Summer 2013

The Crack Room: A Study of Therapeutic Techniques and the Response to Drug-Related Cues

Hallie Smith Carlton

Follow this and additional works at: https://dsc.duq.edu/etd

Recommended Citation

This Immediate Access is brought to you for free and open access by Duquesne Scholarship Collection. It has been accepted for inclusion in Electronic Theses and Dissertations by an authorized administrator of Duquesne Scholarship Collection. For more information, please contact phillipsg@duq.edu.
THE CRACK ROOM: A STUDY OF
THERAPEUTIC SIMULATION TECHNIQUES
AND THE RESPONSE TO DRUG-RELATED CUES

A Dissertation
Submitted to the School of Education

Duquesne University

In partial fulfillment of the requirements for
the degree of Doctor of Philosophy

By
Hallie Smith Carlton

August 2013
THE CRACK ROOM: A STUDY OF THERAPEUTIC TECHNIQUES
AND THE RESPONSE TO DRUG-RELATED CUES

Approved by:

Lisa Lopez Levers, Ph.D.
Professor, Counselor Education Program
Department of Counseling, Psychology, and Special Education
Duquesne University

Debra Hyatt-Burkhart, Ph.D.
Assistant Professor, Counselor Education Program
Department of Counseling, Psychology, and Special Education
Duquesne University

Emma Mosley, Ph.D.

Keith S. Wolfe, Ed.D.
Superintendent, Punxsutawney Area School District
ABSTRACT

THE CRACK ROOM: A
STUDY OF THERAPEUTIC SIMULATION
TECHNIQUES AND DRUG-RELATED STIMULI

By
Hallie Smith Carlton
August 2013

Dissertation supervised by Dr. Lisa Lopez Levers

Drug addiction is a disorder frequently associated with chronic relapse. An individual’s return to use is a fairly prevalent topic in the literature, but receiving less examination is the significance of drug-related stimuli as they apply to drug-seeking behaviors. It cannot be ignored that triggers and cues are a prominent feature in everyday life. Although many non-addicted people fail to become aroused by common stimuli, individuals who are addicted to alcohol and other drugs see depictions of use in unlikely places. In the eyes of an addict, a light bulb may prompt a desire to smoke methamphetamines, and a simple plastic water bottle may conjure memories of huffing methane gas. As such these cues often invoke a desire to engage in the use of psychoactive substances. Using a phenomenologically-oriented approach, this qualitative investigation examined the lived experiences of individuals in recovery from
alcohol and drug addiction, and their experiences in *The Crack Room*. The results of this research reflect relatively consistent findings about the response of individuals in recovery when faced with prominent triggers and cues. This topic largely has been discounted in the literature. The findings illuminated issues regarding familial disconnectedness, the numbing effect of drugs and alcohol, genetic indicators, trauma, specific triggers that may ignite an individual’s desire to use, and the development of skill sets that may be used to combat urges. Another prominent concern for individuals in recovery from alcohol and drug addiction is a fear of returning to placement in prisons, jails, and psychiatric hospitals. The results of this investigation provided evidence that therapeutic simulation is a viable option for individuals seeking treatment for addiction. This phenomenologically-oriented study was conducted through individual interviews and researcher observations. The results of the study also showed a consistency with the original design and purpose of *The Crack Room*, which is to minimize one’s startle response when an individual is faced with drug-related cues. However, this investigation provided additional outcomes that were not expected and offered other positive uses for *The Crack Room* as a solid therapeutic tool.
DEDICATION

To Marsha: You truly are “the wind beneath my wings.”
ACKNOWLEDGMENTS

As I ponder the journey I have taken over the past few years, I am aware of the people who have helped me reach this goal. First, I am grateful for the participants of this study who walk a fine line between sobriety and addiction every day. You welcomed me into your world and became the inspiration for this study. Fight on, my friends. My only hope is that this investigation will provide a viable option for therapists’ searching for ways to assist you in your plight.

Second, I am grateful to my wonderful committee: Dr. Lisa Lopez Levers, Dr. Emma Mosley, and Dr. Keith S. Wolfe. A special thank you goes to Dr. Levers. You encouraged me and never gave up on me when others would have “thrown in the towel.” Your excitement for research and learning is infectious. Doc Mosley, you have been a solid foundation of support and provided guidance when I believed academe would swallow me whole. You are a true and trusted friend. Dr. Wolfe; Woofie, You are my rock. Thank you. I cannot tell you how much your friendship means to me.

I am grateful to my parents, who have been a constant support and helped me keep the dream alive. Leif and Kara, you remained strong and loyal through my emotional roller coaster. I love you both very much. AJ, Jade, and Paul, my less-than-perfect computer skills caused some frustrating obstacles. Thank you for your patience. Riggie, Chad, and Donna, your input “behind the scenes” made this achievement possible. I will never forget your kindness and generosity.

Finally, I am especially grateful for Marsha, whose patience, love, and support have kept me afloat for years. You have remained loyal during the anger, the laughter,
the tears, and the joy. Nothing is possible without you by my side. You will never know how much you mean to me. WE DID IT!
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abstract</td>
<td>iv</td>
</tr>
<tr>
<td>Dedication</td>
<td>vi</td>
</tr>
<tr>
<td>Acknowledgements</td>
<td>vii</td>
</tr>
<tr>
<td>Chapter I: Introduction</td>
<td>1</td>
</tr>
<tr>
<td>Theoretical Framework</td>
<td>3</td>
</tr>
<tr>
<td>An Existential-Phenomenologically-Oriented Approach to Research</td>
<td>3</td>
</tr>
<tr>
<td>An Ecological Perspective</td>
<td>5</td>
</tr>
<tr>
<td>Rationale</td>
<td>5</td>
</tr>
<tr>
<td>Statement of the Problem</td>
<td>9</td>
</tr>
<tr>
<td>Significance of the Study</td>
<td>10</td>
</tr>
<tr>
<td>Importance of the Study</td>
<td>11</td>
</tr>
<tr>
<td>Substantive Assumptions</td>
<td>13</td>
</tr>
<tr>
<td>Research Question</td>
<td>14</td>
</tr>
<tr>
<td>Operational Definitions</td>
<td>15</td>
</tr>
<tr>
<td>Boundaries of the Study</td>
<td>18</td>
</tr>
<tr>
<td>Summary of the Introduction</td>
<td>19</td>
</tr>
<tr>
<td>Chapter II: Review of the Literature</td>
<td>21</td>
</tr>
<tr>
<td>Existing Treatments</td>
<td>23</td>
</tr>
<tr>
<td>Psychological Theories of Personality and Development</td>
<td>23</td>
</tr>
<tr>
<td>Trends and Existing AOD Treatment</td>
<td>23</td>
</tr>
<tr>
<td>Therapies and Intervention</td>
<td>27</td>
</tr>
</tbody>
</table>
Researcher Observations.................................................................................................63

The Researcher as an Instrument..................................................................................63

The Process..........................................................................................................................64

Purposeful Sampling........................................................................................................65

Recruitment of Participants.............................................................................................65

Gathering Volunteers........................................................................................................66

Demographics of the Participants......................................................................................68

The Participants.....................................................................................................................69

Individual Interviews.........................................................................................................72

Thematic Patterns................................................................................................................115

Theme 1 ...............................................................................................................................115

Theme 2 ...............................................................................................................................118

Theme 3 ...............................................................................................................................121

Biopsychosocial Themes .................................................................................................124

Bioecological Themes........................................................................................................125

Social Constructivist Themes ............................................................................................125

Self-Determination Themes ..............................................................................................125

Other Prevalent Themes ...................................................................................................126

Other Participant Comments ............................................................................................128

Summary of Analysis..........................................................................................................128

The Design of the Research..............................................................................................129

Data Collection for This Investigation ...........................................................................130

Organization of the Findings...............................................................................................131
Thematic Similarities ........................................................................................................132

Chapter Summary ..........................................................................................................134

Chapter V: Discussion ....................................................................................................136

Interpretation of Findings 1: Factors Precipitating Use .............................................137

The Ability to Make Emotions Go Away .................................................................138

Genetic Factors ..........................................................................................................139

Triggers and Cues ..........................................................................................................140

Interpretation of Finding 2: Biopsychosocial, Bioecological, Social

Constructivism, and Self-Determination .................................................................140

Biopsychosocial Themes .........................................................................................141

Bioecological Themes ............................................................................................142

Social Constructivist Themes ................................................................................143

Self-Determination Themes ..................................................................................144

Interpretation of Findings 3: Other Themes ..............................................................144

Realization ..................................................................................................................145

Skill Sets .....................................................................................................................145

Specific Cues and Triggers in The Crack Room ......................................................145

Fear of Placement ......................................................................................................146

Interpretation of Findings 4: Remaining Themes ......................................................146

Interpretation of Findings 5: Special Indications of

Trauma and Addiction to AOD .................................................................................147

Analytical Categories ...............................................................................................149

Supportive Factors in Recovery ..............................................................................157
<table>
<thead>
<tr>
<th>Table</th>
<th>Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Meeting Locations</td>
<td>66</td>
</tr>
<tr>
<td>2</td>
<td>Demographic Information</td>
<td>70</td>
</tr>
<tr>
<td>3</td>
<td>Type of AOD</td>
<td>70</td>
</tr>
<tr>
<td>4</td>
<td>Method of Injestion</td>
<td>71</td>
</tr>
<tr>
<td>5</td>
<td>Length of Treatment</td>
<td>72</td>
</tr>
<tr>
<td>6</td>
<td>Participant 1</td>
<td>72</td>
</tr>
<tr>
<td>7</td>
<td>Participant 2</td>
<td>77</td>
</tr>
<tr>
<td>8</td>
<td>Participant 3</td>
<td>82</td>
</tr>
<tr>
<td>9</td>
<td>Participant 4</td>
<td>87</td>
</tr>
<tr>
<td>10</td>
<td>Participant 5</td>
<td>91</td>
</tr>
<tr>
<td>11</td>
<td>Participant 6</td>
<td>95</td>
</tr>
<tr>
<td>12</td>
<td>Participant 7</td>
<td>99</td>
</tr>
<tr>
<td>13</td>
<td>Participant 8</td>
<td>103</td>
</tr>
<tr>
<td>14</td>
<td>Participant 9</td>
<td>107</td>
</tr>
<tr>
<td>15</td>
<td>Participant 10</td>
<td>111</td>
</tr>
<tr>
<td>16</td>
<td>Needs</td>
<td>147</td>
</tr>
<tr>
<td>17</td>
<td>Breakdown</td>
<td>148</td>
</tr>
<tr>
<td>18</td>
<td>Participant 1</td>
<td>149</td>
</tr>
<tr>
<td>19</td>
<td>Participant 2</td>
<td>150</td>
</tr>
<tr>
<td>20</td>
<td>Participant 3</td>
<td>151</td>
</tr>
<tr>
<td>21</td>
<td>Participant 4</td>
<td>152</td>
</tr>
</tbody>
</table>
CHAPTER I

INTRODUCTION

“Perception is strong and sight weak. In strategy it is important to see distance things as if they were close and to take a distanced view of close things.”
from Miyamoto Musashi (Patton, 2010, p. 38)

Drug addiction is a disorder frequently associated with chronic relapse (Cooney, Litt, Morse, Bauer, & Guapp, 1997). While occupational pressures, relationships, or everyday life stress have long been implicated as an important factor in the resumption of use, receiving less examination is the significance of drug-related stimuli as they apply to drug-seeking behaviors. Common images in everyday life continually bombard individuals who are addicted to Alcohol and Other Drugs (AOD) (Sinha, Fuse, Aubin, & O’Malley, 2000). These cues often invoke desires to engage in the use of psychoactive substances. Common advertisements promise fast and efficient ways to induce sleep, promote wakefulness, or stabilize moods. Many gas stations sell flavored tobacco wrappers used to roll homemade cigars filled with marijuana, and television commercials often advocate for the sale of liquor, promising good times and popularity when using their products. Presentations of drugs, alcohol, and their necessary paraphernalia are everywhere. While one individual may notice a simple pipe fitting in a hardware store, an individual who is addicted to AOD may see a way to smoke a multitude of illicit drugs. In the experience of an intravenous drug user, an average spoon used to eat breakfast cereal in the morning easily becomes a cooking surface for opiates and many other drugs.
Although many non-addicted individuals fail to observe common triggers in everyday life, individuals who are addicted to AOD see depictions of, or cues for drug and alcohol use in unlikely places (Otto, O’Cleirgh, & Pollock, 2007). Whether images appear in a restaurant, along the highway on billboards, or in the safety of one’s own home, individuals with issues surrounding addiction frequently experience troubling responses to even minor cues. Therefore, the focus of this study is on discovering the feelings and emotions that occur when an individual who is addicted to AOD is faced with pronounced stimuli, specifically, responses to a therapeutic simulation technique called The Crack Room. The question becomes: What is the experience of individuals who are addicted to AOD when they are faced with the sights, sounds, and memories of use that are provided in The Crack Room?

Because this question has significant implications and deep meaning, a qualitative approach has explored the lived experiences of individuals in recovery from alcohol and other drug (AOD) addiction regarding the therapeutic simulation techniques offered in The Crack Room. This study will help to generate a possible description of the problematic relationship between individuals addicted to AOD and drug-related cues. Theoretical perspectives of this study focus on behavioral approaches, with a preference for the social learning approach which accounts for self-efficacy, or the client’s belief that change is possible (Fishman & Franks, 1997). This study also explores previous therapies conducted in a controlled environment offering alcohol and other drug-related cues in a room decorated to simulate a setting where drugs are often used. As an outcome, this experience hopefully will provide an understanding of an individual’s struggle with addiction when faced with cues and triggers.
Theoretical Framework

The guiding focus of this research is in exploring how individuals in recovery from alcohol and drug addiction react when faced with drug-related cues. Because the central focus points of this investigation are the experiences of study participants who previously engaged in therapeutic simulation techniques in *The Crack Room*, participant response and perceptions are of great importance. Current literature has explored similar studies, but most of these investigations have relied on virtual reality or computer generated replication. As a result, the personal experiences of participants when faced with actual paraphernalia or other physical or emotional cues eliciting memories of use are relatively non-existent. Therefore, a phenomenological approach provides richer meaning and a deeper understanding of these experiences.

*An Existential-Phenomenological Approach to Research*

van Manen (1997) discusses lived experiences as a starting and ending point. Phenomenology can be described best by asking what it is like to have a certain experience (Dilthey, 1985). Phenomenological research explores the essence of the human experience by focusing on both outward appearances and inward consciousness. In creating a picture of an individual’s experience, phenomenology sets aside all personal feelings and judgments (Creswell, 1998). van Manen states that “phenomenology aims at gaining a deeper understanding of the nature or meaning of our everyday experiences” (2003, p. 9). The phenomenon of responding to the sight, smell, sound, or taste of cues associated with AOD use has not been widely studied. In fact, most studies involve quantitative techniques and computer-generated imagery. As stated previously, the phenomenon of an individual’s response to drug-related cues has
not been studied in depth or in a way that truly expresses the participant’s experience. Therefore, an inquiry of this nature is necessary, and important.

Phenomenology follows certain research assumptions. They include the following: (1) the researcher studies phenomena of interest and shares the findings with others; (2) researchers live the experience, rather than simply imagining what they think they know about an experience and; (3) people search for themes representative of the phenomenon. Phenomenological research often is not understood as it occurs. Instead, students of phenomenological research must explore the lived experience reflectively (van Manen, 1997). In fact, the pure essence of a phenomenon describes deep meaning (Patton, 2003). Therefore, this investigation will study the experiences of individuals suffering from addiction to AOD when exposed to the drug-related cues provided in The Crack Room. Due to a noticeable void in research related to this study, an investigation of this nature is relatively fresh and promotes future inquiry.

While an existential-phenomenological approach considers the meaning of an individual’s experience, it also generates suppositions for responding to certain phenomena. By analyzing information through interviews and observations in the field, a researcher can then propose or hypothesize viable theories designed to address the experience in question (Creswell, 1998).

When contemplating such an investigation, a researcher must put aside ideas and preconceived notions to allow new analytical perspectives leading to newly generated hypotheses. The researcher must determine when the study is complete and, finally, focus on the fact that outcomes must include a key phenomenon, reasons outlining the situation, strategies and contexts, and subsequent consequences (Creswell, 1998).
An Ecological Perspective

As stated above, the methodological framework for this study was an existential-phenomenological approach. The theoretical framework revolved around a bioecological approach (Bronfenbrenner, 1979). This perspective accounts for diversity of personality and individual environmental issues. Bronfenbrenner (1979) described human development as “a lasting change in the way in which a person perceives and deals with his environment” (p.3). As such, this study illuminated one of Bronfenbrenner’s (2005) ideas that experiences are fundamental to our development. In other words, as people grow and change, they often react to their environment as well as to their perceptions and experiences of that environment. With an emphasis on the proposition that perception is a function of change and development, it becomes likely that one’s reaction to drug-related stimuli occurs on an intrapersonal level.

Rationale

Due to the frequency of drug-related stimuli in society, an almost certain opportunity exists for an individual who is addicted to alcohol and other drugs to observe and respond to triggers or depictions of drug use, several times a day. This phenomenon occurs regardless of length of sobriety, or strength of personal convictions surrounding recovery (Liu & Weiss, 2007). Cooney, Litt, Morse, Bauer, & Guapp (1997) indicate that individuals who are addicted to or abuse drugs frequently experience a negative response to physical cues that typically go undetected by a non-addicted person. According to Liu and Weiss (2002), individuals who are addicted to AOD typically process cues within a fraction of a second, while others may not assign an emotional connection or even recognize
an image as being related to alcohol and other drugs. By the time a person who is addicted has noticed a physical trigger; insidious thoughts of obtaining a high have already entered consciousness. At precisely that moment, the struggle to remain sober occurs. Some people in recovery from alcohol or other drug addiction are ill equipped to manage this flood of information properly, which often frames thoughts of a return to use (Otto, O’Cleirgh, & Pollock, 2007).

As physical triggers or cues stimulate the desire to resume or begin drinking or drug use the resulting emotions and behaviors cause immeasurable pain and difficulties for individuals and their families. Many researchers have linked criminal activity to drug and alcohol use (Taleff, 1997). Reportedly, many crimes are the result of lifestyle choices, perceptions, and realities created by addiction to alcohol, and other drugs (National Institute of Justice, 1999). In fact, 56% of all individuals incarcerated in penitentiaries across the nation report that they were addicted to, or abusing drugs and/or alcohol at the time of their crime (Bureau of Justice Statistics, 2009). This fact, in addition to other life-altering effects of addiction, should provide strong support for the introduction of an understanding of the connection between cue reactivity and AOD abuse and addiction.

A recent review of the literature indicates a nation-wide increase in drug and alcohol abuse since 1996 (Bureau of Justice Statistics, 2009). In addition, the local Single County Authority (SCA) reports that within the time frame beginning July 1, 2008, and ending June 30, 2011, fifteen individuals in Jefferson County have died as a result of fatal overdoses. Also noteworthy, is the fact that addiction to alcohol and other drugs currently costs United State’s businesses $185 billion dollars per year. In
2010, $13.7 billion was spent for alcohol and other drugs nationally, with 66% of those monies going toward prisons, border control, and anti-production measures. Only 32% was provided for prevention and treatment (Otto, O’Cleitgh, & Pollock, 2011). These numbers are projected to grow as addiction becomes a more prominent feature in the American workforce.

Reportedly, personal and societal devastation and substance abuse and addiction share a strong relationship. Observing the inordinate number of physical triggers available to a person in recovery, the importance of examining the connection between physical cues and a problematic response to those cues is undeniable. As previously stated, individuals addicted to psychoactive substances find difficulty in challenging the onslaught of triggers presented in daily life when simply purchasing a soda or hearing a song on the radio may cue addictive patterns or memories of use (Sinha, Fuse, Aubin, & O’Malley, 2000). However, very little is known about the connection between physical cues and the emotional response of individuals addicted to AOD, when faced with related triggers. In addition, treatments designed to address this issue are fairly non-existent. Therefore, the goal of this study is to develop an understanding of this relationship as it applies to individuals who previously received therapeutic simulation techniques used in The Crack Room. This investigation will call upon individuals in recovery from alcohol and other drug addiction to share and discuss their previous experiences in The Crack Room, an area designated in a clinical setting and designed to elicit strong emotional response and memories of use.

When exploring the history of AOD abuse and addiction in society it is interesting to note that in the late 1800s, heroin was a popular and effective treatment
for coughs and other common maladies. Cocaine, now one of the most abused drugs in modern society, was an active ingredient in Coca-Cola from 1886, until it was removed by the Food and Drug Administration in 1903 (NIDA, 2009). Concerns about the addictive potential of various drugs began to emerge during WW I, when medical doctors observed problematic behaviors in response to certain prescription drugs (NIDA, 2009). Indeed, these considerations grew steadily throughout the 20th century.

Historically, prevention treatment has focused on lowering stress levels and maintaining proper nutrition. Some mental health concerns are thought to be the result of errors in a response to stress; addiction also may be viewed as a maladaptive reaction to both positive and negative stressors (Leavitt, 2000). Such a view is an important factor when considering relapse in alcohol and other drug addiction treatment; however, few studies have explored strategies that address a return to use caused by a negative reflex to physical triggers (Otto, O’Cleirgh, & Pollock, 2007).

The rationale for this study centers on three ideas: (1) limited research exists discussing the success or failure of cue exposure as a way for treatment professionals to understand the feelings and emotions of individuals suffering from addiction and abuse, when faced with drug-related triggers, (2) drug-related cues cause dramatic shifts in awareness and consciousness, often generating relapse or continued use, and (3) solid treatment options specifically designed to help clients and clinicians understand and address the emotions and consequences one may experience when faced with drug-related triggers do not exist.

This inquiry focuses on developing an understanding of the experiences of individuals who have received previous therapeutic simulation techniques; a secondary
focus is to illuminate presenting strategies for better helping patients to apply the skills they acquire to their daily lives. An examination of the relationship between physical cues and the emotions they create leads to an understanding of how individuals who are addicted to AOD perceive and respond to sensory-based triggers. Furthermore, truly understanding this phenomenon can assist counselors in offering provisions to combat relapse, a common problem among individuals in recovery. Finally, this study also aims to develop an understanding of the influence of drug-related cues in maintaining sobriety. The researcher’s long-term hope is to help counselors become better informed about this intriguing relationship.

Statement of the Problem

According to Liu and Weiss (2002), physical cues are commonly an important construct in the relapse of individuals in recovery from alcohol and other drug addiction. The impact of a negative response to drug-related cues is significant, as triggers are thought to be a prominent feature in relapse or the continuation of use (Liu, & Weiss, 2007). Documentation in popular media sources indicates extreme growth of alcohol and other drug use around the globe (United Nations Office on Drugs and Crime, 2008). Indeed, reports demonstrate that addiction has become a world-wide epidemic. For instance, in many European countries where alcoholism and drug addiction were largely unknown disorders, abuse and addiction have become serious problems (UNDCP, 1997). As may be expected, interventions throughout the world typically mirror treatments used in many clinical settings in the United States. Most treatment programs in the U.S. are designed to use psychosocial approaches, including motivational interviewing, behavior therapy, and cognitive behavior therapy (Deas,
2008). However, few programs use modalities that incorporate or focus on an understanding of cue response.

Treatment formats are varied and include multiple models of care, yet a review of qualitative and quantitative research has illustrated little inquiry into the relationship between physical cues and relapse (Sinha, Fuse, Aubin, & O’Malley, 2000). The results of this study will provide a working knowledge of the way in which individuals who engaged in therapeutic simulation techniques in The Crack Room integrate and mentally assemble data relating to physical cues. Assumptions may then be made, enabling counselors to address these potentially negative responses and emotions.

**Significance of the Study**

The significance of this study lies in an ability to provide an understanding of the feelings and emotions that often are produced by sensory-based AOD triggers, through examining individuals who previously received therapeutic simulation techniques in The Crack Room. This inquiry presents strategies to help the therapeutic community develop an understanding of this phenomenon. Describing the participant’s experience provides significance for this investigation. In addition, this investigation will contribute to the body of evidence regarding physical cues as they relate to alcohol and other drug use, arming therapists with the understanding necessary to help clients in combating desires that are triggered by drug-related cues.

As previously stated, the psychological effects caused by physical cues are frequently an important construct in the resumption of use among individuals in recovery from alcohol and other drug addiction (Liu & Weiss, 2002). Treatment formats for drug and alcohol counseling are varied and include multiple models of care, yet a
review of current research has illustrated little inquiry into the relationship between physical cues and the resumption of use or treatment designed to combat this correlation (Sinha, Fuse, Aubin, & O’Malley, 2000). As such, recovery-informed assumptions may then be made, enabling counselors to understand this connection. Additionally, this study has propagated significant and new ideas regarding emotional connections between physical cues and use, thus providing inspiration for further study.

Qualitative research often exposes individuals to a deeper understanding of a given phenomenon. To that end, this investigation offers a distinct need for further attention among practitioners. This hypothesis can generate more extensive inquiry into the connections made between individuals in recovery from substance addiction and their responses to physical cues. Finally, this study offers topics for debate and further investigation in relation to the response of individuals in recovery when encountering physical cues; the ways in which these often negative responses can be minimized or effectively managed; and the ways therapists and clients can understand the connection between cues and response to those cues.

