been used to denote cessation of drug use since long. But still to date it is largely ill defined although this term is being used ubiquitously. Moreover, there is conflicting position among different treatment approaches regarding the use and meaning of the term particularly because of their adherence to different perspectives for understanding drug dependence. Generally the term 'recovery' is used to denote the process of quitting drug use and the person as well who is maintaining drug free life having a prior history of substance dependence.

1.8 Meaning of Recovery

In a usual sense the term 'recovery' means to get rid of particular symptom or syndrome or any kind of addictive behaviors. Similarly, recovery from substance dependence indicates to be abstaining from compulsive drug seeking and drug taking behaviors.

However, as substance dependence can affect all areas of functioning (e.g., social, psychological, emotional, vocational), recovery from dependence is more than the absence of substance use in an otherwise unchanged life. According to Laudet (2007), "Recovery requires abstinence from all mood altering substances but goes beyond substance use;

rather it is a process of self improvement and an opportunity at a new and better life." The World Health Organization has also emphasized on the importance of considering global health as outcome measure. WHO has defined health as not just the absence of pathology but as "a state of complete physical, mental and social well-being." (World Health Organization, 1985, p. 34). The definition of recovery was found in the narratives of the recovery community in a rigorous manner (Laudet, White, & Morgen, 2005). Merely absence of drug use related problems is not enough for this condition but enhanced quality of life was emphasized there. In addition, one needs to have goals, be a productive and valued citizen who helps others, and to have positive social relationships.

In spite of calls for a broader conceptualization of the treatment outcome (McLellan, McKay, Forman, Cacciola, & Kemp, 2005), most researchers implicitly define 'recovery' in terms of substance use only (Cisler, Kowalchuk, Saunders, Zweben, & Trinh, 2005) and most often as abstinence; either total abstinence from alcohol and all other drugs, or from the specific substance under study (Burman, 1997; Flynn, Joe, Broome, Simpson, & Brown, 2003; Granfield & Cloud, 2001; Scott, Foss, & Dennis, 2005). A few authors define recovery in terms of DSM-IV-TR criteria (American Psychiatric Association, 2000); for instance, one group defines years of intervening recovery "as the sum of all the yearly intervals during which alcohol use disorder diagnosis was not present" (Dawson et al., 2005; McAweeney, Zucker, Fitzgerald, Puttler, & Wong, 2005). The emphasis on abstinence is also consistent with the American Society of Addiction Medicine's definition of recovery as "overcoming both physical and psychological dependence to a psychoactive drug while making a commitment to sobriety" (American Society of Addiction Medicine, 2001).

However, the addiction treatment field has for more than 150 years had a clear concept of full recovery (sustained abstinence and increased emotional and relational health), but has lacked an operational concept of partial recovery (reduced frequency and intensity of alcohol and other drug use and related problems and increased quality of life).

Here, one significant notion can be mentioned that the term recovery is largely steeped in 12-step culture but the term remission is used in biomedical fields to describe a state where the individual is free of symptoms e.g., in oncology. The terms remission and recovery both imply the idea that the underlying condition may remain, in contrast to the term cure, which suggests that the underlying condition is no longer present.

Understanding of the phenomenon and process of recovery from substance dependence is an important concern for the mental health professionals as well as researchers working in this field. Although there is controversy among the professionals regarding the meaning and use of the term 'recovery' particularly because of their adherence to different perspectives or models for understanding substance dependence, but in the present study the term had been used to denote the process of being completely abstinent from drug abuse. The process of achieving abstinence is difficult for most of the drug abusers as this process is influenced by multiple factors. Abstinence can be maintained even though the risk of relapse may remain all through the abstinence period. Marlatt and Gordon (1985) metaphorically described the process of recovery as like walking up through a downward escalator.

1.9 Recovery Paths

As substance dependence can be treated through different approaches, any of such treatments can initiate the process of recovery for a dependent individual. But few researchers noticed that the field of substance dependence has begun to document many

pathways to recovery experience (Humphreys, Moos, & Finney, 1995; Vaillant, 1995). This means, this exclusive experience is not dependent only on the professional treatment. Recovery can be achieved with or without professional treatment or participation in peer-based recovery mutual aid groups (Cunningham, 2000; Granfield & Cloud, 1999). Wille (1981) identified two basic patterns in his study of the recovery process; (i) a planned, internally motivated, voluntary way of becoming abstinent, and (ii) an external, imposed way.

Based on literature review, it has recently been observed that besides the formal treatments or participation in self help group, some individuals can achieve successful resolution from addiction on their own. In this regard, several studies have examined long-term recovery, including research on "natural recovery" i.e., remission without help of formal treatment or self-help group (Burman, 1997; Margolis, Kilpatrick, & Mooney, 2000; Snow, Prochaska, & Rossi, 1994; Toneatto, Sobell, Sobell, & Rubel, 1999).

Summarizing all the available literatures on recovery pathways, it can be stated that recovery styles span in three ways among which the center of attention for the present qualitative investigation was natural recovery.

1. Professionally assisted recovery (professional or formal treatment)
2. Peer assisted recovery (mutual aid involvement), and
3. Natural recovery (without the aid of professional or peer support)

In the addiction field, several terms (e.g. self recovery, spontaneous remission, self change, natural resolution, maturing out, spontaneous recovery, "natural recovery", untreated remission, untreated recovery, auto remission, self quitter, spontaneous resolution, self resolution) have been used to describe people who have recovered from

drug related problem on their own i.e., without help of formal treatment. In this research paper few terms such as self change, self recovery, and self resolution have been used interchangeably to describe the same phenomenon 'natural recovery' in order to avoid monotonous feeling and boredom for the reader.

Although the idea of natural recovery or self recovery from drug addiction was discarded by most of the people in the society including mental health professionals, this new concept has started gaining recognition and acceptance as researches on natural recovery has increased recently. Even the prestigious bodies such as the Institute of Medicine (1990) and the American Psychiatric Association (2000) have acknowledged that natural recovery is a legitimate and documented route of recovery.

1.10 Definition of Natural Recovery

The term 'natural recovery' indicates such kind of recovery which occurs in a usual, spontaneous or ordinary manner without influence of any external forces. Natural recovery or self recovery can be defined as the process of change by which a dependent individual remains abstinent from substance dependence without the aid of formal treatment or professional help. In this definition, two specific words 'abstinent' and 'formal treatment' are the most significant terms to be understood.

1.10.1 Abstinence.

The word 'abstinence' originally came from the Latin word 'abstinentia'. It is generally defined as the practice of restraining oneself from indulging in something, typically alcohol/drugs or sex. Similarly, abstinent is meant by refraining from an activity or from the consumption of something, especially alcohol or drugs.

Following the DSM-IV-TR (American Psychiatric Association, 2000) criteria of substance dependence, the term ‘abstinence’ has been defined as meeting none of the dependence criteria lifetime but not within the last 6 months.

1.10.2 Formal treatment.

The second highlighted term in the above definition is ‘formal treatment’ which is the significant concept to define natural recovery. Formal treatment has been defined as the treatment included any intervention which is officially recognized programs or any other treatment specifically addressing drug problems (e.g., drug treatment rehabilitation centers, outpatient, inpatient, public and private drug treatment facilities or programs providing services for drug abusers, or similar self-help groups, professional counseling for drug problems). Almost similar definition was used regarding formal treatment in some famous study of natural recovery with alcohol abusers (L. C. Sobell, Sobell, & Toneatto, 1992; L. C. Sobell, Sobell, Toneatto, & Leo, 1993).

Drug treatment is proposed to help any dependent individual having the aim to stop compulsive drug seeking behavior and drug abuse. It can occur in a variety of settings, in many different forms, and for different lengths of time. A dependent person is usually provided motivational counseling, medication, case management, cognitive and behavioral therapy, and other types of services in specialized drug treatment facilities. Along with these facilities, treatment of drug addiction can be offered both by the government and non-government sector. A variety of providers from multidimensional point of approach are engaged in this regard such as counselor, physician, psychiatrist, psychologist, clinical psychologist, nurse, occupational therapist, community counselor and psychiatric social worker. Treatment is delivered in outpatient, inpatient, and residential settings.

Research studies on addiction treatment typically have classified programs into several general types or modalities such as detoxification or medically managed withdrawal, long term residential treatment, short term residential treatment, outpatient treatment programs, individualized drug counseling, group counseling etc (National Institute on Drug Abuse, 2000).

For better understanding, a short look on the treatment programs for drug addiction is presented in the following.

Detoxification and medically managed withdrawal: Detoxification is defined as the action of depriving of poisonous qualities (Oxford English Dictionary, 1989) The treatment process by which toxic component of any drug in human body is washed out is called detoxification. Through this process the body clears itself of drugs and is often accompanied by unpleasant and sometimes even fatal side effects caused by withdrawal. Generally a physician can manage the detoxification process with medications in an inpatient or outpatient setting. Therefore, it is referred to as "medically managed withdrawal."

Short term residential treatment: Short term residential programs are relatively brief treatment approach. But it provides intensive support to a drug user following the modified 12-step approach. The original residential treatment model consisted of a 3-6 week hospital based inpatient treatment phase followed by extended outpatient therapy and participation in a self help group, such as Alcoholics Anonymous or Narcotics Anonymous.

Long term residential treatment: Long term residential treatment provides care 24 hours a day, generally in non-hospital settings. The best known residential treatment model is the therapeutic community (TC) where the length of stay is planned, usually

between 6 and 12 months. Therapeutic community focuses on the re-socialization of the individual. So, developing personal accountability and responsibility as well as socially productive way of living is the core theme of this program.

Individualized drug counseling: Individualized counseling is the one to one contact of therapeutic relationship which helps the individual to develop coping strategies and learn specific techniques to abstain from drug use and maintain abstinence.

Group counseling: Research has shown that when group therapy is provided in conjunction with individualized drug counseling or is conducted based on the principles of cognitive-behavioral therapy or contingency management, outcomes become more positive.

Outpatient treatment programs: There are various types and intensity of services in the outpatient treatment program. This treatment program is more suitable for people with jobs or extensive social supports.

1.11 Criteria of Natural Recovery for the Present Study

In this exploratory research, those individuals had been selected as respondents who were dependent on substance previously and recovered from it at present for at least one year but never received the available professional treatment services such as detoxification or medically managed withdrawal, short term or long term inpatient treatment program, outpatient treatment program or aftercare program, home based detoxification service, community based detoxification program, any form of recognized psychotherapy, individualized or group counseling service, and self help group.

Individual participating in substance related treatment of any duration, even two or three sessions of individual psychotherapy, was also excluded from the present study

considering it as professional treatment as brief interventions are seen as effective in a growing number of studies (Academy for Health Services Research and Health Policy, 2000; Bien, Miller, & Tonigan, 1993; Fleming & Manwell, 1999; Fleming et al., 2000; Van Beurden, Reilly, Dight, Mitchell, & Beard, 2000).

1.12 Controversy on the Natural Recovery Issue

Whether self resolution of drug addiction is practically possible, is the big question mark not only for layman but also for health and mental health professionals. The topic of self change was viewed as taboo even one decade ago (Chiauzzi & Liljegren, 1993). It was ignored (L. C. Sobell et al., 2001), and was not believed at minimum level (Klingemann et al., 2001; L. C. Sobell et al., 1993). The impossibility of occurrence of natural recovery was pronounced in the published paper entitled "Taboo topics in addiction treatment: an empirical review of clinical folklore" (Chiauzzi & Liljegren, 1993). It was stated that successful self change of addictive behaviors indicates as if the individual was not addicted while inability to stop independently is an indication of addiction. It was claimed by Robert Dupont, former Director of the National Institute on Drug Abuse that "Addiction is not self-curing. Left alone addiction only gets worse, leading to total degradation, to prison, and, ultimately to death" (Dupont, 1993, p. xi–xii). With similar tone, Vernon Johnson stated in his book *I'll Quit Tomorrow* "Alcoholism is a fatal disease, 100 percent fatal. Nobody survives alcoholism that remains unchecked… these people will not be able to stop drinking by themselves. They are forced to seek help; and when they don't, they perish miserably" (Johnson, 1980). Such thinking has led to an assumption that drug users cannot recover on their own. There was also an argument in this ground that not to seek treatment is fatal (Dupont, 1993; Winick, 1962a, 1962b). The view of society was mostly consistent with this notion at that time period.

Natural recoveries have been reported for problems other than substance abuse (Eysenck & Rachman, 1973; Finn, 1997). This concept was also applicable for smoking cessation which was not difficult for general people to believe about the possibility. Many studies estimated that 80% to 90% of all cigarette smokers stopped smoking with their own and thus those studies revealed that natural recovery or self change is a common route to recovery for cigarette smokers (Carey, Snel, Carey, & Richards, 1989; Fiore et al., 1990; Hughes, 1996; Mariezcurrena, 1994; Marlatt, Curry, & Gordon, 1988; US Department of Health & Human Services, 1988). Still, this phenomenon has been largely ignored for alcohol and other drugs until the last decade, although the study of natural recoveries has received increasing attention over the last 10 to 15 years (Klingemann et al., 2001; L. C. Sobell et al., 2001).

In the field of alcohol dependence, most researches were predominantly based on the individuals who enter treatment. However, findings from epidemiological studies show that only a minority of alcohol dependent individuals seek help and that the recovery process usually occur without professional support. Data from the National Longitudinal Alcohol Epidemiological Survey (NLAES) on a household sample of the US population revealed that only 9.9% of individuals with alcohol dependence or alcohol abuse received treatment in the last year (Grant, 1996). It was also found in a study that only a small percentage (10%) of substance abusers receive formal treatment for alcohol and drug problems (Narrow, Regier, Rae, Manderscheid, & Locke, 1993).

In case of such a scenario, it is quite accepted if the question would arise what about the rest of the percentage for the drug users? What happened to them? In this context, it is not surprising to assume that a considerable portion of drug users might push them to be recovered from their addictive behavior on their own. Yet the clinicians and

researchers in the addiction field rarely encounter these naturally recovered individuals until the last decade. When the scenario is like that, the possibility of occurrence and maintenance of natural recovery was viewed very doubtfully. The course and outcome of alcohol and other drug problems are greatly determined by the patterns of addictive behaviors whether it is transient or persistent in nature. The transient patterns are open to self resolution or brief professional intervention; whereas the persistent patterns often demand sustained professional and peer based supports (Kandel & Raveis, 1989). This means, although the occurrence of natural recovery was believed to some extent, it was greatly depend upon some criteria such as the length of addiction period, the severity and intensity of addiction, type of used drug etc and it was also believed that such individuals would not be able to sustain their self recovery status for longer period.

Despite this fact, Hamill (2008) found the existence of natural recovery in the popular literature. Similarly, few studies also found that media reports describe the individuals who have recovered from substance abuse on their own, including those who returned to low-risk drinking (Goodman & Benet, 1991; Park, Johnson, & Matsumoto, 1991; Rosen, Hoover, & Stambler, 1991). Low-risk drinking (78.6%) and limited drug use (46.2%) were commonly reported outcomes in natural recovery studies (L. C. Sobell, Ellingstad, & Sobell, 2000). However, only few members of the public believe that substance abusers can change on their own (Cunningham, Sobell, & Chow, 1993; Cunningham, Sobell, & Sobell, 1998; Ferris, 1994; Klingemann, 2000).

1.12.1 Is natural recovery really possible?

Currently, in the areas of mental health and health behaviors, self-change is a well recognized phenomenon. But there is still lack of empirical knowledge for complete understanding of this phenomenon and the establishment of its wide acceptance.

There are considerable amount of studies which reflect the recent recognition of self change as an important and major pathway to recovery from alcohol and drug problems (American Psychiatric Association, 2000; Carballo et al., 2007; Cunningham, 1999; Dawson et al., 2005; Hasin & Grant, 1995; Institute of Medicine, 1990; Klingemann et al., 2001; May, 1996, 2001; L. C. Sobell, Cunningham, & Sobell, 1996; L. C. Sobell et al., 2000).

Evidence on the existence of natural process of maturing out was provided in a large follow up study (Anglin, Brecht, Woodward, & Bonett, 1986). In a survey report conducted on two Canadian general population samples, (L. C. Sobell, Cunningham, & Sobell, 1996) examined the prevalence of self-change from alcohol problems while found that overcoming problem drinking without formal treatment was the predominant pathway for the respondents who resolved their alcohol problems (75% and 77% respectively). These two Canadian surveys, along with other recent surveys (Dawson, 1996; Schutte, Byrne, Brennan, & Moos, 2001) reveal that recovery without treatment is a major route to recovery and is also associated with outcomes demonstrating a return to low risk drinking.

Several comprehensive reviews of natural recoveries in the addiction field have recently been published (Klingemann et al., 2001; L. C. Sobell et al., 2000; Watson & Sher, 1998). However, very few studies have specifically examined natural recovery process from alcoholism and drug problem and a few researchers have studied some different aspects of natural recovery.

Traditionally, formal drug and alcohol treatment has been considered the sole path to resolution of alcoholism and drug problems (L. C. Sobell et al., 1992). This view of treatment for substance abuse is changing. Collectively, studies of natural recovery challenge the traditional belief that recovery from alcohol or drug problem can only occur

through treatment. Now, however, there is a growing recognition that self recovery is not only a pathway of recovery from alcohol and drug problems but that the study of natural recovery process is a significant and important area of inquiry.

1.12.2 Reasons for going through natural recovery process.

Stigma and discrimination: It can be easily assumed that the stigma of being labeled 'alcoholic or heroin-chi' is probably the strong factor that prevents any problem drinkers or drug users from seeking professional treatment because it is well known that the domain of addiction is full of stigma and it is quite easy to spread out the message whether the individual is addicted or problem drinker if s/he is admitted into drug treatment center or involves with any professional services.

Many studies show that large numbers of problem drinkers do not enter treatment resisting them being called 'alcoholic' (Cunningham, Sobell, Sobell, Agrawal, & Toneatto, 1993; Klingemann et al., 2001; L. C. Sobell et al., 1992). It was observed that the labels elicit resistance (Substance Abuse and Mental Health Administration, 1999). Miller and Rollnick (1991) also did the same observation. Problem drinkers do not want them to be discriminated as alcoholic which is rooted in the public's mind (Cunningham, Sobell, & Chow, 1993; Cunningham, Sobell, Sobell, & Gaskin, 1994). Similar issue may be applicable for the narcotic drug users in terms of the label 'heroin-chi.'

Social context: A dependent person's ability to overcome alcohol and drug problems is significantly influenced by his or her social context. This point is consistent with the classic proposition (Zinberg, Harding, & Winkeller, 1977) which was supported by a wealth of empirical research. The proposition is like that the patterns and experiences associated with alcohol and drug use is greatly influenced by the social context in which an individual is embedded. It might also be concluded that the social context in which a

dependent person is embedded similarly influences his or her ability to change addictive life. The role of social capital in the self resolution of drug associated problems was examined in a study (Granfield & Cloud, 2001) where it was found that the social capital (i.e., the relations within their lives and other resources available to them) that was achieved by the individuals prior to their addiction assisted to their recovery without treatment from drug use related problems.

The social capital of natural recoveries is possibly to be high enough to support them to deal the alcohol or drug use related problems on their own as they might have the opportunities to implement or practice the fundamental strategic techniques in their surroundings. For this, they might not feel the necessity to seek for professional treatment. Few studies have supported this assumption when found the natural recoveries having a high level of social stability (Institute of Medicine, 1990; Kahan, 1996; M. B. Sobell & Sobell, 1993a, 1993b)

Incapability to enter into formal treatment: In the present era of urbanization, there are many available treatment centers addressing the alcohol or drug related problems. But there were lack of opportunity to receive any formal treatment even two decade ago as there was no established treatment center for drug abuse. For example, in Bangladesh, the first treatment center to address drug addiction was established in 1988 even though it was in capital city. So, treatment facilities for drug addiction were not much accessible to the problem drinkers or drug abusers, left alone the individuals dwelling at outside of capital city.

Financial constraint is also a barricade for many individuals to seek formal help as the treatment package for addressing drug related problems is very expensive especially the inpatient treatment services. Besides these, lack of family support and lack of

information for a good treatment center also can play role to be barrier for professional support. All the above mentioned factors might create the incapability to enter into formal treatment which may push the problem drinker or drug user to terminate their drug abuse.

Less severity of dependence: The above mentioned statement that successful self change of addictive behaviors indicate as if the individual was not seriously addicted (Chiauzzi & Liljegren, 1993), is consistent with the commonsense idea that only those individuals can go through self recovery process whose addiction is less severe. Few studies also found that problem drinkers are not severely dependent on alcohol (Institute of Medicine, 1990; Kahan, 1996; M. B. Sobell & Sobell, 1993a, 1993b)

Matured out: Being saturated in drinking or in using drugs might also be a reason for going through natural recovery process. As cited in L. C. Sobell et al. (2001) "sick and tired of drinking" is one of the reasons for self change from alcohol and drug related problems perceived by some of the Canadian and Swiss recovered alcohol abusers.

1.13 Determinants of Natural Recovery

As the phenomenon of substance dependence is explained by multidimensional perspectives, natural recovery is also assumed to be influenced by multiple sources of factors such as psychological, social, environmental etc.

Koski-jännes and Turner (1999) identified some environmental and behavioral factors that play a role in resolving the alcohol and drug related problem and in maintaining the self change. In their study, they found a number of change factors such as love, family, social consequences, and peer group change etc and maintenance factors such as self control, spirituality, social and cognitive coping etc.

Findings from past studies on natural recovery process reveal that motivation (Granfield & Cloud, 1999, 2001; Nelson, 2004), cognitive evaluation or appraisal (L. C. Sobell et al., 1993), coping strategies (Carballo et al., 2008), and social capital (Bischof, Rumpf, Hapke, Meyer, & John, 2000; Bischof, Rumpf, Hapke, Meyer, & John, 2002; Carballo et al., 2008; Granfield & Cloud, 1999, 2001; Nelson, 2004; Rumpf, Bischof, Hapke, Meyer, & John, 2002; Tucker, Vuchinich, & Rippens, 2004) are closely associated with the change process for many alcohol and drug abusers who recovered on their own. Schasre (1966) identified a number of factors which are associated with spontaneous remission from heroin use such as negative experience with peers, pressure from partner, increased awareness of the stigma of addiction, geographical move or the disappearance of a drug dealer.

Waldorf and Biernacki (1979) reviewed the literatures on the natural recovery from opiate addiction and identified certain themes for self change process. They suggested that the process of natural recovery involves the change in person's identity from an addict identity to a more ordinary identity. Biernacki (1986) later proposed that it might be necessary for the individuals deeply involved in the world of drug use, to create a new emergent identity to facilitate natural recovery rather than relying on pre-existing ordinary identity.

1.14 Lack of Empirical Knowledge on Natural Recovery Process

Although we know in the present era that natural recoveries from alcohol and drug abuse occur successfully, studies to date tell us little about what triggers and maintains the process of recovery, i.e. what the actual course of action needed to recover on one's own.

A particularly compelling reason for studying the process of self change from alcohol problems is that the field does not have enduring effective treatments (Klingemann

et al., 2001; L. C. Sobell et al., 1993). Furthermore, the alcohol field was unsuccessful to reach large numbers of less severe problem drinkers (Klingemann et al., 2001; L. C. Sobell, Cunningham, Sobell, et al., 1996). In fact, treated alcohol abusers represent only a small proportion of those who have alcohol problems (Cahalan, 1987; Erickson & Alexander, 1989; Room, 1977). In this regard, Robins (1993, p. 1051) has pointed out that "addiction looks very different if you study it in a general population than if you study it in treated cases. If we examine only the tip of the iceberg (i.e., treated cases), then our understanding of a specific problem is likely to be highly biased."

In his comprehensive review article of recovery without treatment, Glenn Walters, a clinical psychologist at the Federal Correctional Institution in Pennsylvania, reviewed several studies conducted between 1971 and 1996 (Walters, 2000). He pointed out that these studies document the existence of natural recovery in an undeniable manner. There had been very little discussion of how recovery without treatment can occur. While several of these studies have included brief discussions on the process of self change from alcohol and drug problem, a complete understanding of this process has not yet been articulated. Although Patrick Biernacki put his effort in this regard to write his book "Pathways from Heroin Addiction: Recovery without Treatment" (Biernacki, 1986), but it is not sufficient to gain complete insight on natural recovery process. The 101 subjects in Biernacki's study were dependent on heroin for at least one year and were free of addiction for two years who did not receive formal treatment for their heroin addiction. Some studies on natural recovery have focused mainly on triggering mechanisms and little is known about maintenance factors (Snow et al., 1994).

Therefore, exploration of triggering mechanisms and maintenance factors of self recovery will lead to a better understanding of the recovery process and complete

understanding of this process may discover new treatment approaches that can be implemented in population based interventions (L. C. Sobell, Cunningham, Sobell, et al., 1996)

1.15 Implications of Natural Recovery

There is a range of potential advantages of natural recovery which actually can act as the indicators of great implications in the domain of drug and alcohol related problem. These include less cost, less life disruption, less addict identity and stigma, an increased sense of self efficacy, and an increased sense of individual empowerment.

Less cost: It can be easily appreciated that natural recovery can reduce the financial burden of treatment to individuals and also to society. Formal treatment can be extremely costly irrespective of private or public agency, for which it might be impossible for many individuals to adopt it. According to the Health Care Financing Administration that identifies national health care expenditures, $5 billion were spent on the treatment of alcohol misuse in 1996 and an additional $7.6 billion were allocated to drug abuse treatment. In this context, the reduced cost associated with natural recovery is particularly attractive.

Less disruption: Undergoing long term treatment including attending group meetings can be disruptive of other conventional life activities which can be problematic for many people. If the various modes of drug addiction treatment can be viewed along a continuum from the most disruptive to the least, long term residential treatment is the most disruptive of all. Clearly, natural recovery is at the opposite end of this spectrum. It is supposed to be well agreed that recovery without treatment is less disruptive than any other means of recovery from alcohol and drug problems.

Less addict identity and stigma: Enrolling in treatment or joining a traditional self help group has profound lifelong implications for one's identity. Formal treatment confirms to the user and to others that the treated individual is an addict. For many, entering treatment can be significantly disruptive of normal identity processes. Ultimately, this can lessen a person's feelings of efficacy or mastery. The adoption of the 'addict identity' is the harmful product of social reaction, particularly, of the addiction treatment industry and self help groups that hold narrow views about the complex phenomenon of addiction. The consequences of entering treatment for any individual is of being labeled and adopting the identity of an alcoholic or drug addict who has a progressive and lifelong disease. Natural recovery is free of this kind of stigma and its detrimental impact in life.

Increased sense of self efficacy: Natural recoveries might possess increased sense of self efficacy which is associated with solving problems with alcohol and drug abuse unaided by conventional interventions. For Bandura, a self efficacious person has a sense of self determination, motivation, goal attainment, and confidence (Bandura, 1982). Self efficacy is the combination of a variety of qualities that increase an individual's capacity to function in effective ways and achieve his or her desired goals. For natural recovery, when people overcome severe and longstanding drug problems on their own, self efficacy is enhanced. But many individuals avoided formal treatment as they felt sufficiently confident about their ability to overcome their substance use problems on their own. Thus, it can be assumed that self efficacy was not created by their ability to overcome alcohol and drug dependency without treatment; rather it was bolstered as a result of their actions.

Individual empowerment: By drawing on a natural recovery's inner strengths, finding support in the naturally existing relationships of family and friends, and avoiding unhealthy relationships are the kind of empowerment referred to by scholars. Self recovery

can foster individual empowerment, leading to increased involvement in and engagement with one's own natural communities.

It should be mentioned here that the potential advantages of untreated recovery, indicating great implications in the respective area, is discussed in this section not as a rejection of various treatment modalities, since treatment does benefit significant numbers of people.

1.16 Implication in Bangladeshi Context

In Bangladesh, appropriate treatment facilities for substance dependence are still very limited. If we compare with the total number of drug users, only a small number of them can go for formal treatment. It can be assumed that some portion of them get recovered by themselves without receiving any formal treatment. But in our country, no single study regarding this significant phenomenon has been conducted yet.

Apart from gaining knowledge about the process, this study will break silence regarding natural recovery of drug addiction in Bangladesh. The study might contribute to design and the development of community based program in future. Findings of the present research may promote early recovery from drug usage by installing hope among the young generations and inspiring them to take early attempt to give up drug with their voluntary effort through challenging the slogan "once an addict always an addict". Findings of this research can also be incorporated in developing and enhancing the existing prevention and treatment program for drug addiction.

This has been the first study to examine the natural recovery process in our country. This study is supposed to generate indigenous knowledge in Bangladeshi culture and thus give input in Indigenous psychology even to some extent. Thus, it is hoped that

the present study might be a significant step in the domain of recovery from drug addiction in Bangladeshi context.

1.17 Rationale of the Present Study

Natural recovery in substance dependence is largely an unexplored domain. Only handful of studies has been conducted in this challenging area. Still many questions regarding its underlying process, contributing factors, and interrelations among these factors need to be explored. Although a considerable amount of studies have been conducted on the existence of natural recovery at many countries in the world, there is still enormous space in knowledge regarding its process and the comprehensive understanding of this significant phenomenon. As mentioned above that there is no single research in this significant area in Bangladesh, the present topic was chosen to fill up the knowledge gap in our context.

In the resource constraint settings of Bangladesh, where proper treatment of drug addiction is not only expensive but also scarce, natural recovery can be a good hope for dealing with the engulfing problem of drug use. Findings of the present study is hoped to generate important knowledge regarding natural recovery process among people with substance dependence in Bangladesh. Moreover, the present study was thought to be a challenge for the controversy regarding the possibility of natural recovery not only in the mind of layman but also among the professionals and even mental health professionals.

1.18 Research Question

The present study was guided by the research question “how does natural recovery process occur?”

1.19 Purpose of the Present Study

The study was aimed at understanding the process of the natural recovery in substance dependence. With this particular purpose, the study was aimed to explore the factors which enabled the individuals to naturally recover. It was also aimed to consider how they were able to maintain their sobriety. At the same time, the present study was open to investigate the interrelationships among those factors.

CHAPTER 2

METHOD

Method

2.1 Research Design

Literature review indicates that still to date, there is a great deficiency in knowledge in this challenging domain of natural recovery all over the world. In Bangladeshi context, knowledge in this area is almost non-existent. No empirical studies have been conducted on the issue of natural recovery while only informal knowledge is available in the form of professional discussion and case exposure. As dearth of knowledge requires exploratory study, it was obvious that the present research demanded qualitative investigation.