Importance of the Study

The importance of this investigation is focused on three facts: therapeutic simulation techniques are not properly researched; a distorted ability to resist the urges and desires associated with physical cues provide fertile ground for the possibility of relapse; and individuals suffering from addiction are underserved regarding treatment options available to combat the intense thought process often associated with physical triggers.
The use of therapeutic simulation techniques appears frequently in the literature as a treatment option to address obsessive/compulsive behaviors or emotions resulting from posttraumatic stress, but few scholarly inquiries discuss this technique in the field of drug and alcohol treatment (Drummond & Glautier, 1994). Furthermore, among the relatively few studies that explore techniques to ward off negative responses to AOD cues, most involve laboratory animals or the use of computer generated virtual reality (Sinha, Fuse, Aubin, & O’Malley, 2000). Currently, only 32% of the $13.7 billion spent each year in the U.S. for drug and alcohol services treatment focuses on prevention (NIDA, 2009). On the other hand, 66% of those monies are used to support prisons and jails, border control, and anti-production enforcement (NIDA, 2009).

As the number of individuals who abuse or are addicted to alcohol and other drugs increases, so, too, should appropriate services that include supportive prevention and treatment approaches. Terminology that is commonly used among Alcoholics and Narcotics Anonymous groups indicates that individuals in recovery should avoid “people, places, and things.” This catch phrase does not adequately depict the assumptions of this study. Traditional treatment teaches consumers to stay away from people who may remind them of their drug histories, places or situations that conjure memories of use, and things that may be drug related. Such advice, however, is not realistic. Individuals addicted to AOD cannot avoid billboards, former friends they may see at the local market, television programming, or a cooler full of beer that may be found at many family reunions. As research indicates, individuals suffering from addiction are ill equipped to defend the negative emotions associated with physical cues (Otto, O’Cleirgh, & Pollock, 2007). This phenomenon, in fact,
may be one of the cornerstones of relapse. Therefore, a discussion identifying the connection between alcohol and drug cues and the subsequent response seems to be significant.

Finally, although it is often difficult for individuals in recovery to resist the temptations provided by the sights, sounds, smells, and tastes associated with drugs and alcohol, limited treatment approaches have been dedicated to this phenomenon and the often-damaging response to physical cues (Liu & Weiss, 2002). Due to the inordinate amount of societal concerns surrounding addiction, attempts to address the experiences of people who engaged in therapeutic simulation techniques in *The Crack Room* seem logical. Through the existential-phenomenological nature of this research, greater insight into the thoughts and feelings of the participants has been obtained. By recording these emotional experiences, this investigation has given a face to the struggle to remain sober when exposed to drug-related cues.

*Substantive Assumptions*

Patton (2001) relates a tale in which he cites the following quote:

The story is told that at the conclusion of a rigorous course in philosophy, one of the students lamented: professor, you have knocked a hole in everything I’ve ever believed in, but you have given me nothing in its place. To which the professor replied, you will recall that among the labors of Hercules he was required to clean out the Augean stables. He was not, let me point out, required to fill them (p. xxi).

In this passage, Patton illustrates that unbiased research and inquiry should begin with a vault filled with ideas and end with even more questions. In this study,
several presumptions will be made relative to cues and use among individuals addicted to alcohol and other drugs that will open the door for more inquiry.

As researchers begin exploration of the intended domain, indications for further study must be created. Investigators often end with more questions than when they began; however, a few basic assumptions must remain. To that end, it must once again be noted that little investigation has been directed toward the notion that understanding one’s chemical need for AOD use may produce a deep awareness of an individual’s negative response to drug-related stimuli. Therefore, the first assumption of this study is that individuals addicted to alcohol and other drugs are frequently triggered, or reminded of their desire to use AOD, which often prompts relapse (Liu & Weiss, 2007). Furthermore, it may be presumed that the therapeutic simulation techniques used in *The Crack Room* are an effective and beneficial method to uncover the emotions that are common in cue response. With these suppositions in mind, I suggest that treatment strategies surrounding therapeutic simulation techniques can be an effective therapeutic tool in long-term recovery.

*Research Question*

The important question proposed in this study is: What is the lived experience of individuals who are addicted to AOD when faced with drug-related cues in *The Crack Room*? Inquiry indicates that similar studies have been reported with consumers who are suffering with posttraumatic stress and obsessive/compulsive disorders (PTSD, OCD). Similar to addictive cues, PTSD and OCD are frequently triggered by memories or environmental conditions (Rothbaum, Hodges, Kooper, & Opdyke, 1995). This consideration seems to confirm the notion that because *The Crack Room* is designed to
replicate a drug-using environment, clinically controlled simulation techniques can provide an understanding for clients struggling with negative cue response to drug and alcohol-related triggers.

*Operational Definitions*

The following is a list of concepts and definitions that were used within the body of this study. These include: AOD, AOD use, AOD misuse, AOD abuse, AOD dependency, AOD addiction, cues, triggers, startle response, behavior therapy, cognitive behavior therapy, systematic desensitization, exposure therapy, relapse, slips, abstinence, psychoactive substances, co-occurring disorders, participants, and consumers. Definitions are listed below:

**AOD** is an acronym used in the clinical setting to describe alcohol and other drugs.

**AOD use** is defined as the act of using a substance for a purpose, or to consume a substance regularly for benefit or satisfaction (NIAA, 2009). Enjoying a glass of wine with dinner is an example of AOD use.

**AOD misuse** is classified as experiencing negative patterns of behavior while using AOD (NIAA, 2009). Typically, the individual will learn from the negative experience and will not repeat the behavior.

**AOD abuse** is characterized by a maladaptive pattern of substance use which is recurrent and shows significant consequences. Individuals who abuse AOD have multiple and recurrent legal and societal problems and have difficulty in fulfilling obligations (DSM IV, 1994).

**AOD dependency** is indicative of feelings of a strong reliance on a substance, often finding it necessary to engage in its use simply to function normally. Signs of
dependence include: increased tolerance, withdrawal, unsuccessful efforts to decrease use, and continued use of a substance even though physical or psychological problems are continually encountered (NIAA, 2009). For example, an individual may become dependent upon legally prescribed medications or may be dependent upon a drug depending on the mother’s level of use during pregnancy.

**AOD addiction** is typically used to describe AOD dependency when obvious mental and physical changes occur. At this stage, individuals chronically engage in drug-seeking behaviors (NIAA).

**Biopsychosocial model** discusses the mind/body connection.

**Bioecological model** discusses features that are relevant in an individual’s environment.

**Social constructivism** discusses the manner in which groups construct knowledge.

**Cues and triggers** can be characterized as any tangible items prompting the specific desires of an addicted individual in thoughts or cravings, or the resumption of, or continuation of use. This term may be used interchangeably with the physical triggers and environmental stimuli.

**Startle response** can be defined as the development of a strong stress response after exposure to a troubling event or series of events. Prolonged reaction to the stimuli is typically experienced (Bryant, Mastrodomenico, Felmingham, Hopwood, Kenny, Kandris, Cahill, & Creamer, 2007).

**Behavior therapy** is a form of therapy developed by John B. Watson, who believed psychology should be more concerned with studying human behavior like one would study rats or apes. Techniques include operant and classical conditioning and uses terms such as response and extinction (Corey, 2002).
Cognitive behavior therapy (CBT) combines both cognitive and behavioral methods in a short-term intervention placing responsibility on the client to assume an active role during and outside of therapeutic intervention to bring about a change in cognition. CBT is based on the assumption that reorganizing one’s thoughts will result in a reorganization of one’s behavior (Corey, 2002).

Systematic desensitization is a form of behavioral therapy in which anxiety-evoking stimuli are gradually presented to an individual in order to weaken the bond between the stimuli and the anxiety. By using this technique, attempts are made to progressively extinguish connections between threatening situations and adverse emotional response (Corey, 2005).

Exposure therapy is a cognitive behavioral technique based on the principles of habituation and cognitive dissonance. This approach is often used for reducing fear and anxious response. Exposure therapy is similar to systematic desensitization. Both approaches are based on the assumption that key triggers can create unconscious arousal while reinforcing already established emotional states. This form of therapy exposes clients to stimuli, thereby altering existing emotions. A brief period of guided relaxation and imagery is mastered prior to exposure (Santoro, DeLetis, & Bergman, 2004).

Relapse is defined as impaired control, or the unpredictability of a drug-user’s choice to refrain from use. The severity and length of dependence affects this condition (Alcoholics Anonymous, 1956). Relapse is also considered a return to use, as well as a return to previous behaviors, perceptions, and cognitions. Relapse and resumption of use may be used interchangeably.
Slip is a momentary lapse of sobriety, or a brief, transient return to use (Alcoholics Anonymous, 1956).

Abstinence is the voluntary restraint from indulging in the use of AOD (Alcoholics Anonymous, 1956). Cessation is a conscious act, freely chosen to enhance one’s physical and/or emotional life.

Psychoactive substances are chemicals that act upon the central nervous system and alter brain function. Changes in perception, mood, consciousness, and behavior occur (Taleff, 1997).

Co-occurring disorders refer to the presence of any two or more illnesses recognized in the DSM IV, and occurring in the same individual. Co-occurring illnesses may be present simultaneously or sequentially. This concept is also known as dual-diagnosis and a co-morbid illness (Taleff, 1997).

Participants are the subjects engaging in this study.

Consumers are individuals seeking intervention or assistance through counseling.

Boundaries of the Study

The boundaries of this study help to provide an outline and to define the parameters. The focus of this inquiry is to understand the lived experiences of individuals who previously received therapeutic simulation techniques in The Crack Room. This investigation revolved specifically around the following question: did this experience assist participants in understanding his or her own response to drug-related cues?

Thus far, only limited evidence can be found to investigate individual reactivity to cues. Most of these inquiries have explored systematic desensitization, exposure
therapies using computer-generated virtual reality, or experiments conducted in sterile laboratory settings. In addition, most similar investigations have been conducted in urban or collegiate settings with the availability of a wide variety of study participants. Within the scope of this study, due to the rural nature of the clinical setting, and a limited number of individuals who have received therapeutic simulation techniques in *The Crack Room*, it was not possible to obtain a large number of participants. In order to narrow the focus and to provide protection to those involved in the study, certain parameters helped to define characteristics of the participants and the design of the study. Therefore, this investigation targeted participants who were clients at Two Roads Counseling Services, an outpatient drug and alcohol facility licensed by the state of Pennsylvania, providing treatment to individuals seeking therapeutic services.

Intervention had been previously requested by the client or the client’s family or mandated by employers, the courts, or local school districts. Approximately 80% of the clientele seeking services at Two Roads Counseling have been mandated into treatment. The sample for this study came from these individuals. Therefore, participants in this inquiry included individuals over the age of 21 years who were not on state parole or county probation at the time of the study and who previously had received therapeutic simulation in *The Crack Room*.

*Summary of the Introduction*

This study arose out of a significant clinical need to understand how individuals who are addicted to AOD have responded to drug-related cues presented to them in *The Crack Room*. Inquiry for this study is concerned with the experience of individuals in
recovery when faced with drug-related triggers or cues. Chapter I has provided a backdrop regarding the nature, framework, and importance of this study.

In Chapter II I review the literature, beginning with a discussion of the idea of triggers as they apply to AOD addiction and other serious disorders. Information from past research drove the development of the chapter, helping to design a framework supporting specific ideas about cues, recovery, and AOD treatment. The features associated with AOD addiction also are described and discussed. In addition, evidence supporting behavioral approaches to cue extinction is offered. In Chapter III I review the methods and structure of this study, including a discussion of how and why data were collected and analyzed, as well as all requirements for participation. In Chapter IV, the findings of this study are offered through analysis of individual interviews and observations. Emergent themes developed from the analysis of participants’ experiences are discussed in depth. Finally, in Chapter V, I discuss the findings and conclusions of this study. Significant implications of the investigation are noted and identified. In addition, implications for further research are offered and inferred, and the hypotheses generated by this inquiry are identified.
CHAPTER II

REVIEW OF THE LITERATURE

“People are disturbed not by things, but by the view which they take of them.”
from Epictetus (Ellis, 2001, p.6)

There are specific goals of this literature review. The first objective of this inquiry is to acquaint the reader with the literature highlighting pertinent discussions regarding cue exposure and relapse and their significance in AOD abuse and addiction. The second goal of this investigation is to offer an understanding of the experience of individuals who are in recovery from AOD addiction when faced with pronounced cue-exposure in The Crack Room.

Empirical research has demonstrated that the number of individuals who are addicted to alcohol and other drugs has increased significantly in the past decade (Bureau of Justice Statistics, 2004). To date, many treatments have exhibited limited success rates or they offer interventions that are extremely time intensive (Santoro, DeLetis, & Bergman, 2001). Forty-five percent of the U.S. population or 112 million Americans aged 12 years or older have reported illicit drug use at least once in their lifetime (National Household Survey on Drug Use and Health, 2006). In addition, total drug episodes seen in emergency room visits doubled from 323,100 in 1978, to 638,484 in 2001 (Drug Abuse Warning Network, 2001). These numbers appear to be growing exponentially throughout the world. Because there appears to be no decline in the abuse of AOD, these considerations confirm the idea that a deep understanding of the experiences of individuals who are addicted to AOD is needed. In order to analyze the
negative effects of physical cues on an individual’s recovery from addiction, one must study the history of treatment and investigate successful interventions prescribed to combat the often-uncontrollable reactions of individuals falling prey to drug-related triggers and cues. Therefore, the basic goal of this literature review is to develop a theoretical framework to explore cues as they apply to AOD abuse and addiction. In addition, a thorough overview of existing literature that discusses issues related to this topic will be described. Most relevant examination has been approached by professionals working with individuals with complaints of obsessive/compulsive disorder, a condition identified in the DSM IV and marked by a preoccupation with details and interpersonal control (DSM IV, 1994).

Although support is limited, current literature explores the concept that drug-related triggers often have a powerful effect on individuals attempting to remain abstinent from the use of psychoactive substances (Sinha, Fuse, Aubin, & O’Malley, 2000). According to Otto, O’Cleirgh, & Pollock (2007), four principles apply to the extinction of cues in a therapeutic setting: physical cues are a key contributor to substance relapse; exposure treatment can help to weaken cravings; specific situations may limit the effect of exposure therapy; and internal states encourage strong cues that trigger a return to use. Furthermore, it is widely believed that many alcoholics and drug addicts are likely to relapse and return to use at some point in their recovery (Liu & Weiss, 2002). In fact, a study from SAMHSA (2012) indicates that roughly three percent of individuals seeking treatment for AOD abuse or addiction will maintain permanent recovery. To that end, few studies have shown promise in providing a solid understanding of an individual’s response to drug-related cues.
Psychological Theories of Personality and Development

Psychological theories of personality development are an important construct when discussing addiction and psychological aspects of the disease. It is widely acknowledged that emotional growth ends or is slowed considerably when an individual who is addicted to ATOD first becomes conscious of a drug’s mind-altering effect (Taleff, 1997). Erikson’s theory of development is often used as a backdrop in counseling when an individual is newly sober. This theory also helps to clarify an individual’s emotional status. The sequential eight-stage developmental theory discusses stage-related tasks: trust vs. mistrust; autonomy vs. shame and doubt; initiative vs. guilt; industry vs. inferiority; identity vs. role confusion; intimacy vs. isolation; generativity vs. stagnation; and integrity vs. despair (Erikson, 1959). Failure to complete these tasks throughout the life span results in consequences or crises.

Trends and Existing AOD Treatments

Several treatments have shown impressive results for therapeutic intervention relative to phobias and other pathologies, primarily OCD and similar behaviors considered to be compulsive or habitual (Drummond & Glaudier, 1994). In a study conducted by Capafons, Sosa, & Avero (1998), 41 people with a fear of flying were participants in a treatment involving systematic desensitization. In this study, participants were shown videotape from a subjective and seemingly benign point of view regarding an impending airplane trip. The video begins with a traveler packing a suitcase and ends when the flight lands at its destination. Findings indicate that
interactive therapeutic intervention shows success in the treatment group, but lacks successful conclusions in the control group (1998).

In another study conducted by Scott Coffey (2005) at the University of South Carolina, cue reactivity was used in a laboratory-based treatment for post-traumatic stress disorder and AOD abuse and dependency. Researchers exposed subjects to stimuli designed to ignite memories of a traumatic experience. Subject response was subsequently monitored. During the first interview, the participants were asked to discuss their worse traumatic experience. The information was then used in an audiotape that served as the imagery-cue during the experimental session. Participants rated five narratives for pleasure. The script rated closest to neutral was subsequently used as their impartial cue. Researchers discussed the subjects’ substance of choice and offered drug-related triggers, such as a crack pipe, a bag of cocaine, or a bottle of alcohol. Wood chips were used as the neutral cue. Sessions began with a questionnaire asking participants to report their level of craving. Participants experienced four presentations of imagery and drug cues as follows: trauma imagery prior to a drug trigger; neutral imagery prior to a drug trigger; trauma imagery prior to a neutral trigger; and neutral imagery prior to a neutral trigger. Subjects then listened to imagery recordings with eyes closed. When a buzzer sounded signaling them to open their eyes, they were confronted with a drug or a neutral cue. Cravings, as well as other important emotional responses, were rated. Results of this study indicate that cravings for AOD increased significantly when participants were presented with trauma imagery and triggers that related to their drug of choice (Coffey, 2005).
In another laboratory-based experiment using ethanol dependent and non-dependent male rats, ethanol-associated conditional stimulus was used to determine whether drug seeking was induced by stress and alcohol cues. Under imposed chaotic situations rats were given the opportunity to manipulate a lever providing ethanol when pushed. Dependent rats continually pushed the lever while under stress, while non-dependent rats did not. The findings determined that stimuli could, indeed, facilitate drug-seeking response to cues (O’Brien, Chidless, Ehrman, & Robbins, 1998).

In another study more pertinent to this query, Moses (2007) reports that Duke University psychologist Zach Rosenthal in an attempt to help addicts fight their cravings has developed a video game that puts participants in virtual reality settings that mimic actual crack houses and activities related to drug use. According to Rosenthal, the game was designed to allow participants to experience the cravings they may sense in the real world. Participant cravings are triggered through the video game. When desires reach their peak, participants are asked to report these feelings to the researchers and allow their cravings to subside. As the desires begin to diminish, a specific tone is played through a cellular telephone. Following Pavlov’s theory of classical conditioning, hopefully participants in this study will associate the audio tone with defeating the craving to use drugs. Telephones are donated to participants through the 12-week program at Duke University. The program includes one-on-one and group therapy. There are no solid results because the study is in its infancy; however, scattered success has been reported (Moses, 2007).

Reality tours, another relevant program being used across Pennsylvania, are gaining popularity as a way to combat AOD abuse and addiction. This award-winning
program is registered with the National Registry of Evidence-Based Programs (NREPP, 2012) and takes parents and teens on a live-action tour to view the consequences of drug abuse. Using trained volunteers as actors, each tour offers simulations and vignettes of drug arrests, overdoses, funerals, and other disturbing activities involved in AOD use.

The Reality Tour is designed to grab the attention of young people and parents as they experience, first hand, the consequences of drug use. Key individuals throughout the community are also asked to participate, including police officers, physicians and hospitals, probation officers, and funeral home directors. First presented in 2003 in Butler County, Pennsylvania, positive response has led to 29% of Pennsylvania’s counties offering the Reality Tour as a large portion of their drug educational programming (Miller, 2010).

Research conducted on the association between environmental cues and high-risk behaviors has typically relied on models based on behavioral techniques (Monti, 1995). Using classical conditioning, researchers believe that repeated exposure to stimulus or paraphernalia will extinguish the associated meaning or anticipation of obtaining a high (Carter & Tiffany, 1999). As previously discussed, cue exposure and expected cravings for AOD use have been successfully observed in sterile laboratories while studying rats or by using virtual settings. This study will provide a backdrop for further investigation regarding this phenomenon.
Therapies and Interventions

Behavior Therapy

Behavior modification is a technique used to produce change and provide assessment focusing on the development of productive adaptation (Corey, 2005). Miltenberger (2004) indicates that behavior therapy is used to help clients improve a focal point of their daily life. Modern behavior therapy can be interpreted by understanding classical conditioning, operant conditioning, the social learning theory, and cognitive behavior therapy (Corey, 2002).

Classical conditioning is best described as respondent behaviors such as salivation and reflexes and focuses on the pairing of learning and subsequent responses (Wolpe, 1990). In the 1950s, researchers began experimenting with animals using classical conditioning. Their findings were applied in clinical settings to treat individuals with various phobias. Ivan Pavlov also applied respondent conditioning in his famous experiment with dogs (Corey, 2005). The findings of research conducted with classical conditioning illustrates the basic notions of this study.

Not only is it often difficult for individuals who are addicted to AOD to remain sober, but also they are extremely vulnerable to relapse when faced with cues associated with use. Dettaan (1999) found that after twelve months of traditional drug and alcohol therapy, most clients experienced cravings when confronted with items representative of drug use. Paraphernalia often becomes a powerful conditioned stimulus and is usually paired with an unconditioned response to a drug. Slowly, the drug elicits a conditioned response among addicted individuals (Tiffany, 1995). Sensorial cues related to AOD use create psychologically reinforced reactions, also called respondent
behaviors. Reinforcing results of AOD use, for example, having a good time with friends or positive outcomes when AOD is used, continue to make it more likely that use will occur or repeat. When addicted individuals are confronted with drugs, alcohol, paraphernalia, or depictions of use, intense psychological reactions and cravings are experienced (Santoro, McNamara, & DeLetis, 2000). This notion is especially important when discussing the premise and creation of therapeutic simulation techniques, specifically, *The Crack Room*.

Behavior therapy and associated techniques are of particular relevance to this study due to their primary focus on altering perceptions and response, determinants of behavior, and the use of learning experiences to promote change. The following are 10 basic characteristics of behavior therapy: 1) therapists state treatment goals in concrete terms to make modifications possible; 2) behavior therapy focuses on a consumer’s current issues and problematic adaptations; 3) consumers are required to assume the role of an active participant in their therapy; 4) consumers are asked to transfer the learning they derive in therapy to everyday life; 5) therapists assess behavior both directly and as reported by consumers. This information is then used to identify the problem and encourage change; 6) a strong focus on self-management strategies is encouraged; 7) interventions are personalized; 8) the therapist and consumer are partners; 9) therapeutic emphasis is placed on practical applications to be applied to all aspects of daily life and; 10) culturally sensitive techniques are encouraged (Spiegle, & Guevremont, 2003). B.F. Skinner (1974), a notable spokesperson for behavior therapy, placed primary consideration on the effects of our environment on behavior. As such, Skinner’s concepts work nicely with the basic structures of this study.
Although behavior and cognitive behavioral therapies share a common bond of thinking, feeling, and activity-oriented methods, cognitive behavior therapy combines behavioral as well as cognitive principles (Weishaar, 1993). Corey (2005) focuses on four tenets of cognitive behavior therapy: 1) there must be a collaboration between the consumer and the therapist; 2) the idea that psychological distress is often a function of disturbances of cognition; 3) changing cognition can produce desired changes in attitude and behavior and; 4) cognitive behavioral therapy is typically a time-limited educational treatment focusing on specific problems. Cognitive behavioral therapy is structured from a psycho-educational model, placing responsibility on the client to adopt an active role in therapy (Arnkoff, & Glass, 1992). During the therapeutic process consumers are asked to reorganize self-statements and beliefs to better reorganize behaviors. Various techniques, including behavioral rehearsal and modeling, can be applied to one’s internal dialogue (Meichenbaum, 1977). Within the context of cognitive behavior therapy, one approach, in particular, meshes well with this investigation.

In 1955, Albert Ellis combined behavioral therapy, the humanistic approach, and philosophy to develop rational emotive therapy. He later expanded this technique to include elements of behavior, including deciding, judging, analyzing, and action (Dobson, & Block, 1988). The basic presumption of rational emotive behavior therapy (REBT) is the belief that individuals influence their own psychological difficulties by interpreting situations in a certain manner. REBT states that thoughts, emotions, and actions often interact and produce a cause-and-effect relationship (Ellis, 1994). This principle and the tenets suggested by behavior therapy hold value for this study and
other investigations that focus on addressing the connection between AOD use and the response to drug-related stimuli.

*Exposure Response Therapy*

Exposure Response Therapy (ERP) is an established therapeutic intervention used to treat phobias and compulsions. ERP works by exposing the individual to a phobic situation while attempting to prevent a dysfunctional response (Foa, & Kozak, 1986). The use of ERP in the treatment of alcoholism was discussed as early as 1980 and has been used to extinguish the desires often experienced by individuals addicted to opiates (Dawe, Powell, Richards, Gossop, Marks, Strang, & Gray, 1993). In 1994, Blakely and Baker began using ERP in a private treatment center in Brewster, New York (Santoro, McNamara, DeLetis, 2000). In this study, researchers placed participants in a room and exposed them to actual cues designed to trigger their desire to use AOD. Marijuana users rolled and lit joints; heroin users used spoons to cook their drug; and alcoholics were asked to pour their favorite drink. Pulse measures and self-reported craving levels were recorded when participants were handling the drug of choice. As hypothesized, participants responded to AOD stimuli when faced with triggers in a controlled setting. Researchers also found that craving ratings and pulse measures decreased significantly by the end of the study, signifying that startle response to triggers minimized as participants became used to seeing, smelling, and handling specific cues (Santoro, McNamara, & DeLetis, 2000). These results indicate that a solid treatment for individuals suffering from addiction disorders may be achieved when drug-related triggers are provided in a controlled setting coupled with specific treatment techniques.
Systematic Desensitization

Systematic desensitization uses the principles of classical conditioning to assist clients by asking them to imagine anxiety-provoking situations while participating in activities that are reminiscent of the stimuli to minimize or desensitize the stressor (Wolpe, 1990). Additional functions of systematic desensitization include self-monitoring and maintaining records of personal behaviors during stressful situations. Relaxation training, the development of a list of troubling anxieties, and decisions regarding the pace of therapy are also a part of systematic desensitization (Cormier, & Nurius, 2003).

In Vivo Desensitization

In vivo desensitization differs from systematic desensitization by asking clients to face their fears in real time, rather than imagining stress-provoking situations in discussions with their therapist. While using relaxation techniques and breathing exercises, a therapist guides clients as they come face to face with their fears and identified stressors. In numerous situations, therapists go outside of the clinical setting to address client needs during the therapeutic experience (Corey, 2005). Lazarus (1996) contends that therapists do not have to confine themselves or their clients to restrictive settings or themes. Rather, a broad spectrum of activities and techniques can assist the therapeutic process. For example, when incorporating in vivo therapy, a counselor may provide services at a shopping center, in a theme park, or while walking in the forest. Real life exposure is often effective in treating certain unhealthy connections that clients may associate with certain stimuli. According to Marks, Hodgson, and Rachman...
(1975), avoiding important stimuli serves to feed phobias and make them more prominent, and thereby, more stressful.

Flooding

Flooding refers to a technique that can be used during in vivo therapy or systematic desensitization which encourages clients to experience controlled exposure to stressors for an extended period of time. Relaxation techniques, however, are not a function of flooding. Because flooding provides prolonged exposure to maladaptive behaviors, negative responses to anxiety are allowed to decline slowly and on their own (Corey, 2005). Flooding is a rapid therapeutic technique used to extinguish an individual’s negative response.

Backdrop of Theoretical Ideas

This study is focused on illuminating the experiences of individuals who received therapeutic simulation in The Crack Room. The impact of this study seems to be multi-faceted and may involve results that are relevant to biological, social, psychological, and therapeutic levels; limiting this study to one sociological or psychological approach would be inadequate. As a result, two theories were used to guide this inquiry: Bronfenbrenner’s (1979, 2005) bio-ecological model of human development and Engel’s (1977) biopsychosocial model. Although other theories may have provided a useful set of concepts, only two were selected to define the ideas of this inquiry.

Bio-ecological Model

The bio-ecological approach is helpful in this study because it is mindful of all of the systems in which individuals are enmeshed and reflects the truly dynamic nature
of relationships (Swick & Williams, 2006). Relationships play a large role in the recovery from AOD addiction, due to emotional and physical responses to even seemingly benign events and occurrences. Early writings from Bronfenbrenner (1979) discuss lasting changes in the way in which individuals perceive and compromise their environment. As his theory progressed, he discussed continuity and change in the characteristics of all humans (Bronfenbrenner, 2005).

**Perception**

One assertion that is of interest to this study indicates that experience is an important point in the development of all humans. As individuals transition, they often respond to their environment, as well as to their perceptions and experiences (Bronfenbrenner, 2005). An emphasis on Bronfenbrenner’s ideas that perceptions are a driving force in development suggest to this researcher that biopsychological changes occur on an intrapersonal level and relate to the way in which individuals addicted to AOD perceive their surroundings.

**The Proximal Process**

Overt, environmental, and objective changes often are included in the life span and development of humans (Bronfenbrenner, 2005). Proximal process describes the influence of an individual’s growth from childhood and adolescence when skills, growth, and understanding are especially significant. The individuals engaged in this study have reported difficulty in relationships, either during infancy, childhood, adolescence, or adulthood. Thus, the idea that regular and solid supports can only enhance development is relevant for individuals in recovery from AOD addiction when they are confronted by drug-related triggers.
Bronfenbrenner (1986) describes four spheres of the environmental system that impact individuals from the innermost circle to the outermost circle: the microsystem, the mesosystem, the exosystem, and the macrosystem. In detail, these systems define close relationships, as well as systems that lie beyond and within traditional influences. These systems, according to Bronfenbrenner (1986), are microsystems, or the core of the circle (immediate family and personal matters), mesosystems (school, extended family, peers, and outside agencies or other contacts), exosystems (work, social networks), and macrosystems (societal attitudes, poverty, cultural differences).

Bronfenbrenner (1979) also states that transitions occur when an individual’s position changes as the result of an alteration of his or her role or setting. Transitions have long been considered part of the mesosystem and include changes from home to school, school to work, or other important conversions or shifts in one’s life. In the case of an individual who is addicted to AOD, this transition may include the move from one social group to another. Living on the street or in an environment similar to the living conditions designed in *The Crack Room* provides an example of a change that has a significant impact on an individual’s life. Transitions have consequences that include and involve a person in new activities and endeavors (Bronfenbrenner, 2005).

Individual development is often thought to be shaped by a person’s contacts with family and peers (microsystems); however, broader influences also induce change and perception (mesosystems, exosystems, and macrosystems) (Bronfenbrenner, 1979). Maring (2005) discusses these systems in terms of risk and resilience when applied to individuals addicted to AOD.
The study of an individual’s response to drug-related cues when he or she is in recovery from AOD addiction is limited. Therefore, to develop a rich understanding for this inquiry, it was helpful to look at other systems of knowledge. As such Bronfenbrenner’s ideas have been helpful in describing some of life’s transitions.

**Biopsychosocial Model**

The biopsychosocial approach seeks to understand how effect and cause relate to one another and searches for potential causes of a psychological nature (Engel, 1977). These potential causes include difficulties with impulse control, emotional disruption, or negative thoughts. As a model of care, the biopsychosocial approach examines an individual’s entire status on a biological, psychological, and social basis. A focus is placed on an individual’s overall needs, as one’s mind influences one’s body, and one’s body influences one’s mind (Engel, 1977). For example, depression may not cause chronic liver disease, but may motivate an individual to self-medicate with alcohol which may result in chronic liver disease or a compromise of other necessary organs. Understanding an individual’s ailments and the context in which they occur helps practitioners to develop a broader base of knowledge. A base of knowledge regarding the biological, psychological, and sociological history of an individual improves overall care (Frankel, Quill, & Daniel, 2003). Conversely, failing to detect issues that may lie at the heart of a consumer’s problems may lead to continued care and prolonged therapy. Therefore, the biopsychosocial approach is useful in this research, which includes discussions of a participant’s life domains, including family, culture, emotional connections, and life experiences.
To augment the other models, this research also relies upon the self-determination theory of human development and motivation (Ryan & Deci, 2000; 2006). Motivation refers to an individual’s choice, which may be intrinsically or extrinsically induced. Extrinsic motivation includes influences that are forced upon us, such as money, grades, or punishment, while intrinsic motivators are self-directed or because the act is somehow satisfying or interesting (Vallerand & Reid, 2003).

Need for Further Study

Current literature discussing the experience of individuals who are addicted to AOD when faced with the extreme emotions that can occur when one of views, smells, or hears sensations associated with use is difficult to obtain. In addition, there is a marked void of relevant research regarding physical cues, as they apply to recovery from drug and alcohol addiction. This investigation encourages clinicians to consider the implications of physical triggers when discussing treatment options. Specifically, this study intends to offer insight from individuals who are in recovery from AOD addiction and who have experienced Therapeutic Simulation Techniques in *The Crack Room*. Understanding of an individual’s response to the feelings and emotions created by exposure to physical cues is a primary goal. The likelihood of obtaining a vast amount of information and studies relevant to this research is limited; however, several investigators have provided similar ideas and have been discussed in this chapter.

Summary of the Review of Literature

To that end, a review of the literature has shown little but promising evidence regarding the relevance of drug-related physical cues and the resumption of use. As
noted within analysis of recent studies, popular treatment modalities discuss refusal skills and traditional interventions (Miller & Rollnick, 1991). Limited research has been generated that discusses the idea of therapeutic simulation as an effective weapon in the fight against relapse, or unwanted use.
CHAPTER III
METHODOLOGY

“Then, my children, you must go out into the world. Live among the peoples of the world as they live. Learn their language. Participate in their world as rituals and routines. Taste of the world. Smell it. Watch and listen. Touch and be touched. Write down what you see and hear, how they think and how you feel.”

“Enter into the world. Observe and wonder. Experience and reflect. To understand a world you must become part of that world while at the same time remaining separate, a part of and apart from.

“Go then, and return to tell me what you see and hear, what you learn, and what you come to understand.”

From Halcom’s *Methodological Chronicle*  
Patton (2002, p. 259)

The purpose of this study was to investigate the lived experiences of individuals who previously have participated in a therapeutic simulation technique called *The Crack Room*. The original design of this room was to assist individuals in developing the skills and tools that are necessary when an individual in recovery from AOD addiction is faced with an onslaught of drug-related cues. *The Crack Room* offers a realistic simulation of this phenomenon. The significance of this research lies in the ability to provide an understanding of the experiences of individuals who have been addicted to AOD when faced with these triggers. An examination of this relationship and the resultant thoughts and emotions led to an important understanding of an individual’s response when he or she is bombarded by physical cues.

There is a marked void in the writings that discuss physical cues and the potential for relapse felt by individuals who are addicted to alcohol and other drugs (Liu & Weiss, 2002). Furthermore, therapeutic models designed to provide therapists and
consumers with opportunities to address specific emotions and physical response are also virtually non-existent. This study also provides a backdrop for further research investigating a relationship between individuals in recovery from drug and alcohol abuse and addiction, cue response, and therapeutic simulation.

A qualitative approach was used to investigate this relationship and to extrapolate the rich meaning that resulted. The application of a therapeutic simulation technique in the clinical setting was of primary interest. Through the use of a phenomenological approach, this examination interpreted information and described the experiences of participants by using researcher observations and key informant interviews. According to Denzin and Lincoln (2003), qualitative studies observe people in their natural settings, while researchers attempt to interpret the meanings individuals place on a phenomenon. By developing *The Crack Room*, I have been able to place consumers in a setting that is as close to a drug-using environment as possible while maintaining a safe therapeutic environment. Rich meaning can be interpreted as individuals experience drug-related triggers in a controlled atmosphere.

In Chapter III, I discuss methodology, instruments, sampling procedures, recruitment strategies, the collection of data, and analysis used in this study. Interviews and researcher observations took place in an outpatient drug and alcohol facility licensed by the state of Pennsylvania that provides services to individuals seeking treatment for drug and alcohol abuse, dependency, and addiction. As the director of the facility, I approved this research and determined that Two Roads Counseling Services was an appropriate outlet for a study of this nature. Safety and confidentiality for all individuals involved was provided to the best of my ability.
Participants placed in a room decorated to resemble the natural setting of many drug users has made it possible to create a meaningful description of the phenomenon of an individual’s response to AOD cues. This design was exceptionally suited for exploration and helped to develop an understanding of triggers and cues as they apply to relapse and to explore the meaning of one’s experience in *The Crack Room*. This form of research helped to develop an understanding of the experiences of individuals who have been addicted to AOD when faced with drug-related cues. Information was gathered directly from the participants and focused on individual perceptions and interactions regarding their previous experience in *The Crack Room*. Few studies explore trigger response from a natural setting of this type. The intimate and personal experiences of individuals addicted to AOD when faced with drug-related triggers was explored in a semi-natural setting. This study was void of computer-generated images and sterile laboratories which has been the norm among researchers studying cue exposure.

The intent of this study was to describe at a conceptual level the experiences of individuals who previously received therapy in *The Crack Room* and their response to the bombardment of physical cues. A qualitative study was chosen to yield more meaning and a deeper understanding of these experiences. A quantitative study would have only duplicated information that has already been recorded.

Phenomenological-oriented research focuses on what a study reveals, rather than how a phenomenon was previously examined. In addition, vanManen (1997) believes that a researcher must remain involved in a study in the strongest way possible to fully
understand the phenomenon by exploring the overall meaning of an experience and the details of that experience.

_Conceptual Framework_

The focal point for this research was in exploring how individuals addicted to AOD internalize the onslaught of triggers that cue a desire for use. It is important to note that maladaptive responses to drug-related triggers are often the starting point for relapse (Liu & Weiss, 2002). Historically, individuals in recovery from AOD addiction are ill equipped to battle the resultant behaviors and frequently return to use. Another goal of this research was to describe these experiences, as closely as possible, to reveal the information in a manner that is easily understood in a way that has never existed (vanManen, 1997).

As discussed in the introduction, studies of the cue response of individuals addicted to AOD exist, but those explorations have involved computer generated virtual reality or sterile laboratory settings. This study explored the experiences of individuals who have been previously placed in a therapeutic simulation area closely resembling a drug-using environment.

_Lived Experience and Phenomenological-oriented Research_

One may ask, what is the basis of an experience (Patton, 2003)? Solid phenomenological-oriented research capturing the essence and significance in a way not seen before should be delivered in a way that can be grasped and easily understood (vanManen, 1997). As evidenced throughout this study, the phenomenon of individuals in recovery from addiction when faced with drug-related cues has seen limited investigation. By using a phenomenological-oriented approach to this research, I
attempt to develop an understanding of the experiences of the participants involved in this study. My intent was to capture the essence of their previous experiences in *The Crack Room*. This study allows future researchers and therapists to more completely understand the emotions surrounding individuals when they are confronted with AOD cues.

*Methods and Instrumentation*

This investigation was qualitative in nature and, as such, used traditional methods, including key informant interviews and researcher observations. However, due to the population examined in this study, special precautions were used to ensure that the participants were able to engage in this study in a healthy and safe manner. The goal of this qualitative study was to investigate the lived experiences of individuals who previously have participated in therapeutic simulation in *The Crack Room*. This investigation provides an understanding of the experiences of individuals who have been addicted to AOD when faced with drug-related cues. Instrumentation included researcher observations as well as key informant interviews. Instrumentation helped to develop a study rich with meaning.

In this examination, participants were interviewed regarding their response to drug-related cues. Interviews explored individual response to *The Crack Room*, a therapeutic area furnished and designed to resemble the living area of an individual actively addicted to AOD. This area is equipped with a bare mattress, pillow, and sparse blanket. A beach towel covers the lone window facing the street, thereby limiting light projection and observation from the outside. A broken lamp without a shade sits on the floor which is cluttered with candy wrappers, a pizza box, soda cans, cigarette butts,
papers, tissues, and dirty, stained clothing. Various forms of paraphernalia and empty bottles of alcohol are strategically placed in areas of clear observation and provide subjects with pronounced stimuli. Some images are overt, while others are subtle and can be seen within society during the course of normal day. A television is located in one corner of the room with an empty beer bottle protruding from its broken screen.

Items used as physical cues in The Crack Room have been carefully considered for their projection of drug use, abuse, and addiction, and the behavioral response that often occurs. This room was designed to produce an emotional reaction or a desire for substance use. Various forms of stimuli are placed to elicit deep emotional meaning. Individuals participating in this form of therapeutic simulation have the ability to sit on one of two beanbag chairs or on a mattress located in a corner of the room. This area is dimly lit and maintains a temperature of approximately 72 degrees.

The experiences, perceptions, and memories of individuals who previously have received therapy in this room were a primary focus. During an individual’s simulation in The Crack Room, relapse or a strong desire to use AOD has been characterized as any reported fantasy of using alcohol or other drugs. The Crack Room has been deliberately manipulated to invoke a change in arousal states.

This study used two instruments of investigation, including researcher observations and key informant interviews. Due to the intensity of this study, researcher observations must be included as a means of collecting vital data. Researcher observations allowed genuinely collaborative inquiry as the investigator became an additional tool of research (Patton, 2002). As mentioned previously, the feelings and emotions experienced by the researcher played a role in the meaning-making schema of
this study. This study was designed to illuminate the participant’s previous experience in *The Crack Room*. The goal of this investigation was to contribute new understanding to this phenomenon.

**Key Informant Interviews**

Interviews help researchers to enter another individual’s world and to hear or feel things that we are unable to detect through observation. Individual interviews can help to determine who or what may be typical of those in recovery from AOD addiction (Patton, 2002). Individuals interviewed for this study are, or have been consumers at Two Roads Counseling Services, and have previously received a therapeutic simulation in *The Crack Room*. These interviews allowed: (1) information we cannot directly observe; (2) the ability to enter into the participant’s experiential perspectives; and (3) development of a solid conversational relationship with the co-researchers (Creswell, 1998).

Protocols included the standard open-ended interview and specified each question that was relevant to this inquiry. Interviews of this type ensured that the same questions are asked in the same way (Patton, 2002). In addition, analysis of the participant’s response was easier and more efficient while using this type of interview. Transcripts of these sessions will be found in the data collection section of this study.

**Researcher Observations**

While becoming involved in participant or researcher observation, naturally unfolding phenomena of the subject’s world emerged. Unlike interviews, where the majority of behaviors are verbal, participant observation allowed the researcher to witness behaviors and expressions. Occasionally, however, both verbal content and
subtle behavioral nuance will occur simultaneously. At this point, a decision was made dependent upon the value placed on emergent observation versus verbal interaction. Due to the likelihood of this occurrence, a choice was made to determine the path of inquiry. Interests and bias also played a large role in this decision.

In order to provide accurate accounts of a participant’s previous experiences in *The Crack Room*, observations must be reported with accuracy. Patton (2002) describes several ways to promote skilled inquiry: (1) learn to pay attention; (2) practice descriptive writing; (3) know how to separate details of the observation from trivial points of view; (4) validate and triangulate information; and (5) relate one’s own limited perceptions, strengths, and weaknesses.

The goal of my observations was to become well versed in the participants’ lived experience. This process is often achieved by immersing oneself into the environment. In addition, researchers frequently gather information from an experience based on their own curiosities and interests (van Manen, 2003). Because of the relevance of drug-related cues in my own life, *The Crack Room* holds special significance for me.

*Personal Experiences*

For over twenty years I have worked in the field of drug and alcohol counseling. Through my interventions and interactions with individuals suffering from AOD addiction, I have noticed that many concerns among consumers seem to surround drug-related triggers. Therefore, the participant’s reactions, memories, and experiences in *The Crack Room* were of particular interest. *The Crack Room* and its implications are intriguing because they provide participants with the triggers and temptations of a real-
life setting while they experience these feelings in the safety of a clinical setting. Understanding the difficulties that are imminent for individuals who are faced with drug-related cues makes this investigation even more appealing. As mentioned, I am sensitive to the process of prolonged recovery from AOD addiction. Therefore, the positive relationships I developed with the participants and my unique sensibility to this topic provided key advantages while conducting this study.

*Purposeful Sampling*

Purposeful sampling was used in this investigation to obtain information that is insight rich and yields depth of understanding, rather than generalizations (Patton, 2002). The goal of this investigation was to develop descriptions of the emotions and feelings experienced by individuals who previously experienced therapeutic simulation in *The Crack Room*. Two Roads Counseling Services was chosen to represent drug and alcohol facilities and consumers found across the country.

*Parameters of Participation*

Within the scope of this study, obtaining a large number of subjects will not be possible. In order to narrow the focus and provide protection to the participants, certain parameters helped to define characteristics and study design. Therapy at Two Roads Counseling typically has been requested by the individual, the individual’s family, or has been mandated by employers, school districts, or the court system. In addition, Two Roads Counseling Services operates under a full license issued by the Pennsylvania Department of Health, Bureau of Drug and Alcohol Programs. This facility has not had deficiencies in state regulations that have been deemed a danger or injurious to staff or consumers.
One of the goals of this study is to generalize results back to the entire population of individuals suffering from issues surrounding addiction. Therefore, participants in this study, as closely as possible, represented the broader microcosm of drug-using individuals. In addition, all participation in this study was voluntary. Volunteers were able also to cease participation at will.

*AOD Abuse and Recovery*

Due to the complexities of one’s involvement with alcohol and other drugs, only individuals who have been diagnosed with chemical addiction were of primary interest. Others, such as people who use, misuse, abuse, or are dependent upon AOD, were not inclusive in this sample.

Participants chosen for study were individuals who found primary difficulty with issues surrounding addiction to alcohol and other drugs. Only those fitting the DSM IV description of chemical abuse, dependency and addiction were investigated. The decision to exclude individuals who use or misuse AOD was made to clarify and specify the population to be studied. The term addiction conveys the meaning of compulsive drug taking, while dependency implies a condition often occurring among many individuals taking prescribed medication that affects the central nervous system. Abuse implies AOD use that is beyond normal levels (O’Brien, Volkow, & Li, 2006). Alcohol and other drug use and misuse are considered to be less severe with no impending or long-term dysfunction. Therefore, individuals included in this category are presumed to be the most affected by drug-related cues and are the most appropriate for inclusion in this study.
Age

Only individuals over the age of twenty-one years were included in this study due to legal and ethical concerns. The legal age of alcohol consumption in the state of Pennsylvania is 21 years.

Length of Recovery

Only individuals achieving recovery for one year were permitted to participate in this examination. For the purposes of this study, one year of recovery was considered to be substantial for participation. Persons who have not achieved one year of consistent recovery were excluded to prevent the possibility of relapse that is common in newly sober consumers.

Emotional and Cognitive Considerations

Individuals with mental retardation or those with severe psychiatric conditions were also excluded as a matter of practicality and ethical consideration. It is important to note that individuals on the periphery of psychiatric distress were included for study. For those suffering from non-debilitating conditions, poor choice control, or moral challenges, investigation applied. Individuals presenting with a dual-diagnosis were studied due to its frequency in substance addiction. It was imperative that participants were emotionally capable of engaging in this investigation, whereby they were asked to recall their experiences in The Crack Room. Including individuals without severe mental disorders or mental retardation also helped to maintain the integrity and phenomenological nature of this study.
Drugs of Choice

Drugs of abuse commonly encountered at Two Roads Counseling include alcohol, marijuana, opiates and opioids, amphetamines, hallucinogens, club drugs, cocaine, and a variety of prescription and over-the-counter medications. The typical route of administration includes intravenous, oral ingestion, snorting and other uses of soft tissue, and smoking.

Gender

Participation in this study included both male and female volunteers. Including both men and women in this study allowed a well-rounded sample and assisted the study in identifying potential gender specific behaviors. In addition, because men have historically dominated participation in drug and alcohol treatment, including women in this inquiry added to its importance.

Ethnicity

Due to the lack of ethnic diversity surrounding Two Roads Counseling Services, it was difficult to obtain a sample that was diverse and varied. Approximately 98% of the individuals seeking treatment at Two Roads Counseling are of Caucasian descent. However, every effort was made to remain culturally sensitive.

Income Level

Income levels among the consumers seeking treatment at Two Roads Counseling vary; however, the majority of prospective participants are at or are below poverty level. Many consumers obtain treatment funding from Medicare, Access, Community Care Behavioral Health (CCHB), or through funding made available through the local Single County Authority (SCA). Every attempt was made to combine
individuals with medical insurance with those who pay for treatment from “out-of-pocket” funds. This again will allow a rich and well-rounded sample.

Length of Time Since Last Simulation Experience

After careful consideration, it was determined that individuals having received therapy in *The Crack Room* less than one year prior to participation in this study would not be included. This decision was made to minimize possible negative response to memories of *The Crack Room.*

The Researcher as a Counselor

To minimize contamination of information, participants have never been on the researcher’s caseload at Two Roads Counseling.

Probation and Parole

Due to the sensitivity of this study, participants were not on state parole or county probation at the time of the investigation.

The Facility, Licensing Protocols

Although parameters were designed to control the recruitment for participants of this study, a discussion included the boundaries of the facility being used in this investigation. Agencies engaging in out-patient services for consumers who are addicted to alcohol and other drugs vary; however, facilities licensed by the state of Pennsylvania must follow specific guidelines. Currently, the Pennsylvania Department of Health supervises over 700 licensed facilities (BDAP, 2011). In Jefferson County where Two Roads Counseling provides services, there are only two agencies offering treatment under an outpatient license. Each facility differs in a variety of ways, but as previously stated, basic guidelines are expected for a facility of this type.
The Pennsylvania Department of Health, Chapter 709, Subchapter I, standards for outpatient activities are client-driven and address the quality of care provided by licensed facilities. Failure to comply with these regulations results in the issuance of a provisional license. Should this occur, licensing representatives are permitted to conduct a random “spot-check” within a 6-month period. If a facility receives four provisional notifications the agency is then adopted by the state for remediation (BDAP, 2011).