Qualitative research claims to describe life worlds 'from the inside out', from the point of view of the people who participate. Qualitative research investigates the quality, i.e., the distinctive, essential characteristics of experience and action as lived by persons.

Definitions of qualitative research are not entirely consistent. Disciplines of Anthropology, Psychology, Sociology and other Social Sciences each elaborate their own particular orientation towards qualitative research. WHO Division of Mental Health published a guidebook "Qualitative Research for Health Programmes" where a broad definition was suggested (Hudelson, 1996). According to this definition, qualitative research may be characterized by the following three features:

1) "An approach which seeks to describe and analyze the culture and behavior of humans and their groups from the point of view of those being studied."

2) "An emphasis on providing a comprehensive or 'holistic' understanding of the social settings in which research is conducted."

3) "A research strategy which is flexible and iterative."

There are several techniques or approaches for qualitative investigation, such as Case Study, Interpretative Phenomenological Analysis (IPA), Narrative Study, Ethnography, and Grounded Theory (GT). Among all other qualitative approaches, grounded theory method seemed to fit best with the purpose of the present exploratory study.

Grounded theory is particularly suitable for understanding the phenomenon that has not been previously studied or is not well understood. The unit of analysis for this method is to study a process, action or interaction involving many individuals. The phenomenon 'natural recovery' is completely unknown in Bangladeshi context and it will become the first investigation for this country. Moreover, goal of the present investigation was to understand the process of natural recovery. For this reason, the present study was conducted using grounded theory, following the systematic procedures of Corbin and Strauss (1990)

Before going further through the procedural details of grounded theory, it would be helpful to incorporate a brief historical journey of grounded theory methodology. As it is comparatively a new approach in the domain of scientific research, it is important to understand how this methodology was discovered and the diverse journey it has completed.

This history was preferred to be included because prior to preparing this research proposal, the researcher was unaware of the differing opinions in these areas related to grounded theory. It was found confusing to the researcher at the beginning but differences became clearer as the books were studied further on this method written by the pioneers and the newer generation grounded theory researchers. The outcome was a more informed methodological process, which contributed to the trustworthiness of the findings. The

procedure section in this chapter has included the steps which were taken to conduct the complete study through grounded theory method until generating a theory.

2.2 Historical Origin of Grounded Theory

Grounded Theory may now be the most commonly used qualitative research method. It was developed in 1967 by the two researchers, Barney Glaser and Anslem Strauss (Glaser & Strauss, 1967). Some students of these two founders and also their students contributed significantly in the broad extension of this method to be spread out. The influence of grounded theory is now very widespread.

As with all qualitative methods, the method cannot be used in a formulaic way. Every time grounded theory is used, it requires adaptation in particular ways as demanded by the research questions, situations and participants for whom the research is being conducted. Thus, we have a situation in which grounded theory varies over the years and molded by users of grounded theory.

However, to meet the demand of that respective period, the challenge to prepare texts and research guidelines for students was taken up by Glaser and Strauss. They had conducted research together for several years and published their new classic text: The Discovery of Grounded Theory (Glaser & Strauss, 1967).

As the grounded theory approaches to data are very individualized, almost immediately Barney Glaser and Anselm Strauss differed noticeably in using grounded theory strategies. These differences were confounded by their different career paths. Thus, two distinct versions of grounded theory were apparent by the early 1990s. These were identified and labeled by Phyllis Stern as *Glaserian and Straussian grounded theory* (Stern, 1994).

The emergence of grounded theory did not stop with the original developers but has continued through their students in a distinct "genealogy" of development. In the following figure, the major diversion from grounded theory has been depicted.

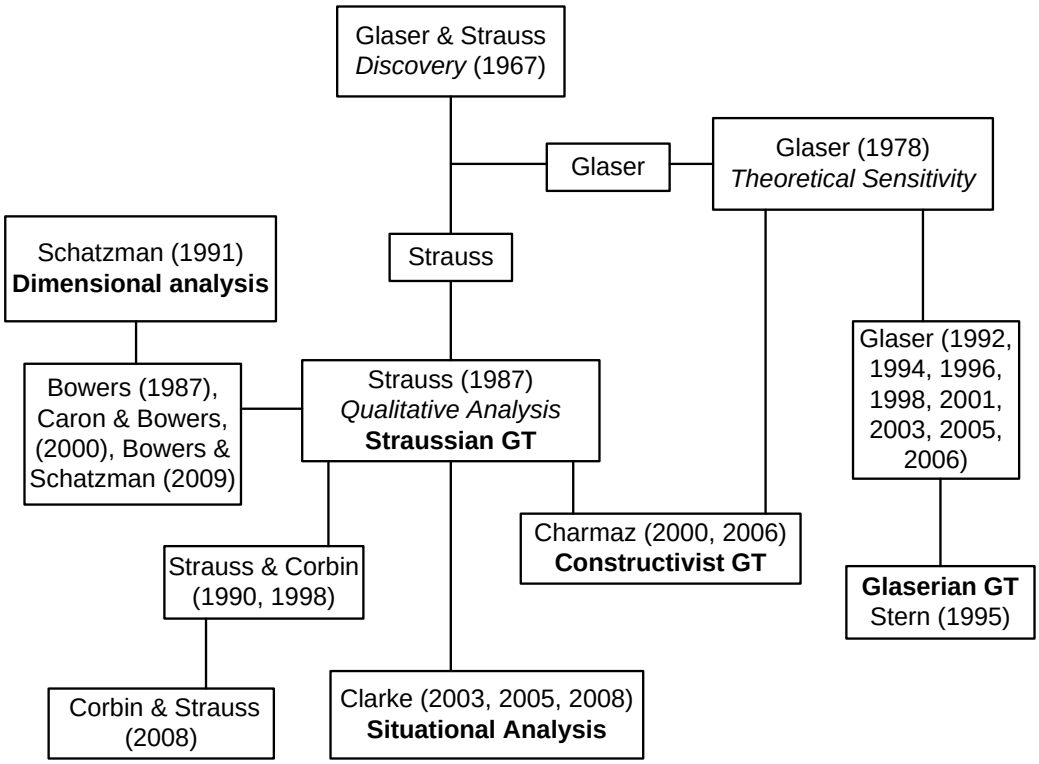

Figure 1. Genealogy of Grounded Theory: Major Milestones (as presented in Morse, 2009)

Grounded theory evolved and changed and the basic mode of operation for doing grounded theory is still changing i.e., changing the way grounded theorists think and at the same time, altering the end products.

2.3 Grounded Theory

Grounded theory can be described as a foundation process for theory development. As defined by Glaser,

"Grounded theory is the systematic generation of theory from data acquired by a rigorous research method. Grounded theory is not findings, but rather is an integrated set of conceptual hypotheses. It is just probability statements about the relationship between concepts" (Glaser, 1998; p. 3).

Three distinctive characteristics of grounded theory method have been mentioned in the above definition; these are, systematic nature, association with the generation of theory, and compilation of hypotheses regarding relationship between concepts. A similar connotation has also been used by Strauss and Corbin in describing grounded theory:

"Theory that was derived from data, systematically gathered and analyzed through the research process. In this method, data collection, analysis, and eventual theory stand in close relationship to one another." (Strauss & Corbin, 1998; p. 12).

The approach in grounded theory is inductive and starts with some form of data (Stommel & Willis, 2004). This inductive process occurs through the interaction of data collection, analysis procedures, and theory development. By following the established systematic steps of grounded theory, a core category emerges (Strauss & Corbin, 1990, 1998). Grounded theory is an appropriate method to employ when no theory currently exists or when a researcher wishes to study complex areas of behavioral problems or concerns where variables may not have been identified (Glaser & Strauss, 1967).

Glaser (2001) contended that both qualitative and quantitative data may be used when conducting a grounded theory study. In the present study, qualitative data was used because it was believed to be the best way to gather information from recovering individuals about their experiences to overcome substance use without the aid of professional treatment. It was viewed that it could provide a richer level of information

than would quantitative data, and would contribute to the development of a theory to help understanding natural recovery process.

The purpose of this qualitative method is theory construction, rather than description or application of existing theories. The processes of grounded theory include the use of analytic memos to describe and explain the emerging categories, making constant comparisons between data, data and emerging categories and the categories themselves, the use of theoretical sampling, and the delay of literature review until after forming an analysis. These processes are the tools that structure this emergent process.

In the current study of natural recovery process from substance dependence, it was appropriate that the theory was identified which emerged to explain how the recovering individuals were able to stop their drug using without receiving any kind of formal treatment. Only the aspects of this topic which were relevant to the emerging theory were included. The researcher kept in mind that a grounded theory is not designed to offer a thorough description of a phenomenon (Glaser, 2001).

Two middle-range theories that emerge from grounded theory are substantive and formal theories (Strauss & Corbin, 1990, 1998). Substantive theories emerge from research in one particular substantive area. Therefore, in the present study, the substantive area is that of natural recovery and their strategic process for self-initiated abstinence. Formal theories evolve in areas that are broader in context and scope. Through conduction of the present qualitative investigation, it was wished to develop a theory about a specific, substantive area of clinical practice.

2.4 Applying Grounded Theory to the Research Question

Grounded theory was selected as the methodology for the present study due to three primary reasons. First, grounded theory is one of the central techniques for understanding phenomena about which little is known. The inductive process of grounded theory allows the participants to speak for their experience to be understood from their own perspectives. As the existing literature can illustrate very limited and insufficient knowledge on natural recovery process, grounded theory is particularly helpful here, in understanding the research question of my study, 'how does natural recovery process occur?' Although many researches were conducted on whether natural recovery occurs or not, very few investigations have focused on understanding the specific process and the associated psychosocial factors. So, this perspective is essential for understanding the interrelation of psychological and social factors playing a significant role in the process through which the individuals become drug free on their own.

Second, Grounded theory is unique among qualitative research techniques in terms of theory construction. Grounded theory focuses on emergent theory that is rooted in the data rather than relying on existing theory. It assists in understanding the experiences of the participants in their own right rather than through the lens of pre-existing theory. This study was targeted to discover the interrelation of psychological as well as social factors involved in the natural recovery process in the experience of naturally recovered individuals that have been under explored or overlooked by the existing theories. This emic nature of grounded theory was logically decided to be suitable to explore the recovery process from drug addiction without any professional treatment and thus to construct a new theory for Bangladeshi context.

And third, grounded theory techniques have the capacity for studying dynamic processes rather than static phenomena. In designing the present study, it was assumed that the experience of struggling with overcoming drug was a process of growth for persons who were experiencing it and that participant in the research would reflect change and growth, in the description of their own experience. The use of grounded theory allows the nature of the participant's experience to emerge and attempts to impose as few restrictions as possible on understanding that experience. In the axial coding process, there is flexibility to include change over time and other dynamic elements in this analysis.

Grounded theory has become an increasingly popular method in psychology research and counseling psychology research in particular (Morrow & Smith, 2000). Although some investigations were conducted on the issues on natural recovery using qualitative research design, but very few researches were designed using grounded theory method. Recently, researchers have used grounded theory to explore women's concurrent experiences of alcohol/drug recovery and transition to parenthood (Brudenell, 1996), to develop a midrange theory of women's addiction recovery (Kearney, 1998), to study self-resolution of alcohol problems as a process of investing and re-investigating in self (Finfgeld, 1999). Patrick Biernacki, the famous name in the field of self change process, also used grounded theory in his study conducted on natural recovery from heroin addiction (Biernacki, 1986). Based on a recent methodological review study on natural recovery from alcohol and drug problems, future directions were suggested in research area. (L. C. Sobell et al., 2000). They stated that future natural recovery studies should explore in some depth what factors, events or processes are associated with the self-change process.

Still to date, no published studies exist that apply grounded theory to the emerging natural recovery process. The present investigation can also be considered to be followed by recommending direction with that review study (L. C. Sobell et al., 2000). In that case, it is obvious that it would require to be designed with grounded theory approach as the unit of analysis of ground theory is to study an action, interactions or a process.

2.5 Respondent

Naturally recovered individuals (i.e., being abstinent from substance dependence on their own) were the respondents for present research. This means, the respondents never went through any kind of professional or formal treatment such as professional detoxification or medically managed withdrawal, long-term or short-term residential treatment, outpatient treatment program or aftercare program, home based detoxification service, community based detoxification program, any form of recognized psychotherapy (individual or group), any form of self-help group (Alcoholic Anonymous/Narcotic Anonymous) etc.

Maximum variation of sampling was tried to be ensured regarding different socio-demographic variables, e.g., age, socio-economic status, habitat, type of previously used drug, duration of past history for drug dependence, duration of present abstinent life etc. The important variable ‘gender’ could not be incorporated in support of maximum variation of sampling because our culture is more restricted for women rather than men. Generally the prevalence rate of female drug users is less than that of male drug users. Moreover, stigma and discrimination plays powerful role in our society for which it is not very easy for any woman to assert herself as a previous drug user once she has recovered from the addiction. Yet, a female case was found who agreed to take part in this research

after being assured about her confidentiality. But her boy friend did not allow her to disclose her "past life story which had been locked forever".

However, it was not possible to anticipate the exact number of respondents at the beginning of this study because the research was guided by theoretical sampling. At the end, total 09 individuals were successfully interviewed.

It was through data analysis and immersion in the constant comparison process that data saturation was achieved and core category was emerged using a sample size of nine self recovered individuals.

In order to get a glimpse for easy understanding of the reader, the inclusion and exclusion criteria for the respondents of this study has been summarized below.

2.5.1 Inclusion criteria.

Inclusion criteria for participation were as follows:

1. Any individual who has naturally recovered from drug addiction for at least 1 year prior to the interview (in accordance with Burman, 1997; Dennis, Scott, Funk, & Foss, 2005). The criterion for 'one year abstinence' was set following the full remission indicator of substance dependence in DSM-IV-TR (American Psychiatric Association, 2000) although duration of the abstinence period for the respondents was found from 3 to 12 years, i.e. 7 years in average.
2. The self recovered individuals having prior history of substance dependence as defined by (DSM-IV-TR; American Psychiatric Association, 2000) for at least one year at a stretch.

3. The person never went through any kind of formal or professional treatment mentioned earlier.

2.5.2 Exclusion criteria.

Exclusion criteria for participation were as follows:

1. Age below 18 years.
2. The individuals who did not meet the DSM-IV-TR (American Psychiatric Association, 2000) criteria for substance dependence during retrospective diagnosis.
3. Prior history of receiving any formal treatment for substance dependence in lifetime.
4. Respondents with less than 12 months of abstinence (in order to correspond with DSM-IV-TR remission specifiers of sustained full remission).
5. Having prior history of substance dependence with chronic physical illness.
6. Having any co-morbid severe psychiatric illness or currently taking any psychiatric medicine.
7. Having any regular substitution for drug e.g. sleeping pill, beer, excessive use of gull or any other socially acceptable addictive substances.

2.5.3 Characteristics of the respondents.

All of the nine respondents were male although one female was possible to be reached out but she did not agree to participate in this study. Age of the respondents ranged from 29 years to 60 years (average 40). The respondents were predominantly from

the capital city while two of them from outside of the capital. All the respondents had a history of multiple substance abuse while they used any combination of varieties of substances such as heroin, phensydil, cannabis/marijuana, foreign alcohol/locally made alcohol, buprenorphine, pathedine, afim (Opium), charash, tablet, jhakki etc. The duration of their drug using period ranged from 5 years to 31 years (average 12 years) and that of their present abstinence period ranged from 3 years to 12 years (average 7 years).

2.6 Sampling

In qualitative research, purposive sampling is used to select "a limited number of informants strategically so that their in-depth information will give optimal insight into an issue about which little is known" (Varkevisser, Pathmanathan, & Brownlee, 2003). In this regard, snowball sampling technique was used which is purposive in nature, to find out and reach naturally recovered individuals from the community level.

Several steps were employed to identify self recovered individuals who were suitable participants for the phenomenon under study. At first, few recovery staffs of a recognized drug treatment center were approached to help as source persons in this regard. They were assumed to have strong link with any kind of recovery in his surrounding area or network. With the help of such a source person, when a single natural recovered individual was identified, the next individual was tried to be searched through that particular respondent. Thus, with the technique of snow balling, all the respondents were searched out.

However, to offer a fuller conceptualization of the participant selection procedure used in this study, it is necessary to reflect on two important concepts: theoretical sampling and saturation.

2.6.1 Theoretical sampling.

Theoretical sampling refers to the collection of data from several sources to gather a wide perspective on the particular phenomenon in the study. It is guided by the theory that is emerging from the data and occurs during the constant comparison phase of data analysis (Corbin & Strauss, 2008).

As data collection and analysis are carried out simultaneously in grounded theory research, each subsequent interview contributes to further understanding of the issues under study. Therefore, participants need to be selected carefully based on the demands of emerging theory. The sampling process is thus termed as 'theoretical sampling'. It is largely purposive in nature. Theoretical sampling demands that the size and nature of sample is to be decided 'on the way' during the process of ongoing data collection and analysis. During theoretical sampling, the researcher may go back to participants with further questions for clarification or to new participants with more focused questions about specific concepts (Corbin & Strauss, 2008).

2.6.2 Saturation.

During the process of data collection, the researcher may reach a point when no new information is coming up and this indicates that the data is saturated or the researcher has reached the point of saturation (Schutt, 2006). The concept of saturation dictates the principle of when to stop. In simple term, it can be said that saturation determines the sample size, but in practice, it is much more comprehensive. The basic level of saturation is achieved when during interview a single participant is unable to give further insight on the topics i.e., the information elicited by a specific participant is repetition of the previously elicited information. Thus, it marks the end of interview with that participant and the researcher decides to move onto next participant for interview. A more important

and broader level of saturation, often termed as 'theoretical saturation', is achieved where new category of concepts and their interrelation ceases to emerge during analysis of data (Corbin & Strauss, 2008). At this point researcher decides that data collection is complete. Saturation ensures completeness of the collected data as required for theory development.

2.7 Tools

To identify eligible respondents for the present study, a set of screening tools were developed. It was devised mainly into two separate forms bearing in mind the two main issues in the inclusion criteria, i.e., a person having prior history of substance abuse and remaining abstinent without any formal treatment for at least one year prior to interview. An additional questionnaire was also prepared for significant members of the assigned respondent to cross check the validity of the information provided by that particular respondent regarding his/her inclusion or exclusion criteria.

2.7.1 Questionnaire for retrospective diagnosis of substance dependence.

The first part of the screening tools was prepared for retrospective diagnosis whether the individual met the criteria for substance dependence following any standard diagnostic manual. Considering the drug history of the respondent, this questionnaire was developed with a purpose to diagnose any individual in a backward manner based on his/her past life information.

Initially, it was planned that a psychiatrist would be involved in this study and each respondent would be diagnosed by the psychiatrist. But later on it was realized that this would not be possible or feasible due to some practical reasons. For this, the idea was generated to create a specific questionnaire for retrospective diagnosis and to authenticate

it by the psychiatrist so that it could be applicable for any individual to be diagnosed independently.

An initial questionnaire was structured following the SCID-I (non-patient version; First, Spitzer, Gibbon, & Williams, 2002) and DSM-IV-TR. The draft questionnaire was verified with the help of a psychiatrist to check its face validity. Then it was given to a senior psychiatrist (professor) to authenticate it whether it was ready for retrospective diagnosis. After doing small correction, it was confirmed to be ready for use. Yet, it was cross-checked again by another psychiatrist to increase its credibility. Finally, an 18-item questionnaire was developed for retrospective diagnosis of substance dependence, having mostly dichotomous questioning while few questions were open-ended. (Appendix-A)

2.7.2 Natural recovery identification screening questionnaire.

The second part of the screening tools was developed to make sure whether the respondent was naturally recovered or not. This 19-item questionnaire incorporated all the inclusion and exclusion criteria indicating the eligibility of the respondent for this study. Unlike the questionnaire for retrospective diagnosis, most of the questions were dichotomous in nature. There were also few open-ended questions. (Appendix-B)

2.7.3 Questionnaire for validity checking.

The third part of the screening tools was prepared for significant members of the respondents to cross check the validity of the information provided by the respondents. This questionnaire consisted of 15 item having ‘yes-no’ formatted questions as well as few open ended questions. The issues of enquiry were related to the pattern of substance dependence, recipient of any formal treatment, starting period of abstinence and nature of lapse experience (if any). Their observation was also incorporated into this questionnaire.

The respondents were informed and the rationale was explained regarding this. If obvious inconsistencies would occur between the report of the respondent and the collateral, it was decided to exclude that individual from the study. But in practical, no such inconsistency was found. Detail questionnaire is attached in Appendix-C.

2.7.4 Topic guide.

To explore the natural recovery process, In-depth Interview (IDI) using a pre-designed topic guide was used. To design that topic guide, step by step procedures was followed.

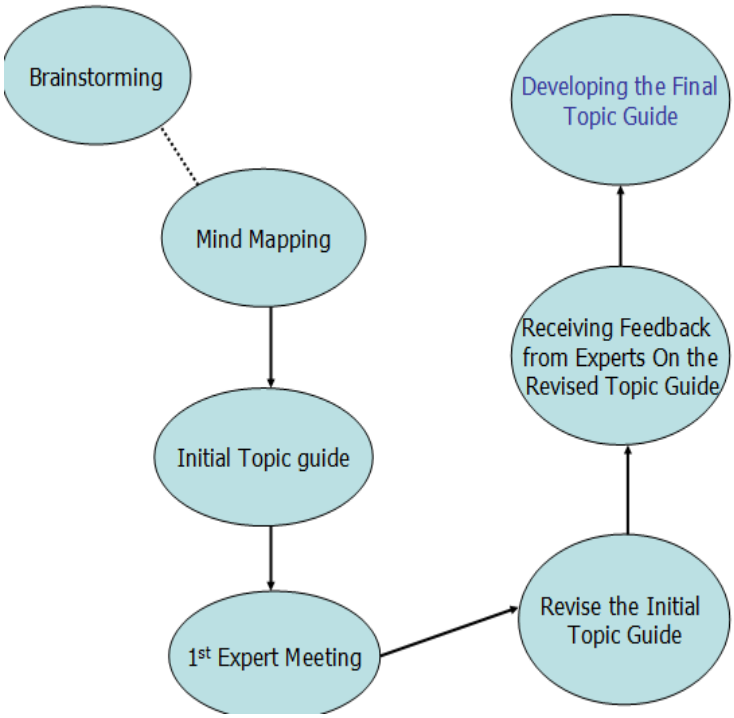

Figure 2. Development of the Topic Guide

At first, mind mapping was done based on purely brainstorming. Initial topic guide covering the main area of questioning, was structured through this process. In doing this important task, the researcher tried her best to keep the special attention to bracket any of her pre-conceived ideas about abstinent process.

Then, first Expert meeting was arranged to explore the maximum information to get the optimal level of data. The expert professionals, who had the practical working experience in the area of drug addiction, were invited to join in the expert meeting. Although 10 experts were invited, only 04 of them were present in the first expert meeting. In a practical sense, no convenient time schedule could be organized to ensure all the experts' presence. For this reason, the expert meeting was arranged with this short number of professionals. A brief presentation was offered mainly focusing on research methodology to share the purpose of the study. Discussion with the professionals had been continuing until they reached to a common platform. Initial topic guide was revised thoroughly afterwards, incorporating all the feedback from the experts.

Second expert meeting was initially planned to be organized to increase the credibility of the topic guide. But the revised topic guide seemed to be more comprehensive and suitable enough to explore the natural recovery process. Still it was planned to arrange the second meeting to make the topic guide more credible; but facing difficulty to organize the first expert meeting made the researcher discouraged to do that. There was also a time limit for completion of the present study. For all these reasons, the idea for second expert meeting was cancelled. Instead, feedback on the revised topic guide was collected individually from all the experts. Then it was revised scrutinously and the final topic guide was developed.

The interview topic guide covered significant areas mainly related to drug using life and drug free life. The topic guide, which was designed just to direct the interview procedure, focused on only some area needed to be explored to understand natural recovery process. But it did not cover any preconceived idea or conception so that it could

direct the interview to confirm any issue rather than to explore. The final topic guide is attached in the Appendix-D.

2.7.5 Demographic information sheet.

A demographic information sheet comprised of several demographic variables was made to be used before interviewing. It contained significant information about the respondent's age, gender, religion, level of education attained, habitat, present employment status, marital status, number of children if married, family size, family income or socio-economic status, total duration of the drug taking period, total duration of the present abstinent life, etc. (Appendix-E)

2.7.6 Consent form and explanatory statement report.

Before conducting IDI, some ethical considerations needed to be ensured for the respondents. With this purpose, consent form and explanatory statement report were prepared. Consent form covered all the information which could protect the respondent's right. Strict confidentiality was assured there (Appendix-F). In the explanatory statement report, the details of the present study were summarized for better understanding of the respondents. Contact address of the researcher and that of her supervisor as well as the secretary of the Bangladesh Clinical Psychology Society (BCPS) was also included in this statement report for further inquiry of the respondents (Appendix-G).

2.8 Procedure for Data Generation

2.8.1 Data collection method.

In the grounded theory method, data collection and analysis are non-linear, simultaneous processes that include collecting, coding, comparing, memoing, sorting, and writing (Corbin & Strauss, 2008). Data may be collected from several sources for a

grounded theory study. These sources include "interview, observation or documents, or from a combination of these sources" (Stern, 1994).

In-depth interview was the main source of data for the present study. All interviews with the respondents were conducted by the researcher to generate main data. Total nine naturally recovered individuals were interviewed while eight of them were interviewed in person and one person by telephone.

Importance of building a trustworthy relationship between the interviewer and the interviewee is well known issue to generate quality data. For this reason, first concern was to establish a sustainable rapport. As the domain of drug addiction is full of stigma and discrimination, a strong trustworthy relationship was significantly essential and it was emphasized to be maintained through non-judgmental attitude. Otherwise, it would not be possible to unfold the hidden life story of the respondents and thus, the purpose of the interview would be hindered. Bearing in mind this sophisticated issue, regular communication with intermittent interval was maintained with the respondents over phone until the actual interview took place.

Before engaging in the in-depth discussion, consent of the respondents was taken both verbally and in written form. The consent form incorporated the issue of informed choice for participation in the present study, approval to record the interview, assurance of confidentiality, the possibility for second interview (if necessary). Every respondent was also provided an explanatory statement report containing essential details of the present study and contact address of all the associated personnel of this study so that the respondents could feel more secured to keep their trust on the whole research procedure. Important socio-demographic variables were recorded in the data information sheet.

In-depth interview was conducted following open interview approach and using the topic guide. Open ended questions were asked to allow them sharing their experiences freely. Questions were mainly focused on the factors that preceded to change drug using problem, mechanisms used to alter behavior, challenges experienced in the process of changing, and maintenance strategies used to sustain new adaptive habits. At the initial level, questions were made based on topic guide. But as soon as the research proceeded being guided by theoretical sampling, the questions did not depend merely upon the topic guide rather was directed to explore the properties and dimensions of any specific category emerged from the previous interview.

All the interviews were recorded with digital recording equipment i.e. digital voice recorder (Sony ICD UX-200F). Recording was done to facilitate the flow of the conversation preventing disruption of the interview process through note taking and to ensure accuracy of information for analysis purpose. Prior to recording, the respondents were oriented with the voice recorder. As it was an unfamiliar tool for them, the purpose of this orientation was to reduce their extra sensitivity towards it. Few respondents were not willing to allow recording their voice but after explaining further on its significance, they permitted to record. Initially, they were feeling a little bit hesitated and was attentive toward the voice recorder but their attention shifted soon while they had been deeply involved in sharing their journey overcoming drug even without receiving any kind of professional support.

Each participant was interviewed for approximately 90 to 110 minutes. The tape was replayed as immediately as possible following the interview. Memos were also written which helped the researcher to trace her thinking process as the theory developed.

The first two interviews were slightly more contrived as the researcher struggled with forcing some of the questions. Since the number of interviews progressed, interviewing skills of the researcher were continued to be refined. The interviews were allowed to be guided more by the participants than by the interview guide. Throughout the interviews, the researcher remained open to new information and reflective of previous interview data and emerging concepts to guide the conversations.

The recorded interviews were transcribed then in a verbatim. Verification from participants was not sought as to the accuracy of the transcripts or emerging analysis. In grounded theory, it is not appropriate to return to past participants to seek verification of the emerging theory. Glaser (2002) stated that the participants themselves may not be able to relate to the emerging theory; therefore, it would not be appropriate to ask them to confirm that it is an accurate reflection of their experiences.

2.8.2 Preparation for transcript.

All the recorded interviews were transferred into computer in MP3 format after completion of whole interview procedure. A research assistant was appointed for this specific task of transcription, who was an undergraduate student in Psychology department of Dhaka University. Later, all the MP3 formatted files were transcribed in the form of text document by the researcher and her research assistant.

Five interviews were transcribed by the researcher herself and the four were transcribed by the research assistant. All the transcriptions were audited by the researcher for accuracy with the recorded version. Each transcript was also reviewed to remove identifying information. The interviews transcribed by the research assistant were listened to in their recorded version at least two additional times to provide further immersion in

the data. This means, the contents of each interview were reviewed two to three times during the preparation of the transcripts.

2.8.3 Data analysis.

Data analysis began with the first interview. The chain of theory development began with substantive coding, which included open and selective coding (Charmaz, 2006; Corbin & Strauss, 2008; Glaser, 1978, 1998). This line-by-line coding keeps a researcher true to the views of participants' realities. The result of open coding is the inductive generation of substantive categories (Glaser, 1978). It was this process that guided the analysis of present research.

The data analysis strategy for grounded theory is constant comparison method. Using this method data were analyzed during the data collection period and the emerging concepts from the analysis was used in gaining greater depth of understanding of the phenomena in later data collection. The whole data generation process was guided by theoretical sampling and In-depth interviews were continued until the data were saturated.

2.8.3.1 Constant comparison with data.

Following the grounded theory procedure, open coding was started just after the first interview was completed along with the transcript. Based on that coding, the second respondent was searched guided by the principle of theoretical sampling. Open coding for the second interview was done unlike the first one. Based on further emerging categories, third respondent was tried to be identified. Thus, iterative data analysis had been going on while the data generation through interviewing and initial analysis through open coding had been continuing simultaneously. Data were compared in a constant manner during

open coding and intermediate coding i.e., merging or renaming any code. Constant comparison was going on within a case as well as between the cases.

The constant comparative method consists of four levels of coding and analysis (open coding, axial coding, selective coding and the construction of the model representing the theory) that begin with the data and move in successive levels of abstraction.

2.8.3.2 Open coding.

In open coding, the raw data (e.g., interviews, art, field notes) are broken down so that ideas and concepts are identified and labeled. During open coding, the researcher codes all the data and places each code in as many substantive categories as appropriate. Categories are the clustered codes from the open coding process. These categories are compared with other categories to see if they were connected or linked, in any way (Corbin & Strauss, 2008). Throughout this entire process of coding and categorizing, the researcher engages in a process of constant comparison of codes, codes with categories, and incidents to incidents. This continues with similar and different groups that may have been coded for the same category. This step of constant comparison soon starts to generate theoretical properties of a category. Constant comparison continues and includes comparing incident with incident and then incident with properties of the category (Corbin & Strauss, 2008).

During this phase of open coding, line-by-line coding was completed. The views of participants' realities were coded almost in an accurate manner because participants' words were highlighted exactly, as line by line coding was completed. The researcher then returned to the initial codes and began to attach conceptual labels to the open codes. While engaging in the process of constant comparison, researchers stop and record memos of

their ideas. These memos are analytical ideas of the researchers and serve to guide the development and revision of codes and categories (Corbin & Strauss, 2008). These memos provide an avenue for the emergence of the core category and substantive theory. They serve as the theoretical notes about the data and identify the conceptual connections between categories (Corbin & Strauss, 2008).

As soon as the coding of first transcript was begun, the process of writing memos was started. Throughout the data analysis process, the analytic memos were written to describe each code, category, and relationship as it emerged in the analysis. These memos served to guide the development and revision of codes and categories later on as it was continued to work through the process of analysis.

2.8.3.3 Axial coding.

Axial coding is a procedure advocated by Anselm Strauss and Juliet Corbin in their guidelines for the development of grounded theory (Strauss & Corbin, 1990). From the open coding, axial coding emerges where the data are reassembled so that the researcher may identify relationships more readily. Axial coding is the phase where concepts and categories that begin to stand out are refined and relationships among them are pursued systematically. Categories represent phenomena such as events, objects, incidents, and actions.

Categories are pursued in greater depth on the way to the identification of core categories and ultimately to the explanation of phenomena (selective coding). As major categories began to emerge, the questions of the data were asked that made me concerned in a focused manner. Through the axial coding process, the codes were analyzed that emerged from the research, according to their relationships with one another.

2.8.3.4 Selective coding.

Selective coding is the next level of analysis. When researchers determine that coding has lead them to see the emergence of a core variable or theory, it is then time to selectively code for only those codes that relate to the emerging theory. To selectively code, the researcher delimits coding to only the variables that seem to relate significantly to the core variable (Corbin & Strauss, 2008). In this phase of selective coding, interviews were continued with the respondents and began to theoretically sample. The process of constant comparison of codes, categories, and memos were also maintained. The core category was emerged as a result of the emergence of key concepts as the codes, categories, and concepts were continuously compared.

2.8.3.5 Model.

The final step is the one where the researcher takes the model and develops propositions (or hypotheses) that inter relate the categories in the model or assembles a story that describes the interrelationship of categories of model. This theory, developed by the researcher, is articulated toward the end of a study and can assume several forms, such as a narrative statement (Strauss & Corbin, 1998), a visual picture (Morrow & Smith, 1995), or a series of hypotheses or propositions (Creswell & Brown, 1992).

Data were analyzed throughout the data collection process and continued after the interviews had been completed. A structured analysis procedure, open coding, was applied to all of the initial interviews. The open coding process finally resulted in 78 codes. Many passages were coded more than once to represent various axis of understanding the content (emotions, actions etc) according to axial coding. Through selective coding, codes were organized into 20 categories having several sub-categories for most of them. These categories were further organized into three general sections, namely encouraging factors

to natural recovery, strategies in natural recovery course, and the prolonging factors for sustenance of natural recovery. Several key categories such as adaptive cognitive structures, gradual goal approximation etc emerged in this formal analysis that became central concepts in the development of the integrated model to understand the process of natural recovery.

A less structured analysis process was also conducted through writing memos, diagramming ideas, comparing interviews and categories, and reviewing the interviews. The topic guide was updated through simultaneous data collection and data analysis. Additional questions were included about emerging concepts on natural recovery process into the ongoing interviews. Thus, the concepts were refined further. These two analysis procedures, the structured and the unstructured procedures, overlapped one another throughout the analysis of the data.

The data analysis resulted in the construction of the specific diagram i.e. model to understand the natural recovery process, which represented the development of the theory on natural recovery process. The model is drawn in the findings section (Chapter 3). Nvivo-8, a computer based soft ware program, was used for analyzing qualitative data to organize and sort the data and also to draw the model on natural recovery process.

2.8.4 Place of interview.

Among the total nine respondents, six of them were interviewed in the capital city at a mutually convenient time and location. Among these six, four of them were interviewed in the community place and the two interviews were arranged in the clinical psychology professional set up. Among the remaining three respondents, two interviews took place in the outside of capital city. The remaining one interview was conducted from outside of the country over telephone.

2.8.5 Time frame for data collection.

Data were collected through interviewing from March, 2012 to December, 2012.

2.9 Ethical Considerations

The guidelines of American Psychiatric Association (2000) were followed to maintain ethical standard of the present research. Some of the major issues have been presented in the following:

2.9.1 Informed consent.

All the respondents were provided detailed information about the nature, purpose and possible future utilization of the present research so that they could have clear understanding on it. It was tried to ensure their voluntarily participation in this study having their informed choice.

A consent form was prepared where each and every issue was mentioned clearly e.g. the recording of their interview, doing second interview (if necessary) etc.

Explanatory statement report was prepared and provided to each respondent so that they could get the detail information of the study and also could have the sense of control as it contained the contact address of the researcher, her supervisor and the secretary of the Bangladesh Clinical Psychology Society (BCPS).

2.9.2 Confidentiality and privacy.

Privacy and confidentiality of the respondents was given a high priority to protect their sensitive and personal information. All interviews and discussions were conducted in a secure place approved by the respondents.

Moreover, all the data were de-identified to make them anonymous during transcribing the audio recorded files. An individual code number was used in the demographic data sheet for each respondent to ensure the anonymity.

However, the respondents were assured about the confidentiality of their information while taking their verbal and written informed consent. Only for one respondent, it was not possible to take written consent as the interview was conducted from outside of the country over phone.

2.9.3 Wellbeing of the participants.

It was believed that the interview process would not cause any severe distress amongst the respondents and thus the study could not cause any severe or long-term harm of any forms. However, consideration of the wellbeing of respondents was given highest priority during the data collection.

2.9.4 Right to withdraw.

It was clearly explained to the respondents that they have the right to withdraw their participation from the research at any stage of the interview.

2.9.5 Researcher's safety.

For some of the respondents, it was not possible to arrange their time during working hour for which few interviews needed to be conducted at night in the crime zone area of capital city. Being a female, the researcher kept some possible risks in her consideration. Close cooperation of the recovery staffs of the drug rehabilitation center (who were the original source persons for the respondents) and liaison with some popular figures of the respective community helped her to minimize the risks associated with data collection.

CHAPTER 3

FINDINGS

Findings

For the present study, all the transcribed data were analyzed qualitatively using NVivo-8, a computer based software program exclusively designed for qualitative data analysis. NVivo-8 was used to organize and sort the huge array of information under themes and categories in accordance to the content analysis done by researcher. Three types of coding, namely open-, axial-, and theoretical coding were used to classify the data into meaningful underlying themes. In the methodology section, the steps of analysis have been described in details. At the end of iterative analysis, the findings have been organized into three broader sections to understand the Natural Recovery process. These were,

- Encouraging Factors to natural recovery
- Strategies in natural recovery Course
- Prolonging Factors for Sustenance of natural recovery

Each section contained several categories and sub-categories which were emerged to explicate the natural recovery process.

3.1 Encouraging Factors to Natural Recovery

The first broader section of the findings was the encouraging factors to natural recovery. Several factors were explored which were observed to play an extensive role to promote the respondents to recover from drug on their own. Some factors were noticed as psychological and some were social factors. Six sub-categories emerged under this broad section.

3.1.1 Inaccessibility to formal treatment.

The respondents failed to access professional treatment services for drug addiction due to several reasons such as fear of being stigmatized, negative idea about rehabilitation center, financial hardship, and unavailability of treatment center, which ultimately pushed them to choose the pathway of recovery on their own.

3.1.1.1 Fear of being stigmatized. Most of the respondents (6/9) reported to have strong fear that they would be discriminated by the main stream society if they were treated through drug rehabilitation center. They believed that being admitted into formal treatment center opens the scope of wide disclosure of their drug using status and thus increasing the possibility of being labeled forever. The following statement has revealed one respondent's intense fear of being discriminated from the main stream of society.

"If I would be admitted into the drug rehabilitation center, then it would be a huge scar for my whole life."

3.1.1.2 Negative idea about rehabilitation center. Most of the respondents (7/9) were found to have strong negative thoughts or schema about the drug treatment center which decreased the accessibility to formal treatment. Idea about physical torture, emotional abuse, sexual abuse, being locked in a lonely room resembling a jail, inappropriate information causing further relapse, additional addiction with the prescribed medicine, harmful effect of such medicine on health, insufficient management of treatment program, information overload, making one's self esteem down by the inappropriate way of delivering any message/information, getting less attention from service providers, and mostly the commercial attitude of the drug rehabilitation center rather than genuine effort to make one cured from this problem made the respondents of my research greatly inspired to be recovered from their drug using behavior on their own. The following

quotation is full of negative concept regarding drug rehabilitation centers stated by one respondent.

"……centers often provide wrong treatment. It is there indeed . . . . . in detoxification you will be treated with another type of drug, isn't it? And in rehabilitation program, they will clear-up your brain though the process of sharing your emotional pain. Sometimes they provide faulty suggestion in this process."

3.1.1.3 Financial hardship. Financial constraint was also found among few respondents (3/9) as a barrier to receive formal treatment. Their family attachment was also seen as associated with this issue as they were found to have considerate attitude for not giving extra pressure on their family for the treatment cost. The following statement has revealed this concept.

"I didn't want to take money from father in that moment because we, the four siblings, were studying then."

3.1.1.4 Unavailability of treatment center. Lack of availability for professional treatment was also found as a barrier to seek formal treatment which created inclination towards naturally recovery for one respondent. It was seen in the individual from outside of the capital city which was far behind from urbanization at that time period.

3.1.2 Intrinsic motivation.

All the respondents (9/9) were found to have strong motivation in terms of their drug cessation. They reported that they had to maintain strong willpower throughout the journey of their drug cassation. The following statement revealed clear intention of one respondent which was internally driven.

"I won't be good for you; I'll be good for myself only. I'm telling you that I don't take drug but I'm taking drug hiding you. You know that 'X' doesn't take drug but am I genuine to me? I am trying to be good (being drug free) for myself".

Another respondent was stating the following statement.

"……I'm the director of my own mind, no one else……. I just need to have the mentality that I'll have to be well (abstinent), that's all, nothing else."

3.1.3 High self respect.

It was observed among the respondents (5/9) that they possess high level of self respect for themselves. Such high sense of self respect was found to be linked with the decision to cease their drug using behavior and to remain abstinent forever. In the transcript, it was also highlighted that during the drug using period, when they had to choose one option that either they need to do anti-social activities and undesirable behaviors to procure drug or they need to quit from it, the respondents of this research were found to select the second option. The following statement is revealing high self respect for one respondent.

"I've been born in such a family that it's not possible for me to collect money by ransom, or mugging on the road; also impossible begging for money to buy drug."

Their high self respect was also expressed in the interview transcript when they were seen to feel shy to ask for or depend on others for money even to buy drug. Their emphasis on independence and self respect was reported to serve as a predisposition for them to be naturally recovered from drug dependence.

3.1.4 Care for family.

Almost all the respondents (8/9) reported their concern for the family which had been reflected frequently. They expressed that they would feel highly attached with their family members. This high attachment helped them to gain control over drug in two ways; firstly, they themselves realized their responsibility towards family; secondly, they had been motivated and influenced by significant family members to give up drugs. They acknowledged the negative impact of drug using behaviors on their beloved family members and felt concerned about the future consequences. All the married individuals were found to worry about their children's future while unmarried males were seen to be concerned about their sister's marriage or their sister's sufferings in her in-laws family for the image of her drug user brother.

3.1.5 Drug related outcome.

Significant consequences of drug usage were frequently reported by all the respondents which ultimately helped them to take the decision of giving up drug using behavior. Three sub-categories comprised this category namely extreme repentance, losses and striking event.

3.1.5.1 Repentance. Almost all the respondents (8/9) were found to have extreme feelings of guilt for the undesirable activities they have done during drug using period. Few of them also reported to believe this guilt feeling as a vital component to natural recovery from drug.

3.1.5.2 Losses. Almost all the respondents (8/9) were observed to evaluate the negative consequences of their drug using behaviors. They were seen to consider those negative outcomes as vital issues while taking decision to cease their drug forever such as

disobeying and violating civic rules, lack of sincerity in work, wastage of time and energy, failure to be established in society, not giving proper guidance to the children, getting discriminatory behavior from others, being mistrusted by others, having impaired judgment, negative impact on sister's marriage and on family, wastage of huge money for drug and taking vast amount of loan, unable to spend money for productive and recreational activity, failure to continue higher education, failure to get standard job, having no significant achievement in life, poor physical condition, incapacity for taking care of family, demolished self image, controversial self identity, failure to do business and having great loss, diminished interest in creative work, being avoided and misbehaved by others, being hated and ignored by family members, diminished self honor to the dust, destroying inherited property, having extreme guilt feeling as sister was being tortured by in-laws family because of brother's drug issue, being forced to leave home and almost boycott, tricking and cheating others, stealing valuable items from family and thus loosing trust, doing various unethical activities which even cannot be uttered, having physical difficulty and negative impact on sexuality, physical illness, diminished status of the family in society, having wild emotion, impaired concentration and memory, and failure to achieve powerful position.

3.1.5.3 Striking event. Some unforgettable incidents or events were shared by many respondents (5/9) during in-depth interview which played a crucial role for their present recovering condition. These incidents were found to have strong and direct association with their high level of remorse as they were bewitched by drug at that time while they did not have any ethical sense i.e., sense of right or wrong. The following quotation has described such an event where extreme guilt feeling is conspicuous.

"I'm telling you one such incident now. One day I saw a sick guy lying on the street. Then I was thinking that it's possible to earn money with help of him. What I did, I hit on his head while it was bleeding……..I took him to doctor and bandage was done. Then I threatened him not to talk anymore and assured him to manage money for his treatment. I took him to several shops and houses and collected almost 25,000 tk showing him. I promised earlier to give him all the money but I gave him only 500 tk while I drove him away beating him. Now I have to repent how I tricked with a sick man."

3.1.6 Matured out.

Few respondents (3/9) were observed to reach in matured level in terms of drug intake which made them feel tired of taking drug and inspired them to be naturally recovered.

"Now I feel disgusted about these (all kinds of drugs)."

The above statement of one respondent clearly indicated his level of matured out when he had been taking drugs for 30 years of his life.

3.2 Strategies in Natural Recovery Course

By definition, course or process means a series of actions or steps taken in order to achieve a particular end. Similar to this definition, natural recovery course can be outlined in this research as a cluster of actions or steps taken in order to remain complete abstinent from drug and maintain that condition.

The respondents reported several techniques and procedures which they used on their own to control their drug using behavior immediately and also to prevent the re-intake of drug. All the methods were revealed to describe how they had become and remained abstinent from drug even without any professional support. These techniques

and procedures were seen to be worked out in two levels; during the immediate phase of drug cessation and also in the subsequent time period.

The preliminary stage for drug cessation, where the prime target was to washout the remnant of drug from the body, is considered as very critical period. This is because during this first step of drug cessation procedures, the person remains highly vulnerable being bounded by his/her withdrawal symptoms and intense craving feeling. Successful accomplishment of this crucial phase greatly influences the continuation of their abstinent life. This means, whether any dependent individual will be recovered or not, is mostly depended upon the successful dealing with their physiological and psychological intense difficulties caused by the drug.

The respondents reported that they used several techniques or followed some principles to end their drug consumption forever. They used specific techniques as a first effort to fight with drug, to deal with withdrawal symptoms as well as the associated intense craving feeling for drugs and some other techniques were used afterwards to prevent re-intake of drug, i.e. relapse. Seven sub-categories were compiled under this broader section ‘strategies in natural recovery course’.

3.2.1 Self managed withdrawal.

To remain abstinent from bewitched condition of drugs, at the first step an individual needs to manage his/her physiological difficulties resulting from stopping drug use i.e., withdrawal symptoms. This is one of the most important issues in a drug user’s life because the painful experience of withdrawal usually hinders many people to recover. Self managed withdrawal indicates the management of physiological symptoms caused by stopping drug without any medical intervention or any other professional supports rather on one’s own.

As the respondents of this research did not seek formal treatment, they were found to allow their body detoxified naturally and manage the withdrawal symptoms on their own. The following quotation from one respondent clearly depicts extreme attempt and strong determination to overcome his withdrawal period.

"I gave a lock-key to my mother and told her 'mother, lock me from outside. I will stay inside the room. Don't unlock me before 3 days at least; no matter how loud I shout or how hard I jump. If I die, I'll die inside. You can supply me food through the window if you want; if you don't want, no problem. But strongly remember don't unlock me unless 3 days have passed' " [naturally recovered for 7 years having past H/O heroin use as a main choice of drug]

Most of the respondents (6/9) mentioned about taking long and excessive showers and body message as their main way to manage their withdrawal. They did it to lessen their acute body pain. Some of them took salt based oral dehydration solution for their diarrhea. Some of them were found to be involved into physical exercises and religious activities. All of them were also found to employ some cognitive exercises such as "pros and cons analysis" regarding drug usage, and to "distract" attention from drug related thought to another thing e.g. watching television etc. During acute body ache of withdrawal period, keeping faith in God and strong determination of not going outside for drug collection were found to be common among all respondents.

3.2.2 Gradual goal approximation.

All the respondents (9/9) were observed to curtail their amount of drug in a gradual manner to reach complete cessation. They emphasized this procedure as most significant technique while mentioned that it would be almost impossible for anybody to stop drug with a sudden notice due to unbearable painful experience of withdrawal symptoms.

Rather, they found it wise and also feasible to reduce drug bit by bit to stop completely at the final end. The following statement from one respondent exposed gradual process to achieve his ultimate goal of drug cessation.

"It's best to reduce drug gradually. I've seen that I can't stand when I go for sudden stop…….So, I quit gradually. Every time I thought - I'm going to take this full ampoule; ok, then I'll reduce 2 point. I'll again reduce 2 point at the evening. Thus, I'll gradually reduce the point marked in the syringe."

Other than the slow reduction of drug's amount, different styles were seen among the respondents for gradual reduction of drug such as increasing the interval gap between drug intake, gradually switching to substitute drug (e.g. from heroin to cannabis), halving one single dose etc.

3.2.3 Drastic attempt.

One naturally recovered individual was found to believe in radical changes of their drug using behavior. Taking any drastic attempt or sudden action to control their drug problem was observed which was reported to be considered as their self invented strategy. Their drastic effort was seen to be guided by strong determination which was expressed in a dramatic way as revealed in the following statement.

"….oh my God! Serious! That's (drug materials) most important. That's more important than own asset. This is the best treatment for any drug user I think – if he is a phensydil user, let him buy 10 bottles of phensydil and let him break– he'll break all those very forcefully in front of his own eyes – to increase the strength of mind, strength, strength"

3.2.4 Personalized craving management.

Craving is the strong powerful desire for drug during the abstinent period which is considered as most alarming issue for the recovery because the successful attempt to cease drug and subsequent maintenance greatly depends on one's capability to control his/her intense urge for drug intake. It is for craving; individuals usually are being bound to re-intake drug and become unable to maintain their recovery journey. Maintaining drug free life largely depends on the skillful management of craving and craving related behaviors.

Among the respondents, dealing with craving was observed as the most important concern which they tried in their personalized way. Although it was seen to be emphasized at the preliminary stage of drug cessation as the respondents remained more vulnerable at their early stage of abstinent life, craving had been addressed throughout their life span to fight with relapse.

3.2.4.1 Supplementary drug use. Using substitute drug was found as another technique to manage craving which the respondents used in their personalized way. Switching from their main choice of drug to the substitute drug was present in most of the respondents (6/9) as their preferred style to manage the craving.

"....when they'd gossip sitting together, they'd inject (Buprenorphine), I also felt high craving observing those; my mind provoked me to inject a bit just for once. That time what I used to do – I just smoked cannabis cigarette.....with this support I tried to control myself."

Above quotation clearly indicated that using substitute drug played important role to fight with craving for the main choice of drug at the early stage of natural recovery course.

This method was seen connected with gradual goal approximation where the individual was reducing the strength of drug on his body by gradually switching from his main choice of drug to the substitute one.

3.2.4.2 Alternative involvement. It was observed that during intense urge for drug intake, there was a trend among the respondents (7/9) to become involved into another type of task which was not associated with drug. Two level of alternative engagement were found in them – in their thought level and behavior level. It was seen that they shifted their attention from drug related thought to another neutral things as well as they made themselves involved into any kind of pleasurable or neutral activities as indicated in the following statement.

"That time (during craving) I was just thinking of my garden--the pot for this plant should be changed; I pulled out weed for the new one; the Kamini is coming into bud, so I gave more soil at its root."

Most of the respondents were found to be habituated to change their drug related thought doing some alternative activities which could be positive or neutral. They greatly emphasized on the importance of this technique reporting that it could be very risky for them if they would continue the drug related thought leading ultimate relapse while it was very helpful to make them engaged in any kind of activity.

3.2.4.3 Thought substitution. This technique was actually the cognitive part of alternative involvement mentioned above. Almost all the respondents (7/9) reported that they used to replace socially accepted thoughts instead of drug related thought during the intense urge for drug re-intake.

The following quotation is indicating one respondent's effort to substitute his drug provoking thought.

"When my urge for drug would take place, that time I tried to import some new thoughts in my brain, e.g. any character in a novel. Umm..this character has been presented here in this way; why such? This could be done in that way also. Then I used to think about my books, etc etc….my previous life style."

3.2.5 Paradoxical intention.

An interesting cognitive pattern was identified being termed as paradoxical intention. It is a process whereby the patient is encouraged to do the things s/he faces trouble or to wish for them to happen. Almost half of the respondents of present research (4/9) made them think that they would take drug after a certain period of time. This was contradictory in terms of their strong willpower of forever abstinence as their firm desire was clearly expressed through verbal and non-verbal communication. This paradoxical strategy was observed to be employed in two ways. Firstly, for the respondents having short abstinent period, it was an effective way to refuse or manage their unavoidable peer pressure. Secondly, for the respondents having comparatively long abstinent period with lacking of self control, it was a winning technique to negotiate with their craving heart. The following statement was singled out from such a discussion with a respondent having short abstinent period.

"I'm fasting now; I'll take (drug intake) when I become 55 years (age)."

This respondent had been trying to negotiate with his craving in temporary manner so that he could be able to achieve ultimate sobriety as illustrated in the following quotation.

"……possibly I'm thinking in this manner just to stay away from drug. I'm soothing my mind by saying that I'll certainly take drug but it's better to wait for few years. But I believe…55 years is too long. After that it won't be possible for me to take drug again. I'll have to learn it completely in a new style."

3.2.6 Avoidance of high risk situations.

It was observed among all respondents (9/9) that they adopted avoidance as a crucial technique to manage their drug problem. This avoidance was seen in two phases; during the first stage of drug cessation when they left their current living place and during the subsequent abstinent period when they tried best to prevent the exposure of certain things associated with drug.

The existing living place or residential area is a common general barrier for any drug user to give up drug because the individual gets strong association with the drug using network at that place. The drug using peer group, availability of drug, specific place for drug usage and several other factors powerfully prevent one to stop drug using behaviors. So, changing the existing setting is a general idea among people to control drug problem.

To be away from the drug using network by temporary leaving their present environment was seen among the respondents as another important course of action at the initial phase of natural recovery process. Some of the respondents were observed to leave their present scenario having two purposes; firstly, the involvement was in religious preaching as revealed in the following statement.

"When my elder brother was asking me to go for Tablig, then I just thought - ok, I can attend Bisshoy Ejtema. That was December, 2002; Bisshoy Ejtema was near. So, I went there. The existing environment and the theme concept of Islam attracted me there.

Then I went for one Chilla (preaching Islam) for 40 days…….from there another Chilla-40 days. I went for 3 times; total 120 days i.e. 4 months. So, it was a long time."

Secondly, traveling outside was expressed in the following statement.

"I've quit drug through traveling…traveling many place; e.g. today I'm in Dhaka, tomorrow in Khulna, next day in Rajshahi, like this moving..moving..moving..moving"

Some above mentioned factors which can powerfully barricade one to stop drug using behaviors can also be experienced as high risk situations for any recovering individual. Usually relapse occurs in this type of situations where the recovering individual remains very vulnerable to drug i.e. in high risk for drug re-intake having low coping skill. Avoiding some selective situations, factors or issues is required for any recovering individual to consider as their regular behavioral practice.

This avoiding pattern was seen among all (9/9) the respondents. They tended to avoid the specific vulnerable situations for them as well as the associated triggers for drug. They were found to avoid specific social party, current as well as occasional drug users, specific drug related places, conflicting situations etc. The purpose of this avoidance was to check or prevent their craving to be raised. Thus, they tried to sustain their forever abstinence by preventing relapse.

This technique was also seen to be used as craving management at initial phase, but it was greatly expressed as relapse prevention technique in subsequent abstinent period.

3.2.7 Self monitoring.

Keeping constant observation on self activity was found as an important strategy among the respondents. Regarding drug abuse, this is closely related with relapse because a recovering individual's every attempt focused on checking his/her re-intake of drug in a

similarly previous pattern. This technique was found to be focused on the permanent stability of their abstinent life or overall sobriety. They were observed to monitor them in two levels; in an overt as well as covert manner.

Almost all the respondents reported that they used to keep an eye on specific craving time, escalating anger, conflicting situations, vulnerability to involve in high risk situations, so that they could avoid or manage them in other ways.

Self monitoring in covert level was found to be working through mental process. Mental process for appraising the advantages and disadvantages of drug intake was noticed through which the respondents could manage their craving. This mental process was explored and found as a form of thought and visual image for their past drug using life. Almost all respondents were found to use this technique when they faced any high risk situation or in front of any trigger. In the following quotation, one respondent had expressed the internal process of his self monitoring while his intense pain feeling was also in-built:

"…. That time (during craving) I used to evaluate my past 10 years. 10 years of my life has been destroyed very badly. People neglected me, people hated me; even I had been denied with my blood relationship. I was kicked out from my home and had to stay in hotel…..I did those all nasty things which one addict can do. I evaluate all these I did. I think about the days I passed dominated by drug! So, I'm determined, I won't enter in that life again."

They also claimed this technique as the cardinal/fundamental process for sustenance of their abstinent life.

3.2.7.1 Internalized oath. Internal utterance for swear words in terms of drug refusal was found in a daily manner for one respondent as a strategy to sustain his abstinence journey. This strategy was observed to be associated with his personal willpower. He took this technique followed by self monitoring to regulate his behavior. The following statement expressed taking internal oath of that respondent.

"Every morning after waking up from sleep, first of all I swear to myself that I won't take drug by all means. Every morning I do this……"

3.2.7.2 Self imposed life style. Drug dependence leads an individual to maladaptive lifestyle which itself plays role as a maintaining factor for one's drug problem. That is why, as soon as a recovering individual stops drug, he sets the target to modify his way of living and struggles much to put him in place of his previous accepted life pattern.

A structured and regulated lifestyle following the disciplinary principles and the rules and regulations of social norm was observed to be governed by their own (7/9).

One respondent stated his mandatory self initiated life style in the following quotation.

"I followed strict discipline for 2/2.5 years; e.g. waking up from bed at 6 am, praying the morning prayer, then going to play football, after returning having limited breakfast, then going outside for my business work, returning home by evening etc."

3.3 Prolonging Factors for Sustenance of Natural Recovery

The third broader section of the findings was the prolonging factors for sustenance of natural recovery. Several factors were explored which were observed to play a significant role to make the respondent's abstinent period longer. Some factors were noticed as

psychological and some were social factors. This broader section was comprised of seven categories.

3.3.1 Adaptive cognitive structure.

Some prominent cognitive structures were observed among respondents which can lead to adaptation. Regarding relapse prevention, this cognitive style was observed in the transcripts of the respondents to be functioning and to process constructively the abstinence violation effect and thus to prevent their relapse. Specific types of thought and explanation, interpretation pattern, different style of orientation and perception etc was discovered among the respondents regarding drug issue.

Five sub-categories had been emerged under this category to represent adaptive cognitive structure.

3.3.1.1 Normalization. It was observed that most of the respondents (7/9) had accepted easily the drug taking period as a part of their life. They were seen to have the attitude of accepting their previous drug using behavior as part of their life instead of denying it or having the intention to forget it. The following quotation was stated by one respondent having long duration (12 years) of abstinence which is indicative of his normalizing attitude for his past drug using life.

"My full alcoholic life exists in my memory……but it won't respond if you click it….it has not been deleted yet. It has been placed in Spam, Yes. But it won't be activated anymore. It isn't deleted; it exists, in the Spam folder. If you want to see, then it may be revealed by clicking on the past life. But it has no influence, no activation in my present life."

Their thinking and perceiving pattern seemed to be constructive leading them to functioning life when they were observed to use the terms ‘well decorated life’, ‘heaven’, ‘as it is normal life’, ‘relax life’ to represent/denote their present abstinent life instead of using the term ‘recovery’. It was noticeable that none of them was thinking themselves as ‘recovery’. They were observed not to impose many restrictions onto their ‘selves’ in the name of relapse prevention groundwork although they were found to have the consideration so that they should not fail to be in track.

3.3.1.2 Non-stigmatized attitude towards self. Most of the respondents (7/9) were found to possess non-judgmental attitude towards them. During the preparation phase of interview and also in the in-depth interview, their verbal and non-verbal attitude was observed as having no discriminating label for them which was again confirmed in the verbatim. The following statement highlights the same expression.

“……I had an infection in my body. It was cut, then sewed and recovered. Now I still have the mark but no infection is there, I’ve no abscess in that place. Is there a mark? So what? Let it go. What is the problem for me? I’ve no infection there.”