Another prominent factor while discussing parameters has included a necessary discussion of therapeutic styles preferred by the treatment staff at Two Roads Counseling Services.

*Differences Among Out-patient Facilities*

A discussion of therapies used at Two Roads Counseling is an important factor in this study relative to the participants’ expectation of alternative treatment options within the therapeutic setting. Although Two Roads Counseling follows all regulations mandated by the licensing board for the state of Pennsylvania, we do follow certain alternative approaches that are individual to this agency. For example, therapists at Two Roads Counseling frequently invite consumers to go for walks, play basketball or Hacky Sack, or engage in a variety of play therapy techniques. In addition, Two Roads participates in canine therapy and employs the services of two certified therapy dogs.

Plato is quoted as saying, “Watch a man at play for an hour and you can learn more about him than talking to him for a year” (McGinnis, 2005). According to Corey (2005) counselors are able to reach consumers through their genuineness. The staff and therapists at Two Roads Counseling are encouraged to model congruent behaviors, foster real relationships, and provide a safe haven for positive risk-taking and change.
For some therapists the introduction of techniques in therapy is secondary to the overall relationship, increasing a counselor’s ability to challenge the client (Brugental, 1990).

As previously stated, Two Roads Counseling offers therapy that is, at times, appropriately alternative. Because we are a licensed facility, we aspire to provide services that are beyond the minimal level of care prescribed by the state of Pennsylvania. Therefore, counselors strive to develop positive relationships and engage in activities encouraging genuine dialogue and healing. Due to options in treatment and the frequent use of adult play therapy at this facility, individuals chosen to participate in this study have not been surprised by the introduction of _The Crack Room._

This study reflects two guiding principles: (1) Two Roads Counseling Services meets the requirements and quality of care determined by the state of Pennsylvania and (2) Two Roads Counseling Services reflects the variability of techniques available in AOD treatment and encourages positive change in clients.

_The Therapeutic Relationship_

Because of the very personal involvement during a study of this nature, a solid connection between the participant and the researcher, which is built upon trust, is significant. In fact, evidence suggests that during the course of therapeutic contact, acceptance, honesty, and understanding are the basic components for successful outcomes (Corey, 2005). Arnold Lazarus (1996) views the therapeutic relationship as the soil enabling the counselor’s interventions to take root. Due to the intimate nature of this study, a solid connection between the researcher and participants was of significance and special sensitivity. A solid relationship increases the probability that
individuals participating in this inquiry will have the opportunity to safely ponder and assess their experience.

Recruitment of Participants

The sample for this study consisted of 10 people with marked AOD issues. The group included five males and five females. Participants were recruited through local Alcoholics and Narcotics Anonymous (AA and NA) programs. Specific delimitations complicated the scope of this study and were inherent in an inquiry of this nature. Due to the design of this investigation, it was difficult to offer participation to a large number of participants, thereby narrowing results and outcomes. In addition, to maintain the facts and focus of this study, certain groups were eliminated to offer protection to the participants. A purposeful sample of participants was used to provide an equal assignment and representation of the group on as many variables as possible. Subjects in recovery from addiction to a number of psychoactive substances were chosen to explore expanded results and to offer consideration for a broad spectrum of drugs in common use.

Group leaders presiding over open-meetings were approached by the researcher and were asked to place study descriptions at various locations within the rooms and areas used by AA and NA groups. Open-meetings are AA and NA meetings that may be attended by the general public. It must be noted that closed meetings are held only for individuals who are in recovery from AOD abuse or addiction. Information tables are a common inclusion in meetings of this type and are placed within group rooms at AA and NA meetings. Pamphlet tables allow members to view and choose hand-outs at their leisure. Pamphlets, work-sheets, and bulletins provided to members typically cover
a wide variety of information, advertisements for treatment facilities, and self-help brochures.

The study description used for this research asked for volunteers who were previous consumers at Two Roads Counseling and who have participated in therapeutic simulation in *The Crack Room* to participate in this study. Confidential contact information for the researcher was included on the study descriptions, as well as limitations for participation. Potential volunteers were asked to contact the researcher if they were interested in participation. Contact information included the researcher’s cellular phone number and a confidential e-mail address.

Upon receipt of phone calls or e-mails from individuals interested in participating, the first five men and five women to respond were chosen for participation. Correspondence was initially going to remain open for 10 days, but it was discovered that 10 individuals who were interested in participation responded very quickly. The tenth and final participant responded within three days of receiving the pamphlet. Respondents were contacted and informed that they had been chosen for participation. When contact occurred, a time and date of the participant’s choosing was scheduled for the interview. All interviews occurred in a confidential office located at Two Roads Counseling. Evening and weekend hours were offered to provide confidentiality.

**Research Design**

Participants were interviewed regarding their previous experience in *The Crack Room*. Each individual was asked to participate in an interview designed to last for approximately one hour. However, more time was allotted as necessary. This study was
designed to elicit meaning regarding one’s response to physical cues provided in *The Crack Room*. A review of literature was conducted to establish an understanding of current investigation regarding this topic and its impact in the field of AOD counseling. The review of literature has demonstrated that therapeutic simulation techniques have not been widely explored as a viable treatment option.

Investigative techniques used in this study allowed for extensive analysis. Although case studies were considered for the collection of valid data, key informant interviews and researcher observations seemed more appropriate for the goals of this investigation. At the center of this study was a phenomenon or curiosity around which the research is developed: What is the previous experience of individuals who previously have received therapeutic simulation techniques in *The Crack Room*?

Data collected through interviews and observations were coded into categories throughout this project and helped to determine theory development by emphasizing meaning. Analysis was visited until the collection was saturated and no more data could be found.

*Data Collection*

The impetus of data collection was an analysis of subject response and information gathered during the interview. The decision of what elements of inquiry that were studied was based on desired outcomes and emergent themes. For this study, I used the structured open-ended interview to allow order; however, I was also afforded the opportunity to address feelings as they arose. Interviews and my observations served as the primary methods of collecting data. Transcripts of all interviews were analyzed,
searching for themes that indicated a common experience among individuals who previously received therapy in *The Crack Room*.

In creating interview questions, I have attempted to structure explorations in a way that was carefully worded prior to the interview, protecting the integrity of the interview and minimizing my personal bias. Questions reflected, as closely as possible, the framework and theme of this study. van Manen (2003) describes the theme of a study as the way to the very phenomenon we are trying to understand. This study focused on explaining the lived experience of individuals who previously received therapeutic simulation in *The Crack Room*. Analysis of subject response allowed the researcher to revisit specific discussions and to examine deeper meaning, while focusing on themes. Patton (2002) indicates that standardized open-ended interviews allow researchers to provide stability and consistency. Interviews were designed to last for approximately one hour or until data was satiated. However, all of the interviews lasted longer than the designed period of time.

**Key Informant Protocol Questions**

Key informant interviews that were used during this investigation asked very personal information. As originally assumed, other relevant information occurred naturally throughout the interview.

Protocol questions used during the Key Informant Interviews were:

1) Tell me about your experiences in *The Crack Room*.

2) Did *The Crack Room* represent an accurate representation of triggers common in AOD abuse and addiction? How?
3) What were some of the key factors in this experience (sights, sounds, odors, memories)?

4) Has anything changed for you since your participation in *The Crack Room*?

5) What strategies have you developed to maintain your sobriety? Have things changed since participating in this study?

6) How do you manage triggers on a daily basis?

7) Has *The Crack Room* helped you to combat desires to use AOD? If yes, how? If not, why?

8) Please share with me the top three factors that were important to you during your experiences in *The Crack Room*.

9) Please share with me anything that you feel is important about your experience in *The Crack Room*.

10) Please discuss anything you would like to add.

*Data Analysis*

Many scholars believe that the very moment researchers cease exploration in a study, one gains insight into that which was explored. More questions than answers often develop (Patton, 2002). While qualitative research provides us with a wealth of flexibility, analysis will be one of the most difficult aspects of this study. Unlike quantitative research, qualitative analysis does not lend itself to certainty; however, insights gained from content analysis will add texture and meaning to this inquiry. A systematic filing style was used to maintain and index coded data, allowing easy and effective access to information. Similarities and dissimilarities or patterns in the data were classified in groups including major topics and subtopics of interest. Analysis of
these interviews uncovered a participant’s conscious, semiconscious, and unconscious psychological characteristics. Subjects were asked to speak freely about their opinions, beliefs, and attitudes regarding previous experiences in *The Crack Room*.

Analysis began as soon as data was collected to its entirety, saturating this inquiry with repetitive themes and ideas. Transcripts of interviews were read and searched for commonalities that illuminated the meaning behind the experiences of the participants. A combination of observation and interviews provides data that is full of meaning (Geertz, 1973). Forming patterns through analysis also helped to confirm study results.

**Delimitations**

Two of the more difficult delimitations for this study were the lack of diversity and a small sample size. One of the goals of this study was to discuss the experiences of individuals who previously have participated in a therapeutic intervention. Participants were asked to explore and discuss their personal feelings, memories, perceptions, and reflections of their previous experiences in *The Crack Room*.

**Summary of Methodology**

The questions posed to participants addressed relevant simulation-related issues, and allowed more extensive clarification. The goal of this investigation was to understand the experiences of individuals who previously have participated in a therapeutic intervention in *The Crack Room*. 
CHAPTER IV

RESULTS

“People only see what they are prepared to see.”

from Ralph Waldo Emerson (Patton, 2010, p. 260)

Qualitative studies are typically generated from the researcher’s desire to understand a phenomenon. This chapter is dedicated to sharing the results of this inquiry as they were collected through participant interviews and researcher observations and a discussion of my own emotional experiences of individuals who previously received therapeutic simulation in *The Crack Room*.

More than one researcher has discussed students of qualitative study as instruments of data collection (Creswell, 1998). According to Maxwell (2005) qualitative examination offers five intellectual and practical goals. They are: (a) understanding the meaning of an event for the individuals involved in a study; (b) an understanding of the context of events, actions, and meanings within which participants act and shape meanings; (c) recognizing unanticipated situations and information that generates new ideas; (d) understanding and placing value in the process that occurs within events and actions and; (e) the traditional belief that only quantitative discovery is of benefit to researchers and further study. Miles and Huberman (1984) argue that “field research is far better than solely quantified approaches at developing explanations of what we call local causality- - the actual events and processes that led to specific outcomes” (pg. 132). One may assume that qualitative and quantitative approaches ask different questions. In this study, the goal is to determine the meaning behind certain emotions and behaviors,
rather than the extent to which variance in x may cause variance in y (Maxwell, 2005).

The intent behind this research has been offered using these assumptions.

It has been difficult to conduct this research and analyze data without rejecting certain theories and perspectives. To interpret data within this study, the framework that was constructed largely uses a bio-ecological model (Bronfenbrenner, 1979; 2005), a biopsychosocial approach (Engel, 1977), and to a lesser degree social constructivism (Gergen, 1997). vanManen’s (1997) ideas regarding lived-experience perspectives were also influential.

Methodology is considered to be the guiding force behind a study (vanManen, 1997). As such, my approach or framework used for this investigation worked as a complement to the question or questions under examination. The question under examination was in wondering about the experience of individuals who are in recovery from AOD addiction when receiving therapeutic simulation in The Crack Room. Listening to the experiences of these individuals is important in order to provide meaningful insight into their lives. Little study has explored therapeutic simulation used in counseling, especially as it relates to individuals who are in recovery from AOD addiction. Given the nature of this investigation, a phenomenological approach was chosen to gain the most insight and meaning.

Phenomenologically-oriented research has been discussed at length by vanManen (1997). In these discussions, he offers six assumptions. They are: (a) inquiry is concerned in a phenomenon that is of interest to the researcher; (b) phenomenologically-oriented studies focus on what a phenomenon uncovers; (c) themes often emerge in research that is based upon lived experiences; (d) a phenomenon is discussed in written form rather
than offered in statistical analysis; (e) researchers are strongly involved in the process; and (f) understanding a phenomenon occurs when one examines all of the details as well as the overall meaning provided by an experience.

As previously stated, it was very important to protect the identity of the study participants as much as possible; therefore, numeric codes were used. Additionally, discussions of significant identifiers were removed from the text. These included tattoos, significant scars, or specifics regarding an individual’s appearance. Although certain information was abundant and would have added to the interest and allure of this study, protecting the participants was more important than the potential benefit that emerged through providing identifying data.

Individuals who participated in this study were provided with as much assurance as possible that their privacy would be safe-guarded. Obtaining information for this study became secondary to maintaining anonymity and privacy.

**Two Roads Counseling**

Two Roads Counseling Services (Two Roads) is located in Punxsutawney, Pennsylvania, and is an out-patient drug and alcohol facility licensed by the state Bureau of Drug and Alcohol Programs (BDAP). Two Roads is a free-standing facility located approximately one mile from the town center. Several businesses can be found surrounding the building, including a restaurant, a convenience store, and an adjacent office building.

Upon entering Two Roads, one enters into an inviting and friendly atmosphere. Large chairs, tables, and a variety of plants fill the waiting room. A glass window separates the main office from the reception area. Clients announce their presence to the
receptionist and wait for their treatment counselor to retrieve them. An overall comforting theme is evident throughout the building and among the staff. Each office occupied by a counselor reflects individual interests and personalities, which tie into the relaxed atmosphere provided by Two Roads. A general theme of openness is evident throughout the building and among the staff. Counselors and facility personnel can be seen wearing shorts, blue jeans, t-shirts, and casual attire that is non-threatening or abject to a consumer’s sensibilities. The atmosphere at Two Roads reflects genuineness and is congruent with the personality of each member of the Two Roads’ team.

Key Informant Interviews

Key informant interviews allow the researcher to observe information that may not otherwise have been noticed (Patton, 2003). Interviews provide researchers with a way to gather information and to develop a deeper understanding of a given phenomenon (vanManen, 1997). The interviews for this research were conducted with individuals who previously had experienced therapy in The Crack Room. Individual interviews provided me with the ability to build upon the information that was gathered, along with the observations which provided a more complete understanding of the experiences of participants.

The protocol used for the interviews was a semi-structured interview guide. The advantages of using the interview guide are as follows: (a) the guide helps the interviewer to stay focused on relevant topics; (b) interviewers are able to plan and control clock management and; (c) the guide offers consistency during the interview (Patton, 2003). Interview guides also allow flexibility to expand on issues that may not have been anticipated.


**Researcher Observations**

This study was designed to explore the lived experience of individuals in recovery from AOD addiction and their recollections of previous therapy in *The Crack Room*. Key informant interviews were coupled with focused and unfocused observations to collect data. It should be noted that observation is not limited to specific moments during the interview; observations often begin during the first contact with a study participant (Jorgensen, 1989). This technique often allows the researcher to step into the participant’s world (vanManen, 1997). Therefore, my initial contact with the individuals engaging in this study was the first step toward understanding their world.

**The Researcher as an Instrument**

I have spent the majority of my professional life as a drug and alcohol counselor. During my interactions with consumers, I have noticed that physical cues and triggers often affect an individual’s recovery. Without properly managing the onslaught of cues found in everyday life, a relapse or a continuation of use often results. Keeping in mind the fact that physical triggers are observable in almost every aspect of life, and on a daily basis, this phenomenon has piqued my interest in cue reaction. I have spent a significant amount of time with individuals who are struggling with AOD addiction and have learned ways to connect and build a trusting relationship with this specific group of people. The connection I have developed with members of the drug-using microcosm, along with my personal interest in the plight of these individuals, was beneficial during this research.
The Process

Initially, I believed that I would have to encourage participants to discuss their experiences; however, I noticed as soon as The Crack Room was mentioned participants were eager to share their feelings and perceptions.

As soon as consent forms were signed, each participant began discussing The Crack Room even before the first question was asked. The participants’ eagerness to share made it difficult for me to maintain an appropriate level of speed in my questioning. It seemed as though the participants were answering questions before they were asked. Because of their enthusiasm, all of the interviews lasted longer than the one hour time limit. The exchange of ideas included thoughts regarding the meaning of The Crack Room, advantages and disadvantages of The Crack Room, and recommendations for future use of this therapeutic simulation.

Numerous themes emerged during the interviews and observations which will be discussed later in this chapter. Several limitations were apparent and are worth acknowledging as they hindered the overall sharing of information. First, a group of ten individuals sampled from a small rural community narrowed the diversity of viewpoints. Two members of the initial group reported that they were practicing harm reduction strategies as a way to continue AOD use while maintaining their ability to function in society. This information was not discovered until the interview began, and it may have tainted the study due to the individual’s inability to remain free from AOD. They were asked to cease participation and new individuals were secured using the process. Interviews took place in a private office of Two Roads Counseling Services, and no interruptions occurred in this process.
I was curious about the participants’ willingness to share their experiences openly and found my curiosity to be satisfied as each protocol question was answered with ease and candor. Because the interviews lasted beyond the prescribed 60 minutes, a decision was made to not end the interview before participants were finished expressing their feelings and perceptions. I did not interrupt their thought process, and I continued dialogues until the participants were satisfied that they had discussed their experiences to satisfaction.

**Purposeful Sampling**

The sampling method that was used to determine participants for this study was reflective of the purpose of the research, which was to uncover rich and meaningful information about the experience of individuals who received therapeutic simulation in *The Crack Room*. Participants were chosen to reflect the experiences of the larger population of individuals who are addicted to AOD. Participants were individuals who are addicted to AOD, when faced with drug-related cues, and who had previously received out-patient therapy at Two Roads Counseling Services. Specifically, this investigation was interested in consumers who had received therapy in *The Crack Room*. Rather than using a random sampling technique, ten participants were purposefully selected due to their earlier participation with therapeutic simulation in *The Crack Room*.

**Recruitment of Participants**

A discussion of the process used for recruitment is provided in this section. This process was at times tedious due to the excessive number of potential volunteers who immediately contacted me after they received information regarding this study. Within
three days of placing study descriptions at local NA and AA meetings, the entire participant pool was selected and interviews were scheduled.

Gathering Volunteers

Prior to the start of numerous local AA and NA meetings, I approached the leaders of 42 open meetings in 11 local communities and asked permission to place study descriptions regarding this research on resource tables. All of the study descriptions were given to group leaders within one week. The local municipalities and number of meetings in each town were as follows: Punxsutawney (6), DuBois (3), Falls Creek (1), Clearfield (7), Brookville (1), Clarion (5), Curwensville (2), Indiana (12), Madera (1), Philipsburg (2), Reynolds ville (1), and Timblin (1).

Table 1

<table>
<thead>
<tr>
<th>Meeting Locations</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Punxsutawney</td>
<td>6</td>
</tr>
<tr>
<td>DuBois</td>
<td>3</td>
</tr>
<tr>
<td>Falls Creek</td>
<td>1</td>
</tr>
<tr>
<td>Clearfield</td>
<td>7</td>
</tr>
<tr>
<td>Brookville</td>
<td>1</td>
</tr>
<tr>
<td>Clarion</td>
<td>5</td>
</tr>
<tr>
<td>Curwensville</td>
<td>2</td>
</tr>
<tr>
<td>Indiana</td>
<td>12</td>
</tr>
<tr>
<td>Madera</td>
<td>1</td>
</tr>
<tr>
<td>Phillipsburg</td>
<td>2</td>
</tr>
<tr>
<td>Reynolds ville</td>
<td>1</td>
</tr>
<tr>
<td>Timblin</td>
<td>1</td>
</tr>
</tbody>
</table>

It should be noted that open meetings include meetings that are made public to non-addicts, while closed meetings include only groups that are provided for individuals who are addicted to, or abusing AOD. I approached the group leaders and departed all
buildings before the start of each meeting. All 42 of the group leaders agreed to offer the letters describing the study to their groups. Within ten days of meeting with the last group leader, 31 individuals contacted me asking to volunteer for participation in this study. Five individuals contacted me through my confidential e-mail, while the remaining 26 individuals contacted me through my confidential cellular phone. As previously discussed, the first five men and five women were chosen for participation. All of the contacts were made through cellular phone, and all of the participants were chosen within one week of my final contact with AA and NA leaders. The first contact was made by cellular phone within two hours of the end of the individual’s AA or NA meeting. Three more contacts were made the day after final contacts with group leaders, four contacts occurred two days after they received information about the study, and the final two individuals chosen for participation were selected five days after receiving information regarding this study.

It remains unclear why other individuals who were appropriate for this study did not contact me for participation, as approximately 300 consumers have received therapeutic simulation in *The Crack Room*. I did not correspond or have further contact with the group leaders of AA or NA beyond my initial request for volunteers.

Ten adults participated in the interviews for this inquiry. This section provides a detailed unfolding of the experiences of these ten individuals who received therapeutic simulation. With all of the volunteers, our first contact enabled me to discuss the details of the study and determine dates and times for the interview.
Demographics of the Participants

Data collected for this study were drawn from ten participants who previously had received therapeutic simulation techniques in The Crack Room. Interviews and researcher observations were conducted at the office of Two Roads Counseling Services. Demographic information includes a participant’s gender, educational level, marital status, ethnic background, length of “clean time,” length of treatment, drug of choice, method of ingestion, and the length of the interview.

It should be noted that two participants who were initially contacted regarding participation are successfully engaged in harm reduction strategies, which places limits on ingestion and focuses on a more responsible relationship with one’s drug of choice. Harm reduction is an alternative treatment option used to encourage responsible patterns of use when an individual who is seeking therapy for addiction refuses or finds it difficult to cease the use of AOD (Single, 1995). The rationale behind this theory is to provide individuals with alternative perceptions regarding their AOD use. Individuals using harm reduction are taught to minimize use or use AOD differently. For example, rather than ingesting ten 12 ounce cans of beer, consumers are instructed to ingest only six to eight cans of beer, with a pre-designed cut-off limit. Likewise, consumers who are attending a social function are advised to make pre-arranged plans for transportation, thus minimizing the risks of driving a motor vehicle while under the influence of an intoxicating substance. In keeping with that line of thought, needle exchange programs are also a function of harm reduction strategies. These programs contend that having a safe alternative may, in fact, protect active drug users from further harm or consequence. The use of Methadone and Suboxone are also forms of harm reduction (Single, 1995).
Harm reduction may not work well as a therapeutic technique for all individuals who abuse or who are addicted to AOD. In fact, harm reduction is often ill-advised as a therapeutic technique. However, this method can be an effective tool for resistant clients. It is interesting to note that the state of Pennsylvania has recently changed the definition of recovery to include individuals who are functioning and active members of society, regardless of amount or type of AOD ingested. Previously, recovery indicated complete abstinence from any form of AOD (SAMHSA, 2012). The two participants engaged in harm reduction were asked to step down from the study, and two more individuals who had expressed interest in participating in this research were contacted.

The Participants

Participants for this study included five men and five women. The following is a discussion of demographic information surrounding the participants of this study. Of the 10 individuals who engaged in this study, five were men and five were women. Ages ranged from 25 to 68 years. Drugs of choice included heroin (5), marijuana (2), alcohol (3), prescription pain killers, anti-anxiety, and narcotic drugs (3), and amphetamines (3). Six of the participants have a poly-substance addiction. In other words, they are addicted to more than one drug. This is often the case and is not an uncommon phenomenon in AOD addiction.
Table 2

<table>
<thead>
<tr>
<th>Gender</th>
<th>P1</th>
<th>P2</th>
<th>P3</th>
<th>P4</th>
<th>P5</th>
<th>P6</th>
<th>P7</th>
<th>P8</th>
<th>P9</th>
<th>P10</th>
</tr>
</thead>
<tbody>
<tr>
<td>M</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Age</th>
<th>P1</th>
<th>P2</th>
<th>P3</th>
<th>P4</th>
<th>P5</th>
<th>P6</th>
<th>P7</th>
<th>P8</th>
<th>P9</th>
<th>P10</th>
</tr>
</thead>
<tbody>
<tr>
<td>56</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>28</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>32</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>42</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>37</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>29</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>68</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>62</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>51</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>25</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Drug Of Choice</th>
<th>P1</th>
<th>P2</th>
<th>P3</th>
<th>P4</th>
<th>P5</th>
<th>P6</th>
<th>P7</th>
<th>P8</th>
<th>P9</th>
<th>P10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heroin</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Meth</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Marijuana</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcohol</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prescription</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Muscle relaxers</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Narcotics</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Amphetamines</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Method of Ingestion</th>
<th>P1</th>
<th>P2</th>
<th>P3</th>
<th>P4</th>
<th>P5</th>
<th>P6</th>
<th>P7</th>
<th>P8</th>
<th>P9</th>
<th>P10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oral</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Smoke</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Soft Tissue</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inject</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Martial Status</th>
<th>P1</th>
<th>P2</th>
<th>P3</th>
<th>P4</th>
<th>P5</th>
<th>P6</th>
<th>P7</th>
<th>P8</th>
<th>P9</th>
<th>P10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Married</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Separated</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spouse Deceased</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In a Relationship</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Educational Level</th>
<th>P1</th>
<th>P2</th>
<th>P3</th>
<th>P4</th>
<th>P5</th>
<th>P6</th>
<th>P7</th>
<th>P8</th>
<th>P9</th>
<th>P10</th>
</tr>
</thead>
<tbody>
<tr>
<td>No High School Diploma</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>High School Diploma</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>College Degree</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Technical / Trade School</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>P1</th>
<th>P2</th>
<th>P3</th>
<th>P4</th>
<th>P5</th>
<th>P6</th>
<th>P7</th>
<th>P8</th>
<th>P9</th>
<th>P10</th>
</tr>
</thead>
<tbody>
<tr>
<td>African American</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Caucasian</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Time in Treatment</th>
<th>P1</th>
<th>P2</th>
<th>P3</th>
<th>P4</th>
<th>P5</th>
<th>P6</th>
<th>P7</th>
<th>P8</th>
<th>P9</th>
<th>P10</th>
</tr>
</thead>
<tbody>
<tr>
<td>36 M</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>24 M</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>25 M</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15 M</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18 M</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>48 M</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>40 M</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10 M</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>29 M</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15 M</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Length of Sobriety</th>
<th>P1</th>
<th>P2</th>
<th>P3</th>
<th>P4</th>
<th>P5</th>
<th>P6</th>
<th>P7</th>
<th>P8</th>
<th>P9</th>
<th>P10</th>
</tr>
</thead>
<tbody>
<tr>
<td>19 M</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>32 M</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>17 M</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13 M</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20 M</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16 M</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>25 M</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18 M</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>24 M</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16 M</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The following is a cross-reference of various findings that emerged throughout this study regarding types of AOD used and methods of ingestion, as well as a re-cap of basic participant demographics.

Table 3

<table>
<thead>
<tr>
<th>Type of AOD Reported</th>
<th>Number of Participants Reporting Use</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol</td>
<td>8</td>
</tr>
<tr>
<td>Marijuana</td>
<td>5</td>
</tr>
<tr>
<td>Prescription “downers”</td>
<td>2</td>
</tr>
<tr>
<td>Prescription narcotics</td>
<td>2</td>
</tr>
</tbody>
</table>

70
Methods of ingestion include seven individuals who injected drugs directly into a vein; eight individuals who orally ingested AOD, six individuals who smoked drugs and seven participants who snorted drugs through their nasal cavity or other soft tissue. Due to the number of participants with poly-addiction, their methods of ingestion varied. Only four individuals reported ingesting drugs by using only one method.

Table 4

Method of Ingestion

<table>
<thead>
<tr>
<th>Method of Ingestion</th>
<th>Number of Participants Reporting Use</th>
</tr>
</thead>
<tbody>
<tr>
<td>Injection</td>
<td>7</td>
</tr>
<tr>
<td>Soft Tissue</td>
<td>7</td>
</tr>
<tr>
<td>Oral</td>
<td>8</td>
</tr>
<tr>
<td>Smoke</td>
<td>6</td>
</tr>
</tbody>
</table>

The least amount of time spent in treatment was reported to be 10 months, while the longest amount of time engaging in treatment reported by the participants was 48 months. Participants also report the longest amount of clean time to be 36 months, while 13 months is reported to be the least amount of time free from AOD. Lengths of
individual interviews ranged from 1 hour and 45 minutes as the longest interview, and 1 hour and 5 minutes as the shortest interview.

Table 5

<table>
<thead>
<tr>
<th>Length of Treatment</th>
<th>“Clean Time”</th>
<th>Length of Interview</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shortest: 10 months</td>
<td>Shortest: 36 months</td>
<td>Shortest: 1 hour 5 minutes</td>
</tr>
<tr>
<td>Longest: 48 months</td>
<td>Longest: 13 months</td>
<td>Longest: 1 hour 45 minutes</td>
</tr>
</tbody>
</table>

Individual Interviews

Participant 1

Participant 1 contacted me through cellular phone two hours after receiving the introductory letter inviting individuals to participate in this study. She is a 56-year-old, Caucasian female with a high school education. She is single but has resided with her boyfriend for eight years. Prior to the interview she had been in treatment for 36 months and was free from heroin and marijuana addiction for 19 months. The participant reports that she usually injected and smoked her drugs of choice, heroin and marijuana. Her interview lasted for 1 hour and 35 minutes. Participant 1 received therapeutic simulation in The Crack Room four times.

Table 6

<table>
<thead>
<tr>
<th>Participant 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender: Female</td>
</tr>
<tr>
<td>Age: 56</td>
</tr>
<tr>
<td>Drug of choice: Heroin, marijuana</td>
</tr>
<tr>
<td>Method of Ingestion: Injection, smoke</td>
</tr>
</tbody>
</table>
Marital status: Unmarried (8 year relationship)
Education level: High school diploma
Ethnicity: Caucasian
Time in treatment: 36 months
Length of sobriety: 19 months

Protocol Questions: Participant 1

1. Tell me about your experiences in The Crack Room.

2. “(sigh). I don’t know how to explain it. I didn’t feel like I belonged there (in The Crack Room). But after being there for a minute, I knew that it was familiar to me. Made me kinda sick.”

3. Did The Crack Room represent an accurate representation of triggers common in AOD abuse and addiction? If yes, how?

   “Absolutely. It made me face my denial…I tried to forget about that part of my life…tried to ignore it. That room was real.”

4. What were some of the key factors in this experience?

   “The plate with the egg. My son ate more eggs than a person should. It was easy. The JD bottle (fifth of Jack Daniels), the beer bottle through the TV. That damn picture on the wall. Could tell a kid drew it…a kid was in that room. My son lived like that. It bugged me. I was violent…the room reminded me. The spoons, the trash, the bed all tore up with no sheets on it. Nasty. “

5. Has anything changed for you since your participation in The Crack Room?

   “Comes to me every time I want to get fucked up. I’m serious. I get urges, and I think about that fucking room…where drugs put me. Not going back to that man.”

6. What strategies have you developed to maintain sobriety? Have they changed since participating in this study?
“I don’t want to go there again…I’m telling you. That room rocked my world. I’m embarrassed that I lived like that. I’m ashamed that I made my son live like that. It wasn’t fair.”

7. **How do you manage triggers on a daily basis?**

“I think *The Crack Room* helped me with that. I’m serious. I get set off every day by one thing or another. Sometimes I think what the hell…go ahead and use. Just get high once. I know that once will lead to twice…you know what I’m saying? I remember *The Crack Room* and those fantasies go away. I actually have a note on the visor of my van that says *The Crack Room* (laughs). That’s kinda fucked up!”

8. **Has *The Crack Room* helped you to combat desires to use AOD? If yes, how?**

   **If no, why?**

   “Like I said, I don’t want to go back to that life. I found a kid’s sand bucket full of paraphernalia in the attic the other day. I about shit. My nipples actually got hard. I yelled for my old man and he got rid of it. I just had to keep remembering what my counselor taught me…how to talk to myself so I could deal with what I was feeling. So…I guess the answer is yes. It helped me.”

9. **Please share with me the top 3 factors that were important to you during your experience in *The Crack room*.**

   “Get out of there, don’t go back, realization. That’s three, right? Need more (laughs)?

10. **Please share with me anything that you feel is important about your experience in *The Crack Room*.**
“I don’t want to go back there. I have flashbacks once in a while. That room is a flashback. It isn’t far from my head…ever.”

*Individual Interview: Participant 1*

My interview with Participant I provided an insightful glimpse into her personal experience in *The Crack Room*. Themes of self-respect, low self-esteem, thinking things through, and self-talk were predominant throughout this interview. She also expressed an eagerness to begin the interviewing process and stated that she had a lot to say.

Participant I was the first individual to contact me regarding this study. She contacted me through cellular phone two hours after receiving the pamphlet at an NA meeting. After introducing myself and asking her to sign the necessary paperwork, I noticed that she anxiously awaited the interview to begin. Participant I stated, “Let’s do this. I have a lot to say. I’ve thought about that room a lot.” I learned that she was actively and enthusiastically involved in most aspects of her life. While using AOD, participating in this study, or engaging in activities involving her son and grandchild, she displayed an energy that was unparalleled among the other participants.

During the interview, Participant I informed me that she has had difficulty remaining AOD free and that counseling “didn’t help that much.” “That room made me look at my life. Made me face who I was. I was a junkie and I knew it. I guess I never owned up to it. I never had to.” She later lamented about the fact that she struggles with addiction on a daily basis. “I really want people to know how good that room is. How it helped me,” she said.

Participant I further stated, “I was lucky that I even graduated from high school. I was a horrible student, always in trouble. I didn’t like rules. I still don’t.” She moved to
Texas shortly after graduating from high school and worked in various bars and clubs. At one point, she worked as a stripper. She returned to Pennsylvania shortly after her son, an only child, was born. She returned “home” because she did not want her son to grow-up “in the fucking madness” of her life in Texas. However, her addiction continued, and her son was pulled into her life as a heroin addict. “He’s a junkie, too,” she states. “Can you fucking believe it? I can’t believe I gave him this God damn disease.” Participant 1 then inquired if her son would be able to participate in sessions in *The Crack Room*. “It would do him some fucking good.”

Participant 1 further explained, “I don’t know how to explain it (sigh). I didn’t really belong there. In that room, but I lived there for years, and so did my son. Not there, but like that. I lived like that for a long time. To see that, where you been, when you’re not fucked up… to realize how I lived and how I made my son live… I don’t want to go back there. I went to a friend’s house a while ago. It was a mess…dirty. It made me sick. She sat on the couch and smoked bowls the whole time I was there. I didn’t stay long.”

Participant 1 described *The Crack Room* as “a shock” and believes that her experience with therapeutic simulation was an influencing factor in her recovery. “That fucking room made me think,” she stated. “I have trouble staying clean but I sure don’t want to go back to that… when I was banging dope all the time (sigh) and lived in shit…lived in filth.” While trying to understand the significance of her experience, participant 1 confirmed that her experience in *The Crack Room* had been an important part of her decision to cease the use of AOD. She repeatedly stated that she did not wish to “go back to that,” indicating that she did not want to return to the life she knew as an active heroin user.
Participant 2

Participant 2 contacted me via cell phone the day after being notified of this study. She is a 28-year-old, single Caucasian female who graduated from high school. She has been clean from injecting heroin for 32 months and had spent 24 months in treatment. Her interview lasted for 1 hour and 15 minutes. Participant 2 received therapeutic simulation in *The Crack Room* two times.

Table 7

<table>
<thead>
<tr>
<th>Gender:</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age:</td>
<td>28</td>
</tr>
<tr>
<td>Drug of choice:</td>
<td>Heroin, methamphetamines, marijuana</td>
</tr>
<tr>
<td>Method of Ingestion:</td>
<td>Soft tissue, injection, smoke</td>
</tr>
<tr>
<td>Marital status:</td>
<td>Unmarried</td>
</tr>
<tr>
<td>Education level:</td>
<td>High school diploma</td>
</tr>
<tr>
<td>Ethnicity:</td>
<td>Caucasian</td>
</tr>
<tr>
<td>Time in treatment:</td>
<td>24 months</td>
</tr>
<tr>
<td>Length of sobriety:</td>
<td>32 months</td>
</tr>
</tbody>
</table>

Protocol Questions: Participant 2

1. Tell me about your experiences in *The Crack Room*.

   “Initially it freaked me the fuck out. I thought my counselor was nuts to bring me into a room like that. Then all of a sudden I got it…I understood. It hit me hard.”

2. Did *The Crack Room* represent an accurate representation of triggers common in AOD abuse and addiction? If yes, how?

   “Fuck yeah. That room was dead on. You didn’t miss a damn thing. Everything was there. I felt like I was back in the party zone. There were even pizza boxes...yeah...it was pretty good.”
3. **What were some of the key factors in this experience?**

“The room smelled like shit. There was garbage everywhere, empty bottles, needles, pipes and shit. The biggest thing for me was the little kid drawing on the wall. My sister used to draw me pictures every time I went to jail. I hung them on the walls of my cell. That really got to me.”

4. **Has anything changed for you since your participation in *The Crack Room*?**

“I think about that room a lot and what me and my counselor talked about. How things got so bad…kept getting worse. I’m doing good now. I don’t live like a pig no more.”

5. **What strategies have you developed to maintain sobriety? Have they changed since participating in this study?**

“I guess I look at fucking reality now dude. I see what is out there, and it doesn’t change for anyone. Some of my friends are still out there (using AOD). Scares the shit out of me man…now I think before I just start banging dope.”

6. **How do you manage triggers on a daily basis?**

“I don’t watch certain TV shows. I don’t watch most of the commercials. I know where all of the bars and dope houses are on the roads where I live. I try not to get with old friends. The problem is, everyone fucking parties. I used to think about moving away, but the bars and dope houses will be where ever I go. It’s tough…really tough.”
7. Has *The Crack Room* helped you to combat desires to use AOD? If yes, how? If no, why?

“Holy shit, are you serious? That room is one of the reasons I’m sober. Sitting in there I would wonder how I lived that way. I never even noticed. Can you believe it? I never ever fucking noticed the filth. I guess seeing it sober…kind of takes on a different meaning. That room is harsh, but it works. Whoever came up with that idea is a fucking genius.”

8. Please share with me the top three factors that were important to you during your experience in *The Crack Room*.

“The smell, the picture the little kid drew, and of course the paraphernalia…pipes and shit.”

9. Please share with me anything that you feel is important about your experience in *The Crack Room*.

“That room made me think about the way my fucking life was. I have a car now. I never would have had that if I would have stayed on drugs. Like I said, I’m clean now because of that room (laughs). I just picture it my head sometimes and remember what it was like to live like a fucking pig. Helps man.”

10. Please discuss anything you would like to add.

“That room is sweet…fucked up but sweet. Everyone who uses drugs should have to see it. It should be a part of probation and shit. It makes you wake the fuck up.”
**Individual Interview: Participant 2**

Participant 2 was one of the youngest volunteers in this study. When I met her face-to-face for the interview, I immediately noticed her abrupt manner and crude, often harsh language. Although she had been clean for 32 months, she states that she thinks of using heroin often. She has even contemplated using alcohol or marijuana to ease the urge to get high, but in the end, she makes the decision to maintain her abstinence.

“Initially it (*The Crack Room*) freaked me the fuck out. I thought my counselor was fucking nuts to take me into a room like that. But then I got it. It all clicked. It hit me like a ton of fucking bricks.”

Participant 2 was an unmarried 28 year old female who injected approximately 25 to 30 stamp bags of heroin per day for a period of 6 years. She graduated from high school but has several felony convictions on her criminal record. Because of this, she indicates that she has had great difficulty in obtaining a “good” job. She states that during her active addiction she often stole items to sell for cash and became one of the area’s largest drug dealers, frequently driving to Pittsburgh from Punxsutawney to purchase bricks of heroin, returning to Punxsutawney to re-sell and get high. “Fuck dude,” she stated. “I went to the burgh three times a day. I made a lot of fucking trips and a lot of fucking money slinging dope. Fuck of it is I blew all my money in my arm.” Participant 2 seemed to be saddened by her past, often returning to thoughts of high school, when she was popular and maintained fairly good grades until, as she stated “drugs snagged my ass.” Participant 2 added:

“I did ok man. I had it all. Friends, my family was behind me. Then dope came along and I started missing school. I ended up in a shit hole like *The Crack Room.*"
I didn’t even realize I was living like that…didn’t think there was a fucking problem with it until I was sober. What got me the most was the fucking picture hanging on the wall. That shit really got to me. When I was in prison my sister would send me pictures that she drew with crayons. The envelope was always written in crayon too, in her handwriting. Fucking prison address written with a crayon. That’s fucked up. That picture reminded me of my sister’s pictures. I mean, the room smelled like shit. It had needles and spoons everywhere. Bottles and shit, and the thing that got me the most was that fucking picture. Yeah…I think about that room. I think about how I used to live when I was using. It didn’t matter then. I was too fucked up…all up in my own head. I guess I just don’t want to go there again. I don’t want to be like that again. That room taught me that. It’s so fucked up. You really don’t notice when you’re high, but you don’t see it when you’re straight except when they put you in that torture chamber (participant laughs). Nah… it’s all good. That shit worked. That room makes you think about what you’ve done and where you were.”

Participant 2 stared at her hands for a short while then said, “Man…I really fucked shit up…I’m on the mend. You might not believe me but that room is part of the fucking reason that I’m clean today. Can’t go back dude…can’t go back. I guess I had to take a hard look at fucking reality when I was in that room.” An important aspect of the interview with participant 2 was her memory of the 8”x 10” picture that was hand drawn by a child. It was placed on the wall as an afterthought and with no therapeutic intent. Yet several participants have reported that the picture was one of the more potent and significant components of The Crack Room.
Similar to information obtained from other volunteers, Participant 2 reported that seeing *The Crack Room* while in a state of sobriety was somewhat surprising and helped her to understand how the use of AOD had allowed her to lower her concept of acceptable standards of living. Participant 2 was also very vocal when discussing triggers that are abundant within society. “Fucking movies, people you see in the God damn grocery store, everything makes me think of fucking using, you know? To be honest…I’d have to live in a fucking cave to keep away from shit that triggers me…the shit that makes me want to get high.” She ended our conversation by indicating that therapeutic simulation in *The Crack Room* makes one aware of how bad life can become during the course of addiction to AOD.

**Participant 3**

Participant 3 contacted me via cell phone the day after she obtained information regarding this study. She is a 32-year-old single Caucasian who graduated from high school. She was seen in treatment for 25 months and had achieved sobriety for 17 months. Her drug of choice (D.O.C.) is prescription pain killers and anti-anxiety medications, which she has ingested through soft tissue. The interview for Participant 3 lasted for 1 hour and 35 minutes. Participant 3 received therapeutic simulation in *The Crack Room* five times.

Table 8

<table>
<thead>
<tr>
<th>Participant 3</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gender:</strong></td>
</tr>
<tr>
<td><strong>Age:</strong></td>
</tr>
<tr>
<td><strong>Drug of Choice:</strong></td>
</tr>
<tr>
<td><strong>Method of ingestion:</strong></td>
</tr>
<tr>
<td><strong>Marital status:</strong></td>
</tr>
</tbody>
</table>

82
Protocol Questions: Participant 3

1. Tell me about your experiences in *The Crack Room*.

“It blew my mind. Couldn’t believe what I was seeing. At first I said that I was never in a place like that…but I was. I really lived like that. So did my friends.”

2. Did *The Crack Room* represent an accurate representation of triggers common in AOD abuse and addiction? If yes, How?

“Oh wow. Sure did. That room brought back a lot of memories. That room is good…looks real.”

3. What were some of the key factors in this experience?

“Seeing all that stuff made me realize where drugs took me. Hard to see…but worth it. More people should go in there. Kids should have to go in there and see where they could end up.”

4. Has anything changed for you since your participation in *The Crack Room*?

“I’ve been clean for 17 months. I went into *The Crack Room* a lot. It made sense. Know what I mean? I wouldn’t have known how to react to seeing things…hearing things…seeing things…Now I know what to do…I talk to myself like my counselor taught me. I’ve actually used that…talking to myself. It’s easier now."
5. What strategies have you developed to maintain sobriety? Have they changed since participating in this study?

“Before, I just took my chances. Now I think things through, think about the stuff I talked about with my counselor…when we were in The Crack Room. Now when I see shit I’m not so stressed out. I actually think before I do something. Maybe it’s a matter of how bad you want your sobriety. All I know is that I needed someone to help me handle that shit…the triggers.”

6. How do you manage triggers on a daily basis?

“Like I said, I talk to myself. Sometimes I remember the room. I refuse to go through that again….man…I don’t want to live like that.”

7. Has the Crack Room helped you to combat desires to use AOD? If yes, how? If no, why?

“No. Desires are always there. The only time you don’t want to use is when you’re dead. I just don’t give into the urge like I used to.”

8. Please share with me the top 3 factors that were important to you during your experience in The Crack room.

“Straws, pills, powder on the CD cover. Trash…pizza boxes.”

9. Please share with me anything that you feel is important about your experience.

“The Crack Room made me really look at who I was…who I could become again. It helped me make sense of my life in a way. I’m amazed at the way I was willing to live…the way I was willing to disrespect myself.”

10. Please discuss anything you would like to add.
“Every place should have a Crack Room. It works. Every drug addict on planet earth should have to do it. It sticks with you.”

Individual Interview: Participant 3

Participant 3 graduated from high school one year later than her classmates, due to failing marks in 7th grade. Her drug of choice is prescription pain killers and anti-anxiety medication, which she ingested through soft tissue using a method called pill blowing. This technique requires the user to fill a turkey baster with a crushed pill, fill the tube with hot water, and insert the tube into the anus or vagina, allowing soft tissue to absorb the drug quickly. Participant 3 stated, “That room blew my mind. At first I thought I had never seen anything like that. I told my counselor that, but I did…I was. I lived like that and had friends who lived like that.” Participant 3 paused and stated, “That room looked real…brought back a lot of memories.” She states that the numerous straws, crushed pill residue on CD covers, and trash lying on the floor were the major triggers for her. “The pizza boxes got me, too,” she stated. When I DID eat, it was usually pizza… all the time… it was easy to call a restaurant and get some slabs. No cops to deal with, too.”

Participant 3 added more insight into her memories of The Crack Room:

I’ve been clean for 17 months. I went into that room a lot. I wanted to…it helped me…made me see…it made sense. I didn’t know how to react to seeing things…to seeing drugs or hearing about parties at work before I went to that room. I hear people at work talk about their weekends and I used to go nuts before. I guess I remember where that stuff will lead me…where the parties will end up. I remember what it was like to have nothing but drugs…nothing but drugs. Before I went to that room I guess I just took my chances. Now I think
things through…I think about the things I talked about in there. I talk to myself now and picture my life, my family. Drugs are a quick fix but none of it lasts…you need more the next day…the next hour. It’s not worth it. I just think that every counseling place in the world should have one of those places…The Crack Room (laughs). The minute you take a drink or take a pill you should be swept away by the cops and be forced to sit in that cock sucking room. It would teach people a lot. It taught me a lot.

Similar to a common theme that occurred with other participants, Participant 3 related the effectiveness of having her experience in The Crack Room while being in a state of sobriety. Throughout the interview, Participant 3 related the feelings and emotions that she experienced and can draw upon in the future. “I will never forget that room…the smell…those damn pizza boxes…the feelings I had when I went in there. That room changed things for me. It really changed how I look at my use…how I look at my addiction…how I used to not care about myself.”

**Participant 4**

Participant 4 contacted me via cellular phone the day after receiving information regarding this study. The participant is a 42-year-old male Caucasian with no high school diploma, GED, or other certifications or licensures. He is married but has been separated from his wife of seven years for two years. Participant 4 received treatment at Two Roads Counseling Services for 15 months, and reported no use of AOD for 13 months. His D.O.C. is alcohol, which he has ingested orally or through injection. The interview with participant 4 lasted for approximately 1 hour and 10 minutes. Participant 4 received therapeutic simulation in The Crack Room five times.
Table 9

Participant 4

<table>
<thead>
<tr>
<th>Gender:</th>
<th>Male</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age:</td>
<td>42</td>
</tr>
<tr>
<td>Drug of choice:</td>
<td>Alcohol, marijuana</td>
</tr>
<tr>
<td>Method of ingestion:</td>
<td>Oral, smoke</td>
</tr>
<tr>
<td>Marital status:</td>
<td>Married (separated)</td>
</tr>
<tr>
<td>Education:</td>
<td>No high school diploma</td>
</tr>
<tr>
<td>Ethnicity:</td>
<td>Caucasian</td>
</tr>
<tr>
<td>Time in treatment:</td>
<td>15 months</td>
</tr>
<tr>
<td>Length of sobriety:</td>
<td>13 months</td>
</tr>
</tbody>
</table>

Protocol Questions: Participant 4

1. **Tell me about your experience in *The Crack Room*.**

   “It was awesome. Crazy…kind of scary, actually.”

2. **Did *The Crack Room* represent an accurate representation of triggers common in AOD abuse and addiction? If yes, How?**

   “Fuck. It was scary. Realistic? Yes. Some junkie put that room together.”

3. **What were some of the key factors in this experience?**

   “Makes me mad the way I lived. The way I didn’t care about the places I went and the people I hung with…I went to places like that to just hang out. I judged them. Thought I was better but there I was…right beside them.”

4. **Has anything changed for you since your participation in *The Crack Room*?**

   “Stopped drinking. I sure don’t live like a fucking hog no more. I have respect…my counselor called it self-respect.”

5. **What strategies have you developed to maintain sobriety? Have they changed since participating in this study?**
“I just think about low self-esteem. I never realized that’s what it was. I guess I just didn’t give a shit before. I didn’t care about anything else…just getting fucked up.”

6. **How do you manage triggers on a daily basis?**

   “Stay away from certain people. But you can’t stay away from everyone. Especially when your whole family is a bunch of dopers. When my brothers start partying, I just leave. Sometimes I just walk around, but I know I gotta leave when they get started. Otherwise, I’ll do it too.”

7. **Has the Crack Room helped you to combat desires to use AOD? If yes, how? If no, why?**

   “Um…not really help get rid of desires. I still get those…suppose I always will. The Crack Room just made me see how I was before. It really helped with that. I’m really, really clean now (laughs). I’m almost a freak about it. Guaranteed I won’t ever hang out in an apartment like that again.”