They were found to use the word ‘well decorated life’ to represent their current abstinent period while they were observed not to use any kind of word which can discriminate them with the main stream of population.

3.3.1.3 Internal attribution. One important cognitive pattern was discovered that the respondents (5/9) had attributed their drug taking behavior onto their own responsibility. In case of relapse, it is very essential whether the individual focuses on external issues as causal factor for drug re-intake or takes own responsibility. Through this style of attributing, the respondents were observed to check their re-intake of drug withdrawing liability from their biological or any other environmental issues. The respondents were

observed to have the tendency of interpreting any issue based on logic or reason. The following statement clearly indicates the shift of attention from external issues to inner liability of the individual.

"……e.g. I'm drinking, alcohol is going inside; taking phensydil, there's some medicine in that; smoking cannabis, one kind of nicotine is there. All these chemicals are mixing with my blood. When these chemical mixtures washed away, my blood has been refined again, then that blood doesn't push me saying 'take this drug', 'do this'…that blood would not provoke me to use drug."

3.3.1.4 Problem focused orientation. Few respondents (3/9) were observed to have problem focused orientation. It was seen as their overall principle of all strategies they followed to fight with drug. Their main intention was explored to have the effort for solution-oriented task to resolve the drug problem. The following statement is clearly indicating the attitude towards resolving any problem.

"…I have to go that place from here. Ok, I'll go, tomorrow…the next day…but I'm not going actually. That will not work. I must go and how will I go? I've to decide the mode of transportation accordingly. Will I go by bus, or on foot, or cycle, or rickshaw?…anyhow I've to reach there; I need to have strong determination and that's the main point."

This cognitive pattern was also observed having close linked with strong motivation.

3.3.1.5 High self esteem. Almost all the respondents (8/9) were observed having value for their 'self'. Their acceptance level towards them was high as seen in the

transcript of the verbatim. Their self respect was observed to be expressed through the healthy self concept and non-stigmatized attitude towards their self

They were found to embrace their present positive impression about them. They were seen to enjoy their abstinent life while they know their strengths and limitations also. In the following quotation of one respondent, enjoyment has been expressed along with his positive self concept.

"……as if I was a day laborer earlier and now I am flying aero plane."

They were found to have an idea about themselves as perfect man, exceptional person to be able to fight with the hard drug, capable of doing any task, independent, having more self control etc. Another respondent used metaphor to make understandable about his self. He compared him with a flower to indicate his innocence.

Their level of self confidence was observed to play a significant role on the sustenance of their abstinent period. They were found to have self control to prevent re-intake of drug which had increased their self reliance of preventing any lapsing situation or relapse. Their self reliance was seen to develop gradually after conquering some high risk situations. The following statement has indicated the strength of self confidence of one respondent.

"If the situation may happen like that I'm dwelling in the midst of drug, still it is not possible for me to re-intake drug."

High self confidence was also found to play a significant role as an encouraging factor where the respondents were observed to think that they did not need to be treated professionally.

3.3.2 Family and social support.

It was found that almost all the respondents (8/9) had cooperation and support from their family as well as their relatives and friends. They were seen to get inspiration and sometimes direct assistance from them. This factor was also reported to play a role as encouraging factor to natural recovery for few respondents.

3.3.3 Global outcome of drug cessation.

It was observed that when the respondents became drug free, there was an effect in their entire life pattern which itself played an important role to increase duration of their abstinent period. This effect was seen in their changed behavior pattern, emotional regulation, interpersonal relationship, and their sense of responsibility.

Radical changes in behavior pattern were observed among most of the respondents (7/9) which led them from malfunctioning to functioning level of overt and covert behavior. A simple statement from one respondent reflected this point.

"I took drug before. Now I'm not taking it, the life style is completely changed."

These behavioral changes was noticed through the alteration and modification of their drug using behavior, impulsive behavior, self injurious behavior, aggressive outburst, non-productive behavior to more productive behavior, religious activity and behavior guided by stable mood. The following statement also reflected this notion.

"Behavior is totally changed. At that time the situation was like, I badly need money for drug, nothing else. Anyhow I've to collect it, either selling blood or any other way. My conduct was very rude. I had irritable behavior, quarreled frequently and shouted etc. But now completely opposite…."

It was also found that emotional reaction was changed among the respondents which were reflected in their verbatim. Almost all of them (7/9) reported that during drug using period their affect used to regulate in such a way which was expressed in anger, impulsivity, irritability, demanding, low frustration tolerance, anhedonia in any productive task etc. But in their present abstinent period they were observed having changed emotional regulation when they had certain level of frustration tolerance, comparative absence of anger, patience, stable emotion, perseverance etc. They were also found to have the realization that their negative emotional reactions could be a strong threat for their present abstinent period which has been reflected in one of the respondent's following statement.

"……if you've irritability, you can't proceed. If you've irritable mood, you'll show angry behavior to me here, again you'll express your temper with anyone else. In this way, you'll be carrying the chance for relapse. "

They mentioned that their interpersonal relationship was disrupted during their drug using period, where lack of contact with family members, communication gap, mistrust and misunderstanding, quarreling, withdrawal of caring attitude and denial of relationship by family members, separation from family was present. In this aspect, it was also observed that during abstinent period, their interpersonal relationship had improved a lot in every sphere. In terms of their relationship, they mentioned about good understanding, respect and caring intention for each other, cooperation and helping attitude, getting trust and positive evaluation from others, increased rate of contact with family members and relatives, and happiness with proud feeling among family members.

It was also reported by them that they had much lacking in their sense of responsibility during their drug using period as they were preoccupied and busy with drug

related behaviors all the time. But they were found as responsible persons in their present abstinent life. They were observed accountable not only to their family but also to the society. During their self evaluation in the in-depth interview, it was also observed that they believe in having the sense of responsibility as their basic characteristics what was washed off by drug. The following quotation has also indicated the recovered good qualities which got buried under drug taking behavior.

"…..these good qualities were always in-built with me…..I was a good person….but I didn't apply those, that's why…..drug had established all of my illogical and irrational things; minimized my logical, responsible sense, and maximized my bad qualities a lot. I went through the hell."

3.3.4 Life style change.

During the phase of initial level management, it was seen among the respondents that they were following a self governed regulated lifestyle reflecting the rules and regulations of social norm to replace their previous accepted life pattern. All of them were observed to continue this healthy way of living which was playing a vital role on their sustenance of abstinent life. But they reported that rigidly strict discipline was not maintained afterwards as like beginning part of abstinent because of their growing confidence in self control for drug re-intake. Although they were seen to be comparatively flexible in this regard, yet they complied with the healthy practice of life style. They were found to have the belief that this adaptive life style was very helpful for them to sustain their present status of abstinence which must be continuous. The following statement also indicated this notion.

"…..whole life will have to be guided by discipline."

3.3.4.1 Spiritual activity. Strong faith in 'Higher Power' and engagement in religious activities were frequently found as important strategies among almost all the respondents (7/8). Religious performance was observed to help them in two ways; to strengthen their personal motivation by complying with their religious values (e.g. 87.5% respondents were Muslim and drug is strictly prohibited in Islam) and to distract them from drug related thought or behavior.

This technique could be merged into distraction as it was also behavioral occupation to be distracted from drug. But this had been categorized separately because it was highly emphasized and highlighted frequently by almost all them.

3.3.4.2 Healthy addiction. Most of the respondents (5/9) were observed to be involved in non-drug related activity as an alternative option. They were seen to fall in deep love with somebody, to be devoted in the freedom fight in 1971, to be engaged in recreational activity such as gardening, photography, to be involved in gossiping, meditation, traveling, fully engaged in any kind of activity even without payment. They were found to have their focus on the above mentioned area to divert their attention on drug and hence, sustain their abstinent period.

3.3.5 Need for quality life.

All the respondents (9/9) were found to have thirst for social status or position, approval from society, and social wellbeing for which they could nurture their motivation for not taking drug anymore and had been able to sustain their abstinent life accordingly. The following quotation has revealed this connotation.

"I am continuing this drug free life only to hold my status, my position."

Few respondents also reported that this factor played important role to push them to be natural recovery.

3.3.6 Driving spirit.

Some factors were found to have kindling effect on the respondents which directed their abstinent period to be strengthened enough in a continuous manner. Having the feeling of being 'hero', receiving positive support for drug cessation, having the feeling of conquering such a notorious drug and related proud feeling were seen to play their role distinctively on their maintenance period. Although all the above mentioned prolonging factors were helpful for them, but these four factors were seen to act as strong inspiration to make them continuously drug free.

3.3.6.1 Becoming the hero. Among the nine, eight respondents of present research expressed that they were appraised by others as 'Role Model' in this sense that they were able to complete cessation of their drug taking behavior without any professional aid. In this regard their intention was observed that controlling drug without formal treatment was just like a rare performance as the saying 'once an addict always an addict' is deep rooted believe in the heart of society while the success rate of treatment center is also very poor. Based on such a frustrating context having poor outcome even with professional treatment, the respondents of present research were found to think of them as exception figure. The following quotation of one respondent (having 7 years of abstinent life) is also revealing this self perception.

"Isn't it like that they (currently admitted clients of drug treatment center) have the scope to learn from me? Because I'm a significant example among the people, okay? I can understand why they (authority of a specific drug treatment center) call me because I am a role model. Their message is like that 'you (re-admitted clients) are in the midst of

treatment center, you can't stop drug even receiving treatment; but look at him, and he is well enough even without treatment. He is a real proof who is standing in front of you.' For this reason only I'm being invited here and there or they evaluate me very highly."

Another respondent's statement is also bearing the same idea while his gesture and posture was also observed during interview supporting his verbal content.

".....it seems to me that I am a great conqueror....learn from me how it can be achieved……."

The respondents were also observed to have the self-importance that they were successfully able to overcome the bewitched condition of drug. The following quotation of one respondent (male, having 08 years of abstinence) has revealed clear overpowering sense in this regard.

"I think that I'm mentally a great hero/conqueror. I've accomplished such a great things….umm….I've saved my soul, my life; I've protected myself getting out of rid from it (drug) and have been passing my present days with sobriety. That's why I believe that I'm a great hero/conqueror."

They were seen to feel proud for this. This feeling itself was observed to regulate the practice for not taking drug again. The following quotation has revealed such emotion for one respondent (male, having 07 years of abstinence).

"I feel very proud that I've been cured without any treatment. This means…when other people see me, they become so surprised to know it 'he has been able to do this but I (current drug user) can't do yet. They just gaze at me."

3.3.6.2 Being reinforced. The well known reinforcement theory was also found applicable on the naturally recovered individuals of the present research. They (6/9) were seen to get positive feedback of quitting their drug using behavior which was ultimately strengthening their motivation and sustaining the abstinent period. The source of positive feedback was their improved physical condition, interpersonal relationship, and evaluation of respective community. The following quotation has revealed getting positive feedback from improved physical health.

"While I was taking drug, my physical health and appearance was just like a skeleton. But now my appearance has been improved a lot. Even they (current drug users) often regret for them seeing me."

Another respondent's statement has revealed getting inspiration from his social acceptance.

"I have regained my lost value and respect in my society which I had previously. It seems to me as if I've got back all the things which I lost by this time."

The respondents were also found to be encouraged when they noticed to get direct positive outcome for their drug cessation which has also been described in section-A (Encouraging factors to natural recovery).

3.3.7 Psychological growth.

The natural recovery individuals of the present research (4/9) were observed to grow psychologically after cessation of their drug taking behavior, in terms of enhancing their self esteem and self confidence as well as acquiring specific skills or qualities which they did not possess in their pre-morbid drug life. The following statement is indicating this notion in a sense.

".....any kind of bad deed… I've quit drug, I've overpowered it. But still now, if I do any ill act or tell a lie then I feel very guilty and think myself as stupid that why did I need to tell the lie!"

3.4 Challenges of Natural Recovery Progression

Some challenges were also reported during the ongoing natural recovery course and afterwards, i.e. throughout their abstinent life. That means the recovering individuals had to face some barriers or obstacles for which they needed to struggle hard to continue their drug free life. They reported that they had some issues or to deal with certain situations in which there was always the possibility either to relapse or to sustain their abstinence journey. Successful accomplishment of these challenges greatly depended on whether they had self control on their lapsing situations, whether they could be able to cope with mistrust getting from their family and society, whether they had the capability to scan their behaviors in a continuous but technical manner, whether they were able to carry on the structured and disciplined life style essential for the sustenance of their recovery life, whether they had the trend to have the impact of abstinence violation effect and whether they had appropriate learning to use some strategy to remain themselves drug free when they could not but face some high risk situations.

Six main challenges were expressed by the respondents for which they were seen to struggle constantly.

3.4.1 Control on lapse.

Re-intake of single dose of drug, i.e., lapse is very crucial phenomenon in a recovery individual's life journey because it can be the starting point for any relapse episode.

The respondents were found to have self control on their lapsing situations and rarely lapsing. That means, they were not guided by impulsive action regarding sudden intake of single dose of either the main choice of drug or the supplementary one, rather they were in charge of his lapsing situation and thus had the power over his relapse.

They were found to be aware of what they were going to do. Even if they took single dose, they did not continue this behavior later to welcome their relapse episode. One respondent exposed his self control in the following quotation when he was in a high risk situation surrounded by his drug using peer which could be considered as great challenge for any recovery.

"…..what I did (taking one stick cannabis), I was aware of that, in front of toilet of the train. There's much space in front of the toilet. They (past drug using friends) were returning after seeing a concert. I was there…..I did this being aware of."

3.4.2 Mistrust.

Being mistrusted by others was found to be another continuous challenge for the naturally recovered individuals. They were mistrusted not only by society but also by their own family as illustrated in the following quotation.

"*Father is suspicious of me. Father is mistrustful because he thinks like; the son will be cured if he stays in Dhaka. If the son comes at home, there will be problem again*."

Some behaviors were also reported by them to be the source of being mistrusted such as drowsy feeling which might be associated with their past behavior during drug using period.

3.4.3 Adequate self monitoring.

The respondents were found to face challenge when they applied the strategy 'self monitoring' as their relapse prevention method. It was challenging for them because they had to monitor their behaviors in a continuous manner but at the same time without making them pressurized or being labeled.

3.4.4 Adjustment with new life style.

The respondents were found to practice adaptive life style which was very structured and disciplined in nature. This aspect had been classified as prolonging factor as it was seen to play significant role to sustain their recovery journey. Using metaphor, the following statement was expressed which indicates how difficult this respondent had felt to follow the structured life.

"Suppose, you eat rice every day. If suddenly bread is supplied instead, for few days you'll face great trouble."

3.4.5 Abstinence violation effect.

The respondents were found to have no impact for abstinence violation in their recovery journey. This phenomenon is very significant in any recovery life as it is directly linked to relapse. Usually relapse occurs due to the impact of abstinence violation effect where the continuous abstinence rule is violated. When a single lapsing incident breaks the rule to be complete abstinent, several episodes of drug intake are then followed by the influential thought that the individual has no control on drug. This effect ultimately leads a recovery to fall into relapse. But interestingly this abstinence violation effect was observed to be absent among the respondents of this research. As mentioned earlier that they were found to have control on their lapse, in that case it was implied that they had no

detrimental effect of abstinence violation for drug re-intake even in mere single dose. It can be assumed that perhaps for this reason all the respondents (8/8) had no history of relapse episode.

3.4.6 Unavoidable exposure to high risk situations.

The respondents were found to face a challenge when they were bound to be exposed with some of their high risk situations. As mentioned in the technique 'avoidance of high risk situations' under the behavioral strategy, they tried to avoid some subjects but there were also some other issues which were very difficult to stay away from. For example, two respondents were found to work directly with the current drug users which they reported as their great challenge because drug had been frequently associated for them.

"Yes, I am working with these (current drug users) peoples; this is my challenge. It is my challenge that I'll work with drug users but do what you like, I won't go there. I won't do that (drug intake)"

From the above statement, it was revealed that avoiding high risk situations was almost impossible for this respondent and at the same time his strong motivation of not taking drugs had been expressed.

CHAPTER 4

DISCUSSION

Discussion

Data from the first exploratory study in Bangladesh on natural recovery from critical alcohol and illicit drug consumption are presented in this research report. Three broad sections took shape from the verbatim of this qualitative investigation incorporating twenty categories associated with natural recovery process. These were encouraging factors to natural recovery, strategies in natural recovery course, and prolonging factors for sustenance of natural recovery. Among all the categories some are psychological while some others are social factors. Many categories again incorporated different sub-categories. Six challenges were also identified in this natural recovery progression. A detailed discussion of all these factors is presented in the following sections.

4.1 Encouraging Factors to Natural Recovery

Several factors were highlighted in this research as the source of inspiration for natural recoveries to overcome their addictive behaviors on their own. These factors did not act for inspiration in a sequential manner; rather they were mostly overlapping. That means, multiple factors work together for a person to be naturally recovered rather than a single factor playing its role. For example, some people gave up alcohol or drugs when they left their present dwelling place which was risky for drug intake and at the same time a new dimension was added in their life such as creating intimate relationship with somebody. It is not possible to conclude that which factor came after which factor to act as a motivating spirit for the respondents to win in the battle of quitting drug.

Intrinsic motivation: It is empirically well supported that strong motivation is essential to fight with drug and to overcome it. But the strength as well as the impact of motivation greatly depends on whether the commitment is imposed by the individual's own self, or by external factors such as family, society, and rehabilitation centers. In case

of self recovered persons, the motivation was originated exclusively from internal commitment of themselves. At this stage, the persons usually take the responsibility of own actions which guides them to keep control on their behavior and to improvise if necessary. The respondents of present research themselves made the decision to say 'good bye' to alcohol or drugs. Their inner strength to regain control over their lives was the prime way to make them able to recover from their drug problem without formal treatment.

In our society, there are numerous triggering factors contributing to relapse for an ex-user and it is almost impossible to control all the stimuli in the environment to prevent relapse. In case of triggering situations it is very common for the recovered individual to intake the drug again. However, individuals with intrinsic motivation would be able to maintain self control and refrain from taking drug again. Thus intrinsic motivation among naturally recovered individual serves as a cardinal determinant to initiate and maintenance of natural recovery process.

The self resolution process of alcohol problems as a process of investing and re-investing in self was explored in a study where it was found that self resolvers tend to independently change for their own benefit rather than the benefit of others (Finfgeld, 1999). In the first study in Switzerland on spontaneous remission from substance abuse, Klingemann (1991) analyzed that when individuals feel the stress of an addiction that life has become burdensome; this feeling is transformed into a serious motivation to change. Even professional treatment is either strongly rejected or considered irrelevant for their own treatment needs.

Inaccessibility to formal treatment: The respondents demonstrated that they did not have easy access to formal treatment due to their fear of being labeled as 'drug addict'

(used in a local slang, 'heroin-chi', 'dal khor' etc), financial constraint of their family, having lots of negative idea about drug rehabilitation centers, and for few respondents treatment center was unavailable.

It is mostly viewed that the treated individuals are being labeled as an addict when they admit into professional treatment centers or join in a traditional self help group. The detrimental impact of this 'addict identity' is huge when associated with stigma in an abstainer's life. The traditional belief about addict identity generally diminishes the individuals' self confidence and the spirit through which they are supposed to overcome their problems. In an exploratory survey on spontaneous remission (i.e., natural recovery), Tuchfeld (1981) revealed that the problem drinkers resisted being labeled 'alcoholic' and did not seek formal treatment. In another study the younger subjects reported that the stigma of being labeled 'alcoholic' was a barrier for them to seek formal treatment (L. C. Sobell et al., 1993). In Patrick Biernacki's highly respected study on recovery from heroin addiction without treatment, 14% among the 101 participants thought that they would be stigmatized when they were asked why they did not use formal treatment (Biernacki, 1990).

Formal treatment is usually expensive irrespective of private or public setting although public setting is comparatively cheap. As Bangladesh is a developing country and per capita income is low, many people cannot access formal treatment due to their financial constraint. Financial hardship was linked with care for family as the respondents showed considerate attitude by not giving financial burden to their family for the treatment cost. Concern for family is a great source of encouragement for the respondents to take the challenge to quit drug on their own.

Another reason for which formal treatment was prevented in the psyche of most of the respondents was the negative conception regarding drug rehabilitation centers. Negative conceptions altogether discouraged the respondents to seek formal treatment and pushed them to choose the option for self resolution. This was also supported by the findings of the survey (Tuchfeld, 1981) where the respondents were found having negative attitudes toward institutional forms of intervention. 9% participants in Biernacki study were found to have a negative image of treatment programs while 19% did not believe that treatment would work (Biernacki, 1990).

Unavailability of treatment centers was another reason for inaccessibility to formal treatment when the individuals who were genuinely eager to stop drug, found no other alternative rather than go for self resolution. 10% participants of Biernacki study mentioned that treatment was not available when they were asked for the reason of treatment rejection (Biernacki, 1990).

For all the above mentioned reasons, professional treatment for drug addiction was not easy to access for the respondents of present research. It can be generally understandable that when professional or formal treatments becomes difficult to reach for an individual who had already decided to say ‘good-bye’ to alcohol or drugs, the person would not have any other options other than going though self resolution for their problems.

High self respect: It can be generally understandable that greater respect for own self may prevent a drug user from going down and create inhibition comparatively at an early level for doing amoral activities for drug seeking behaviors. As people with high self respect usually have a particular standard of behaviors, they do not want to cross that limit and go down from it. It was also applicable for the respondents of present research. Their self esteem was also high which was linked with high self respect. Thus, it can be assumed that high self respect can act as an important factor to initiate and also to maintain natural recovery progression.

Care for family: Concern for family members directly enhanced the individuals' willingness to stop drug when they already acknowledge the devastating impact of drug abuse on their life and start thinking the necessity of drug cessation. Caring attitude for family not only pushed them to take initiatives for becoming abstinent but also encouraged them to prevent re-addiction during their abstinent life. In the study conducted on natural recovery from problem drinking, the respondents mentioned about family responsibility (captured as 'care for family' in the present research) as one of the reasons when they were asked why they stopped drinking (Kunitz & Levy, 1994; May, 2001). Jasperse (2006) also found in his study on natural recovery from drinking problems that the study participants took on responsibility for their families and they took care of themselves.

Drug related outcome: The most negative outcome of drug in the respondents' life had been manifested through three concepts such as repentance, losses, and striking events.

The respondents' guilt feeling for their past misconduct was expressed both verbally and non-verbally during interviews. Even few respondents could not disclose some incidents occurred during their drug using period in front of the researcher. Their

emotion was so strong that it was very difficult for them to be exposed even with that mental scenario. It can be assumed that those unexpressed incidents may have been associated with gross violation of human ethics. It may happen that an internal conflict aroused from the mismatch between individuals' basic personal morals or values and the amoral activities they did during their addictive life. This level of emotion may help a drug user to reach 'bottom stage'. It may be possible that their repentance had offered gradual predisposition for them to be activated for drug cessation. Repentance or guilt feeling is associated with drug cessation but it cannot be claimed that it is specifically associated with self recovery.

The strong realization of the respondents came mainly from their guilt feeling and also from the observation regarding ultimate negative consequences of drug abuse. It is more likely that the emerged feelings such as guilt, resentment guided them to feel disgust with drug and finally to stop it. The memory of those incidents contradicted with their present ethical status and acted as a reminder which helped them to maintain their sobriety. The following statement from one respondent clearly emphasized strong bonding between repentance and strong motivation.

"……guilt feeling must have to come. If there's no remorse, then there won't be strong determination to be cured (from drug)."

Repeated losses happened in different important areas of life helped the respondents to do cost-benefit analysis of drug abuse through which they realized the necessity of drug cessation. Several reasons for resolution of problem drinking were discovered in an exploratory survey among which financial losses were highlighted (Tuchfeld, 1981). In another study, naturally recovered individuals from drinking problem reported that

drinking became unrewarding while they were acknowledging their huge amount of losses (Kunitz & Levy, 1994; May, 2001).

Some remarkable incidents (containing negative outcome) happened in the respondents' life which provoked their extreme guilt feeling and made them bound to be regretful. Those striking events ultimately guided them to acknowledge the devastating outcome of drug abuse in a deep manner. It is mainly related to immediate triggering factors for abstinence which were working as like precipitating factors. Extraordinary events were reported by the respondents as one of the reasons for their resolution of problem drinking (Tuchfeld, 1981) but it was not described in details in that report.

Matured out: Getting 'sick and being tired up' from drinking and drug intake is clearly linked with abstinence process as the individuals become saturated with substance usage at this stage. For many individuals, the pleasant or positive expectations on drug gradually reduce within a certain period of time. This phenomenon was first suggested by (Winick, 1962a, 1962b). who explored the process of recovery (Winick, 1964) and concluded that drug users may "mature out" of addiction. The findings of May (May, 2001) also supported Winick's idea when it was found that the tendency of most American Indians' abstaining from problem drinking without help of an alcohol treatment program increases in later years of life. He described this phenomenon of "maturing out" as a hallmark of Indian drinking (May, 1996, 2001). This was also found in Navajo men which indicated the 'maturation' of the process for heavy drinking (Levy & Kunitz, 1974). L. C. Sobell et al. (1993) also examined natural recovery from the perspective of a person's age at the time of his or her recovery to see whether there was an involvement of a maturational process.

4.2 Strategies in Natural Recovery Course

Practicing several methods and techniques during the entire natural recovery course helped the respondents of present research to stop their drug seeking behaviors, give up the consumption of drug, manage the adverse effects of withdrawing drug, and to check their intense urge for re-intake i.e., to prevent relapse. Seven main strategies addressing these issues are discussed in the following.

Self managed withdrawal: It does not require explanation that self managed withdrawal is directly linked with natural recovery. The respondents needed to handle their physiological symptoms on their own which was caused by withdrawing their regular dosage of drug. As they were not admitted into any treatment center, they did not have the opportunity to get medical support through which they could lessen the unpleasant experience of drug withdrawal. Apparently, this is the opening stage of natural recovery process. All the respondents took their first step toward recovery with their voluntary effort. The first step to recovery is perhaps the hardest step to take, especially if the individuals feel no one is there to support them. Facing this difficult situation they started the fight against drug by taking steps to lessen their bodily symptoms on their own.

Gradual goal approximation: The idea and principle of gradual goal approximation is very much similar to the well known behavioral strategy ‘Graded Task’ where an individual plans his/her activity level step by step to achieve something gradually. The main benefit for this graded task method is that the person can be reinforced both in intrinsic or extrinsic way for successful completion of each step and be encouraged to take preparation for the next step. It seems to be feasibly related with self change process. As it is widely believed in our society that giving up drug is quite impossible, in that case gradual goal approximation is the practical scope for a drug user to achieve the status of

natural recovery. Since the natural recoveries did not receive professional medical support, it would be very difficult for them to manage their withdrawal symptoms. As they decreased their dosage bit by bit, the effect of withdrawing drug was not so adverse to be managed when they finally stopped it. So, it is acceptable that it was much better for them to fight with the dominating drug in a gradual manner. Since it was found in the Biernacki study that the participants used to substitute some other non-opiate drugs to resolve their heroin problem without formal support, it is in built that they proceeded gradually in their mission (Biernacki, 1986).

Drastic attempt: Taking a drastic step as a means of saying 'good bye forever' to drugs helped few respondents to achieve drug free life in a dramatic way. This kind of sudden attempt minimized the procrastination to implement the decision of giving up drug and forced the individuals to activate the planning to reach in abstinence stage.

Personalized craving management: Three main techniques such as supplementary drug use, alternative involvement, and thought substitution were used by the respondents to control their intense urge for drug re-intake and to arrest the associated behaviors through which they could prevent relapse. Supplementing less influential drug (e.g. using cannabis) was much helpful for the respondents to meet their bodily demand even to some extent while they were switching from their main choice of drug (e.g. heroin). Handling craving in this way, this technique made it possible for them to stop drug in a gradual manner during the starting phase of self recovery journey. Alternating the craving related thought into a thought unrelated to drug and involving themselves into another area of task facilitated them to manage their craving and thus maintain the self recovery status. It was found that the participants used to substitute some other non-opiate drugs as their first strategy to overcome heroin cravings while they were trying to resolve their drug problem

without the aid of formal treatment (Biernacki, 1986). The most popular substitutes in his study were marijuana, alcohol, and tranquillizers such as valium. In the same study, the participants used to reinterpret their thoughts about using drugs and supplanted them by thinking and doing other things as second strategy of craving management.

Paradoxical intention: It also seems to be an important factor for natural recovery. It can be seen in the treatment of some problems (e.g. insomnia) or disorders (e.g. phobia), paradoxical intervention can shape the specific undesirable behavior. The effectiveness of paradoxical interventions in psychotherapy was evaluated in a meta-analysis where it was found as effective as the typical treatment mode (Shoham-Salomon & Rosenthal, 1987). Paradoxical interventions even showed relatively greater effectiveness than other interventions in some cases. Following the same principle, naturally recovered persons did the opposite behavior or thought in opposite manner when they expected to be abstinent forever.

Avoidance of high risk situations: This is a common factor for any kind of recovery revealed in addiction literature. According to the well known classical conditioning theory, urge for re-intake of drug is conditioned and associated immediately after being exposed with any person, paraphernalia, place etc which had a strong relation with previous drug habit. The newly abstainer usually had less skill to refuse the offer of drug or deal with the risky situations which could provoke the urge for drug very strongly. In this vulnerable stage, the respondents of present research would prevent the chance of craving to be raised by avoiding risky situations specific to them and thus invest their effort to be naturally recovered persons forever.

Self monitoring: Self monitoring was accomplished in two ways; in behavioral as well as cognitive manner. The technique ‘internalized oath’ served the purpose of keeping

an eye on covert behavior while 'self imposed life style' supervised the overt behaviors. Since the performance of any supervised activities remains in higher rank, regular checking of both internal and external behaviors guided the self recovering individuals to keep them in track, i.e., to practice socially desirable behaviors which is most significant for maintenance of drug free life. Self monitoring can lead to individuals seeking advice and feedback, procedures that have been incorporated into motivational interventions (M. B. Sobell & Sobell, 1993a, 1998). It was also found in another study that the respondents actively reviewed their behavior and took steps to change (L. C. Sobell et al., 2001).

4.3 Prolonging Factors for Sustenance of Natural Recovery

As the natural recovery journey is a continuous process, it does not indicate termination when the individuals successfully stop their behavior only for a certain period of time. It requires sustaining for long time and even forever. Several issues or aspects played significant role as maintaining factors for self recovery such as adaptive cognitive structure, family and social support, global outcome of drug cessation, life style change, need for quality life, driving spirit, and psychological growth. Similar to encouraging factors, these factors were also overlapping to contribute on natural recovery.