8. **Please share with me the top 3 factors that were important to you during your experience in The Crack room.**

   “Garbage, the smelly mattress, holes in the wall, coffee cans filled with butts. What else… all of it. Pizza boxes…I used to roll blunts in those…broken bottles, crushed cans. Beast Ice cans. That was my beer. Holes in the walls got me. I got pretty wild back in the day.”

9. **Please share with me anything that you feel is important about your experience.**
“It made me think. I guess I never noticed before. I thought living like that was normal. I just didn’t know better dude.”

10. Please discuss anything you would like to add.

“All I have to add is…fucking awesome….”

Individual Interview: Participant 4

Participant 4 is currently married, but the union is somewhat problematic due to his previous legal and behavioral issues surrounding alcoholism. He and his wife have been separated for two years. Participant 4 laments that after 15 months of sobriety, his wife is still not secure in their relationship. He states that she “gets wigged out” when he indicates that he has been in circumstances that trigger his desire to use AOD. “She gets so upset. She doesn’t understand that I won’t get over my addiction any time soon… never. I will have this thing the rest of my life. She wants to watch football games and have people over for holidays. They all drink. Do you know what that does to me? She doesn’t get it. How hard it is.” Participant 4 stated that he has a desire for his wife to have an experience in The Crack Room. “My wife needs to see how hard it is to stay clean…how much shit is out there to look at every day. What I was like back in the day…the place I went. She thinks things are bad now because I get pissed off and shit. She doesn’t know what I was like. Fuck, I didn’t remember until I went into that fucking room.”

Regarding his experience in The Crack Room, participant 4 states:

That room was awesome…crazy. Made me think about how I treated myself. I can’t believe I let myself go to that point…I mean…I was in that room. I knew that room. Makes me sick. I don’t drink no more and I don’t live like a fucking
hog. I have respect for myself now. I didn’t give a shit back then. I been clean for over a year. Looking back on that room…I see why my counselor took me in there. Smacked me in the damn face. You know…my whole family gets fucked up. It’s really hard for me to stay away from it. I guess that room made me see the shit I was willing to put up with when I was using…the hate I had for myself. That makes me sick. I don’t want to go back to that. I’m done. I think the thing that got me most was the beer cans all over the place. Beast Ice… that was my beer…seeing that with all of the dirt and holes in the walls…it just made my skin crawl. I thought living like that was normal. You asked me to name three things that got to me in the room. I can’t name three. I have like 15…20 things that got to me. I was just so wasted all the time. I didn’t know. I do now. I see man…I know.

Once again, a common theme was an awakening or knowledge of the manner in which participants had lived their lives. Participant 4 expressed a shock or intimate acknowledgement of his past while living in subpar conditions. He, as other participants have, related the fact that he was not aware of his living conditions until he was sober and experienced therapeutic simulation. The final words from Participant 4 were, “that fucking room was awesome. That’s about all I can say.”

**Participant 5**

Participant 5 contacted me through cellular phone two days after receiving information regarding this study. He is a 37-year-old single Caucasian male with a college education. Participant 5 received therapy at Two Roads Counseling Services for 18 months and reported 20 months of sobriety from amphetamine addiction, specifically
methamphetamines. He also reports an addiction to alcohol. Participant 5 ingests these substances through soft tissue and injection. This interview lasted for 1 hour and 10 minutes. Participant 5 received therapeutic simulation in *The Crack Room* four times.

Table 10

<table>
<thead>
<tr>
<th>Participant 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender: Male</td>
</tr>
<tr>
<td>Age: 37</td>
</tr>
<tr>
<td>Drug of choice: Alcohol, cocaine, methamphetamines</td>
</tr>
<tr>
<td>Method of ingestion: Oral, soft tissue, injection, smoke</td>
</tr>
<tr>
<td>Marital status: Unmarried</td>
</tr>
<tr>
<td>Education level: College degree</td>
</tr>
<tr>
<td>Ethnicity: Caucasian</td>
</tr>
<tr>
<td>Time in treatment: 18 months</td>
</tr>
<tr>
<td>Length of sobriety: 20 months</td>
</tr>
</tbody>
</table>

*Protocol Questions: Participant 5*

1. **Tell me about your experiences in *The Crack Room*.**

   “*The Crack Room* was intense. I saw rooms like it when I would go pick up drugs. At a dealer’s place. That room brought back some deep shit. I mean…I never lived like that…in a room like that, but I saw it a bunch of times.”

2. **Did *The Crack Room* represent an accurate representation of triggers common in AOD abuse and addiction? If yes, How?**

   “Oh wow, yes. There was a slinger (drug dealer) who lived in his parent’s basement. Their house was ok, pretty nice, but his room in the basement looked like *The Crack Room*. It smelled like piss. His room might have even been worse (than *The Crack Room*). His place is the first thing I thought about when I went into *The Crack Room*. ”

3. **What were some of the key factors in this experience?**
“No sheets on the mattress, no sheets on the mattress, no sheets on the mattress. (laughs). The pipes too but my slinger didn’t have sheets on his damn mattress. That always really bothered me.”

4. Has anything changed for you since your participation in The Crack Room?
   “The Crack Room scared the bejesus out of me. I just kept thinking how I thought I was better than him (his dealer). I thought he was a loser. But there I was…sitting in that pig pen…using with him. I’d pass out there for days…but I thought I was better than him. It’s disturbing now to look back. I realize all that now.”

5. What strategies have you developed to maintain sobriety? Have they changed since participating in this study?
   “I suppose I think about all of the bad things that happened when I was using and out and about. I went pretty freakin low. I guess I didn’t realize it until I was sober…then I had to look at the reality of things.”

6. How do you manage triggers on a daily basis?
   “Just remember all the bad stuff that happened to me. I mean…I can’t believe I actually smoked someone’s piss (a method of retrieving methamphetamines from the cooked residue found in the urine of someone who has ingested meth).”

7. Has the Crack Room helped you to combat desires to use AOD? If yes, how?
   If no, why?
   “The desire and urges are there. I guess they will never go away but I think I can handle them now.”
8. Please share with me the top three factors that were important to you during your experience in *The Crack Room*.

   “Pipes, the mattress…that mattress blew me away. I really couldn’t take my eyes off that damn mattress.”

9. Please share with me anything that you feel is important about your experience.

   “I guess I just really got to see how I was living. I rationalized everything when I was high. Being sober…it was just…I don’t know what to say. It was life changing for me…it really was.”

10. Please discuss anything you would like to add.

   “This woke me up. I think it didn’t make the urges go away…I don’t know what would do that. *The Crack Room* just made me see things clearly.”

*Individual Interview: Participant 5*

Participant 5 was initially aloof in his manner when our interview began. He eventually relaxed and became more open about his experiences in *The Crack Room*. “I guess I need to apologize. The room just made me think about the way my life turned out. I get sort of ashamed. It wasn’t supposed to be like this,” he said.

Participant 5 states that although he had never lived in a place similar to *The Crack Room*:

   “I saw places like that all the time. Anytime I bought drugs or partied, I had to go to a place like *The Crack Room*. A few times I even woke up on a dirty couch and thought what the hell am I doing here?” Participant 5 recalls the living quarters of a dealer with whom he conducted business on a weekly basis. “There was a guy
who lived in his parent’s basement. The house was pretty nice…normal looking. Then here’s this guy in their basement slinging dope. The basement was nice, I guess…at one time, but the kid totally destroyed it. Everything was dirty, and it smelled like piss. I’d spend a few days sometimes if I was too fucked up to go home. The next morning I’d wake up and think…wow…this guy’s in bad shape…look at this place…but I’d start getting high again and sit on that nasty couch for days. I was no better than him.”

Participant 5 thought about his statements, and added:

“The biggest thing in The Crack Room (that affected him emotionally), was no sheets on the mattress. Those Goddamn drug dealers never had sheets on them… I mean…how hard is it to make a bed and put some sheets on it? That room scared the crap out of me. I had no respect for the dealer I told you about. I thought he was a pig…to live the way he did…I thought I was better than him…but when I sat in The Crack Room, I realized that when I spent days staying there and getting high, I was living the same way he did…I was a pig too. The Crack Room smelled like piss…it reminded me of something. People…meth heads…they cook their piss when they run out of ice. They cook piss…I mean…I smoked some guy’s piss for Christ sake. I guess all of that stuff just never sunk in until I got clean. I walked into The Crack Room and thought of that basement…thought of that dealer…thought of smoking piss. I used to laugh to myself about the dealer. I wondered how he could live the way he did. I shook my head. Then I thought…holy shit…I allowed myself to be there…for days. I was just like the guy I made fun of. Made me sick. The Crack Room definitely affected me…made
me think and sort of see the reality of my life with drugs. I guess my life could get a whole lot worse. I guess that room in the basement (dealer’s bedroom)… *The Crack Room* …could eventually be where I live.”

A common practice among many individuals who use methamphetamines is to cook residue remaining in one’s urine to a powdered consistency. Forty to 60% of methamphetamines that are ingested are excreted through urine. Participant 5 thought for a moment then added, “Its fucking sick. Cooking down piss and smoking it. Really? Who does that?”

As has become common throughout these interviews, Participant 5 remarks on the positive outcome of his experiences in *The Crack Room*, specifically as it relates to a form of knowledge gained from seeing *The Crack Room* while participating in therapeutic simulation while in a state of sobriety.

**Participant 6**

Participant 6 contacted me by cell phone the day after receiving information regarding this study. He is a 29-year-old single Caucasian with an advanced degree from a trade school. Participant 6 received treatment at Two Roads for 48 months and reports 36 months of sobriety. His D.O.C. is alcohol and prescription narcotics, specifically Oxycontin. He reports that he ingested these substances orally and through soft tissue or injection. The interview for Participant 6 lasted for 1 hour and 15 minutes. Participant 6 received therapeutic simulation in *The Crack Room* five times.

Table 11

<table>
<thead>
<tr>
<th>Gender:</th>
<th>Male</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>95</td>
</tr>
</tbody>
</table>
Protocol questions: Participant 6

1. Tell me about your experiences in *The Crack Room*.
   “It was a trip. Freaky. I got scared every time I had to go in there. I didn’t like it.”

2. Did *The Crack Room* represent an accurate representation of triggers common in AOD abuse and addiction? If yes, How?
   “Sure did. I had a room like that…well…more like a corner. I lived with some people and they gave me a little corner. I lived like that for months. I had a blanket, a pillow, and lots and lots of beer cans and bottles…both booze and pill bottles. My little corner…That room scares the piss out of me. Made me remember.”

3. What were some of the key factors in this experience?
   “The pillow and blanket. The pill bottles and beer cans. The smell of the room. The whole vibe…the whole room.”

4. Has anything changed for you since your participation in *The Crack Room*?
   “Looking back, I guess *The Crack Room* sort of sucker punched the whole trigger thing. I was in that room quite a few times. Eventually the pill bottles and the pillow didn’t bother me. I could even pick some things up and mess with them. That room worked I guess, huh?”
5. What strategies have you developed to maintain sobriety? Have they changed since participating in this study?

“Well, I don’t get freaked out when I see shit anymore. It used to put me in a zone and no one could get me out of it until I used. The room sort of pulled the plug.”

6. How do you manage triggers on a daily basis?

“I stay away from that dealer. That’s for sure. It’s like you can’t stay away from bottles and cans all the time but you don’t have to throw yourself under the bus.”

7. Has the Crack Room helped you to combat desires to use AOD? If yes, how?

If no, why?

“I think it has. It helped me get rid of all the pressure I felt when I saw triggers. I used to freak out. Now I don’t. Talking helped, and learning how to handle seeing things like bottles and cans and straws. All that stuff lost its power over me.”

8. Please share with me the top three factors that were important to you during your experience in The Crack Room.

“The bottles, that pillow, and the fact that I could see all that shit and not freak out.”

9. Please share with me anything that you feel is important about your experience.

“Made seeing stuff ok and safe.”

10. Please discuss anything you would like to add.

“I guess the room meant more to me than I realized. At first I was afraid of it, then I thought it was bullshit. Now I love that room. I even asked to go in once in a while. It was good, yeah, it was good.”
Participant 6 reports alcohol and prescription narcotics, specifically Oxycontin, as his drug of choice. These include opiates, opioids, anti-anxiety medications, and sleep aids, which were ingested in pill form orally, injected, or using soft tissue techniques. Participant 6 reports using sleeping pills in abundance to obtain “a buzz.” He states, “Most people use sleeping pills to sleep. Not me. I’d take a bottle of them just to catch one.” Participant 6 indicates that during a brief period when he was homeless, he lived with friends who used AOD on a daily basis. Commenting on this he stated:

“I lived with some people…old friends…when I didn’t have a place to go. When my folks didn’t want me. They lived worse than I ever did…dirty dishes and clothes…kid’s toys everywhere. They lived like The Crack Room. What freaked me out about that room was the pill bottles and beer cans…bottles of liquor too. I had a little corner in my friend’s house. Like a cage. I slept there…ate there…hung out there…in that corner. I even had a fucking pillow without a cover, just like in The Crack Room. I was in that room like five or six times. After a while, the pill bottles, the smell, nothing got to me. I felt kind of free…felt like maybe seeing that shit over and over and then talking about it, sort of made it all lose its hold on me. Seeing drugs and booze used to put me in a zone…no one could get me out of it until I used. I think The Crack Room got rid of the nervousness I had when I saw drugs. Kind of cool, huh?”

Participant 7

Participant 7 contacted me by cellular phone two days after receiving information regarding this inquiry. He is a 68-year-old Caucasian who has been married for 49 years.
He has no high school diploma or other licensures or certifications. Participant 7 reports that he received therapy at Two Roads Counseling for 40 months. He had been using harm reduction strategies during the initial stages of his therapy but discovered that this technique was not effective for him. He currently reports 25 months of sobriety prior to this interview. His drugs of choice are alcohol and amphetamines, which he consumes orally and through smoking and soft tissue. The interview with Participant 7 lasted for 1 hour and 20 minutes. Participant 7 received therapeutic simulation in *The Crack Room* six times.

Table 12

<table>
<thead>
<tr>
<th>Participant 7</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gender:</strong></td>
</tr>
<tr>
<td><strong>Age:</strong></td>
</tr>
<tr>
<td><strong>Drug of choice:</strong></td>
</tr>
<tr>
<td><strong>Method of ingestion:</strong></td>
</tr>
<tr>
<td><strong>Marital status:</strong></td>
</tr>
<tr>
<td><strong>Education level:</strong></td>
</tr>
<tr>
<td><strong>Ethnicity:</strong></td>
</tr>
<tr>
<td><strong>Time in treatment:</strong></td>
</tr>
<tr>
<td><strong>Length of sobriety:</strong></td>
</tr>
</tbody>
</table>

**Protocol Questions: Participant 7**

1. **Tell me about your experiences in *The Crack Room*.**

   “I seen places like that a couple times but never lived in them. My wife keeps the house pretty good. I got dope in places like that and I was always glad to get out of them places.”

2. **Did *The Crack Room* represent an accurate representation of triggers common in AOD abuse and addiction? If yes, How?**
“From what I seen…that was pretty good. Looked like them places…you know, at the dope dealer’s house.”

3. **What were some of the key factors in this experience?**

“The things I seen in it. A lot of garbage everywhere. It smelled like a garbage heap. Music was playing…that rock crap.”

4. **Has anything changed for you since your participation in *The Crack Room*?**

“I been clean more than two years. I guess I wonder about that room once in a while. I start getting high again, my wife will leave me. I bet I would end up in a place like that there room. I wouldn’t have the wife to clean. The house would get real dirty without her here fussing.”

5. **What strategies have you developed to maintain sobriety? Have they changed since participating in this study?**

“I’m just scared my wife will go. She already told me she’d go if I start that stuff again. NA helps but she gets mad when I go to too many of them meetings. I lost jobs from using. I don’t want to keep messing things.”

6. **How do you manage triggers on a daily basis?**

“Think about the problems that was with using. Mostly my wife. Mostly thinking about my wife going is what keeps me clean.”

7. **Has the Crack Room helped you to combat desires to use AOD? If yes, how? If no, why?**

“No. Not really. I guess I think about it (*The Crack Room*). Without my wife, I would live like them there people. Maybe it helps with that. Lose the wife, live
like a hog. Just like them people I got speed from...just like that there room. I
don’t want that no more.”

8. Please share with me the top three factors that were important to you during
your experience in The Crack Room.
“The garbage, the trash, smelled bad. Know’d I’d end up there without the wife
keeping things good. She does my clothes...that there room has dirty clothes on
the floor. It was all pretty smelly.”

9. Please share with me anything that you feel is important about your
experience.
“Sure don’t want to go back to a place like that...dealer’s house. Brung back
some memories of stuff like that there. Makes me sick.”

10. Please discuss anything you would like to add.
“The room scares ya.”

Individual interview: Participant 7
Participant 7 has no formal education beyond ninth grade and reports dropping
out of high school because as he stated, “I seen no use for schoolin.” He indicates that he
is familiar with environments similar to The Crack Room. “I seen places like that. My
wife keeps the house up pretty good, so I was always glad to get out of them places.”
Participant 7 sat quietly for a moment then stated, “I got my dope in places like that there
room. I was always glad to get out. I been clean more than two years. I think about that
there room...I wonder if I would end up living like that if the wife left...I start using
again...I would end up in a place like that there room...wouldn’t have the wife to
clean...house would get dirty and I’d be there...in a just like that.”
Participant 7 indicated that although his experience in *The Crack Room* has not helped him to manage triggers on a daily basis, he reports that this particular intervention has had a strong influence on his thoughts concerning his life’s path. He stated:

“That there room didn’t make me think about them triggers, or whatever you call them…I just kept thinking about losing the wife and how I’d probably end up living like that if she was to leave me. The garbage and trash on the floor…the place smelled…know’d I’d end up in a place like that there without the wife…so I would. That there room brung back bad memories…like when I had to go to a shithole to get drugs. I don’t want…I can’t go to a room like that forever…I can’t lose the wife. I DO love her. If I start with them drugs again, I can guarantee you that she’ll be gone. She ‘aint gonna stick around for more of them drugs. I guess that there room made me look at my life…made me get bad memories all brung back. Triggers? No…can’t say as the room helped me with all that…it just made me know I don’t want to be without the wife. Guess I needed to know that…I sure know I don’t want to go back to that there room. It was bad. What’s worse, I seen that before…when I was taking drugs. Brung back memories that I don’t want no more. Kinda sick…the way I would live without the wife being around…I need to have her.”

**Participant 8**

Participant 8 contacted me by cellular phone two days after having heard about the study at an NA meeting. She is a 62-year-old Caucasian female with a high school diploma. She was previously married, but her husband passed away 11 years ago. She has not injected heroin for 18 months. Participant 8 was seen at Two Roads Counseling for
10 months. This interview lasted for 1 hour and 5 minutes. Participant 8 received therapeutic simulation in *The Crack Room* seven times.

Table 13

<table>
<thead>
<tr>
<th>Participant 8</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gender:</strong> Female</td>
</tr>
<tr>
<td><strong>Age:</strong> 62</td>
</tr>
<tr>
<td><strong>Drug of choice:</strong> Alcohol, heroin</td>
</tr>
<tr>
<td><strong>Method of ingestion:</strong> Oral, injection</td>
</tr>
<tr>
<td><strong>Marital status:</strong> Married (spouse deceased)</td>
</tr>
<tr>
<td><strong>Education level:</strong> High school diploma</td>
</tr>
<tr>
<td><strong>Ethnicity:</strong> Caucasian</td>
</tr>
<tr>
<td><strong>Time in treatment:</strong> 10 months</td>
</tr>
<tr>
<td><strong>Length of sobriety:</strong> 18 months</td>
</tr>
</tbody>
</table>

*Protocol Questions: Participant 8*

1. **Tell me about your experiences in *The Crack Room*.**

   “At first I thought the room was ridiculous. Then it made me feel anxious.”

2. **Did *The Crack Room* represent an accurate representation of triggers common in AOD abuse and addiction? If yes, How?**

   “Yes. Places I went to get my stuff. Been in rooms and houses like that a lot. I used to sell, so I’ve seen a lot.”

3. **What were some of the key factors in this experience?**

   “Smell, filth, posters on the walls, pipes, needles, and other stuff like bottles…bong. The whole thing…the whole thing.”

4. **Has anything changed for you since your participation in *The Crack Room*?**
“I don’t want to do that again (return to a life of AOD). The room made me see how low I was. I think being clean and seeing all of that made a big difference.”

5. **What strategies have you developed to maintain sobriety? Have they changed since participating in this study?**

“I need to steer clear of certain people…my dealers and people I used to sell for. I need to talk to myself when I feel an urge or see something that makes me want to get high (laughs). Hell… even cooking wine makes me think about getting drunk….and I never even liked hooch. I learned that if I get drunk, I won’t be able to fight off urges as easy and I’ll probably use something else. All of that comes from being in The Crack Room…talking to my counselor and just working through all of it.”

6. **How do you manage triggers on a daily basis?**

“I journal about feelings, look back at things I didn’t think were triggers. Looks like commercials trigger me, always hooch commercials…now you can watch a show called *Moonshine* (*Moonshiners*). I just go outside and smoke a cig until commercials are over. I tried watching that Intervention show. I about went through the ceiling. It’s weird. Sometimes my lighter will make me want to get high. That’s when I start talking to myself to stay clean.”

7. **Has the Crack Room helped you to combat desires to use AOD? If yes, how? If no, why?**

“Oh yeah. What it did was make me realize a lot of things. It helped me look at ME. The room, plus talking to my counselor were two things that make me
stay clean. I was in there probably five or more times…best hours I ever spent (laughs).”

8. Please share with me the top three factors that were important to you during your experience in The Crack Room.

“All of it. I can’t pick out three. All of it made me think. I guess if you hold me to it…I’d say the needles, the garbage, and the pipes.”

9. Please share with me anything that you feel is important about your experience.

“It just makes you think. I mean…who wants to live like that? Who wants to be in places like that?”

10. Please discuss anything you would like to add.

“This was great. I’m glad I got to talk about it. I talk about The Crack Room all the time…tell all my friends about it. It should be in court orders and stuff…people should HAVE to go in there.”

Individual Interview: Participant 8

Participant 8 has been AOD free for 18 months but she stated, ”It hasn’t been easy. When discussing this issue she adds:

“You can’t believe how much I want to use…how much I think about just sayin screw it and start using again. I used the whole time my husband was alive…our whole marriage. Then when he died it got worse. I was up state when he died…died in a car wreck after coming to see me at Muncy. I can’t get over that. At first I thought that room was fucking ridiculous. I didn’t understand why my counselor took me in there. What the fuck was I doing in that crazy fucking
room? I felt anxious…I wanted to get out…then I realized that I had …I had been there….”

Participant 8 was very anxious at this point in our interview when she said, “I don’t want to go back to that…shit …go that low…again. That fucking room made me realize where it was that I was headed.” Participant 8 considered her statements and further stated:

“Listen. I was a mess. I did state time (a sentence in a state penitentiary). I got triggered all the time. I learned that I need to keep away from anything that will get me off track…I see people I used to party with in town…in stores…and I think that I could party one more time. Then I see how they are…how disgusting and gross my old party buddies are…and I remember that room….how close I always am to getting back to that. My counselor told me to journal about my feelings in *The Crack Room*. After doing that, I know that commercials on TV trigger me…I usually go outside and smoke a cigarette until they’re done. I can talk to myself now when a light bulb makes a trigger. A damn light bulb can make me want to get high. I think that room made me aware of what triggers me, and how to handle it…my counselor taught me how to talk myself out of using when I see something that makes me want to get high. I guess all and all, that room…*The Crack Room*, was a good thing. I think if you just threw me in there without somebody helping me through it…you know…somebody telling you what you were seeing, and why…then maybe it would be bad. It’s not that way though. They put you…the counselors go in with you and talk you through what’s going through your head. Yeah…that’s some serious shit. It works though…I won’t
forget what I learned in there. Probation and cops should make people go into that room. It sucks but it’s awesome.”

Participant 9

Participant 9 contacted me by cellular phone two days after being informed of this study. He is a 50-year-old single male who left high school as a sophomore and did not return. He is an African American male who was raised in Haiti until the age of eight. Participant 9 reports 24 months of clean time from addiction to alcohol and heroin. He states that he injected and used soft tissue to ingest heroin and orally consumed alcohol. Participant 9 was seen for therapy at Two Roads for 29 months. His interview lasted for 1 hour and 45 minutes. Participant 9 received therapeutic simulation in The Crack Room three times.

Table 14

<table>
<thead>
<tr>
<th>Participant 9</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender:</td>
</tr>
<tr>
<td>Age:</td>
</tr>
<tr>
<td>Drug of choice:</td>
</tr>
<tr>
<td>Method of ingestion:</td>
</tr>
<tr>
<td>Marital status:</td>
</tr>
<tr>
<td>Education level:</td>
</tr>
<tr>
<td>Ethnicity:</td>
</tr>
<tr>
<td>Time in treatment:</td>
</tr>
<tr>
<td>Length of sobriety:</td>
</tr>
</tbody>
</table>

Protocol Questions: Participant 9

1. Tell me about your experiences in The Crack Room.

“I been around a lot…seen a lot of shit. The Crack Room kicked my ass. It sent me back to a place I don’t want to go no more.”
2. Did *The Crack Room* represent an accurate representation of triggers common in AOD abuse and addiction? If yes, How?

“The violence…yes. The beer bottle through the TV screen. That stuck with me. I was mean. I did a lot like that (sighs). That room made me go back to all the mistakes I made.”

3. What were some of the key factors in this experience?

“The beer bottle in the screen of the TV. When I saw it, I thought…what kind of dick does that…then I realized that I was the dick that did that (laughs). That was me. I did shit like that.”

4. Has anything changed for you since your participation in *The Crack Room*?

“I see things different. I’m done with violence. The thing is…I wasn’t high or nothing when I went into the room. Wow, all I can say is it was harsh.”

5. What strategies have you developed to maintain sobriety? Have they changed since participating in this study?

“Well, I try to stay away from as much of it as I can. Besides that, I just think more. I think what will happen if I have a slip or two. My family has put up with too much from me…I’m done.”

6. How do you manage triggers on a daily basis?

“I’m tired of the game. I would see a spoon and flip out. Now I see a spoon…I eat my Cocoa Puffs (laughs). I wish I had that room and a good counselor when I was 12…would have saved me a lot of grief. My family too.”
7. Has *The Crack Room* helped you to combat desires to use AOD? If yes, how? If no, why?

“FUCK YEAH. I think the holes in the wall and the beer bottle sticking out of the screen really did it to me. I was a mean son-of-a-bitch. I think that really made me think about who I am…what I’m about…what I was when I was using.”

8. Please share with me the top three factors that were important to you during your experience in *The Crack Room*.

“That fucking beer bottle in the TV. That was it...the big thing for me. Holes in the wall got me too but that beer bottle is a movie in my head…a repeat of me.”

9. Please share with me anything that you feel is important about your experience.

“I got to see stuff being clean as a bean…sober. I never did that before. I never took the time. I guess you can say that place (*The Crack Room*) made me see what I should have looked at a long time ago.”

10. Please discuss anything you would like to add.

“Made me think. I thought I was all cool back then, but I didn’t have a clue. I guess now I know what an ass I was. *The Crack Room*? I’ll give it some credit but most of it is just my balls…my guts. I’m clean cause I want to be.”

*Individual Interview: Participant 9*

Participant 9 was very anxious to begin our interview and states, “I have a lot of stuff to say about *The Crack Room*. I was headed down a pretty rough road.” Participant
Participant 9 suggested that he injected alcohol as well as heroin, stating, “I was addicted to the needle. Everything that went in my body went through the syringe. Booze, pills, heroin…everything.” Participant 9 reports being clean and sober for 24 months, after receiving 29 months of therapy at Two Roads. His interview lasted for 1 hour and 45 minutes.

“The violence is what got me in that room. The holes in the walls, broken bottles…the beer bottle in the TV screen. I was mean. I got real violent. When I seen all the holes in the walls and the broken stuff on the floor, I thought…I did all that… I did that. I threw things and broke things. I was the one who made things look like what I saw in The Crack Room. I see things different now. I don’t want all that violence…don’t want the madness anymore. The big thing is…I wasn’t high or drunk when I went into the room with my counselor. I was sober…stone cold sober…made me see things in a different way…made me look at things. I lost my family ‘cause I was so mean. All that shit made it worse…the dope and booze… I liked vodka. I banged it. My kids seen me bang it (inject). That made them sick…that plus all the violence. I guess it was too much for my family. They left. I was mad for a long time about them leaving. I went to that room and then I guess I seen why they were so scared all the time. I seen what I did to them…no wonder they were scared. I’d have been like a scared little bunny rabbit too. The first time I went to The Crack Room, I never wanted to go back. Then every time I went to counseling, I asked if I could go in…if the room was free. Being there made me feel better in a odd way…made me understand, I think…I guess…made me see why my family left me. It was my fault. Dope,
needles, booze…what did I expect? I know I won’t do that again. Let me say this. I don’t want to do that again. I finally talk to my kids. They never used to answer the phone when I’d call. Can I say The Crack Room saved my life? No, but I think it made me…being in that room made me think about my life…made me think about my life.”

**Participant 10**

Participant 10 contacted me through a cellular phone three days after receiving information regarding this study. She is a single 25-year-old Caucasian who reports an addiction to prescription narcotics, heroin, marijuana, and alcohol. Methods of ingestion have included snorting, intravenous injections, smoking, and orally consuming alcohol. She reports that she graduated from college and has been abstinent for 16 months. She received therapy for 15 months. The interview with participant 10 lasted for 1 hour and 25 minutes. Participant 10 received therapeutic simulation in *The Crack Room* four times.

Table 15

<table>
<thead>
<tr>
<th><strong>Participant 10</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gender:</strong></td>
</tr>
<tr>
<td>Female</td>
</tr>
<tr>
<td><strong>Age:</strong></td>
</tr>
<tr>
<td>25</td>
</tr>
<tr>
<td><strong>Drug of choice:</strong></td>
</tr>
<tr>
<td>Prescription “downers” heroin, marijuana, alcohol, methamphetamine</td>
</tr>
<tr>
<td><strong>Method on ingestion:</strong></td>
</tr>
<tr>
<td>Soft tissue, smoke, oral, injection</td>
</tr>
<tr>
<td><strong>Marital status:</strong></td>
</tr>
<tr>
<td>Unmarried</td>
</tr>
<tr>
<td><strong>Education level:</strong></td>
</tr>
<tr>
<td>College degree</td>
</tr>
<tr>
<td><strong>Ethnicity:</strong></td>
</tr>
<tr>
<td>Caucasian</td>
</tr>
<tr>
<td><strong>Time in treatment:</strong></td>
</tr>
<tr>
<td>15 months</td>
</tr>
<tr>
<td><strong>Length of sobriety:</strong></td>
</tr>
<tr>
<td>16 months</td>
</tr>
</tbody>
</table>

**Protocol Questions: Participant 10**

1. Tell me about your experiences in *The Crack Room*. 

111
“It sucked dick. That room was bad, man. I honestly hyperventilated…made my skin crawl…brought back a lot of feelings I’d just rather forget.”

2. Did The Crack Room represent an accurate representation of triggers common in AOD abuse and addiction? If yes, How?

“Really? You’re asking me that? Yes. It was perfect. I bet whoever set it up knows something (smiles). How else would you know how to do it?”

3. What were some of the key factors in this experience?


4. Has anything changed for you since your participation in The Crack Room?

“Sort of. I mean…I still think about it…using. I’ve been clean and happy being clean. I just think about using once in a while.”

5. What strategies have you developed to maintain sobriety? Have they changed since participating in this study?

“I never had skills or strategies. I don’t know what I thought. I know that seeing that room and talking to my counselor made me start putting my head in gear. We did our best talking in The Crack Room. That’s where I did the best…felt and thought the most.”

6. How do you manage triggers on a daily basis?

“I just put my mind elsewhere. I look to the future…I look at what I can have. Here’s the thing about The Crack Room, you can see where you were at. You can see where you will go and end up. I don’t want paramedics pulling my dead ass out of a shit hole. I don’t want that.”
7. **Has the Crack Room helped you to combat desires to use AOD? If yes, how?**

   **If no, why?**

   “I would say…YES ! (sighs). It was hard to be in there…but you know what? It worked. I guess it helped me see…how do I say this… I can talk myself out of using now.”

8. **Please share with me the top three factors that were important to you during your experience in The Crack Room.**

   “All of it. The whole nine yards. It was a trip. I’d say the top three? Bottles, needles, CD covers, filth, pipes and bong. Woops. That’s not three.”

9. **Please share with me anything that you feel is important about your experience.**

   “People need to see this room. It gets you…it makes you really go back. Everyone should have to go there.”

10. **Please discuss anything you would like to add.**

    “Can I bring my friends in there? Can I call my dealer…my cousin who struggles… Can I let people know about this?”

*Individual Interview: Participant 10*

Participant 10 appeared to be embarrassed by her involvement in the use of AOD.

“I have a college education for God’s sake. I’m not a dumb person.” She further states, “I just couldn’t stop myself. Once I got a taste for the high…I was gone.” Participant 10 was quite adamant in her sentiments regarding *The Crack Room*. “It sucked dick. That room was bad, man…real bad.” She further commented by saying, “It made my skin crawl…brought back a lot of shitty memories…a lot of shitty feelings.” However,
Participant 10 remarked with excitement when describing her experiences in The Crack Room:

“The room was spot on, dude. I bet the counselors here have been in rooms like that, or they’re a bunch of junkies. You had to, to know what it’s all about. The trash, the pipes, the fucking smell in there. It all fucking reminded me…know what I mean? Junkies live like swine. You know what swine is? Fucking pigs. That’s what junkies and anyone who does dope…that’s how they live. Counseling and the room made me think hard about it. I mean…I knew what was going on in my life…what I was doing to myself but I didn’t give a fuck. I don’t think I made the connection from that to this…to my life. I remember using H. I spent most of my time in, with, and around dopers. I don’t want that anymore dude. I don’t want the filth and the swine (sighs). You know I like that word, huh? Swine. Dirt balls. I really didn’t think I was like them until I got clean. I looked around that place…the room, and I knew right then and there that it would be easy for me to go back to it. I went to college…I’m not a dumb individual but I let my life just spiral out of control. Who does that? I remember thinking how fucked up my world had gotten…how I let it get way out of control…The Crack Room…that’s where it’s at. Taught me a lot. I guess it made me see things I didn’t…wouldn’t see before…did I say that already? If I didn’t, I’ll say it again. That room was a real…what do people say? An eye opener…an eye opener. You go in there all clean and you see how messed up it can become. When you’re using…shit’s all fucked up. You don’t see it until you’re clean and someone LIKE YOU throws it in your face. It’s ok. I look at things from a different head space now…I’m
clean…God bless The Crack Room…did I say THAT yet? No? Well I should…God bless that fucking room…made me feel where I was and where I can be without chemicals.”

**Thematic Patterns and Factors that Precipitated AOD Addiction**

Although the reason for an individual’s involvement in AOD use was not an interest of this study, numerous participants returned to this topic frequently. An exploration into one’s initial involvement in AOD use seems important in order to discuss this phenomenon as it applies to cue response and The Crack Room. This theme, although not initially inclusive in the design of the study, became a prominent feature. The following is a break-down of the feelings shared by the individuals involved in this study. They are: 1) the ability to numb emotions; 2) genetic indicators and; 3) the prevalence of triggers and cues.

**Theme 1**

**The Ability to “Make Emotions go Away”**

It became clear during the interviews that many participants feel shame or sadness when discussing their addiction. One participant indicated that individuals do not “dial up addiction; ” it is simply a matter of “where we got dropped.” After several interviewees repeated similar sentiments, it became clear that a theme was emerging regarding precipitating factors that led to their addiction.

Eight participants indicated that bad or negative experiences as a child were enormous factors in their decisions to continue AOD use beyond the experimental phase of use. Participant 2 stated: “My life sucked. My step-father beat me all the time. No one ever backed me up. My mom always took his side. I never understood that. How could
she do that to me?” Participant 7 also related issues of a disruptive childhood as precursors to her addiction. She said:

    I was raped by my uncle for 5 years when I was a kid. My babysitter raped me too. Then I got into high school and my math teacher raped me. Seemed like all people wanted from me was sex…to screw. Crack took all that away.

Likewise, Participant 4 indicated that childhood discord had encouraged her use and eventual addiction to AOD. She indicates this by saying:

    Being a kid was like being in hell. My family was so messed up…fighting, yelling, telling me how stupid I was. And there was sex. I was abused. The only thing that helped me through the torture was my pills. I was 10 years old the first time I got high I drank my dad’s whiskey.

Participant 5 related a story in which childhood trauma played a key role in his addiction to AOD. “A lot of people died when I was young. Friends, family, neighbors. I couldn’t stand being around all that death, so I used. Got high.” Participant 7 remarked that his abuse of AOD was, in large part, due to the chronic sadness he felt throughout his childhood. “Both of my parents were depressed. It was horrible. Life just plain ’ol sucked.” Participant 8 also indicated issues from childhood that she believes hastened “the inevitable.” She explains:

    My dad died when I was about 11 years old. Things just went to shit after that. My mom got depressed and didn’t care what I did…didn’t even care if I ate. I started selling to get the shit I needed, kept selling until I stopped using. That still hurts. My mom didn’t care about me after Daddy died.
Likewise, Participant 3 indicated that childhood discord had encouraged her use and eventual addiction to AOD. She said:

Life has always been tough…hard life ya know? My family was never very full of support or help. They all used a lot. I never felt safe or happy. I can remember coming home late when I was in junior high. No one was awake. Everyone was passed out in bed or on the couch. I was just a kid and no one waited up to see if I made it home ok. They just didn’t care, I guess.

A similar theme emerged while talking to Participant 9. She also reported negative experiences as a precipitating factor in her AOD use. She said:

Shit was all fucked up when I was little. My old man was in and out of jail all the time. My mom had boyfriends when he was gone. They weren’t good guys. They hit me and my sister. We heard my mom having sex a lot. It was disgusting. I just laid in bed and stared at the ceiling while I listened to my mom getting fucked. Then the old man would come home from where ever he was and get drunk…start hitting my mom…hitting me and my sister. Totally fucked man.

Finally, Participant 10 stated indicated the same sentiments as five other individuals when she said:

Listen dude. No one had a worse childhood than me. I wanted to die every day until I found out that all of my thoughts and anger would go away when I was high. That meant a lot to me…you know? I’d get all drunked up and quit giving a fuck. Pretty soon, I didn’t want to care more and more. The worse things got, the more I’d use. After a while I was drunk or high all day every day. Wake up and do a wake and bake (a method of waking in the morning and immediately
smoking marijuana). Finally I just said screw it…started bumping lines of smack…started shooting after that.

Theme 2

Genetic Indicators

Another theme that emerged during the interviews was the notion of genetic indicators. All of the participants who were involved in this study reported hereditary factors as a predominate issue in their desires to engage in continued AOD use. Participant 1 indicated this notion by the following statement:

“I come from a long line of train wrecks. Most of my family has middle names like Drunk, Junkie, Tweaker…(laughs). My grandpa was a drunk, I have aunts and uncles who used, and a lot of junkie cousins. I guess the fruit really don’t fall far from the tree…huh?”

Similar feelings were expressed by Participant 2 as she stated:

Most of the people I know are junkies, drunks, or something…my family too.

Everybody uses…everybody gets fucked up. I feel like I didn’t stand a chance. I got my dad’s green eyes, and a taste for junk (heroin). Just like him.

Participant 3 also reported a history that has been marked by AOD use, abuse, and addiction.

I knew this would happen (addiction). I used to watch my family get messed up and I really admired them. I wanted to be just like them. Can you imagine? (sighs) I guess I did. I ended up just like them. I got my wish.
Participant 4 also specifically identified genetics as an important indicator of his difficulties with AOD use. This individual introduced the topic of genetics at the beginning of our interview when he said:

People think addicts are losers…idiots…but I’ll tell you what. There is something to the idea that it runs in the family. I have three brothers and one sister. Three of them use drugs and one drinks too much. I heard my pop (grandfather) drank a lot too. No one really talks about him, though. I just heard he was a bastard when he got drunk…that was most of the time.

Participant 5 also described a family history regarding AOD abuse and addiction when he said:

I had a P.O. (probation officer) when I was a teenager that told me I was going to end up like my family. They’re all in trouble. Potheads and drunks. I was pissed off when he said that. I was a kid and got so Goddamn mad. In fact…I was so mad that I went out and got really drunk, robbed a hunting cabin and got violated (probation violation). I was sent away for that…shit (laughs). Stupid. That P.O. was right. I turned out like my family. Hell…it was bound to happen.

Likewise, Participant 6 identified genetics as a precipitating factor when discussing his use:

Ya know…getting fucked up is what we do (family members). We’re known around town for being good at getting wasted. My people get wasted when we’re happy, my people get wasted when we’re sad…celebrating…bored…you name it. We just get wasted. I never knew anything different. I used to think I was just born to party.
Participant 7 also related hereditary factors as playing a dominant role in his addiction to AOD:

I get addicted to every fucking thing that comes my way. If I’m liking pizza that’s all I eat for months. If I’m liking a TV show, that’s all I’ll watch. My whole family does that. My father ate nothing but peanut butter and jelly (sandwiches) in his lunch bucket for years. Everyone in my family gets hooked on shit. Everyone. All of us would rather get high than do anything else. Well…not me…not anymore.

Participant 8 likewise reports genetics as an important point of interest when discussing his issues with AOD and refers to the hereditary factor as being “monsters in my blood.” He said:

I grew up with addicts. I had a bowl (pipe) for a binky (pacifier). My mom used to put vodka in my bottle so I would sleep all night. Both of my parents were drunk and high 24/7. It was horrible. My folks were bikers, and all of their friends were addicts, too. Hell, I learned how to roll a joint before I learned my ABC’s. My folks gave me this thing (addiction). It’s in my blood. It’s a monster cruising around in my veins.

During an interview with Participant 9, she indicated similar sentiments by saying:

We all have family that are addicts and alcoholics. I have cousins that I don’t even know that are junkies…all because somewhere along the lines, a grand pa or grandma had the disease. Christ, probably a great, great, great grandpa had it.

Finally, Participant 10 summarized the strong feelings of the other participants by stating:
I came home from school one time and found my mom passed out against the wall. Overdose. She was a stone cold addict. There was vomit everywhere…and all I wanted to do was show her the fucking picture I made for her out of noodles. She wasn’t dead, but she was in and out of the hospital and looney bins when I was growing up. I never met my dad. He was a sperm donor (laughs). I heard he was an addict, too. He split when I was little, I guess. My nana pretty much raised me, but papa was a drunk. I kinda think being an addict isn’t really my fault.

**Theme 3**

*Triggers and Cues*

After hearing the accounts of the participants and the factors that precipitated their prolonged use of AOD, I discovered that a particular theme resonated with every individual who was involved with this study. All of the participants cited triggers and cues as factors that are/were difficult to combat when they are becoming or trying to remain sober.

Participant 1 was an excellent example of an individual who views triggers as the most difficult component to ignore when becoming AOD free. “To stay clean I damn near have to stay in a bubble. Something is constantly triggering you.” In a similar vein, Participant 2 discussed triggers as a danger in recovery by stating:

It’s horrible. You can get set off first thing in the morning just by watching the damn news. I can’t even eat a bowl of soup without thinking about dope. I get all wound up. It’s hard to calm yourself down without some trick…some way to talk yourself out of using. I take that back. It’s impossible.
Likewise, Participant 3 stated, “Seeing something, smelling something. Did you know that tea smells like weed? Hearing a song that reminds you…all that fucks with your head…makes you want to get high.” Participant 4 echoed the feelings of other individuals involved in the study and reports that television is the worst trigger for her:

TV is bad, dude. All them people partying…the commercials…watching football is the worst with commercials. TV has a lot of reminders about the street, too. Little things people like you wouldn’t even see. I guess I can kind of watch what I watch man, but the shows I like mostly show things from the street. The way people talk…stuff like that.

Likewise, Participant 5 mentioned triggers as one of the most difficult factors within recovery when he said:

It fucking sucks. I can’t even drive down the road without seeing a beer billboard. Music is tough, too. Sometimes I just have to turn off the radio but by then it’s too late. I already want to get high because of a song I heard. I’ll be fucking fine and then all of a sudden, boom. I see something or hear a song and all I want is to get high. I was walking down the street one day and smelled stank (marijuana) coming from a building. I about shit, but I thought about what I learned in my counseling…in The Crack Room. I work through my thoughts now.

Participant 6 talked about triggers as impairments for one’s ability to remain sober, stating:

If I didn’t have to deal with triggers I’d be golden. Not perfect…just better. It’s a bitch to deal with going past bars or seeing places where I used to hang out. It’s hard. People don’t realize how much all that shit mess with your head. You’re
going along all happy and shit, and then you’re hit with something and you’re day is ruined. The rest of the day, you’re thinking about using…throwing things away and just using…it’s sick.

Participant 7 repeated similar themes when he discussed triggers in this manner:

Triggers suck. They make you think about shit you shouldn’t be thinking about. My wife doesn’t get it. Thinks I’m weak…tells me to snap out of it (sighs then laughs). It ain’t that easy. I mean. He can drive past an apartment building or a bar and not freak out. Not me…I still wig out…certain things freak a junkie out dude.

Once again, a theme emerged when discussions with Participant 8. He discusses triggers as an annoyance:

Triggers or whatever you call them is a pain in my ass. People don’t care if it’s bugging you. You know what I mean? They drink in front of you. I’m a damn tweaker and my buddies will light up bowls in front of me…do lines on my kitchen table. Then I go to Wal-Mart and I see turkey basters and light bulbs and all kinds of stuff to use to get high.

Likewise, Participant 9 reports similar issues while facing the realities of daily life. Regarding this issue, he states:

I came to U.S. when I was eight years old. I’ve always been around booze. My moms still likes to have her drinks at night. She doesn’t understand how that affects me. And I like the ladies, so when I see a nice-looking woman I want to talk to her. That’s hard for me to do. I still have a little Haitian twang. So to make it easier I always got high…I drank…something…anything to build my
confidence. I guess you could say that nice-looking women...they are a trigger for me. Every time I sees one, I want to get high.

Finally, Participant 10 expressed similar sentiments by saying:

Hell...I did every drug known to man. College was a joke. I tried to get clean one time there...forget it. That is a party time in someone’s life. Now, I’m so hooked that I can’t look back. I can’t even talk to people about the old days. Music is a big thing to set me off. I hear a song and bam...I want to use. It’s hard. Sometimes I drive all day without listening to the radio.

**Biopsychosocial Themes**

There was a variety of themes detected throughout the interviews. A prominent theme was related to the biopsychosocial theory of development and an individual’s experience regarding the connections between mind, body, and society (Engel, 1977). The fear of losing independence through placement in jails or prisons, psychiatric units, or rehabilitation centers was a prominent thematic pattern. Four individuals discussed this issue with anger, fear, and desperation. Another issue discussed by the participants of this study was the multitude of drug-related triggers found throughout society. As one participant stated, “Triggers are everywhere. You can’t escape them.” Individuals indicated that it is difficult to fight-off cues that are seen on a daily basis. Quite often, individuals who do not have difficulties with AOD addiction do not even notice these triggers (Liu & Weiss, 2002).

The ability to numb emotions was also a predominant theme during individual interviews. All of the participants discussed traumatic issues from their childhood as a
strong factor that precipitated their entry into AOD use and eventual addiction. One participant stated, “Look…my life was hell…torture. What did people expect?”

Genetic factors were also a strong theme that became predominant throughout the interviews. All of the participants reported family histories that included patterns of AOD abuse and/or addiction.

**Bioecological Themes**

Bioecological themes were also uncovered and were related to an individual’s experience in key environments throughout his/her lives. All of the participants discussed negative environments during their formative years. Patterns of abuse or neglect typically continued into adulthood. Many participants discussed these levels in terms of microsystems (friends and family), mesosystems (relationships between microsystems), exosystems (social settings), and macrosystems (culture) (Bronfenbrenner, 2006).

**Social Constructivist Themes**

Social constructivism was also a well-defined theme among the participants. All of the individuals who participated in this study reported a common knowledge or a sense of being kindred spirits among fellow drug users. One individual stated, “We’re all the same. We all have a junkie mentality. Get fucked-up…nothing else matters.”

**Self-determination Themes**

Self-determination also was a fairly prominent theme among the participant responses. Most of the individuals involved in this investigation discussed intrinsically motivated factors such as heredity and the circumstances of their childhood and adolescence. Indeed, the participants indicated that due to the issues beyond their control they were “destined” to enter into a life of AOD abuse and addiction. “I had no
choice man. My life has been a huge pile of shit. Drugs and drinking were the only way I stayed sane. I guess I’m not really sane but you know what I mean,” said one participant.

*Other Prevalent Themes*

Other unique themes emerged relating to an individual’s experiences in *The Crack Room*. Participants discussed their experiences in a way that communicated strong opinions on an emotional level. These were categorized as: 1) realization; 2) skill sets; 3) specific physical cue identification and perception within *The Crack Room*.

*Realization*

During the individual interviews, a sense of recognition occurred with eight of the participants. Several of the interviewees stated that seeing *The Crack Room* while in a state of sobriety was significant. One individual remarked, “It became real to me when I went into that room being 100% clean.” It was almost as if being under the influence of AOD somehow hid the truth of their existence; as one participant reported, “That room was normal when I was getting high. I didn’t think twice about the garbage or the shit thrown everywhere. Kinda sad now, if you think about it…sad that I didn’t even notice how disgusting it was.” Another participant related realization as waking up from a bad dream. “You know you have a bad dream and wake up all sweaty and nervous? That’s how I did when I went into the room. I got sweaty and about passed out. It was different not being all on a run and shit. Got to see it for real…not in a dream or in a fog.”