Adaptive cognitive structures: It seems to be an exclusive and very significant factor discovered in the present research. Cognitive pattern of the naturally recovered individuals included normalization, non-stigmatized attitude towards self, internal attribution, problem focused orientation, and high self esteem which is productive for an individual to deal with any diverse situation.

Normalization seems to be a unique factor for natural recovery. It was such a cognitive aspect while the respondents attributed any critical or sensitive issue in a normal way which did not create negative emotion such as stress, anxiety etc on them and thus

played a very significant role to prevent relapse. For example, they perceived lapse as a normal phenomenon. It is very usual for abstainers to fall in lapse as they had been habituated with drug related behaviors for long time but it does not mean that the person is totally inadequate to maintain the sobriety. This theme can challenge the famous dogma "First dose does the damage", widely popular and followed in any form of professional treatment, where the treated recovery start continuing drug intake after taking a single dose having the strong feeling of incapability to prevent their relapse. The respondents of present research normalized the drug issue in their life. They did not deny the attractive power of drugs, i.e., they accepted the truth or real scenario that drugs can invite them very strongly. So, the generally agreed statement 'forbidden, avoidable, or deniable things are more attractive' was not applicable to them. Drug was involved as normal part of their previous life as well as being drug free was also normal part of their present life. Moreover, as they did not ignore their vulnerability for relapse, they needed to make a structured plan, a disciplined life and tried to maintain this. They did not need to be preoccupied with any strict rules and regulations while they believed that rehabilitation treatment programs usually impose many restrictions on the individual's brain or mind which ultimately make them vulnerable for relapse. During the observation, it was also noticed through non-verbal cues (facial expression, tone of voice, eye contact, posture, body language) that their acceptance level was wide. They did not have any hesitation for their past drug identity and they were very confident while sharing any idea or opinion regarding this.

It also seems to be a unique factor for natural recovery that they had the stigma free attitude towards their self. The verbal and non-verbal communication of the respondents clearly indicated that their attitude was much open and the self was free of being labeled. This attitude was associated with normalization. That means, the individual

having non-stigmatized attitude normalized any sensitive issue which reduced their mental load and decreased the chance for relapse. They did not use the term ‘recovery’ anywhere in the interview to designate them which might give birth to the assumption that this term is possibly the production of formal drug rehabilitation centers which ultimately keep the abstainers in a specific mental boundary and give them a narrow vision towards them, towards the life. Along with the overall way of talking, their facial expression and body language also gave impression of their relaxed and stigma free attitude. During the observation, it was also noticed that they were not much concerned about confidentiality as they did not feel inhibited while disclosing their identity in the midst of other people. They wrote their name and mobile no in the consent form without any hesitation though it was optional. An informal discussion with a natural recovered person also supported this observation.

Since their attitude was open and they had respect for themselves, they did not feel inferior and did not need to be preoccupied with stigma related non-productive issue. Rather they were able to invest their full capacity to perform well enough for as usual assigned activities. Consequently the final outcome is long term abstinence. Biernacki described four general stages of auto remission process; ‘resolving to stop’, ‘breaking away from addiction’, ‘staying abstinent’, and ‘becoming and being ordinary’ (Biernacki, 1986). At the last stage, he has described about identity transformation of the ex-addicts in relation to the stigma associated with the addiction. In the context of his description, it seems that ‘non-stigmatized attitude towards self’ was absent among the participants although it was not explicated clearly.

Holding the internal style of attribution, they were active to prevent relapse and tried to resolve the difficulty with genuine heart of solution focused intention. At the same

time their high self esteem helped them to think in a functional manner and maintain socially desirable behaviors. In the study conducted by Graevens, data suggested that untreated heroin addict had higher self-esteem than the treated addicts (cited in Waldorf & Biernacki, 1979). The study also suggests that personal and family resources contribute to natural recovery. Moreover, self confidence of the respondents of present research seemed to be in a standard balance because neither they felt inferior having stigmatized attitude, nor they ignored their vulnerability being over confident on controlling drug as they agreed with the attractive power of drug. As a result they were able to maintain appropriate behaviors suitable for long term abstinence.

In general, their cognitive structures were constructive in nature through which the natural recovered individuals processed any information, interpreted any incident or attributed anything in such a way which helped them to keep their emotion in control. It is scientifically and empirically supported that there is strong interrelation between cognition and emotion (Greenberger & Padesky, 1995). The knowledge of inter-relation between the cognition, emotion, physiological response and behavior in determining problem as well as functioning behavior is strongly supported by the Five Part Model (Greenberger & Padesky, 1995) widely used in Cognitive Behavior Therapy (Beck, 1963). This model revealed that the formation and development of any psychopathology occurs with the influence of inter-relation between cognition, emotion and behavior that plays the central role even to sustain that disorder. This is also applicable for any kind of behavior. So, it is obvious that efforts for effective and sustainable behavioral change will be fruitful if it can be interfered at all three levels. Under the same principle, outcome of the adaptive cognitive structures was their socially desirable behaviors and continuous abstinence.

Family and social support: Involvement in any activities was acknowledged by all the respondents as a crucial strategy for maintenance of abstinence. Family and society can ensure this involvement. That means, when the recovering individuals were supported by their family members, stayed connected with friends, relatives, acquaintances etc, it was easy for them to get access any work or job which was an active channel to make them distract from drug. (Tuchfeld, 1981) found 'direct intervention by immediate family' as one of the reasons for their resolution from problem drinking. In another qualitative study of Australian aboriginal men who naturally stopped drinking without formal treatment, family factors was found to be one of the common reasons for which 50% of the subjects gave up their problem drinking (Brady, 1993). The same study also observed that social tie helped the abstention from drinking. Data of Graevens' study suggested that untreated heroin addict had better family relations than the treated addicts (cited in Waldorf & Biernacki, 1979). The study also suggests that personal and family resources contribute to natural recovery. It is an accepted idea that a positive environment or social support has been associated with positive outcomes in treatment (Longabaugh, Wirtz, Zweben, & Stout, 1998; M. B. Sobell & Sobell, 1998; M. B. Sobell, Sobell, & Leo, 2000). It has also been reported as an important maintenance factor in alcohol and drug natural recovery studies (L. C. Sobell et al., 2000; L. C. Sobell et al., 1993; Toneatto et al., 1999; Watson & Sher, 1998). In another study respondents were found to feel that feedback from others was important to the change process while they were stating about social support and references to others (L. C. Sobell et al., 2001).

Global outcome of drug cessation: As the recovering individuals were no longer preoccupied with drug seeking as well as drug taking behaviors, radical changes occurred in every aspect of their life. Their modified behavioral pattern, emotional regulation, interpersonal relationship, and sense of responsibility resulted from drug cessation acted as

a strong reinforcement for them. Following the reinforcement theory, any behavior persists depending on its consequences. During the abstinent period, their socially acceptable behaviors, controlled emotion, improved interpersonal relationship and sense of responsibility gave them the impression of increased acceptance to others which in turn reinforced them to be alert for maintenance of long term abstinence.

Life style change: It is well agreed that life style pattern is strongly connected with one's performance or achievement. During abstinent period, healthy life style of the respondents allowed them to abstain from drug seeking behaviors making them involved into productive, creative or useful activities. Spirituality played a key role in this regard. It gave the respondents the competence to take the challenge against drug. Seeking help from higher power increased their mental strength to keep continue fighting with the urge for drug. Spirituality is an abstract phenomenon and the exact process of enhancing motivation through this aspect is still unknown. But it is evident that religious reason or spirituality is one of the strong factors for self change process (Jasperse, 2006; Kunitz & Levy, 1994; May, 2001; Tuchfeld, 1981). Religion was also revealed in another study to play a strong role in natural recovery process (Biernacki, 1986).

Another contributing factor in changed life style at abstinent period was healthy addiction. The respondents were able to quit from alcohol or drugs when they were obsessed with some healthy matters. They got some new achievement or found new meaning in their life. That means, the person with continued use is completely busy with drug while there is nothing new in his life. On the other hand, those who found an alternative option or any significant issue like career, marriage, fiancé, child etc could replace drug with those things in their life. Like spirituality, the process for impact of

healthy addiction could not be discovered. After much exploration, one respondent uttered the following statement.

"Love from heaven makes me so motivated for change".

Need for quality life: Once the naturally recovered individuals got the taste of quality life after giving up drugs, their passionate urge to maintain this productive life itself acted as an inspiration for which they were active enough to invest their effort to sustain their drug free life forever.

Driving spirit: Growing to be a 'hero' and getting reinforcement worked together as a leading stimulation to encourage the continuation of drug free productive life. The natural recovering persons felt very proud when they were identified as significant example in the locality and were invited into different treatment centers to evident them as successful winner against drug. During observation, their non-verbal cues (e.g. facial expression, tone of voice, body posture, sparkling of eye) indicated their proud feeling and firmness. This was also supported by another study on natural recovery from drinking problem where the subjects were quite proud of their ability to resolve the alcohol problem (Tuchfeld, 1981). Along with non-verbal cues, the way of talking of the respondents indicated that they had been enjoying their present abstinent life. Their impression seemed to be a 'Hero' who had conquered dangerous fight and people were celebrating their 'Heroics' afterwards. This was actually great reinforcement for them. Since the reinforcement theory establishes that behavior increase if anyone gets reinforcement, so it can be said that getting praises for being hero and getting well behavior, love and affection from people for being abstinent increased their socially desirable behaviors and thus helped them to work for lasting abstinence. The respondents of the present research claimed it as the main inspiring factor for sustainability of their present abstinent life.

Psychological growth: It is possible that suffering and distress can potentially yield positive change. After drug cessation, mental development of the respondents played role as similar to the concept of 'post-traumatic growth'. Post-traumatic growth refers to positive psychological change experienced as a result of struggle with highly challenging life circumstances. The respondents found ways to use their experience of drug as a vehicle for psychological growth. The maturity and knowledge acquired from the intense drug related experience impacted on their adaptive behaviors and thus contributed on the long term abstinent life.

4.4 Challenges of Natural Recovery Progression

There were some challenges (such as mistrust, control on lapse, adequate self monitoring, adjustment with new life style, abstinence violation effect, unavoidable exposure to high risk situations) in the entire self recovery course which had continuously determined whether the individuals would be in a position of natural recovery or not. For example, self monitoring was a challenging point because lack of monitoring leads an individual to reach in high risk situations and creates vulnerability for re-addiction while excessive monitoring creates an extra pressure on their mind making him always preoccupied which is also risky for relapse. For this, it was a challenge for them to make a balance in their behavior checking.

4.5 Development of the Model on Natural Recovery

The general model developed from the data of present research is drawn in the following.

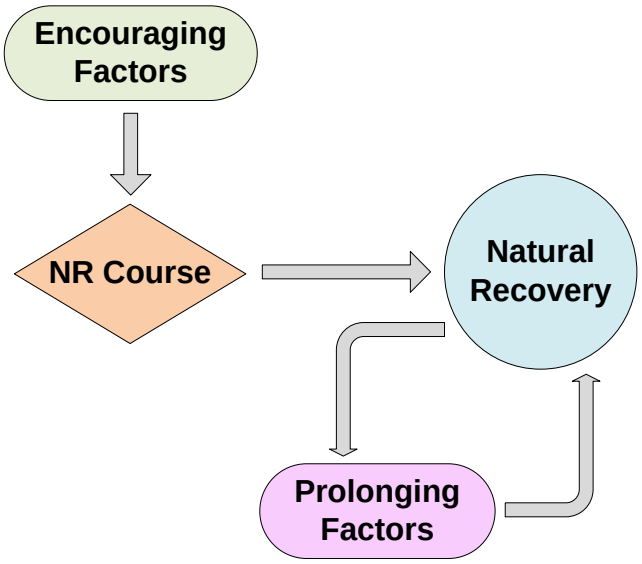

Figure 3: Basic model on natural recovery process

It can be said as emerging statement that one can be a natural recovery through specific strategies used in natural recovery course, when some encouraging factors facilitate this process. After that, several prolonging factors play significant role for maintenance while 'being natural recovery' itself promote this process greatly acting as a prolonging factor. However, those factors are correlated with each other which are depicted below.

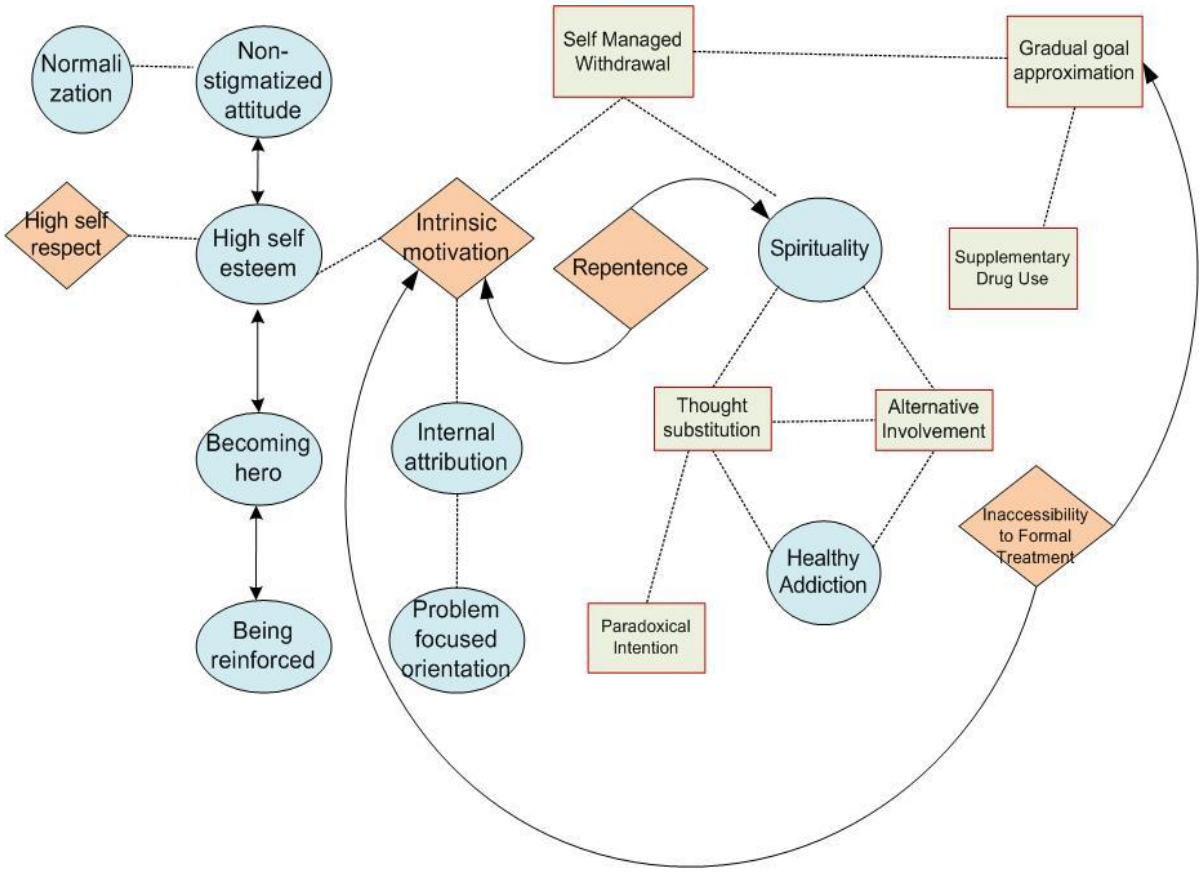

Figure 4: Interrelations among the factors associated with natural recovery.

In the above diagram, some factors are seen to have causal indication while few others are correlated with each other. However, few factors are revealed as most frequently associated with other factors such as high self esteem, intrinsic motivation, gradual goal approximation, and spirituality etc. High self esteem has two-way causal indication with non-stigmatized attitude towards self. Several psychological theories predict that members of stigmatized groups usually have low global self esteem (Crocker & Major, 1989). In this regard, it can be assumed that the natural recovering individuals having high self esteem are likely to have stigma free attitude as they are supposed to depend on self approval rather than other people's malfunctioning negative comments leading to being labeled. On the other hand, non-stigmatized attitude towards self also may boost up individual's self esteem as they hold positive concept regarding them. High self

esteem has also two-way causal indication with ‘becoming the hero’. From the perspective of social learning theory, perceived self-efficacy is the foundation of human motivation, performance accomplishments, and emotional well-being (Bandura, 2006). Self-efficacy mechanism influence thought patterns, actions, and emotional arousal. It is predicted that the higher the level of induced self-efficacy, the higher the performance accomplishments and the lower the emotional arousal (Bandura, 1982). So, it can be anticipated that high self esteem may facilitate an individual to become a hero by accomplishing drug cessation without treatment which in turn increase self efficacy of the person i.e., enhancing self esteem. When an individual becomes a significant hero overpowering drug with his voluntary effort, he gets external as well as internal reward. It can be explained with reinforcement theory that the natural recovering individuals get appropriate reinforcement while they become remarkable hero which may cause to increase their self confidence and self concepts i.e., enhance self esteem. The Reinforcement theory by Behaviorist B. F. Skinner (1969) states that "an individual’s behavior is a function of its consequences." If the organisms get positive reinforcement for their behavior, they can have desirable effects or consequences and chance of that behavior will be increased by repeating in the future. Following this principle, behaviors of the natural recovering individuals were also regulated by its outcome. Being a significant example, it became strong positive reinforcement for the respondents when they got much love from others and huge appreciation to overcome drug without any professional support. According to the principle of positive reinforcement, their drug free productive behaviors are being continued with the intention of keeping ‘hero position’ as permanent.

Intrinsic motivation is seen to have causal indication with inaccessibility to formal treatment. When the respondents did not have easy access to professional treatment especially when they embraced strong negative conceptions about drug treatment centers

but wanted to say 'good bye' to drugs, they had no option other than going through self change process. In that case, it is possible that their inherent motivation would be increased. When the motivation was inherent, their style of attribution was also more likely to be internal as their focus was on their own self and they could take own responsibility. When they could accept their own responsibility, they were more likely oriented to problem focused approach, i.e., their intention was solution focused while they tried to make a concrete plan to resolve their difficulty or drug problem. Intrinsic motivation can also be sourced from repentance. Extreme guilt feeling pushed them to reach at 'bottom stage' (known as 'rock bottom' in the treatment field) while the predisposition of their inherent motivation was grounded. Not only enhancing motivation, repentance also directed them to be engaged with spiritual activity which ultimately fueled the maintenance of abstinence. Religion is enmeshed in Asian culture and people tend to seek mercy to higher power if they become deviated from standard ethical trend. As the respondents needed to do various amoral activities during their addictive life to collect money for drug, they had to suffer from extreme guilt feeling when they came back to their normal life. Spirituality acted as the constructive remedy in this regard. When they entered into spiritual life, it was easy for them to replace craving related thought being afraid of order of the higher power and made them engage into religious activity as an alternative approach of drug usage. Replacement of craving related thought and involvement in alternative activity to prevent re-addiction is also correlated with healthy addiction. Topics or issues related to healthy addiction (e.g. photography, gardening, intimate relationship etc) helped the respondents to shift their thought during craving time and start doing related action.

Managing withdrawal symptoms is cardinal issue for natural recovery process since overcoming drug greatly depends on successful accomplishment of it and also due to

the general idea of its complexity with unpleasant experience. Both spirituality and intrinsic motivation helped the individuals in this regard. It is clearly understandable that without motivation it was almost impossible for them to take this challenge and tackled those unwanted moments. Religious activity performed at that time helped them to shift their attention from drug by altering their thought and behavior. Self managed withdrawal was also benefited by gradual goal approximation since gradual reduction of substances with the use of supplementary drug assisted them to reduce severity of withdrawal symptoms at the final stage of their drug cessation. Inaccessibility to formal treatment generated this idea of gradual reduction in them. Through all the actions and interactions of these factors, a drug user finally reaches in the position of natural recovery.

4.6 Comparison with Treated Recovery

With a view to comparing the present findings on natural recovery process with the recovery process of formally treated individuals, four experienced clinical psychologists working in drug field were interviewed as an expert. The purpose of this comparison was to generate the assumption regarding some specific discovered factors to be claimed as novel factors for natural recovery. The expert opinions were taken in two phases. Firstly, all the experts' interviews were recorded with digital equipment when they were asked to describe in the light of their experience about factors they would think as responsible for the recovery process of treated individuals. The experts shared their knowledge spontaneously without any probing or interference. Then those factors were sorted out which are playing role in the recovery process of treated individuals. Secondly, after completion of interview, the experts were shown a checklist of twenty categories responsible for natural recovery process explored in the present research and asked them to give a tick mark on that list which are commonly related to the treated recovery process.

The second part was done to ensure in a better way which factors are exclusively associated with natural recovery. If the experts would forgot to mention about any factor during their first phased interview, they would have the option to select it while it was visibly presented in front of them. So, the remaining factors which were neither stated in the first phased interview nor were selected from the checklist can be claimed as novel factors for natural recovery. Among all the factors, eight were sorted out from first phased experts' interview as contributing factors for self recovery such as intrinsic motivation, inaccessibility to formal treatment, high self respect, gradual goal approximation, supplementary drug use (under personalized craving management), adaptive cognitive structures (normalization, non-stigmatized attitude, internal attribution, high self esteem, problem focused orientation), paradoxical intention, and becoming the hero (under driving spirit). Among these, five factors such as inaccessibility to formal treatment, high self respect, adaptive cognitive structures (normalization, non-stigmatized attitude, internal attribution, and high self esteem), gradual goal approximation, and supplementary drug use were selected after second phased experts' interview which can be demanded as exclusive factors responsible for natural recovery. The experts commented that there is no possibility of three factors such as inaccessibility to formal treatment, gradual goal approximation, and supplementary drug use to be linked with treated individuals as they are directly admitted into treatment center either willingly or forcefully. Regarding few other factors such as intrinsic motivation, paradoxical intention, problem focused orientation, and becoming the hero, one expert shared her knowledge that those are rarely observed in the treated recovery and the individuals are given training on these factors (such as intrinsic motivation enhancement, problem focused orientation) through therapeutic intervention.

4.7 Strengths of the Study

The present study followed the pre-planned methodological design appropriately. Besides this, two major strengths of this qualitative investigation can be mentioned here which are as follows.

1. Research findings were grounded purely in data
2. Indigenization of knowledge in Bangladeshi culture

4.8 Limitations of the Study

The present study had also some drawbacks which is the scope for improvisation in future studies. The drawbacks are in the following.

1. Maximum variation of sampling could not be ensured in a satisfactory level.
2. Iterative analysis was not possible in an Ideal manner (in terms of interviews taken from outside of Dhaka)

4.9 Implications of the Study

This study has great implications stated in the following.

1. Ultimate contribution to design and development of community based interventions to foster self change.
2. These findings may promote early recovery from drug usage.
3. Findings of this research have applicability to facilitate the development of current treatment practices that better help people to overcome their drug problems. Further comprehensive researches on this area may be helpful to design and

evaluate the existing interventions for substance abusers and treatment program for drug addiction.

Findings from this study have also important implications for clinical practice.

The study revealed that self change process of drugs or alcohol problems did not always occur in ideal environment having full and active support of surrounding networks. Recognition and acceptance of these examples may promote personal responsibility and independent self change initiatives. Individuals may realize that if change is going to occur, they must independently accomplish it based on their personal resources. In turn, mental health care providers may empower individuals by sharing emergent research evidence, which suggests that individuals can accomplish change on their own.

Another important finding is that handling withdrawal did not appear to be a life threatening issue which may reduce the existing fear related to withdrawal management without treatment. Many individuals perceive the withdrawal condition as fatal for which people cannot stop drug in spite of having willingness to quit. Consequently, it is believed that if people try narcotic drugs, then they are on the path to ruin. Still now our society considers that addiction to narcotic drugs is inevitable, and the route to being drug free is almost impossible. Many treatment professionals also believe that it is essential for a drug user to access treatment to recover. In this aspect health care providers may encourage individuals by sharing this important message along with the notion of gradual reduction.

Since the core of the self change process appears to be personal responsibility, self efficacy is a personal asset to promote among drug users. This includes promoting one's ability to accept the reality of the problem, recognize its consequences, and independently change. Moreover, strengthening individuals' positive qualities, capabilities, and achievements seems essential to promoting further accomplishments. It should be noted

that this strategy is in contrast to Alcoholics Anonymous mandate, which encourage admissions of powerlessness over alcohol (Bufe & Peele, 1998). However, among individuals who prefer to resolve their problems independently, self esteem and self efficacy appears to be of great importance.

CHAPTER 5

CONCLUSION AND RECOMMENDATIONS

Conclusion and Recommendations

The present qualitative investigation explored the recovery process of Bangladeshi substance abusers who had stopped drugs on their own without any support of professional treatment with the dream of ultimate contribution to design and development of community based interventions to foster self change. Since the purpose of the present study was to understand natural recovery process in substance dependence, it discovered various psychosocial factors associated with natural recovery process while investigating the interrelationships among those factors. Grounded theory approach was used to generate knowledge on this promising and challenging phenomenon. The study gathered in-depth interview data from nine self recovered individuals while some unique aspects were discovered about the occurrence of natural recovery in their lives.

This qualitative investigation explored 20 emerging themes which were organized into three broad sections such as encouraging factors, strategies in natural recovery course and prolonging factors to sustenance of natural recovery. Present findings were compared with the treated recovery with the help of expert opinions. Unique contributory factors for natural recovery were sorted out through expert interview. Five factors such as inaccessibility to formal treatment, high self respect, adaptive cognitive structures (normalization, non-stigmatized attitude towards self, internal attribution, and high self esteem), gradual goal approximation, and supplementary drug use appeared to be the core contributors for natural recovery. Nine factors were found to be causally linked where rest of the factors was revealed to be associated with each other.

However, the findings presented in this paper have provided detailed understanding of self change process. It is hoped that the information obtained from the

respondents can be integrated with the current treatment and prevention modalities to enhance the effectiveness for substance dependence treatment in Bangladesh. Although these findings are preliminary and more refined analyses are needed, they suggest some understandable themes for the natural recovery process. These findings will be enormously beneficial for the health care providers, individuals, drug rehabilitation centers, organizations working with drug induced health problems such as HIV/AIDS, community, and above all policy makers in Bangladesh.

The present research has made some theoretical contributions. There is no theoretical understanding on natural recovery process in Bangladesh. Along with grounded theory approach, the present study used the perspective of indigenous psychology. Thus it has been attractive in the particular sense. Indigenous psychology is considered necessary since existing psychological theories are not necessarily universal, and may often represent the psychology and cultural traditions of Europe and North America. Bearing in mind this important message, the present research took the attempt to develop context-specific knowledge in Bangladeshi culture. Indeed, it opened up a new avenue for indigenization of psychological knowledge in Bangladesh.

The present research has also made worldwide contribution. Most of the researches on self recovery revealed in the literature were conducted in western countries. The light of knowledge on self change process may have not reached yet to the Asian people. The present research generated knowledge in Bangladeshi context. But the findings can also be used in Asian context to gain useful insight regarding natural recovery process from drug addiction. As there is a similarity in the cultural context of Asian countries, it may be possible that the factors identified in the present research might have somewhat similarities in the context of other countries in Asia especially in south-east Asia.

Moreover, these findings will also be helpful in understanding natural recovery process in the world context.

Assumptions derived from the present study: The following assumptions have emerged from the present study which deserved to be investigated and tested.

- Limitations of current treatment centers may promote natural recovery.
- The psyche of a natural recovered person is stigma free and their attitude is much open which is most significant aspect to be a natural recovery.
- Lapse even occurs rarely in their life possibly because of their strong intrinsic motivation and adaptive mental structure.
- Along with non-stigmatized attitude towards self, normalization as a mental process is of special importance for natural recovery.

Recommendations for Future Research

There were a number of important lessons learned from this unique and challenging study. From these lessons, the following recommendations are made for future research on natural recovery.

1. Further refinements of this research area are needed to better understand the multifaceted processes associated with natural recovery. Further studies should be designed to find out the exact factors which are responsible to underlie the predominant path to natural recovery and also to accommodate all other factors which can claim to be associated with the self change process in order to provide a comprehensive explanation of natural recovery from addictive behaviors. In those

studies maximum variation of sampling should also be tried to validate the findings.

2. Findings from this study shed light on how and why individuals accomplish self-recovery of drug problems. However, a question may arise what are the core differences between individuals who successfully give up drugs with voluntary effort and those who do not? Research should be conducted on this.

3. Further exploration can be designed in future studies focusing on specific psychosocial factors identified in this research to enhance the rigorousness of knowledge on natural recovery process. For example, answer should be sought for such a question 'what is the root of non-stigmatized attitude towards self?'

4. Although the present study has indirectly compared its findings with the treated recovery through experts opinion but it cannot strongly claim which specific factors are correlated or causally linked with self recovery. Comparative analysis need to be done in this regard to refine the present findings. Treated recovering individuals should be interviewed to explore specific factors associated with their recovery process and then it can be compared with the identified factors related to natural recovery. Only then unique and exclusive aspects for self recovery process can be revealed.

5. Large scale study with quantitative approach should be designed for confirming those factors so that the findings can be generalized. With this purpose a semi-structured questionnaire can be constructed if needed.

6. The study guided a need for development of a network system for individuals who have resolved drug addiction with their voluntary effort. Some of the respondents

indicated that they were interested in helping others to recover from their drug problem but did not want to do this in an institutional type of setting. Instead, they wanted to help these individuals in a community setting to facilitate positive change. With this purpose research should be conducted on essential issues related to how to build up support and educational network for them.

In conclusion, it should not be misunderstood that this study is suggesting formal treatment is unnecessary and ineffective rather it is simply suggesting that recovery from drug addiction without treatment is possible. This study promotes the idea that natural recovery is also an important pathway to recovery. We need to learn from this research to help others take this pathway since the present study is explaining its process. Although it was not directly linked with the purpose of present research, still it can be mentioned here that the findings of the present study will break the silence regarding natural recovery of drug addiction in Bangladesh.

REFERENCES

REFERENCES

Academy for Health Services Research and Health Policy. (2000). Brief Interventions. *FrontLines,* November:1-8.

American Psychiatric Association. (2000). *Diagnostic and Statistical Mannual of Mental Disorders (Fourth Edition): Text-Revision (DSM-IV-TR)*. Washington, DC: American Psychiatric Pub.

American Society of Addiction Medicine. (2001). *Patient Placement Criteria for the Treatment if Substance Use Disorders*. Chevy Chase, MD: American Society of Addiction Medicine.

Anglin, M. D., Brecht, M. L., Woodward, J. A., & Bonett, D. G. (1986). An Empirical Study of Maturing Out: Conditional Factors. *Substance Use & Misuse, 21*(2), 233-246.

Bandura, A. (1982). Self-Efficacy Mechanism in Human Agency. *American Psychologist, 37*(2), 122-147. doi: 10.1037/0003-066X.37.2.122

Bandura, A. (2006). Toward a Psychology of Human Agency. *Perspectives on Psychological Science, 1*(2), 164-180.

Beck, A. T. (1963). Thinking and Depression: Idiosyncratic Content and Cognitive Distortions. *Archives of General Psychiatry, 9*(4), 36-45. doi: 10.1001/archpsyc.1963.01720160014002

Bien, T. H., Miller, W. R., & Tonigan, J. S. (1993). Brief Interventions for Alcohol Problems: A Review. *Addiction, 88*(3), 315-336.

Biernacki, P. (1986). *Pathways from Heroin Addiction: Recovery without Treatment*. Philadelphia: Temple University Press.

Biernacki, P. (1990). Recovery from Opiate Addiction without Treatment: A Summary. *The Collection and Interpretation of Data from Hidden Populations*, 113-119.

Bischof, G., Rumpf, H. J., Hapke, U., Meyer, C., & John, U. (2000). Maintenance Factors of Recovery from Alcohol Dependence in Treated and Untreated Individuals. *Alcoholism: Clinical and Experimental Research, 24*(12), 1773-1777.

Bischof, G., Rumpf, H. J., Hapke, U., Meyer, C., & John, U. (2002). Remission from Alcohol Dependence without Help: How Restrictive Should Our Definition of Treatment Be? *Journal of Studies on Alcohol, 63*(2), 229-236.

Brady, M. (1993). Giving Away the Grog: An Ethnography of Aboriginal Drinkers Who Quit Without Help. *Drug and Alcohol Review, 12*(4), 401-411.

Brudenell, I. (1996). A Grounded Theory of Balancing Alcohol Recovery and Pregnancy. *Western Journal of Nursing Research, 18*(4), 429-440.

Bufe, C., & Peele, S. (1998). *Alcoholics Anonymous: Cult or Cure?* Tucson, AZ: See Sharp Press

Burman, S. (1997). The Challenge of Sobriety: Natural Recovery without Treatment and Self Help Groups. *Journal of Substance Abuse, 9*, 41-61.

Cahalan, D. (1987). Studying Drinking Problems Rather than Alcoholism. Recent Developments in Alcoholism: An Official Publication of the American Medical Society on Alcoholism. *The Research Society on Alcoholism, and the National Council on Alcoholism, 5*, 363.

Carballo, J. L., Fernández-Hermida, J. R., Secades-Villa, R., Sobell, L., Dum, M., & García-Rodríguez, O. (2007). Natural Recovery from Alcohol and Drug Problems: A Methodological Review of the Literature from 1999 through 2005. In H. Klingemann & L. Sobell (Eds.), *Promoting Self Change from Problem Substance Use: Practical Implications for Policy, Prevention, and Treatment*. London: Springer Verlag.

Carballo, J. L., Fernández-Hermida, J. R., Sobell, L. C., Dum, M., Secades-Villa, R., García-Rodríguez, O., . . . AlHalabí-Diaz, S. (2008). Differences among Substance Abusers in Spain Who Recovered with Treatment or on Their Own. *Addictive Behaviors, 33*(1), 94-105.

Carey, M. P., Snel, D. L., Carey, K. B., & Richards, C. S. (1989). Self Initiated Smoking Cessation: A Review of the Empirical Literature from a Stress and Coping Perspective. *Cognitive Therapy and Research, 13*(4), 323-341.

Carr, A., & McNulty, M. (2006). *The Handbook of Adult Clinical Psychology: An Evidence Based Practice Approach*: Routledge New York.

Charmaz, K. (2006). *Constructing Grounded Theory: A Practical Guide through Qualitative Analysis*: Pine Forge Press.

Chiauzzi, E. J., & Liljegren, S. (1993). Taboo Topics in Addiction Treatment: An Empirical Review of Clinical Folklore. *Journal of Substance Abuse Treatment, 10*(3), 303-316.

Cisler, R. A., Kowalchuk, R. K., Saunders, S. M., Zweben, A., & Trinh, H. Q. (2005). Applying Clinical Significance Methodology to Alcoholism Treatment Trials: Determining Recovery Outcome Status with Individual and Population Based Measures. *Alcoholism: Clinical and Experimental Research, 29*(11), 1991-2000.

Corbin, J., & Strauss, A. (1990). Grounded Theory Research: Procedures, Canons, and Evaluative Criteria. *Qualitative Sociology, 13*(1), 3-21.

Corbin, J., & Strauss, A. (2008). *Basics of Qualitative Research: Techniques and Procedures for Developing Grounded Theory (3rd ed.)*. Los Angeles: Sage.

Creswell, J. W., & Brown, M. L. (1992). How Chairpersons Enhance Faculty Research: A Grounded Theory Study. *Review of Higher Education, 16*(1), 41-62.

Crocker, J., & Major, B. (1989). Social Stigma and Self Esteem: The Self Protective Properties of Stigma. *Psychological Review, 96*(4), 608-630. doi: 10.1037/0033-295X.96.4.608

Cunningham, J. A. (1999). Untreated Remissions from Drug Use: The Predominant Pathway. *Addictive Behaviors, 24*(2), 267-270.

Cunningham, J. A. (2000). Remissions from Drug Dependence: Is Treatment a Prerequisite? *Drug and Alcohol Dependence, 59*(3), 211-213.

Cunningham, J. A., Sobell, L. C., & Chow, V. (1993). What's in a Label? The Effects of Substance Types and Labels on Treatment Considerations and Stigma. *Journal of Studies on Alcohol and Drugs, 54*(6), 693.

Cunningham, J. A., Sobell, L. C., & Sobell, M. B. (1998). Awareness of Self Change as a Pathway to Recovery for Alcohol Abusers: Results from Five Different Groups. *Addictive Behaviors, 23*(3), 399-404.

Cunningham, J. A., Sobell, L. C., Sobell, M. B., Agrawal, S., & Toneatto, T. (1993). Barriers to Treatment: Why Alcohol and Drug Abusers Delay or Never Seek Treatment. *Addictive Behaviors, 18*(3), 347-353.

Cunningham, J. A., Sobell, L. C., Sobell, M. B., & Gaskin, J. (1994). Alcohol and Drug Abusers' Reasons for Seeking Treatment. *Addictive Behaviors, 19*(6), 691-696.

Dawson, D. A. (1996). Correlates of Past Year Status Among Treated and Untreated Persons with Former Alcohol Dependence: United States, 1992. *Alcoholism: Clinical and Experimental Research, 20*(4), 771-779.

Dawson, D. A., Grant, B. F., Stinson, F. S., Chou, P. S., Huang, B., & Ruan, W. J. (2005). Recovery from DSM-IV Alcohol Dependence: United States, 2001-2002. *Addiction, 100*(3), 281-292.

Dennis, M. L., Scott, C. K., Funk, R., & Foss, M. A. (2005). The Duration and Correlates of Addiction and Treatment Careers. *Journal of Substance Abuse Treatment, 28*(Suppl 1), 51–62.

Dupont, R. L. (1993). In G. R. Ross (Ed.), *Treating Adolescent Substance Abuse* (pp. xi–xii). Boston: Allyn and Bacon.

Erickson, P. G., & Alexander, B. K. (1989). Cocaine and Addictive Liability. *Social Pharmacology, 3*(3), 249-270.

Eysenck, H. J., & Rachman, S. J. (1973). *Neurosen: Ursachen Unde Heilmethoden: Einführung in die Moderne Verhaltenstherapie [The Causes and Cures of Neurosis]*. Berlin-OST, Germany: Cerlag der Wissenschaft.

Ferris, J. (1994). *Comparison of Public Perceptions of Alcohol, Drug and Other Tobacco Addictions—Moral vs. Disease Models.* Paper presented at the 20th Annual Alcohol Epidemiology Symposium, Ruschlikon, Switzerland.

Finfgeld, D. L. (1999). Self Resolution of Alcohol Problems as a Process of Investing and Re-investing in Self. *Archives of Psychiatric Nursing, 13*(4), 212-220.

Finn, P. (1997). Adults Recovered from Stuttering without Treatment: Perceptual Assessment of Speech Normalcy. *Journal of Speech, Language and Hearing Research, 40*(4), 821-831.

Fiore, M. C., Novotny, T. E., Pierce, J. P., Giovino, G. A., Hatziandreu, E. J., Newcomb, P. A., . . . Davis, R. M. (1990). Methods Used to Quit Smoking in the United States. *Journal of the American Medical Association, 263*(20), 2760-2765.

Firoz, A. H. M., Karim, M. E., Alam, M. F., Rahman, A. H. M., & Zaman, M. M. (2007). *Prevalence, Medical Care, Awareness and Attitude Towards Mental Illness in Bangladesh*. Dhaka: World Health Organization-Country Office Bangladesh Publication.

First, M. B., Spitzer, R. L., Gibbon, M., & Williams, J. B. W. (2002). *Structured Clinical Interview for DSM-IV Axis I Disorders, research version, non-patient edition (SCID-I/NP)*. New York: Biometrics Research, New York State Psychiatric Institute.

Fleming, M. F., & Manwell, L. B. (1999). Brief Intervention in Primary Care Settings. *Alcohol Research & Health, 23*(2), 128-137.

Fleming, M. F., Mundt, M. P., French, M. T., Manwell, L. B., Stauffacher, E. A., & Barry, K. L. (2000). Benefit Cost Analysis of Brief Physician Advice with Problem Drinkers in Primary Care Settings. *Medical Care, 38*(1), 7-18.

Flynn, P. M., Joe, G. W., Broome, K. M., Simpson, D. D., & Brown, B. S. (2003). Looking Back on Cocaine Dependence: Reasons for Recovery. *The American Journal on Addictions, 12*(5), 398-411.

Glaser, B. (1978). *Theoretical Sensitivity: Advances in the Methodology of Grounded Theory* (Vol. 2). Mill Valley, CA: Sociology Press

Glaser, B. (1998). *Doing Grounded Theory: Issues and Discussions*. Mill Valley, Ca: : The Sociology Press.

Glaser, B. (2001). *The Grounded Theory Perspective: Conceptualization Contrasted with Description*. Mill Valley, CA: Sociology Press.

Glaser, B. (2002). Constructivist Grounded Theory? *Forum Qualitative Sozialforschung/Forum: Qualitative Social Research* (Vol. 3).

Glaser, B., & Strauss, A. (1967). *The Discovery of Grounded Theory: Strategies for Qualitative Research*. New York: Aldine Pub. Co.

Goodman, M., & Benet, L. (1991). *People, August 19*, 69-70, 72-73.

Granfield, R., & Cloud, W. (1999). *Coming Clean: Overcoming Addiction Without Treatment*. New York: New York University Press.

Granfield, R., & Cloud, W. (2001). Social Context and "Natural Recovery": The Role of Social Capital in the Resolution of Drug Associated Problems. *Substance Use & Misuse, 36*(11), 1543-1570.

Grant, B. F. (1996). Prevalence and Correlates of Drug Use and DSM-IV Drug Dependence in the United States: Results of the National Longitudinal Alcohol Epidemiologic Survey. *Journal of Substance Abuse, 8*(2), 195-210.

Greenberger, D., & Padesky, C. A. (1995). *Mind Over Mood: A Cognitive Therapy Treatment Mannual for Clients*. New York: Guilford Press.

Hamill, P. (2008). *A Drinking Life: A Memoir*: Hachette Digital, Inc.

Hasin, D., & Grant, B. (1995). AA and Other Help Seeking for Alcohol Problems: Former Drinkers in the U.S. General Population. *Journal of Substance Abuse, 7*, 281-292.

Hudelson, P. M. (1996). *Qualitative Research for Health Programmes*: World Health Organization, Division of Mental Health and Prevention of Substance Abuse.

Hughes, J. R. (1996). Treating Smokers with Current or Past Alcohol Dependence. *American Journal of Health Behavior, 20*, 286-290.

Humphreys, K., Moos, R. H., & Finney, J. W. (1995). Two Pathways Out of Drinking Problems Without Professional Treatment. *Addictive Behaviors, 20*(4), 427-441.

Institute of Medicine. (1990). *Broadening the Base of Treatment for Alcohol Problems*. Washington, DC.: National Academy Press.

Islam, A. K. M. S. (2006). *The Integration of Islamic Values into Drug Demand Reduction Strategies Prevention*. Dhaka: Department of Narcotics Control.

Jasperse, M. L. (2006). *Assessment of Navajo Men Who Have Naturally Recovered from Their Drinking Problems Without Treatment (Doctoral dissertation)*. University of New Mexico.

Johnson, V. E. (1980). *I'll Quit Tomorrow: A Practical Guide to Alcoholism Treatment*. San Francisco: Harper & Row.

Kahan, M. (1996). Identifying and Managing Problem Drinkers. *Canadian Family Physician, 42*, 661.

Kandel, D. B., & Raveis, V. H. (1989). Cessation of Illicit Drug Use in Young Adulthood. *Archives of General Psychiatry, 46*(2), 109.

Kearney, M. H. (1998). Truthful Self Nurturing: A Grounded Formal Theory of Women's Addiction Recovery. *Qualitative Health Research, 8*(4), 495-512.

Klingemann, H. K. H. (1991). The Motivation for Change from Problem Alcohol and Heroin Use. *British Journal of Addiction, 86*(6), 727-744.

Klingemann, H. K. H. (2000). Natural Recovery from Alcohol Problems. In N. J. P. T. Heather & T. R. Stockwell (Eds.), *Handbook of Alcohol Dependence and Related Problems, Section VI. Treatment and Recovery* (pp. 161). New York: John Wiley & Sons.

Klingemann, H. K. H., Sobell, L. C., Barker, J., Blomqvist, J., Cloud, W., & Ellingstad, T. P. (2001). *Promoting Self Change from Problem Substance Use: Practical Implications for Policy, Prevention and Treatment*. Boston: Kluwer Academic Publishers.

Koski-jännes, A., & Turner, N. (1999). Factors Influencing Recovery from Different Addictions. *Addiction Research & Theory, 7*(6), 469-492.

Kunitz, S. J., & Levy, J. E. (1994). *Drinking Careers: A Twenty Five Year Follow-up of Three Navajo Populations*. New Haven, CT: Yale University.

Labouvie, E., & Bates, M. E. (2002). Reasons for Alcohol Use in Young Adulthood: Validation of a Three Dimensional Measure. *Journal of Studies on Alcohol, 63*, 145-155.

Laudet, A. B. (2007). What Does Recovery Mean to You? Lessons from the Recovery Experience for Research and Practice. *Journal of Substance Abuse Treatment, 33*(3), 243-256.

Laudet, A. B., White, W., & Morgen, K. (2005). What Does Recovery Mean to You? Definition, Goals, and Experiences from the Recovering Community *133rd Annual Meeting of the APHA*. Philadelphia.

Levy, J. E., & Kunitz, S. J. (1974). *Indian Drinking: Navajo Practices and Anglo-American Theories*. New York: Wiley.

Longabaugh, R., Wirtz, P. W., Zweben, A., & Stout, R. L. (1998). Network Support for Drinking, Alcoholics Anonymous and Long Term Matching Effects. *Addiction, 93*(9), 1313-1333.

Margolis, R., Kilpatrick, A., & Mooney, B. (2000). A Retrospective Look at Long Term Adolescent Recovery: Clinicians Talk to Researchers. *Journal of Psychoactive Drugs, 32*(1), 117-125.

Mariezcurrena, R. (1994). Recovery from Addictions Without Treatment: Literature Review. *Cognitive Behaviour Therapy, 23*(3-4), 131-154.

Marlatt, G. A., Curry, S., & Gordon, J. R. (1988). A Longitudinal Analysis of Unaided Smoking Cessation. *Journal of Consulting and Clinical Psychology, 56*(5), 715-720.

Marlatt, G. A., & Gordon, J. (1986). *Relapse Prevention*. New York: Guilford Press.

Marlatt, G. A., & Gordon, J. R. (1985). *Relapse Prevention: Maintenance Strategies in the Treatment of Addictive behaviors*. New York: The Guilford Press.

May, P. A. (1996). An Overview of Alcohol Abuse Epidemiology for American Indian Populations. In G. D. Sandefur, R. R. Rundfuss & B. Cohen (Eds.), *Changing*

Numbers, Changing Needs: American Indian Demography and Public Health (pp. 235-261). Washington, D.C.: National Academy Press.

May, P. A. (2001). Alcohol Use and Abuse Among American Indians. In C. D. Bryant (Ed.), *The International Encyclopedia of Criminology And Devient Behavior* (Vol. IV, pp. 63-68). Philadelphia, PA: Brunner-Routledge.

McAweeney, M. J., Zucker, R. A., Fitzgerald, H. E., Puttler, L. I., & Wong, M. M. (2005). Individual and Partner Predictors of Recovery from Alcohol Use Disorder Over a Nine Year Interval: Findings from a Community Sample of Alcoholic Married Men. *Journal of Studies on Alcohol and Drugs, 66*(2), 220.

McCrady, B. S. (2004). To Have But One True Friend: Implications for Practice of Research on Alcohol Use Disorders and Social Networks. *Psychology of Addictive Behaviors, 18*(2), 113-121.

McLellan, A. T., McKay, J. R., Forman, R., Cacciola, J., & Kemp, J. (2005). Reconsidering the Evaluation of Addiction Treatment: From Retrospective Follow Up to Concurrent Recovery Monitoring. *Addiction, 100*(4), 447-458.

Miller, W. R., & Rollnick, S. (1991). *Motivational Interviewing: Preparing People to Change Addictive Behavior*: Guilford Press.

Miller, W. R., & Rollnick, S. (2002). *Motivational Interviewing: Preparing People for Change*. New York: Guilford Press.

Morrow, S. L., & Smith, M. L. (1995). Constructions of Survival and Coping by Women Who Have Survived Childhood Sexual Abuse. *Journal of Counseling Psychology, 42*, 24-33.

Morrow, S. L., & Smith, M. L. (2000). Qualitative Research for Counseling Psychology. In S. D. Brown & R. W. Lent (Eds.), *Handbook of Counseling Psychology (3rd ed.)* (pp. 199-230). Hoboken, NJ, US: John Wiley & Sons Inc.

Morse, J. M. (2009). *Tussles, tensions, and resolutions. Developing grounded theory: The second generation*.

Narrow, W. E., Regier, D. A., Rae, D. S., Manderscheid, R. W., & Locke, B. Z. (1993). Use of Services by Persons With Mental and Addictive Disorders: Findings from the National Institute of Mental Health Epidemiologic Catchment Area Program. *Archives of General Psychiatry, 50*(2), 95.

National Institute on Drug Abuse. (2000). *Principles of Drug Addiction Treatment: A Research Based Guide*: National Institute on Drug Abuse, National Institutes of Health.

Nelson, C. (2004). Natural Recovery from Alcohol Problems and Its Implications on the Disease Model of Addiction and the DSM-IV Diagnostic Criteria for Alcohol Dependence. *Graduate Faculty Psychology Bulletin, 2*(2), 115-127.

Oxford English Dictionary. (1989). Oxford: Oxford University Press.

Park, J., Johnson, K., & Matsumoto, N. (1991). *People, August 26*, 58-60.

Reddy, A., Hoque, M. M., & Kelly, R. (2008). HIV Transmission in Bangladesh: An Analysis of IDU Programme Coverage. *International Journal of Drug Policy, 19*, 37-46.

Robins, L. N. (1993). Vietnam Veterans' Rapid Recovery from Heroin Addiction: A Fluke or Normal Expectation? *Addiction, 88*(8), 1041-1054.

Room, R. (1977). Measurement and Distribution of Drinking Patterns and Problems in General Populations. *Alcohol Related Disabilities, 32*, 61-87.

Rosen, M., Hoover, E., & Stambler, L. (1991). *People, August 19*, 74-78, 80.

Rumpf, H. J., Bischof, G., Hapke, U., Meyer, C., & John, U. (2002). The Role of Family and Partnership in Recovery from Alcohol Dependence: Comparison of

Individuals Remitting With and Without Formal Help. *European Addiction Research, 8*(3), 122-127.

Schasre, R. (1966). Cessation Patterns among Neophyte Heroin Users. *Substance Use & Misuse, 1*(2), 23-32.

Schutt, R. (2006). *Investigating the social world (5th ed.)*. Thousand Oaks, CA: Pine Forge Press.

Schutte, K. K., Byrne, F. E., Brennan, P. L., & Moos, R. H. (2001). Successful Remission of Late Life Drinking Problems: A 10 Year Follow Up. *Journal of Studies on Alcohol and Drugs, 62*(3), 322.

Scott, C. K., Foss, M. A., & Dennis, M. L. (2005). Pathways in the Relapse—Treatment—Recovery Cycle Over 3 Years. *Journal of Substance Abuse Treatment, 28*(2), 63-S72.

Shoham-Salomon, V., & Rosenthal, R. (1987). Paradoxical interventions: A meta-analysis. *Journal of Consulting and Clinical Psychology, 55*(1), 22-28. doi: 10.1037/0022-006X.55.1.22

Skinner, B. F. (1969). *Contingencies of Reinforcement*: Appleton-Century-Crofts.

Snow, M. G., Prochaska, J. O., & Rossi, J. S. (1994). Processes of Change in Alcoholics Anonymous: Maintenance Factors in Long Term Sobriety. *Journal of Studies on Alcohol and Drugs, 55*(3), 362-371.

Sobell, L. C., Agrawal, S., Annis, H., Ayala-Velazquez, H., Echeverria, L., Leo, G. I., . . . Thomas, S. (2001). Cross Cultural Evaluation of Two Drinking Assessment Instruments: Alcohol Timeline Followback and Inventory of Drinking Situations. *Substance Use & Misuse, 36*(3), 313-331.

Sobell, L. C., Cunningham, J. A., & Sobell, M. B. (1996). Recovery from Alcohol Problems With and Without Treatment: Prevalence in Two Population Surveys. *American Journal of Public Health, 86*(7), 966-972.

Sobell, L. C., Cunningham, J. A., Sobell, M. B., Agrawal, S., Gavin, D. R., Leo, G. I., & Singh, K. N. (1996). Fostering Self Change Among Problem Drinkers: A Proactive Community Intervention. *Addictive Behaviors, 21*(6), 817-833.

Sobell, L. C., Ellingstad, T. P., & Sobell, M. B. (2000). Natural Recovery from Alcohol and Drug Use Associated Problems: Methodological Review of the Research with Suggestions for Future Directions. *Addiction, 95*(5), 749-764.

Sobell, L. C., Klingemann, H. K. H., Toneatto, T., Sobell, M. B., Agrawal, S., & Leo, G. I. (2001). Alcohol and Drug Abusers' Perceived Reasons for Self Change in Canada and Switzerland: Computer Assisted Content Analysis. *Substance Use & Misuse, 36*(11), 1467-1500.

Sobell, L. C., Sobell, M. B., & Toneatto, T. (1992). Recovery from Alcohol Problems Without Treatment. In N. Heather, W. R. Miller & J. Greeley (Eds.), *Self Control and Addictive Behaviors* (pp. 198-242). New York: Maxwell Macmillan.

Sobell, L. C., Sobell, M. B., Toneatto, T., & Leo, G. I. (1993). What Triggers the Resolution of Alcohol Problems Without Treatment? *Alcoholism: Clinical and Experimental Research, 17*(2), 211-224.

Sobell, M. B., & Sobell, L. C. (1993a). *Problem Drinkers: Guided Self Change Treatment*. New York: Guilford Press.

Sobell, M. B., & Sobell, L. C. (1993b). Treatment for Problem Drinkers: A Public Health Priority. In J. S. Baer, G. A. Marlatt & R. J. McMahon (Eds.), *Addictive Behaviors Across the Lifespan: Prevention, Treatment, and Policy Issues* (pp. 138–157). Beverly Hills, CA.: Sage.

Sobell, M. B., & Sobell, L. C. (1998). Guiding Self Change. In W. R. Miller & N. Heather (Eds.), *Treating Addictive Behaviors, 2nd Ed.* (pp. 189–202). New York: Plenum.

Sobell, M. B., Sobell, L. C., & Leo, G. I. (2000). Does Enhanced Social Support Improve Outcomes for Problem Drinkers in Guided Self Change Treatment? *Journal of Behavior Therapy and Experimental Psychiatry, 31*(1), 41-54.

Stern, P. N. (1994). Eroding Grounded Theory. In J. Morse (Ed.), *Critical Issues in Qualitative Research Methods* (pp. 212-223). Thousand Oaks, CA: Sage.

Stommel, M., & Willis, C. E. (2004). *Clinical Research: Concepts and Principles for Advanced Practice Nurses*: Lippincott Williams & Wilkins.

Strauss, A., & Corbin, J. (1990). *Basics of Qualitative Research: Grounded Theory Procedures and Techniques*. Newbury Park, CA: Sage.

Strauss, A., & Corbin, J. (1998). Basics of Qualitative Research: Techniques and Procedures for Developing Grounded Theory (2nd ed.). Thousands Oaks: CA, London: Sage Publication.

Substance Abuse and Mental Health Administration. (1999). *Enhancing Motivation for Change in Substance Abuse Treatment (Treatment Improvement Protocol Series)*. Rockville, MD.: US Department of Health and Human Services.

Toneatto, T., Sobell, L. C., Sobell, M. B., & Rubel, E. (1999). Natural Recovery from Cocaine Dependence. *Psychology of Addictive Behaviors, 13*(4), 259-268.

Tuchfeld, B. S. (1981). Spontaneous Remission in Alcoholics: Empirical Observations and Theoretical Implications. *Journal of Studies on Alcohol and Drugs, 42*(07), 626.

Tucker, J. A., Vuchinich, R. E., & Rippens, P. D. (2004). A Factor Analytic Study of Influences on Patterns of Help Seeking Among Treated and Untreated Alcohol Dependent Persons. *Journal of Substance Abuse Treatment, 26*(3), 237-242.

United Nations Office on Drugs & Crime. (2010). *World Drug Report 2010*: United Nations Publications.

US Department of Health & Human Services. (1988). *The Health Consequences of Smoking: Nicotine Addiction, a Report of the Surgeon General*. Washington, DC: US Government Printing Office.

US Dept. of State–Bureau for International Narcotics, & Law Enforcement Affairs. (2005). International Narcotics Control Strategy Report.

Vaillant, G. (1995). *The Natural History of Alcoholism Revisited*. Cambridge, MA: Harvard University Press.

Van Beurden, E., Reilly, D., Dight, R., Mitchell, E., & Beard, J. (2000). Alcohol Brief Intervention in Bars and Taverns: A 12 month Follow-up Study of Operation Drinksafe in Australia. *Health Promotion International, 15*(4), 293-302.

Varkevisser, C. M., Pathmanathan, I., & Brownlee, A. (2003). *Designing and Conducting Health Systems Research Projects. Volume I: Proposal Development and Fieldwork*. Amsterdam: KIT Publishers.

Vielva, I., & Iraugi, I. (2001). Cognitive and Behavioural Factors as Predictors of Abstinence Following Treatment for Alcohol Dependence. *Addiction, 96*, 297-303.

Waldorf, D., & Biernacki, P. (1979). Natural Recovery from Heroin Addiction: A Review of the Incidence Literature. *Journal of Drug Issues, 9*(2), 282-289.

Walters, G. D. (2000). Spontaneous Remission from Alcohol, Tobacco, and Other Drug Abuse: Seeking Quantitative Answers to Qualitative Questions. *The American Journal of Drug and Alcohol Abuse, 26*(3), 443-460.

Watson, A. L., & Sher, K. J. (1998). Resolution of Alcohal Problems Without Treatment: Methodological Issues and Future Directions of Natural Recovery Research. *Clinical Psychology: Science and Practice, 5*(1), 1-18.

WHO Expert Committee on Drug Dependence. (2003). *WHO Expert Committee on Drug Dependence: Thirty Third Report* (Vol. 33): World Health Organization.

Wille, R. (1981). Ten Year Follow Up of a Representative Sample of London Heroin Addicts: Clinic Attendance, Abstinence and Mortality. *British Journal of Addiction, 76*(3), 259-266.

Winick, C. (1962a). Maturing Out of Narcotic Addiction. *Bulletin on Narcotics, 14*(1), 1-7.

Winick, C. (1962b). *The Narcotic Addiction Problem*. New York: American Social Health Association.

Winick, C. (1964). The Life Cycle of the Narcotic Addict and of Addiction. *UN Bulletin on Narcotics, 16*(1), 1-11.

World Health Organization. (1985). *Basic Documents. 35th ed*. Geneva, Switzerland: WHO.

World Health Organization. (1992). *International Classification of Mental and Behavioural Disorders: ICD-10*. Geneva, Ill: WHO.

Zinberg, N. E., Harding, W. M., & Winkeller, M. (1977). A Study of Social Regulatory Mechanisms in Controlled Illicit Drug Users. *Journal of Drug Issues*.

APPENDICES

Appendix **A**: **Questionnaire for Retrospective Diagnosis of Substance Dependence**

মাদকাসক্তির রেট্রোস্পেকটিভ ডায়াগ্‌নসিস-এর প্রশ্নমালা
(অংশগ্রহনকারীর জন্য)

১	আপনি মোট কত মাস বা বছর নেশা গ্রহন করেছিলেন?		
২	কি কি নেশা নিতেন?		
৩	প্রধান নেশা কি ছিল?		
৪	সর্বশেষ নেশা করার সময়কালে কি পরিমাণ নেশা সেবন করতেন?		
ক	প্রতিদিন মোট কত এ্যাম্পুল/স্টিক/পুরিয়া/গ্রাম ইত্যাদি সেবন/গ্রহন করতেন?		
খ	সারাদিনে কতবার নিতেন?		
৫	প্রথম যখন নেশা আরম্ভ করলেন, তখন কি ঠিক এই পরিমানেই গ্রহন করতেন?	হ্যাঁ	না
৬	অভ্যাস পুরানো হওয়ার সংগে সংগে কি লক্ষ্য করেছিলেন যে নেশা আরও অধিক মাত্রায় প্রয়োজন হচ্ছে?	হ্যাঁ	না
৭	কতগুন বৃদ্ধি পেয়েছিল বলে আপনি মনে করেন?		
৮	কি কারনে নেশার পরিমান বৃদ্ধি করতে হয়েছিল?		
৯	আপনি কি প্রায়ই নেশা ব্যবহার বা জোগাড় করার জন্য সর্বদাই ব্যস্ত থাকতেন?	হ্যাঁ	না
১০	কখনও কি নির্দিষ্ট সময়ে নেশা ব্যবহার করতে না পারার কারনে অসুস্থ হয়ে পরেছিলেন?	হ্যাঁ	না
১১	নেশা ছাড়ার সময় কি কি উপসর্গ বা লক্ষন দেখা দিত?		
	চোখ ও নাক দিয়ে পানি পরা?	হ্যাঁ	না
	বমি করা?	হ্যাঁ	না
	বমি বমি ভাব?	হ্যাঁ	না

	সারা গায়ে প্রচন্ড বা মাঝারী ব্যাথা?	হ্যাঁ	না
	পাতলা পায়খানা?	হ্যাঁ	না
	শরীর দুর্বল বোধ করা?	হ্যাঁ	না
	ঘুমের সমস্যা?	হ্যাঁ	না
	খাওয়ার রুচি না থাকা?	হ্যাঁ	না
	অন্যান্য লক্ষণ?		
১২	এই সমস্যার উপসর্গ কি একটানা ১ মাস বা গত ৬ মাসে বার বার আপনাকে কষ্ট দিয়েছিল?	হ্যাঁ	না
১৩	নেশা পুন:ব্যবহারে কি এই অসুস্থতা বা উপসর্গ দূর হয়েছিল?	হ্যাঁ	না
১৪	আপনি কি কোন Prescribed Medicine প্রয়োজনের অতিরিক্ত Dose নিয়েছিলেন অথবা দীর্ঘ সময়ের জন্য সেবন করেছিলেন?	হ্যাঁ	না
১৫	নেশার কারনে কি কার্যক্ষেত্রে বা পরিবারে কোন ঝামেলার সৃষ্টি হয়েছিল?	হ্যাঁ	না
১৬	নেশার জন্য কি কোনদিন কর্তব্য পালনে ব্যর্থ হয়েছিলেন?	হ্যাঁ	না
১৭	নেশার কারনে কোন শারিরীক রোগ হওয়া সত্ত্বেও কি নেশা ব্যবহার চালু রেখেছিলেন?	হ্যাঁ	না
১৮	নিজে থেকে কখনও নেশার ব্যবহার কমাতে বা বন্ধ করতে চেষ্টা করেছিলেন?	হ্যাঁ	না
	কখনও কি সম্পূর্ণ বন্ধ করতে পেরেছিলেন?	হ্যাঁ	না
	(যদি পেরে থাকেন) কতদিন সুস্থ ছিলেন?		
	আংশিক বন্ধ করতে পেরেছিলেন?	হ্যাঁ	না
	এভাবে মোট কতবার চেষ্টা করেছিলেন?		

অংশগ্রহনকারীর নাম: (ঐচ্ছিক) . . . . . .

স্বাক্ষর: . . . . . **বা** টিপ্‌সই: . . . . . .

তারিখ: . . . . . .

Appendix **B: Natural Recovery Identification Screening Questionnaire**

গবেষণায় অন্তর্ভুক্তি বিষয়ক নির্বাচনী প্রশ্নমালা

(অংশগ্রহনকারীর জন্য)

১	আপনি মোট কত মাস বা বছর নেশা মুক্ত আছেন?		
২	আপনি শেষ কবে নেশা করেছিলেন? (আনুমানিক তারিখ বা মাসের নাম উল্লেখ করুন)		
৩	এর আগে কি কখনও নেশা ছাড়ার চেষ্টা করেছিলেন?	হ্যাঁ	না
৪	(করে থাকলে) কতবার চেষ্টা করেছিলেন?		
৫	সম্পূর্ণ সফল হয়েছিলেন?	হ্যাঁ	না
ক	আংশিক সফল হয়েছিলেন?	হ্যাঁ	না
খ	(সম্পূর্ণ সফল হয়ে থাকলে) কতসময় ধরে নেশামুক্ত থাকতে পেরেছিলেন?		
৬	আপনি কি নেশা ছাড়ার জন্য জীবনে কখনও কোন চিকিৎসা কেন্দ্রে ভর্তি ছিলেন?	হ্যাঁ	না
৭	(উত্তর হ্যাঁ হলে) প্রতিষ্ঠানের নাম?		
৮	চিকিৎসা গ্রহনের সময়কাল		
৯	চিকিৎসার ধরন কি ছিল?		
১০	এভাবে মোট কতবার চিকিৎসা নিয়েছিলেন?		
১১	আপনি কি সম্পুর্ন নিজের চেষ্টায় স্বেচ্ছায় নেশা থেকে বিরত হয়েছেন?	হ্যাঁ	না
১২	আপনি কিভাবে নেশা প্রত্যাহারজনিত শারিরীক উপসর্গসমূহ মোকাবেলা করেছিলেন?		
	আপনি কি জীবনে কখনও ডিটক্সিফিকেশন চিকিৎসার আওতাধীন ছিলেন?	হ্যাঁ	না
	(যদি থেকে থাকেন) কতবার ছিলেন?		
	(প্রতিবারে) কতদিন করে ছিলেন?		
	আপনি কি বেড়া সামলানোর জন্য কোন ওষুধ গ্রহন করেছিলেন?	হ্যাঁ	না
	(করে থাকলে) কোথা থেকে জানলেন?		
	ওষুধের নাম কি?		
	অন্যান্য প্রক্রিয়াসমূহ বর্ণনা করুন?		
	আপনার বর্তমান নেশামুক্ত জীবনে কোনদিন কি এমনটা হয়েছে যে, আপনি কোন প্রতিকুল পরিস্থিতিতে অথবা অন্য কোন কারনে এ্যাক্সিডেন্টালি বা ভুলবশত: অল্প পরিমান নেশাদ্রব্য গ্রহন করে ফেলেছিলেন, অর্থাৎ স্লিপ করেছিলেন? (এক্ষেত্রে কেবলমাত্র সিগারেট প্রযোজ্য নয়)	হ্যাঁ	না
	(যদি করে থাকেন) পরবর্তীতে কি সেটা (নেশা গ্রহন) কিছু দিনের জন্য	হ্যাঁ	না

	অব্যাহত ছিল?		
১৩	(হয়ে থাকলে) কতদিন নিয়েছিলেন?		
১৪	কি নিয়েছিলেন?		
১৫	কি পরিমান গ্রহন করেছিলেন?		
১৬	আপনি কি বর্তমানে মাঝে মাঝে কোন সামাজিক অনুষ্ঠানে বা আনন্দদায়ক পরিস্থিতিতে উপভোগের জন্য কদাচীৎ ভাবে এ্যালকোহল বা অন্যান্য কিছু গ্রহন করেন?	হ্যাঁ	না
১৭	বর্তমানে কি আপনার নিম্নোল্লিখিত কোন নিয়মিত অভ্যাস রয়েছে?	হ্যাঁ	না
	* গুল ব্যবহার		
	* অতিরিক্ত জর্দাযুক্ত পান ব্যবহার		
	* এ্যানার্জি ড্রিংক		
	* বিয়ার খাওয়া		
	* অন্যান্য		
১৮	আপনি কি কখনও কোন প্রয়োজনে মনোচিকিৎসকের শরনাপন্ন হয়েছিলেন? অথবা আপনার ফ্যামিলি কখনও আপনাকে কোন মনোচিকিৎসকের কাছে যেতে বাধ্য করেছিল ?	হ্যাঁ	না
১৯	আপনি কি বর্তমানে কোন কারনে মনোচিকিৎসক কর্তৃক প্রেরিত কোন ওষুধ সেবন করেন?	হ্যাঁ	না

অংশগ্রহনকারীর নাম: (ঐচ্ছিক) . . . . . .

স্বাক্ষর: . . . . . **বা** টিপ্‌সই: . . . . . .

তারিখ: . . . . . .

Appendix **C: Questionnaire for Validity Checking**

গবেষণায় অন্তর্ভুক্তি বিষয়ক প্রশ্নমালা (পরিচিত ও তাৎপর্যপূর্ণ ব্যক্তিদের জন্য)

১	আপনার জানামতে উনি কতদিন ধরে সম্পূর্ণভাবে নেশামুক্ত আছেন ?		
২	আপনি কি স্মরণ করে বলতে পারেন যে উনি শেষ কবে নেশা গ্রহন করেছিলেন? (আনুমানিক তারিখসহ মাস/বছর)		
৩	আপনার জানা মতে কি উনি মাঝে মাঝে অল্প পরিমাণ নেশা গ্রহন করে থাকেন?	হ্যাঁ	না √
৪	আপনার জানা মতে, বর্তমান নেশামুক্ত সময়কালে উনি কি গত এক বছরের মধ্যে একদিনের জন্য হলেও নেশা গ্রহন করেছিলেন?	হ্যাঁ	না
৫	নেশা প্রত্যাহারজনিত শারিরীক উপসর্গগুলো কি আপনি বুঝতে পারতেন বা পারেন?	হ্যাঁ	না
৬	অতীতে কখনও অতিরিক্ত নেশা করলে আপনি কি লক্ষণ দেখে বুঝতে পারতেন?	হ্যাঁ	না
৭	উনি যখন নেশা করতেন তখন কি ধরনের আচরণগত সমস্যা ছিল?		
৮	নেশা থেকে বিরত হবার পর আপনি উনার মধ্যে কি কি আচরণগত পরিবর্তন লক্ষ্য করেছেন বা করছেন?		
৯	নেশা মুক্ত হবার পর আপনি উনার মধ্যে কি ধরনের আবেগীয় পরিবর্তন লক্ষ্য করেছেন বা করছেন?		
১০	কোন রকম শারিরীক পরিবর্তন কি লক্ষ্য করেছেন?	হ্যাঁ	না
১১	উনার অতীতের (নেশাকালীন সময়) অবস্থার সাথে বর্তমান (নেশামুক্ত সময়) অবস্থার কি একটা তুলনামূলক চিত্র তুলে ধরতে পারেন?		

১২	আপনি কিভাবে নিশ্চিত হতে পারেন যে উনি বর্তমানে একদম কোন প্রকার নেশা গ্রহন করেন না? (একাধিক টিক চিহ্ন গ্রহনযোগ্য)		
	* আচরণ দেখে	হ্যাঁ	না
	* মেজাজের পরিবর্তন বা ধরন দেখে	হ্যাঁ	না
	* শারিরীক অবস্থা পর্যবেক্ষণ করে	হ্যাঁ	না
	* ঘুমের ধরন দেখে	হ্যাঁ	না
	* লাইফ স্টাইল-এর পরিবর্তন দেখে	হ্যাঁ	না
	* অন্যান্য (যদি কিছু থাকে)		
১৩	আপনি কি নিশ্চিতভাবে উনাকে একজন নেশামুক্ত ব্যক্তি হিসেবে আখ্যায়িত করতে পারেন?	হ্যাঁ	না
১৪	আপনি এই ব্যাপারে কত ভাগ নিশ্চিত? (০ মানে 'একদম নিশ্চিত নই' এবং ১০০ মানে 'সম্পূর্ণ নিশ্চিত')		
১৫	(যদি % বেশী হয়) একটু কি বলবেন, আপনি কিভাবে এতটা নিশ্চিতভাবে বলতে পারছেন?		

মন্তব্য প্রদানকারী পরিচিত ব্যক্তির নাম: . . . . . .

স্বাক্ষর: . . . . . **বা** টিপ্‌সই: . . . . . .

তারিখ: . . . . . .

Appendix **D: Topic Guide**

Topic Guide on the Exploration of

"Natural Recovery Process"

** ***How have you been able to quit drugs?***

* **Details on Pre-morbid drug life, Drug taking life and Recovery life:**

- Life involvements:-
  Relationship
  Significant life events
  Self-conception
  Experience of transaction period (e.g. from normal life to drug life)

*** Details on Drug taking period:**

- Reasons for involvement into drug life.
- Extent of drug use
- Attitude towards self and addiction
- Conditions that brought about idea to stop using drugs.
- Experience of transition period (e.g. from practicing life to drug free life)

* **Attempt for abstinence:**

- Frequency
- Duration of sobriety (each episode)
- Any Relapse? Reasons for relapse?
- Prevention of relapse at present (which failed in the past)

*** Actions taken to enact idea to stop:**

- Reasons for not seeking professional help
- Craving management (High risk situation and Trigger management)

*** Details on Recovery period:**

Challenging issues in present recovery life:

- Ways to handle those challenging issues
- Coping strategy to handle own emotional feeling
- Factors influencing the maintenance of recovery.

* Changes undergone in self-conception and life style:

Conception:-

- About self
- About addiction and drug treatment
- Personal philosophy

Life style :-(Prior to recovery/Present or new)

- Description about new life style
- Description of a typical day on last week
- Difference of the present life style from the old life style
- Difficulties experienced since giving up old life style

*** Barriers to stop using drug:**

Ways to manage those barriers.

* **Challenges during the transition period of quitting drug.**

Ways to handle those challenges.

* A lot of people fail to quit drug; what do you think about the reasons?
* What will you suggest for them?

** Plans for your future?

** Achievements since changing life?

** Summary:-

- Most important things that led to your present life style (rank your responses according to strength)
  i.
  ii.
- Most significant things that have helped you to control your drug use(rank your responses according to strength)
  i.
  ii.

*** Common Probe Questions to be asked at appropriate space:-

- Specific cognition
- Particular memory
- Pattern of appraisal
- Style of interpretation
- Emotion or feeling
- Physiological change (if any)
- Specific behavior

Appendix **E: Demographic Information Sheet**

Demographic Information Sheet

তারিখ: - - ১ ২	ক্রমিক নং: Code

লিঙ্গ: ( ) পুরুষ ( ) মহিলা	বয়স: . . . . .

বৈবাহিক অবস্থা: ( ) বিবাহিত ( ) অবিবাহিত ( ) ডিভোর্স ( ) বিধবা/বিপত্নীক
( ) আলাদা বসবাসরত ( ) অন্যান্য...

ছেলে-মেয়ে (যদি থাকে): ছেলের সংখ্যা... ... . মেয়ের সংখ্যা... ... ...

পরিবারের মোট সদস্য সংখ্যা: ... ...

পেশা: ( ) চাকুরীজিবী ( ) ব্যবসা ( ) ছাত্র ( ) বেকার ( ) গৃহিনী ( ) খন্ডকালীন চাকুরী
( ) অন্যান্য. . . . . .

মোট আয়: পরিবারের সম্মিলিত. . . . . কেবলমাত্র ব্যক্তিগত . . . .

আর্থ-সামাজিক অবস্থা: ( ) নিম্নবিত্ত ( ) উচ্চ-নিম্নবিত্ত ( ) নিম্ন-মধ্যবিত্ত ( ) মধ্য-মধ্যবিত্ত
( ) উচ্চ-মধ্যবিত্ত ( ) উচ্চবিত্ত

শিক্ষাগত যোগ্যতা: ( ) স্বাক্ষর জ্ঞান সম্পন্ন ( ) প্রাথমিক ( ) মাধ্যমিক
( ) উচ্চ মাধ্যমিক ( ) স্নাতক ( ) স্নাতকোত্তর ( ) অন্যান্য... ... ...

ধর্ম: ( ) ইসলাম ( ) হিন্দু ( ) বৌদ্ধ ( ) খ্রিস্টান ( ) অন্যান্য ... .

বর্তমান অবস্থান: ( ) রাজধানীতে ( ) রাজধানীর বাইরে মূল শহরে ( ) রাজধানীর বাইরে গ্রামে

আপনি কি রাজধানীতে স্থায়ীভাবে বসবাসরত
( ) অথবা ( ) মাইগ্রেটেড/স্থানান্তরিত ?

নেশা করার সর্বোচ্চ মোট সময়কাল: ... .

নেশামুক্ত জীবনের মোট স্থায়ীত্বকাল: .... ..

আপনি শেষ কবে নেশা করেছেন ? দিন.. .. .. মাস.. .. .. .. বছর.. .. .. .. (আনুমানিক)

মাঠ পর্যায়ের নোট:

Appendix **F: Consent Form**

গবেষণায় অংশগ্রহনের জন্য সম্মতি পত্র

গবেষণার শিরোনাম: **নেশার নির্ভরশীলতার ক্ষেত্রে চিকিৎসা ব্যতীত নেশামুক্তি লাভের প্রক্রিয়ার মনো-সামাজিক উপাদানসমূহ অনুধাবণ**

এই সম্মতি পত্রটি গবেষণার রেকর্ড হিসেবে ঢাকা বিশ্ববিদ্যালয়ের (Dhaka University) গবেষকের কাছে জমা থাকবে।

আমি ঢাকা বিশ্ববিদ্যালয়ের (Dhaka University) উপরোল্লিখিত গবেষণা প্রকল্পে অংশগ্রহন করার জন্য সম্মতি দিচ্ছি। আমাকে গবেষণা প্রকল্পটি সম্পর্কে বিস্তারিতভাবে বুঝিয়ে বলা হয়েছে এবং আমি এই সংক্রান্ত ব্যাখ্যামূলক বিবৃতি পড়েছি (বা আমাকে পড়ে শোনানো হয়েছে) যা আমার কাছে রেকর্ড হিসেবে রাখা আছে। আমি বুঝতে পারছি যে, সম্মতি প্রদানের মানে হচ্ছে:

আমি গবেষকের কাছে সাক্ষাৎকার প্রদানে সম্মতি দিচ্ছি ☐ হ্যাঁ ☐ না

আমি সাক্ষাৎকারটি ক্যসেটে রেকর্ড করার সম্মতি দিচ্ছি ☐ হ্যাঁ ☐ না

আমি প্রয়োজনে পরবর্তীতে আবারও সাক্ষাৎকার প্রদানে সম্মতি দিচ্ছি ☐ হ্যাঁ ☐ না

এবং

আমি বুঝতে পারছি যে, আমার অংশগ্রহন স্বেচ্ছামূলক; আমি ইচ্ছে করলে আংশিক বা সম্পূর্ন প্রকল্পে অংশগ্রহন করা থেকে বিরত থাকতে পারি এবং গবেষণা চলাকালীন যে কোন পর্যায়ে আমার অংশগ্রহন প্রত্যাহার করতে পারি যার জন্য আমাকে কোন ভাবেই ক্ষতিগ্রস্থ করা হবে না।

এবং

আমি বুঝতে পারছি যে, গবেষণায় একক সাক্ষাৎকারের মাধ্যমে যে তথ্য আহরন করা হয়েছে তার প্রকাশনা বা উপস্থাপনায় কোন অবস্থাতেই অংশগ্রহনকারীর নাম-পরিচয় লিপিবদ্ধ থাকবে না বা প্রকাশ করা হবে না।

এবং

আমি বুঝতে পারছি যে, আমি যা তথ্য দেব তার গোপনীয়তা রক্ষা করা হবে, এবং এমন কোন তথ্য কারো কাছে বা কোন রিপোর্টে প্রকাশ করা হবে না যা থেকে আমাকে চেনা সম্ভব।

এবং

আমি বুঝতে পারছি যে, সাক্ষাৎকারের অডিও রেকর্ড ও তা থেকে আহরিত তথ্যের লিখিত অনুলিপি সমূহ একটি নিরাপদ স্থানে সংরক্ষিত থাকবে এবং কেবলমাত্র গবেষক ছাড়া অন্য কারো কাছে তা সহজলভ্য হবে না। তাছাড়াও এসব তথ্য ৫ বছর সংরক্ষনের পর ধ্বংস করে ফেলা হবে যদি এই তথ্য অন্য কোন গবেষণায় ব্যবহারের জন্য আমার পূর্বানুমতি না নেয়া হয়।

অংশগ্রহনকারীর নাম: (ঐচ্ছিক) . . . . . .

স্বাক্ষর: . . . . . **বা** টিপ্‌সই: . . . . . .

তারিখ: . . . . . .

Appendix-G: **Explanatory Statement Report**

গবেষণায় অংশগ্রহনের জন্য ব্যাখ্যামূলক বিবৃতি

গবেষণার শিরোনাম: **নেশার নির্ভরশীলতার ক্ষেত্রে চিকিৎসা ব্যতীত নেশামুক্তি লাভের প্রক্রিয়ার মনো-সামাজিক উপাদানসমূহ অনুধাবণ**

এই ব্যাখ্যামূলক তথ্যসমূহ আপনার কাছে রাখার জন্য

আমি জোহরা পারভীন, আমার এম.ফিল ডিগ্রির অংশ হিসেবে ঢাকা বিশ্ববিদ্যালয়ের চিকিৎসা মনোবিজ্ঞান বিভাগের সহযোগী অধ্যাপক জনাব কামাল উদ্দিন আহমেদ চৌধুরী-এর তত্ত্বাবধানে একটি গবেষণা করছি। এই গবেষণাটির উপর ভিত্তি করে আমাকে একটি থিসিস (প্রাপ্ত তথ্যের উপর ভিত্তি করে রিপোর্ট) লিখতে হবে।

গবেষণার লক্ষ্য

কিভাবে একজন নেশাগ্রস্থ ব্যক্তি স্বেচ্ছায় কোন রকম প্রাতিষ্ঠানিক চিকিৎসা ছাড়াই নেশা প্রত্যাহার বা বর্জন করতে পারে, সেই প্রক্রিয়া বিশদভাবে খুঁজে বের করার চেষ্টা করা হবে এই গবেষণার মাধ্যমে।

কেন আপনাকে এই গবেষণায় অংশগ্রহন করতে অনুরোধ করা হচ্ছে?

এই অনুসন্ধানমূলক গবেষণার তথ্য সংগ্রহের প্রয়োজনে আমি এমন ব্যক্তিদের সাক্ষাৎকার নিতে চাই যারা একসময় নেশা করেছেন কিন্ত বর্তমানে কোন রকম প্রাতিষ্ঠানিক চিকিৎসা ব্যতীত সম্পূর্ণ নিজের প্রচেষ্টায় পুরোপুরি নেশামুক্ত আছেন। আমি আপনার কাছে এসেছি কারন আমার সাহায্যকারী বন্ধু/সহকর্মী/আত্মীয়/পরিচিত (জনাব. . . . . .) আমাকে জানিয়েছেন যে আপনি এই গবেষণায় মূল্যবান তথ্য দিতে পারবেন। কিন্তু এই গবেষণায় আপনার অংশগ্রহনের পূর্বে আমার জানা দরকার যে, আপনার বয়স ১৮ বছরের কম নয়, আপনার এমন কোন মানসিক বা শারীরিক অসুস্থতা নেই যা আপনার কর্মক্ষমতা বাঁধাগ্রস্থ করছে, কারন সে ক্ষেত্রে এই গবেষণায় অংশগ্রহন আপনার জন্য কষ্টকর হতে পারে এবং আপনার দেয়া তথ্য গবেষণায় গুরুত্বপূর্ণ ভুমিকা রাখতে সক্ষম হবে না।

গবেষণায় যা করা হবে

প্রথমত গবেষণায় অন্তর্ভূক্তি বিষয়ক প্রশ্নমালা ব্যবহার করে দেখা হবে আপনি এই গবেষণায় আংশগ্রহনের জন্য উপযুক্ত কিনা। আপনি উপযুক্ত বিবেচিত হলে, একক সাক্ষাৎকারের মাধ্যমে আপনার কাছ থেকে তথ্য আহরন করা হবে এবং তা অডিও ক্যাসেট ও লিখিতভাবে রেকর্ড এবং সংরক্ষন করা হবে।

গবেষণায় অংশগ্রহন করলে যে পরিমান সময় দিতে হবে

গবেষণায় অন্তর্ভূক্তি বিষয়ক প্রশ্নমালাটি পূরন কবতে ১০-১৫ মিনিট সময় লাগতে পারে। আপনি উপযুক্ত বিবেচিত হলে, একক সাক্ষাৎকারে অংশগ্রহনের জন্য আপনাকে ৬০ থেকে ৭৫ মিনিট সময় দিতে হতে পারে। কিন্তু আপনার দেয়া তথ্যের গুরুত্ব অনুসারে পরবর্তীতে আরও এক বা একাধিক বার আপনার সাক্ষাৎকার দেয়া প্রয়োজন হতে পারে। সেক্ষেত্রে আমি তার সময় ও তারিখ আপনার সুবিধা অনুসারে আপনার সাথে আলোচনা করে ঠিক করে নেব।

সম্ভাব্য সুবিধা

নেশা মুক্ত হওয়া এবং তা অব্যাহত রাখতে পারার প্রক্রিয়া অনুধাবনে বর্তমান গবেষণাটির ফলাফল তাৎপর্যপূর্ন ভূমিকা রাখবে বলে আশা করা যায়। পরবর্তীতে সমাজ থেকে মাদকের ভয়াবহ সমস্যা অপসারণের ক্ষেত্রে এই জ্ঞান সফলভাবে ব্যবহার করা সম্ভব। আপনি নিশ্চয়ই জানেন যে, মাদকের মরণ ছোবলের কারনে সারা বিশ্বে এবং বাংলাদেশে অনেক মানুষের মৃত্যু হয়েছে এবং এখনও হচ্ছে। তাছাড়া বাংলাদেশের সর্বপ্রকার অপরাধমূলক কর্মকান্ডের পিছনে মূল ভুমিকা হিসাবে মাদক অন্যতম। অতএব মাদক সমস্যা নিরসনের গুরুত্ব সম্পর্কে আমরা সকলেই কম-বেশী অবহিত।

এই গবেষণায় অংশগ্রহন আপনাকে ব্যাক্তিগতভাবে কোন প্রত্যক্ষ সুবিধা না দিলেও, মাদক সমস্যা নিরসনে সমাজ ও বিশ্বের জন্য এটি হতে পারে একটি সম্ভাবনার শুরু।

গবেষণায় অংশগ্রহনের সম্ভাব্য অসুবিধা

আমি যে সব বিষয়গুলো নিয়ে কথা বলব তার অনেকগুলোই আপনার পূর্বস্মৃতি ও আবেগ বিষয়ক হতে পারে এবং এসব আলোচনায় আপনার মন খারাপ হয়ে যেতে পারে বা এটি সাময়িকভাবে আপনার মধ্যে অস্বস্তি বা কষ্টের উদ্রেক করতে পারে। কিন্তু এটি আপনার মধ্যে কোন দীর্ঘস্থায়ী ক্ষতির কারন হবে বলে মনে হয় না। তার পরেও আপনি যদি কাউন্সেলিং বা থেরাপিউটিক সহায়তার প্রয়োজন অনুভব করেন তাহলে ঢাকা বিশ্ববিদ্যালয়ের চিকিৎসা মনোবিজ্ঞান বিভাগে (Dept of Clinical Psychology) যোগাযোগ করতে পারেন।

গবেষণায় অংশগ্রহন প্রত্যাহার

এই গবেষণায় অংশগ্রহন সম্পূর্ন আপনার স্বেচ্ছাধীন। অংশগ্রহন করতে হবে এমন কোন দায়বদ্ধতা আপনার নেই। এমনকি গবেষণাটিতে অংশগ্রহন করার সিদ্ধান্ত গ্রহনের পরও যে কোন পর্যায়ে আপনি আপনার অংশগ্রহন প্রত্যাহার করতে পারেন।

গোপনীয়তা

আপনার গোপনীয়তা রক্ষা করার বিষয়টি সর্বোচ্চ বিবেচনায় রাখা হবে। এমন কোন তথ্য কারো কাছে বা কোন রিপোর্টে প্রকাশ করা হবে না যা থেকে আপনাকে চিহ্নিত করা সম্ভব।

গবেষণার ফলাফল

যদি আপনি এই গবেষণার ফলাফল সম্পর্কে জানতে চান তাহলে অনুগ্রহ করে আমার সাথে (জোহরা পারভীন) ইমেইল: (bania12@gmail.com) অথবা ফোন: (০১৭১২০৪২১২৬) এর মাধ্যমে যোগাযোগ করবেন।

যদি আপনি এই গবেষণার কোন বিষয় সম্পর্কে আরও বেশী কিছু জানতে চান তবে অনুগ্রহ করে মূল গবেষকের সাথে নিম্নোক্ত ঠিকানায় যোগাযোগ করবেন:	এই গবেষণাটি যেভাবে পরিচালিত হচ্ছে সেই সম্পর্কিত কোন অভিযোগ যদি আপনার থাকে তবে অনুগ্রহ করে নিম্নোক্ত ঠিকানায় যোগাযোগ করবেন:
জনাব কামাল উদ্দিন আহমেদ চৌধুরী সহযোগী অধ্যাপক চিকিৎসা মনোবিজ্ঞান বিভাগ ঢাকা বিশ্ববিদ্যালয় ফোন:০১৭১৪০৭৮৭৪৭ ইমেইল:kachowdhury@yahoo.com	জনাব তরুন কান্তি গায়েণ সেক্রেটারি বাংলাদেশ ক্লিনিক্যাল সাইকোলজি সোসাইটি ফোন : ০১৭১১১৫৩১৯৭ ইমেইল: tarungayen@yahoo.com

আপনার সহযোগীতার জন্য অশেষ ধন্যবাদ।

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জোহরা পারভীন

তারিখ:

Appendix-H: **List of Experts**

A. For the expert opinion regarding comparison with treated recovery

1. ***Tarun Kanti Gayen***
   Clinical Psychologist & Part time Faculty,
   Dept of Clinical Psychology, University of Dhaka, &
   Executive Chairman, CREA (Drug Rehabilitation center)

2. ***Shanoor Hossain***
   Clinical Psychologist & Assist Professor,
   Dept of Clinical Psychology, University of Dhaka

3. ***Ismot Jahan***
   Clinical Psychologist &Head,
   National Trauma Counseling Center
   Multi-Sectoral Programme on Violence against Women
   Ministry of Women & Children Affairs

4. ***Tamima Tanjin***
   Clinical Psychologist, Roquiya Hall, Dhaka University

B. For the development of retrospective diagnosis tool

1. ***Prof. Dr. Md. Ahsanul Habib***
   MBBS, FCPS (Psychiatry)
   Fellow WHO (India)
   Retd. Director, Mental Hospital, Pabna

2. ***Dr. Niaz Mohammad Khan***
   Assist Professor,
   Shahid Sohwardee Hospital,
   Sher-e-Bangla Nagar, Dhaka.

Appendix-I: **Original Quotation and Translated Quotation**

Original quotation	Translated quotation
"এইটা আমার লাইফের একটা স্পট হয়ে থাকবে যে, এ তো ট্রিটমেন্ট হইয়া আসছে।"	"If I would be admitted into the drug rehabilitation center, then it would be a huge scar for my whole life."
"...যে কোনো সেন্টারে ভুল চিকিৎসা আছে। অবশ্যই আছে। যেমন ডিটক্সে কইলাম মানুষ যে...যেই লোকটা সুস্থ হইতে যায়, তার লাইফটা নষ্ট কইরা আসে সে। ডিটক্সে কইলাম তারে...আপনের নেশা ছাড়ানোর জন্য আরেকটা নেশা দিয়া আপনেরে ফিরাইয়া আনতাছে। আনতাছে না? আর রিহাবে আপনাকে শিখাচ্ছে আপনের...আপনাকে সব কিছু তার কাছে খুইলা বলতে হবে। ভিতরে যত কষ্ট আছে সব খুইলা বলার জন্য। বা ওইখানে আপনার ব্রেইনডারে ওয়াশ করবে। কিছু সময় তারা কইলাম ভুল কিছু কিছু পরামর্শ দিয়া দেয়।"	"……centers often provide wrong treatment. It is there indeed . . . . . in detoxification you will be treated with another type of drug, isn't it? And in rehabilitation program, they will clear-up your brain though the process of sharing your emotional pain. Sometimes they provide faulty suggestion in this process."
"তবে আমি চাচ্ছিলাম না বাবার কাছ থেকে এই মুহূর্তে নতুন করে টাকা পয়সা নেয়ার। কারন আমরা ওই সময় ৪টা ভাই বোনই পড়াশুনা করি।"	"I didn't want to take money from father in that moment because we, the four siblings, were studying then."
"আমি তো আপনার কাছে ভাল থাকব না। আমি তো আমার কাছে ভাল থাকব। আমি আপনাকে বলে গেলাম যে আমি ড্রাগ নেই না কিন্তু আমি চুপি চুপি ড্রাগ নিচ্ছি। আপনি জানলেন 'ক' ড্রাগ নেয় না, কিন্তু আমি কি আমার কাছে ভাল রইলাম? আমি আমার কাছে ভাল থাকার জন্য ভাল হচ্ছি।"	"I won't be good for you; I'll be good for myself only. I'm telling you that I don't take drug but I'm taking drug hiding you. You know that 'X' doesn't take drug but am I genuine to me? I am trying to be good (being drug free) for myself."
"আমার মনের চালক আমি নিজেই, আরেকজন না। ...তো আমার মেন্টালিটিটা থাকতে হবে যে না, আমাকে সুস্থ থাকতে হবে; তাইলেই কিন্তু যথেষ্ট। আর কিছু না।"	"……I'm the director of my own mind, no one else……. I just need to have the mentality that I'll have to be well (abstinent), that's all, nothing else."

Original quotation	Translated quotation
"আমি বাংলাদেশি সমাজ ব্যবস্থায় আমন একটি পরিবারে জন্মগ্রহন করেছি যে আমার পক্ষে কোন অফিসে গিয়ে চাঁদা আদায় করাও সমভব না। রাস্তায় দাঁড়িয়ে ছিনতাই করাও সম্ভব না। ভিক্ষাতো করা সম্ভবই না।"	"I've been born in such a family that it's not possible for me to collect money by ransom, or mugging on the road; also impossible begging for money to buy drug."
"এমন একটা ঘটনা বলি এখন। একটা লোক রাস্তায় শুইয়া আছে; মনে করেন শুইয়া আছে, অসুস্থ। সেই লোকটারে মনে করেন চিন্তা ভাবনা করলাম এই লোকেরে দিয়া টাকা ইনকাম করাইতে পারবো। তো এই লোকের অসুস্থ হওয়ার পর, সেই লোকের মাথায় একটা বাড়ি দিলাম। মাথায় বাড়ি দিয়া মাথাটা ফাটাইয়া ফালাইলাম। ফাটাইয়া ফেলার পর মাথা দিয়া রক্ত পরতাছে, তখন তার মাথাডা বাইন্ধা ডাক্তারের কাছে নিয়া গেছি। ব্যান্ডেজ করাইছি। এহন কইছি কোনো কথা কইছ না, তোরে টাকা ইনকাম কইরা দিতাছি। তো প্রত্যেকটা দোকান-দোকান, ঘর-বাড়ি, ঘরে নিয়া গেছি। নিয়া যাইয়া প্রায় ২৫ হাজার টাকা ইয়া হইছে। ওর লগে কথা হইছে তোরে সব দিয়া দিমু। ওরে ৫০০ টাকা দিয়া মাইরা ক্ষেদাইয়া দিছি। তো এই জিনিস গুলা চিন্তা হয় যে একটা অসুস্থ লোক নিয়া আমি কত নয়-ছয় করছি।"	"I'm telling you one such incident now. One day I saw a sick guy lying on the street. Then I was thinking that it's possible to earn money with help of him. What I did, I hit on his head while it was bleeding……I took him to doctor and bandage was done. Then I threatened him not to talk anymore and assured him to manage money for his treatment. I took him to several shops and houses and collected almost 25,000 tk showing him. I promised earlier to give him all the money but I gave him only 500 tk while I drove him away beating him. Now I have to repent how I tricked with a sick man."
"এইগুলার প্রতি আমার ঘেন্না আইসা গেছে।"	"Now I feel disgusted about these (all kinds of drugs)."
"কইলাম মা, বাইরে থেইকা আপনে তালা মাইরা দেন। আমি ঘরের ভিতরে আছি। আমি যতই চিল্লাবো, যতই দাবড়াবো, আপনি তালা খুলবেন না। আমি মইরা গেলে ভিতরেই মইরা যামুগা। কিন্তু তালা খুলবেন না, তিন দিনের আগে। আমারে জানালা দিয়া আমার খাবার...মন চাইলে খাবার দিয়েন, না মন চাইলে না দিয়েন। কিন্তু তিন দিনের আগে দরজা খুলবেন না।"	"I gave a lock-key to my mother and told her 'mother, lock me from outside. I will stay inside the room. Don't unlock me before 3 days at least; no matter how loud I shout or how hard I jump. If I die, I'll die inside. You can supply me food through the window if you want; if you don't want, no problem. But strongly

Original quotation	Translated quotation
	remember don't unlock me unless 3 days have passed"
"ধীরে ধীরে কমান সবচেয়ে ভালো উপায়। একবারে বন্ধ করলে পারতেছিনা। তাই আমি ধীরে ধীরে কমাইছি। প্রতিবার আমি চিন্তা করি এই যে এখন ফুল এ্যাম্পুল নিব, কিন্তু আমি দুই দাগ কম নিব। তারপরে যখন আবার সন্ধ্যায় নিব তখন আবার দুই দাগ কম নিব। মানে যতবার নিব আমি ঐ সিরিঞ্জে দুইটা দাগ আছে দুই দাগ পরিমান কম নিব। "	"It's best to reduce drug gradually. I've seen that I can't stand when I go for sudden stop…….So, I quit gradually. Every time I thought - I'm going to take this full ampoule; ok, then I'll reduce 2 point. I'll again reduce 2 point at the evening. Thus, I'll gradually reduce the point marked in the syringe."
"আরি বাপরে বাপ! মারাত্মক! ওটা খুবই গুরুত্বপূর্ণ। ওইটা নিজের এসেট থেকেও আরও গুরুত্বপূর্ণ মনে হয়। যারা নেশা করে হ্যাঁ, আমি মনে করি একটা বেস্ট ট্রিটমেন্ট হচ্ছে গিয়ে; সে যদি ফেন্সিডিল খায়, দশটা ফেন্সিডিল কিনুক, আজকে ভাঙ্গুক। চোখের সামনে ঢাসা ঢাস্ ভাইঙ্গা শেষ করে ফেলবে। তিখ আনা ভিতরে তিখ্, তিখ্।"	"….oh my God! Serious! That's (drug materials) most important. That's more important than own asset. This is the best treatment for any drug user I think – if he is a phensydil user, let him buy 10 bottles of phensydil and let him break– he'll break all those very forcefully in front of his own eyes – to increase the strength of mind, strength, strength"
"ওরা যখন ঐ বসে যেখানে আড্ডা দিত, ওরা ঐ যে ইঞ্জেক্ট করতো; ওইটা দেখে আমারও শরীর পিল পিলাত; যে আমি একটু নেই। তখন আমি করতাম কি, ঐ স্টিক বের করে আমি ওদের সাথে..ওরাও ওইটা খাইত, আমি সিগারেট..ঐ গাঁজার সিগারেট খেতাম। ঐ খায়ে নিজেকে মানে কন্ট্রোল করতাম।"	"….when they'd gossip sitting together, they'd inject (Buprenorphine), I also felt high craving observing those; my mind provoked me to inject a bit just for once. That time what I used to do – I just smoked cannabis cigarette…..with this support I tried to control myself."

Original quotation	Translated quotation
"আমি আমার মতো গাছ গাছারি নিয়েই ভাবছিলাম যে এই গাছটা কে একটু অবস্থান তৈরি করতে হবে, নতুন গাছটার গোড়াটাকে পরিষ্কার করে দিলাম। কামিনী গাছ টার মধ্যে ছোট ছোট কলি এসেছে, ওটার গোঁড়ার মধ্যে মাটি ফেলে দিলাম। "	"That time (during craving) I was just thinking of my garden--the pot for this plant should be changed; I pulled out weed for the new one; the Kamini is coming into bud, so I gave more soil at its root."
"ওই সময়টা চিন্ড্র আসলে আমি আবার নতুন কিছু চিন্তা নিয়ে আসার চেষ্টা করতাম। যেমন উপন্যাসের কোন চরিত্র, আচ্ছা এই চরিত্রটাকে এভাবে সেট করল, এভাবে কেন করল এটা ত এভাবে করা যেত। তখন আমি বই হাবিজাবি আগের যে লাইফ স্টাইল্টা ছিল সেটা চিন্তা করতাম। "	"When my urge for drug would take place, that time I tried to import some new thoughts in my brain, e.g. any character in a novel. Umm..this character has been presented here in this way; why such? This could be done in that way also. Then I used to think about my books, etc etc….my previous life style."
"আমি এখন রোজা আছি, ৫৫র পরে আমি ইফতার করব।"	"I'm fasting now; I'll take (drug intake) when I become 55 years (age)."
"এটা মনে হয় ড্রাগ থেকে দূরে থাকার জন্যই বলছি। এটাও একটা কারন হতে পারে। আমি মনে হয় ড্রাগ থেকে থাকার জন্যই বলছি যে আমিতো ড্রাগ খাবই। কিন্তু কয়েকটা দিন অয়েট করে খাই। কিন্তু আমার বিশ্বাস, ৫৫ বছর কিন্তু অনেক সময় কারন আপনি চিন্ড্র করেন ২৭-২৮ থেকে ৫৫ বছর মানে আর ও ২৭ বছর। সাতাশ বছর পর , এটা সম্ভব না। আবার নতুন করে শিখতে হবে। "	"……possibly I'm thinking in this manner just to stay away from drug. I'm soothing my mind by saying that I'll certainly take drug but it's better to wait for few years. But I believe…55 years is too long. After that it won't be possible for me to take drug again. I'll have to learn it completely in a new style."

Original quotation	Translated quotation
"আমার বড় ভাই হঠাৎ আমাকে বললেন যে, 'তুমি তব্লিকে চলে যাও।' তো তব্লিকে, তব্লিকে আমার কাছে তব্লিকের কন্সেপ্টটা ভাল লাগেছে। তো আমি চিন্তা করলাম আচ্ছা যাই; বিশ্ব এজতেমা ছিল, ২০০২ এর ডীসেম্বর মাসে; ঐ খানে গেলাম। গিয়ে একটা পরিবাশ দেখলাম। ঐখানে ইসলামের কন্সেপ্টটা আমার খুব মনে লাগছে। তারপর আমি এক চিল্লাতে গেলাম ৪০ দিনের। তো ঐখান থেকে আবার আরেক চিল্লা ৪০ দিন। আমি ৩ বারের জন্য গেলাম; ১২০ দিন মানে ৪ মাস। তো ৪ মাস একটা লং টাইম।"	"When my elder brother was asking me to go for Tablig, then I just thought - ok, I can attend Bisshoy Ejtema. That was December, 2002; Bisshoy Ejtema was near. So, I went there. The existing environment and the theme concept of Islam attracted me there. Then I went for one Chilla (preaching Islam) for 40 days…….from there another Chilla-40 days. I went for 3 times; total 120 days i.e. 4 months. So, it was a long time."
"আমি বিভিন্ন সফরে, বিভিন্ন সফরে গিয়ে নেশা ছেড়েছি। যেমন- আজকে ঢাকা, কালকে খুলনা, পরশু রাজশাহী, এরকম ঘুরতে ঘুরতে ঘুরতে ঘুরতে..."	"I've quit drug through traveling…traveling many place; e.g. today I'm in Dhaka, tomorrow in Khulna, next day in Rajshahi, like this moving..moving..moving..moving"
"যখন নেশার টান উঠে তখন ১০টা বছর মুল্যায়ন করি যে, ওর মত তো আমিও চলছি ১০টা বছর, ওর মত আমার জীবনটা গেছে। খারাপ ভাবে গেছে, মানুষ অবহেলা করছে, মানুষ ঘিন্না করছে, মানুষ ভাই বলতে ভাইয়ের পরিচয় দেয় নাই, মা ছেলে বলে পরিচয় দেয় নাই, ঘর থেকে বাইরে গিয়ে মেছে থাকতাম। বা আমি তাদের কি অত্যাচার করছি তাদের জিনিসপত্র, আমার বহুত, মা'র স্বর্নের জিনিস আমি নিজে বেইচা ফেলছি, টাকা দিত না, চুরি করে বেইচা ফেলতাম। এইটা নিয়ে যেতাম ঐটা নিয়ে যেতাম। একটা এডিক্টেড যা করতে পারে, জঘন্য যত কাজ আছে সবই করছি। তো ঐ জিনিসটা মুল্যায়ন করি যে, জিনিসটা আমি করছি, এখন জিনিসটা মুল্যায়ন করি যে, জিনিসটা আমি করব না।"	"…. That time (during craving) I used to evaluate my past 10 years. 10 years of my life has been destroyed very badly. People neglected me, people hated me; even I had been denied with my blood relationship. I was kicked out from my home and had to stay in hotel…..I did those all nasty things which one addict can do. I evaluate all these I did. I think about the days I passed dominated by drug! So, I'm determined, I won't enter in that life again."

Original quotation	Translated quotation
"সব সময় আমি সকাল বেলা উইঠাই প্রতিজ্ঞা করি আগে, নেশা খাবো না। ঘুমে থেইকা উইঠাই প্রতিজ্ঞা মানে, নেশা খাবো না , কেউর সাথে ঝগড়া করবো না, কেউর সাথে চিটারী করবো না, বা যেখানে খারাপ লাগা তৈরী হবে সেই...সাথে সাথে জায়গাটা, স্থানটা ত্যাগ কইরা ফেলবো। প্রতিদিন সকাল বেলা উইঠা আমি এই চিন্তাটা করি আগে"	"Every morning after waking up from sleep, first of all I swear to myself that I won't take drug…by all means. Every morning I do this……"
"টাইট বাইন্ডিংস টা যেমন আমি দুই/আড়াই বছর করছি; সেই জিনিসটা এখন করি না। যেমন সকাল ৬ টার সময় উঠতাম, উইঠাই নামাযটা পড়তাম। নামাযটা পইড়া ফুটবল খেলতে আসতাম, নামাযটা ঠিক মতো পড়তাম; ফুটবল খেইলা বাসায় আইসা স্রেফ অনলি ফর দুই পিছ রুটি খাইতাম। বেশী না। দুই পিছ রুটি খাইয়া কাজে চইলা যাইতাম; সন্ধ্যার সময় হইলে বাসায় চইলা যাইতাম।"	"I followed strict discipline for 2/2.5 years; e.g. waking up from bed at 6 am, praying the morning prayer, then going to play football, after returning having limited breakfast, then going outside for my business work, returning home by evening etc."
"আমি কিন্ত..আমার এই এ্যালকোহলিক লাইফটা কিন্ত..টোটালি কিন্ত আমার ইয়াতে, মেমোরীতে..মেমোরীতে আছে বলতে ঐভাবেই আছে। এটা আপনার ক্লিক করলেও কিছু হবে না। এটা মনে করেন, এটা কি বলে আপনাকে..এটাকে..ডিলিট্ও না। স্পাম-এ বসাইয়া রাখছি এটারে..হ্যা..কিন্ত এটা আবার ইয়া হবে না। এটা ডিলিট্ হয় নি। এটা আছে। স্পাম ফোল্ডারে আছে। আপনে যদি দেখতে চান তাহলে অতীত লাইফটাকে ক্লিক করলে হয়ত এগুলা আসবে।"	"My full alcoholic life exists in my memory……but it won't respond if you click it….it has not been deleted yet. It has been placed in Spam, Yes. But it won't be activated anymore. It isn't deleted; it exists, in the Spam folder. If you want to see, then it may be revealed by clicking on the past life. But it has no influence, no activation in my present life."
"আমার শরীরে একটা ইনফেকশন হইছিল। কিন্তু সেখানে ইনফেকশনের দাগটা আমার আছে, কিন্তু ইনফেকশন তো আর নাই। আমার দাগটা..কেটে গেছে, সিলাই হইছে, সিলাইয়ের দাগ আছে। কিন্তু ওখানে তো আমার ইনফেকশন, ওখানে ত আমার ঘা নাই। কিন্তু সেটা কেটে গেছিল, সিলাই করছে ভাল হয়ে গেছে। দাগ আছে? থাক। তা আমার সমস্যাটা কি? কিন্তু আমার ওখানে ত আর ঘা নাই। "	"……I had an infection in my body. It was cut, then sewed and recovered. Now I still have the mark but no infection is there, I've no abscess in that place. Is there a mark? So what? Let it go. What is the problem for me? I've no infection there."

Original quotation	Translated quotation
"যেমন মদ খাবেন, এ্যালকোহল ঢুকতেছে। ফেন্সি খাবেন, ঐটার মধ্যে মেডিসিন আছে। গাজা খাবেন, সেটার মধ্যে এক ধরনের নিকোটিন আছে। এগুলা তো সমস্ত মানুষের ব্লাডের সাথে সংমিশ্রন হচ্ছে। তো সংমিশ্রন যখন চলে যায়, ব্লাড যখন রিফাইন হয়ে আবার ঠিক হয়ে যায়, তখন তো আর ঐ ব্লাড বলে না, যে এইটা খা, এইটা কর।"	"……e.g. I'm drinking, alcohol is going inside; taking phensydil, there's some medicine in that; smoking cannabis, one kind of nicotine is there. All these chemicals are mixing with my blood. When these chemical mixtures washed away, my blood has been refined again, then that blood doesn't push me saying 'take this drug', 'do this'…that blood would not provoke me to use drug."
"আমাকে এখান থেকে অমুক জায়গায় যেতে হবে; যাবো, ঠিক আছে অমুক দিন তমুক দিন, কিন্তু যাচ্ছি না। তাহলে হবে না। আমাকে যাতে হবে, এবং কিভাবে যাবো, সেই পথ অবলম্বন..এখন বাসে যাব, না হেঁটে যাব, না সাইকেল, রিকশায় যাবো..যেভাবেই হোক আমাকে ঐ খানে যাওয়ার মানে মনোবল ঠিক থাকতে হবে এবং ওখানে যেতে হবে এটাই হল কথা।"	"…I have to go that place from here. Ok, I'll go, tomorrow…the next day…but I'm not going actually. That will not work. I must go and how will I go? I've to decide the mode of transportation accordingly. Will I go by bus, or on foot, or cycle, or rickshaw?…anyhow I've to reach there; I need to have strong determination and that's the main point."
"আগে মনে করেন ছিলাম, দিনমজুর। এখন মনে করেন প্লেন চালাচ্ছি। "	"……as if I was a day laborer earlier and now I am flying aero plane."
"পরিস্থিতিটা যদি এমন হয় যে আমি নেশার মধ্যে বসবাসও করি, তাহলেও আমার পক্ষে নেশা নেয়া সম্ভব না।"	"If the situation may happen like that I'm dwelling in the midst of drug, still it is not possible for me to re-intake drug."
"আমি ড্রাগ নিতাম। এখন আর নেই না। লাইফ স্টাইল্টা একেবারেই চেঞ্জ। "	"I took drug before. Now I'm not taking it, the life style is completely changed."
"আচরনতো পুরাটাই চেঞ্জ। তখন একটা পার্থক্য ছিল অন্যরকম, আমার নেশার টাকা দরকার, আমার আর কোন কিছু না। নেশা হইলেই আমার চলবে। সে যারটা হোক, রক্ত	"Behavior is totally changed. At that time the situation was like, I badly need money for drug, nothing else. Anyhow I've to collect it, either selling blood or

Original quotation	Translated quotation
বেইচা হোক আর যেমনেই হোক। আমার লাগবেই। আচরনতো, আচরন খারাপ ছিল। ছ্যান ছ্যান মেজাজ ছিল, ঝগরা করতাম, লাগায়ে দিতাম ঝগরা, চিল্লা- ফাল্লা। আর এখন তো সেটার ভিতরে”	any other way. My conduct was very rude. I had irritable behavior, quarreled frequently and shouted etc. But now completely opposite….”
“আপনের, মনে করেন ছ্যান ছ্যান মেজাজ থাকলে তো আপনি পারবেন না। আপনের মেজাজটা থাকলে আপনি এখান থেকে আপনি আমার সাথে মেজাজগিরি দেখাইবেন, আপনি আবার যাইয়া আরেকজনের সাথে মেজাজটা দেখাবেন। মেজাজটা দেখাইলে আপনের ভিতরে কইলাম একটা রিল্যাপ্স ক্যারী হইতে থাকবে।”	“……if you’ve irritability, you can’t proceed. If you’ve irritable mood, you’ll show angry behavior to me here, again you’ll express your temper with anyone else. In this way, you’ll be carrying the chance for relapse.”
“এটা সবসময়ই ছিল কিন্ত আমি এ্যাপ্লাই করি নি। নেশার জন্য। অলওয়েজ ছিল আমার ভিতরে এই ভালো..বল্লামতো, আমি ভালো ছিলাম। কিন্ত গুড ফর নাথিং। আমি এ্যাপ্লাই করি নাই, দ্যাটস হোয়াই..নেশা এসে আমার অযৌক্তিক জিনিসগুলাকে দাড় করিয়ে দিয়েছে; যুক্তিগুলোকে ছোট করে দিয়েছে আর মন্দগুলাকে অনেক বড় করে দিয়ে গেছে। নরকে চলে গিয়েছি।”	“…..these good qualities were always in-built with me…..I was a good person….but I didn’t apply those, that’s why…..drug had established all of my illogical and irrational things; minimized my logical, responsible sense, and maximized my bad qualities a lot. I went through the hell.”
“সারা জীবনই বাইন্ডিংসের ভিতর চলতে হবে।”	“…..whole life will have to be guided by discipline.”
“নেশা ছেড়ে থাকছি শুধু নিজের স্ট্যাটাসটা ধরে রাখার জন্য। নিজের অবস্থানটা ধরে রাখার জন্য। ”	“I am continuing this drug free life only to hold my status, my position.”
“আমার কাছে শিখার আছে না? আমারে কইলাম মনে করেন, এহন মনে করেন…উদাহরন। কারন আমি কিন্তু একটা উদাহরন মানুষের ভিতরে। ঠিক আছে? আমি কইলাম বুঝি যে আমারে এই সেন্টারে ডাকে; কারন কি? আমি একটা উদাহরন। তোরা সে…সেন্টারের ভিতরে, তোরা ট্রিটমেন্ট নিয়াও সুস্থ থাকতে পারোস না। আর ও ট্রিটমেন্ট ছাড়া সুস্থ	“Isn’t it like that they (currently admitted clients of drug treatment center) have the scope to learn from me? Because I’m a significant example among the people, okay? I can understand why they (authority of a specific drug treatment

Original quotation	Translated quotation
আছে। এটা কইলাম একটা জ্বলজ্যান্ত প্রমাণ; প্রমাণ স্বরূপ জিনিস যেটা খাড়াইয়া রইছে, সাপোর্ট। তার জন্যই মনে করেন আমারে এইখানে-ওইখানে ডাকতাছে। বা আমার মূল্যায়নডাও অতিরিক্ত করে।"	center) call me because I am a role model. Their message is like that 'you (re-admitted clients) are in the midst of treatment center, you can't stop drug even receiving treatment; but look at him, and he is well enough even without treatment. He is a real proof who is standing in front of you.' For this reason only I'm being invited here and there or they evaluate me very highly."
"আমার মনে হয় যেন আমি বীর যোদ্ধা। তোমরা আমার কাছে শিখ; এটা কেমনে কিভাবে করা যায়? "	".....it seems to me that I am a great conqueror….learn from me how it can be achieved……."
"আমি ত মনে করি যে আমি মনের দিক দিয়ে বীর যোদ্ধা। হ্যা। যে আমি মনে করি যে বীর যোদ্ধা; যে আমি এত বড় একটা..এ ইয়া থেকে আমি নিজেকে, আমার নিজের মানে কি বলে নিজের আত্মাটাকে, নিজের জীবনটাকে, আমি নিরাপত্তা দিয়ে ওখান থেকে সরে আসছি। এবং সুস্থভাবে জীবন যাপন করতেছি। আমি মনে করি যে আমি একজন বীর যোদ্ধা। "	"I think that I'm mentally a great hero/conqueror. I've accomplished such a great things….umm….I've saved my soul, my life; I've protected myself getting out of rid from it (drug) and have been passing my present days with sobriety. That's why I believe that I'm a great hero/conqueror."
"মানে বুকটা গরবে ভইরা যায়। যে আমি আজকে ট্রিটমেন্ট ছাড়া সুস্থ হইছি। এইটা মানে, দশ জনের চোখে গেলেই সবাই হা কইরা তাকাইয়া থাকে হেই, সে পারছে, আমি পারতাছি না। একটা অবাক..."	"I feel very proud that I've been cured without any treatment. This means…when other people see me, they become so surprised to know it 'he has been able to do this but I (current drug user) can't do yet. They just gaze at me."
"আমার যে আগে ঐ নিশা করা অবস্থায় আমার শরীর..চেহারাটা বলতে গেলে কঙ্কালের মতো ছিল। এখন একটু চিহারা ফিরে আসছে। তে এই নিয়ে ওরা মানে..ওরা	"While I was taking drug, my physical health and appearance was just like a skeleton. But now my appearance has

Original quotation	Translated quotation
আফসোস করে।"	been improved a lot. Even they (current drug users) often regret for them seeing me."
"সমাজে যে আমার আগে মুল্যায়ন ছিল না, এখন সে মুল্যায়ন আমার ফিরে আসছে। আবার সব জানি আমার হারান যেগুলা সব আমি হাতে পেয়ে গেছি।"	"I have regained my lost value and respect in my society which I had previously. It seems to me as if I've got back all the things which I lost by this time."
"যে কোন খারাপ কাজ; যে কোন খারাপ কাজ। নেশাতো ছেড়েই দিয়েছি; এটা থেকে উৎরাইয়্যা উঠছি। যে কোন খারাপ কাজ বা একটা মিথ্যা কথা বলাও, যদি করি সেটা একটা লোক যদি বুঝে যে এই লোকটা মিথ্যা কথা বলছে তখন নিজেকে খুব অপরাধী এবং অপদার্থ মনে হয় যে আমি কেন, কি কারনে মিথ্যাটা বলতে গেলাম।"	".....any kind of bad deed… I've quit drug, I've overpowered it. But still now, if I do any ill act or tell a lie then I feel very guilty and think myself as stupid that why did I need to tell the lie!"
"যেটা করেছি সেটা কিন্তু জেনেই করেছি, ট্রেনের বাথরুমের সামনে। ট্রেনের বাথরুমের সামনে কিন্তু অনেক টা জায়গা থাকে। সেখানে ওরা সব কনসার্ট দেখে ফিরছে, আমি সেখানে এটা আমি জেনে করেছি।"	".....what I did (taking one stick cannabis), I was aware of that, in front of toilet of the train. There's much space in front of the toilet. They (past drug using friends) were returning after seeing a concert. I was there…..I did this being aware of."
"বাবা সন্দেহ করে। বাবা সন্দেহ করে যে ছেলেটা ঢাকা থাকলে ভাল থাকবে। ছেলেটা যদি (নিজের জেলার নাম) আসে তাহলে আমার প্রবলেম।"	"Father is suspicious of me. Father is mistrustful because he thinks like; the son will be cured if he stays in Dhaka. If the son comes at home, there will be problem again."
"আপনে প্রতিদিন মনে করেন যে ভাত খান। যদি আপনেরে সকাল বেলা যদি রুটি দেয়, আপনের কইলাম খাইতে কয় দিন খুব কষ্ট হবে।"	"Suppose, you eat rice every day. If suddenly bread is supplied instead, for few days you'll face great trouble."

Original quotation	Translated quotation
"হ্যাঁ, এদেরকে নিয়েই কাজ করতেছি; এটা আমার একটা চ্যালেঞ্জ। এটাই আমার চ্যালেঞ্জ যে আমি নেশাখোর নিয়েই কাজ করব কিন্তু তোরা কি করিস কর, আমি ওখানে যাব না। আমি ওইটা করব না। "	"Yes, I am working with these (current drug users) peoples; this is my challenge. It is my challenge that I'll work with drug users but do what you like, I won't go there. I won't do that (drug intake)"
"একটা অপরাধবোধ যদি মনের মধ্যে না আসে তাহলে মানুষ কিন্তু ভাল হউয়া টাফ হয়ে যায়। একটা অপরাধ বোধ আসতে হবে। এখন আপনে, মানে অপরাধ বোধ যদি না আসে তাইলে তিখ আসবে না, জেদ আসবে না। "	"……guilt feeling must have to come. If there's no remorse, then there won't be strong determination to be cured (from drug)."
"স্বর্গীয় প্রেম কিন্ত আমার এই পরিবর্তনে উদ্বুদ্ধ করছে।"	"Love from heaven makes me so motivated for change".