*Skill Sets*

Another theme that emerged was the development of a set of skills to assist individuals in rejecting or subduing the emotional pathways that may develop when one
attempts to combat the fall-out associated with drug-related cues. Participants stated that these skill sets were taught to them by their treatment counselors during sessions in *The Crack Room*. These skill sets are 1) learning to talk to themselves regarding triggers; 2) a method of remaining calm when faced with triggers; and 3) staying away from individuals who are known to influence AOD use (drug dealers or individuals with whom they may have engaged in previous use).

Developing skill sets was seen as a way to rationalize their emotions when faced with drug-related cues. Numerous participants stated:

My counselor taught me how to talk myself out of using. We’d sit in the room…I’d go nuts at first…but I eventually learned how to calm down. I used that at a family reunion this summer…worked pretty good. Everyone was drinking and a few people would sneak in to the woods to get high. I just played horse shoes with gramps. Before, I would have spent all day trying to figure out how to angle in on the keg, or how to get my hands on my aunt’s pills. Nope. I just played horse shoes and went on about my business.

*Specific Cue Identification and Perception*

Identification of specific physical cues found in *The Crack Room* was also a distinct theme that derived from the individual interviews. Pipes, needles, empty bottles of beer and liquor, holes punched into walls and the television screen, posters, odors, garbage and clothing strewn on the floor, a bare mattress and pillow, and a small picture drawn by a child were all noted as triggers that sparked emotional response.
Other Comments

Finally, a number of supportive factors were discovered that surround an individual’s experience in *The Crack Room*. Prevalent themes were 1) the notion of individuals engaging in violence while using AOD; 2) the fact that several participants did not initially recall spending time in drug-using environments similar to *The Crack Room*; 3) the idea that other individuals entering sobriety from AOD use should be encouraged to participate or be mandated into treatment in *The Crack Room*. A less prevalent theme indicated that several participants continue to struggle with a desire to return to use. In fact, two individuals stated that *The Crack Room* did not affect their urges to use AOD.

Summary of Analysis

Cross-case analysis provides a synopsis of the way themes surfaced during this inquiry, both during the individual interviews and researcher observations. Similarities and differences in meaning occurred in many areas. A prominent theme that emerged relating to an individual’s experience in *The Crack Room* was recognition of the fact that a real-life crack room was something that the participants wanted to avoid. To clarify, all of the ten individuals involved in this study stated that they did not wish to return to the type of life that made involvement in such a room inevitable. One individual remarked that prior to a Friday afternoon therapy appointment she had intended to engage in a “planned relapse.” Her treatment counselor was not aware of this fact but by chance decided to hold their session in *The Crack Room*. Upon leaving the appointment the client drove directly home, bypassing the home of her drug dealer and engaged in
healthier endeavors. She stated, “I didn’t buy dope. I don’t want to go back to that life…that way of living.”

The Design of the Research

This study was designed surrounding the lived experience of individuals who received therapeutic simulation in The Crack Room. The initial intention of this study was to contribute to the existing research and to gain an understanding of an individual’s experience when faced with pronounced AOD stimuli, specifically in The Crack Room. I was also interested in the generation of ideas that could add an additional layer of knowledge to this topic. While basic research often attempts to explain a given phenomenon, some research techniques attempt to understand a social issue and apply the knowledge that was obtained (Patton, 1990). According to Patton (1990), quite often research contributes information that will help individuals control their response to environments more effectively. Whereas basic research is concerned with scholarly questions, additional research is also concerned with problems and difficulties that may be experienced by an individual. Often, these concerns are voiced and represented by policy makers (Patton, 1990). Although this particular inquiry has seen little attention in programs that study AOD recidivism based on drug-related triggers, one of my desires was to test the hypothesis.

As noted, many researchers have linked criminal activity to drug and alcohol use as, quite often, many crimes are the result of lifestyle choices, perceptions, and the realities that are created by addiction to alcohol and other drugs (National Institute of Justice, 1999). Issues surrounding AOD abuse and addiction are a growing concern throughout the United States. Individuals who struggle with abuse or addiction to AOD
frequently experience a negative response to physical cues. Accordingly, these triggers are processed within a fraction of a second (Liu & Weiss, 2002). Some individuals in recovery from AOD addiction are ill-equipped to properly manage this flood of information. These facts not only raise issues for individuals who are suffering from abuse or addiction to AOD but also for counselors and our response to this growing concern.

*Data Collection for this Investigation*

During this study, I used semi-structured interview guides with Key Informant Interviews to obtain rich meaning regarding the experience of individuals who are addicted to AOD when faced with drug-related cues. These interviews, along with my observations, acted as my methods of data collection. Transcriptions of these interviews and observations were analyzed for themes that represented the nature of the interest of this study.

Quite often individuals such as students or clients become the unit of analysis (Patton, 2003). The essence of the collection of data focuses on what is happening in a particular environment and how the individuals who are engaged are affected by the setting (Patton, 2003). The decision was made to choose 10 participants who had received previous therapeutic simulation in *The Crack Room*. The participants of this study were chosen to provide a deep and descriptive account of the lived experience in *The Crack Room*.

An interview protocol was used with participants during the interviews. While developing the questions, an attempt was made to categorize the assumptions I propose regarding one’s experience in *The Crack Room*. Throughout the individual interviews, I
discovered that categorizing assumptions was a continual function of this study. In several interviews some reflections did not match the assumptions I made about the experiences of individuals who experienced therapeutic simulation in *The Crack Room*. I had to try to understand these experiences as they were reported by the participant. As much as possible, the questions asked to participants represented, to the best of my ability, the methodological or lived experience framework designing this study. Data collection for this study relied upon interviews that lasted approximately one hour. In addition, observations were used as an additional resource.

Literature discussing lived-experience research prevailed in this study. Lived experience focuses on an individual’s personal reflections, emotions, and adventures that make meaning (van Manen, 2003). Therefore, I relied heavily on the notion that lived space, lived time, lived body, and lived relationships are productive elements for postulation, reflection, and writing (van Manen, 1997). As we explore van Manen’s concepts, those connections, as used within this study, become valuable regarding meaning-making schemas.

Each participant was informed of the potential benefits and risks of participating in this study. Each person participating in this research was assigned a numeric code that was used for the purpose of analysis. I was the only individual aware of these numeric codes.

*Organization of Findings*

According to van Manen (1997), the expression of meaning within a certain context is largely a personal discrimination. As investigators, we often interpret text differently. However, one interpretation is not more true than another. As such, I had the
possibility to err or to see things that were idiosyncratic. This occurs when we, as researchers, search for themes within the text (vanManen, 1997).

Themes that were discovered during the individual interviews are briefly discussed below. During the analysis process of data collection, emergent themes reflected several thematic ideas. Findings are organized into five major categories that are contingent upon the previously mentioned theoretical foundations. The categories are (a) precipitating factors (factors that created a participant’s journey into AOD addiction), (b) biopsycosocial factors, (c) bioecological factors, (d) social constructivist factors; and (e) other themes that emerged.

Thematic Similarities

Unique themes emerged relating to individuals’ experiences in The Crack Room, a category relating to participant comments and perceptions. Members of the study talked about The Crack Room in a way that communicated strong opinions on an emotional level. These were categorized as: 1) realization; 2) skill sets and; 3) physical-cue identification and perception. These categories represented the highest level of emotional response.

Additionally, a fifth category labeled “other” was included to explain themes that did not fit into the primary categories of focus. Four participants stated that a prominent feature in their desire to remain AOD free is an overwhelming fear of placement or losing their independence. Participant 1 illustrated this by saying, “Listen. If I fuck up again, I’m gone. This time I’ll do state (incarceration in a state prison). I’m not doing that. It’s either stay clean or split…leave my grandson…I’ll stay straight.” Likewise, Participant 4 discussed similar concerns when he said the following:
I was in jail before. You feel hopeless. You’re stuck in a building with rapists and murderers…I ‘aint going back man. The only way I figured out to stay away from prison is to steer clear of the bottle. That starts everything for me. Keep me off booze, I’ll be fine.

Participant 6 reported similar sentiments:

My family always sent me to psych wards. Three North, they called it. Then there was Braddock Hospital. I got stabbed with a sharpened spoon in that fucking place. Then there was jail. I’m a little dude…I never did well in jail. Not something I look forward to. Can’t use in jail anyhow…unless you have a lot of scratch.

Participant 9 discussed the topic of placement or confinement with anger when he said:

I been in jail for fighting and shit. Been in jail more than once. I’m sure that if I get caught fighting again I’ll be sent up state. I don’t want that. I know how bad county time was. It sucked. Plus, my kids don’t need to see dad in jail no more. It was hard on them. Up state I’ll be gone for a couple years. It just isn’t worth it.

Individuals indicated that previous placement in prisons, jails, or psychiatric hospitals and units are factors that help them maintain recovery. As one participant indicated, “I’m not going back.”

Finally, Participant 10 discussed the topic of placement or confinement with anger when she said:

Oh hell no…I’ll hang myself before I go back to jail, to rehab, to church, to a place where they put nuts…to a place where they control you. None of those places worked anyhow. It’s all 12 stepper bullshit. Even in jail. Do sponsors get
kick-backs from new members? I heard they do. All I know is that the only way I’m staying clean is to stay away from drugs. Remember those places keeps me clean…keeps me on track.

Other prevalent themes were the memory of violence, an inability to initially recall having experienced an actual environment similar to *The Crack Room*, and the notion that other individuals in recovery should be encouraged to participate in therapeutic simulation. Finally, all of the participants indicated that triggers are a constant issue in their daily lives. Individuals report seemingly benign objects as troubling influences threatening their sobriety. Namely, media representations (television, billboards, music), other individuals (with whom they used or purchased AOD), and objects that do not invoke response or emotions from individuals with no AOD history (spoons, cigarette lighters).

*Chapter summary*

The results reported in this chapter derive from individual interviews and researcher observations. A total of ten adults who are in recovery from AOD addiction participated in this study. These were individuals who had previously received therapy in *The Crack Room*. Through the continuous process of data collection, I recorded notes regarding my personal experiences with the individual interviewees and established theoretical frameworks that discuss similar topics and questions that emerged. Upon completion of each interview, I transcribed the conversation and began to search for themes or repeated topics that occurred with other participants. I was especially aware of conversations that related to biopsychosocial, bioecological, social constructivist, and self-determination structures.
It remains unclear why other individuals who were appropriate for this study did not contact me for participation. It may be assumed, for example, that some individuals who received therapy in *The Crack Room* returned to use or are not participants in AA or NA programs. In addition, it is plausible to believe that some individuals left the area through voluntary relocation or have been mandated into placement in prisons, jails, or psychiatric units. Finally, one may assume that some individuals who previously received therapeutic simulation were simply not interested in participating in this study.
CHAPTER V

DISCUSSION

“There once was a man in a country with no fruit trees. A scholar, he spent a great deal of time reading. He often came across references to fruit. The description entices him to take a journey to experience fruit for himself. He went to the marketplace and inquired where he could find the land of fruit. After much searching he located someone who knew the way. After a long and arduous journey, he came to the end of the directions and found himself at the entrance to a large apple orchard. It was springtime and the apples were in blossom. The scholar entered the orchard and, expectantly, pulled off a blossom and put it in his mouth. He liked neither the texture of the flower nor its taste. He went quickly to another tree and sampled another blossom, and then another, and another. Each blossom, though quite beautiful, was distasteful to him. He left the orchard and returned to his home country, reporting to his fellow villagers that fruit was a much overrated food. Being unable to recognize the difference between the spring blossom and the summer fruit, the scholar never realized that he had not experienced what he was looking for.”

from Halcolm (Patton, 2010, p. 3)

Addiction to AOD is a prominent concern in America today. It is estimated that these societal issues will continue to grow as we experience considerable and mounting difficulties regarding this phenomenon. Indeed, current AOD trends point toward a more frightening expansion of use as gasoline, lye, lithium, and embalming fluid are often common ingredients in drug manufacturing. The increase of AOD use, abuse, and addiction, and the resulting concerns of society regarding this plague provide two important reasons to study the experiences of individuals who are addicted to AOD when faced with pronounced stimuli and triggers. Of specific interest were the experiences of individuals who previously received therapy in The Crack Room, a therapeutic simulation that places individuals in a drug-using environment. Other factors, such as concerns regarding relapse and an individual’s response to drug-related cues, provided additional rationale for this study. The purpose of this investigation was to explore the lived
experience of individuals who previously received therapy in *The Crack Room*. Results emerged from ten individual interviews coupled with researcher observations.

Existential phenomenologically-oriented research was used in this inquiry. While this approach considers the meaning of an individual’s experience, it also generates suppositions for responding to certain phenomena (Creswell, 1998). By analyzing information through interviews and observations in the field, I was able to explore the lived experience of the participants.

In this chapter, I discuss the preliminary findings by focusing on the information that emerged in the investigation. There were five primary categories that surfaced during the interviews: a) important factors that precipitated the participants’ involvement in AOD abuse and addiction; b) biopsychosocial themes; c) bioecological themes; d) social constructivist themes; e) self-determination themes; and f) other prevalent themes that became important factors in the findings. This chapter will discuss conclusions, hypotheses, and questions for further research in this area. The creation of deep meaning and the development of more questions are often an outcome of qualitative inquiry (Corey, 2002). As such, new hypotheses will surely be generated. Finally, limitations of the study are noted as well as recommendations for future research.

*Interpretation of Finding 1: Factors that Precipitated AOD Abuse and Addiction*

The first major category that emerged during analysis was somewhat surprising and was not an interest of this study. Each participant discussed at some level and in great detail elements that precipitated their journey into abuse and addiction. The discussion that follows focuses on a break-down of those factors. They are: 1) the idea that the use
of AOD helped individuals to numb negative emotions; 2) genetic factors of heredity; and 3) the inordinate number of triggers and cues found throughout society. The prominence of such themes was not anticipated, but because of the prevalence they had to be included in the study results and discussion. It became obvious that factors precipitating use and subsequent addiction are prominent and play a significant role in his/her thoughts surrounding their use. Therefore, exploration into a consumer’s past would help uncover, understand, and identify maladaptive decisions and behavioral response.

*The Ability to Make Emotions “Go Away”*

One of the most consistent findings in this study is the role that negative childhood experiences played in their journey into AOD abuse and subsequent addiction. Given the idea that addiction to AOD and mental health issues often run concurrently with each other, this finding should not be surprising. Consistent with other research, it was determined that negative experiences during childhood (especially physical, emotional, and sexual abuse) often create negative pathways in the way in which one perceives the world (Taleff, 1997). The severity of the challenges faced in childhood varied among participants. Some individuals experienced severe circumstances, while others reported deaths of loved ones or other set-backs that triggered an on-going instability in their functioning. Regardless of the circumstances, the feelings and beliefs we form as children are often maintained into adulthood. Most of the participants who engaged in this study reported that without negative childhood issues having occurred, they may not have moved from the experiential stage of AOD use and misuse into abuse
and addiction. One participant stated, “Drugs made me forget everything that hurt. Makes dope pretty appealing, doesn’t it?”

*Genetic Factors*

Another precipitating factor reported by the participants was an individual’s ideas and understanding of heredity as it applies to AOD addiction. Initially, this theme could be seen as one’s attempt to excuse previous maladaptive behavior patterns. Several participants stated that this dynamic “set them up” for a life of continued AOD use. Participant 3 was especially insightful when she stated, “I never stood a chance. I was fucked from the womb.” From this perspective, it appeared as though all of the participants believed that, although they had ultimate control over the decisions made in their lives, addiction to AOD would have occurred regardless of preventative measures or prevention education. However, I suspect that as sobriety continues, these individuals will no longer use heredity as an excuse but rather as a way to explain their path, and factors that led them into abuse and addiction. One participant stated, “Fuck man…when I was born you open my veins and Tequila would have came out. I guess I just wonder what people expected from me. I can’t blame anyone, though. Getting hooked was my fault.” Clearly, most of the individuals who volunteered for this study were uncomfortable in blaming heredity for their AOD use, yet some of the participants seemed to harbor resentment. Participant 7 stated, “I can’t blame anyone for my addiction, but if I wasn’t born to druggies and drunks, who knows where I would end up…what I could be.”
Triggers and Cues

Another consistent theme that emerged as a precipitating factor that led to the participants’ addiction to AOD was the intensity and frequency of triggers and cues found throughout society. While reflecting on the results of this study and identifying key components regarding precipitating factors, reports of triggers that can be found on a daily basis seem to be significant. One of the interests of this study has been in exploring the experiences of individuals in recovery from addiction to AOD, when faced with drug-related cues. Therefore, the importance of this particular component held great meaning. For example, participants 1 and 8 indicated that it is almost impossible to escape the onslaught of drug-related triggers and cues that are in abundance in daily life. Both of these individuals discussed feeling the need to live in a “bubble” or in a “cave” in order to stay away from significant cues. In this inquiry, every individual discussed an inability to combat cue recognition as a recurrent factor in relapse and as one of the most dangerous risks to continued recovery. The participants discussed *The Crack Room* as a valuable tool in their continued battle with addiction and indicated that through their exposure they have been able to minimize severe reactions when observing drug-related stimuli.

*Interpretation of Findings 2:*

*Biopsychosocial, Bioecological, Social Constructivism, and Self-determination*

Four major categories emerged during the analysis of data. While bioecological themes appeared to be the most prominent, biopsychosocial, social constructivist, and self-determination ideas were also evident. It became interesting to note that a blending
of these primary themes occurred and was sometimes difficult to decipher where one guiding theory ended and another began. The biopsychosocial theory discusses a mind/body connection or how an individual’s physical status can or may be affected by environmental or societal factors (Engel, 1977). Participant 1 elaborated on this issue by stating, “Listen. I had a shitty life. People always looked down on me. Drugs let me say fuck you to everyone.” The bioecological model indicates continuity and change across generations and often speaks to the experience of a person living in a given environment (Bronfenbrenner, 2002). Participant 8 states, “Shit is everywhere. How do you stay straight when everyone you know and everything you see reminds you of getting fucked up?” Finally, the social constructivist theory discusses groups as individuals who construct collaborative knowledge, thus creating small cultures with shared meaning (Gergen, 2000). One participant indicated this by saying, “Once I hooked up with my crew I knew where I was meant to be. I didn’t want to be at home that was for sure. I just felt like I belonged somewhere when I was with my hommies.”

*Biopsychosocial Themes*

When exploring a biopsychosocial perspective, perception is a key force in one’s development, suggesting that changes occur on an intrapersonal level. Often seen as a connection between the mind and body, biopsychosocial themes discuss cause and effect (Engel, 1977). For example, depression does not directly cause liver damage, but increased alcohol use does. Depression is often diffused or tempered by increased alcohol use. Therefore, an indirect link between depression and liver damage can be made. While individuals cited negative childhood experiences, genetics, and prominent triggers in society as factors that precipitated addiction, one’s decision to engage in
addictive behaviors was easily linked to a biopsychosocial theory. In other thematic patterns, a participant’s decision to remain clean and sober included many factors, including a desire not to be a burden to their families, and fear of placement or a loss of independence.

Bioecological Themes

Bronfenbrenner (2005) believed that as individuals transition they react and respond to their environment, as well as to their perceptions of certain experiences. He understood the concept of childhood connections and was one of the founding fathers of Head Start, a popular pre-kindergarten program in the United States. The bioecological theory discusses early childhood experiences as being an important construct in one’s transition into adulthood, and, thus, has implications in adult functioning. Furthermore, Bronfenbrenner (2005) discusses the proximal process as influencing the emotional growth of an individual during childhood and adolescence. This period is an important time for the development of certain skills and understanding, especially in the formation of relationships. Levers (2012), states, “Environmental factors, along with genetic predispositions, influence the child, and continual reciprocal transactions within the environment, or ecology, determine risk and protective factors” (p. 6). The majority of the participants engaged in this study report conflict during their formative years when developing connections and understanding relationships is especially important. This idea became evident when several participants reported negative childhood experiences.

The bioecological theory discusses microsystems, mesosystems, exosystems, and macrosystems (Bronfenbrenner, 2005). Microsystems involve one’s immediate surroundings and include family, peers, school, and neighbors. Often, the individual is
involved in forming these relationships and bonds. Mesosystems involve one’s relationship between various microsystems. For example, many of the participants of this study discussed negative childhood experiences as being one of the key factors of their initial and long-term involvement in AOD. Exosystems explore the connection between social settings in which an individual does not control or have a role. One of the participants explained feeling helpless when his father left the family home due to frequent incarcerations. Thus, his absence left a void in the basic functioning of the family. Finally, macrosystems discuss the culture in which one lives. The majority of the participants report poverty level or low socioeconomic status and embarrassing situations that left them feeling vulnerable throughout their lives. For example, one participant stated:

I was never as good as the other kids. Money-wise, everyone had more stuff or better clothes. I was really good at basketball. Better than the other kids, but I never got to play. The rich kids got to play but I didn’t. That bugged me for a long time. I had the wrong sneakers, the wrong equipment…never got to go to skills camp…had the wrong parents and no money. My mom would drop me off at practice in a beater fucking truck…tattoos all over her arms…black leather…coaches always looked at me like I was dirt. Eventually I just didn’t care.

Social Constructivist Themes

Finally, themes emerged regarding a social constructivist theory. While focusing on the interview with Participant 6 this theoretical framework became evident when he discussed feeling a sense of belonging and acceptance while engaging in activities.
surrounding AOD use: “Using…getting high…THAT was my identity. I didn’t make it with the popular kids, but I was the king of the dopers.” Likewise, other participants commented on the process of developing bonds through being a member of a microcosm, specifically, a drug-using culture. Through the course of the shared learning that occurred during their drug use, participants report special meaning in the development of these bonds. Some of the feelings and emotions remain years after the use of AOD has ended. One individual illustrated this by saying, “We’re all the same.”

**Self-determination Themes**

This research also relied upon the self-determination theory of human development and motivation (Ryan & Deci, 2000; 2006). Much of an individual’s life experience may be intrinsically or extrinsically induced. In this inquiry the participants discussed extrinsic motivations that included influences that were forced upon them in childhood, such as poverty, genetic factors, or child abuse or trauma. Additionally intrinsic motivators were described as decisions or life-style choices that were self-directed or because the act somehow satisfied them. In this case an individual’s decision to begin or continue the use of AOD was to numb emotional pain.

**Interpretation of Findings 3: Other Themes**

Finally, other prominent themes emerged that were significant when specifically discussing their experiences in *The Crack Room*. These themes related to issues that were discussed regarding realization, the development of a series of skills, and the identification of drug-related cues.
Realization

Eight participants discussed a realization of where a life of chronic AOD use had led them. One participant stated, “I guess I didn’t know how bad my life was until I saw that room.” The participants indicated that observing *The Crack Room* while in a state of sobriety helped them to obtain a clearer picture of the realities of their past while using AOD. A key component of an individual’s realization is the fact that the participants were sober when receiving therapeutic simulation in *The Crack Room*.

Skill Sets

Participants also discussed learning a specific set of skills in terms of how to calm and rationalize their emotions when faced with drug-related cues. These techniques were taught to the participants by the counselors who were involved in therapy during sessions in *The Crack Room* which included the development of self-talk. Individuals receiving treatment in *The Crack Room* are also instructed to minimize risk by staying away from key individuals, such as former dealers or people who do not respect another’s sobriety.

Specific Cues and Triggers in The Crack Room

Although *The Crack Room* is filled with multiple items that depict drug-related cues, some of the elements were especially effective in prompting an emotional response. The paraphernalia and related items that created the most disturbance for the participants were, pipes, needles, empty liquor and beer bottles, holes in the wall and television screen, posters on the walls, garbage and clothing on the floor, a mattress and pillow with no sheet, and a small picture that was hand-drawn by a child. The fact that the crayon drawing was an emotional trigger was especially surprising. It was placed in *The Crack Room* as an after-thought with no anticipation of a response. However, two participants
specifically noted a strong emotional reaction to the picture. In both cases, the picture reminded them of children who were involved in their lives while they were actively addicted to AOD.

Interpretation of Findings 4:

Remaining Themes

Some minor themes emerged and although these elements did not specifically speak to cue response, it seemed important to include them in the analysis. A few participants discussed a thread of violence that they had experienced while using AOD. Certain aspects of The Crack Room or of our discussion of addiction reminded them of these previous behaviors. In addition, several individuals stated that they had not initially recalled being in a room similar to The Crack Room. Eventually, memories returned and one individual admitted to living with her children in a home that resembled The Crack Room:

At first I was pissed and said I never saw anything like that. Then all of a sudden it hit me...holy shit...I lived like that...made my kids live like that. I really didn’t remember. Guess I didn’t want to remember.

A few participants stated that they believed that others who may be struggling with abuse or addiction should be mandated into treatment in The Crack Room. As one participant stated, “That room is fucking nuts. Everyone should have to go in there. It makes you think…it really works.”

Fear of Placement

Another finding that emerged related to an individual’s fear of being placed in prison, jail, or psychiatric units. Four participants discussed this topic in terms of
remaining clean and sober in order to avoid further involvement with agencies and/or placement in various facilities. Participant 10 indicated this by saying, “I’m not going back man. The thought of losing my freedom again drives me nuts.”

**Interpretation of Findings 5:**

*Special Indications of Trauma and Addiction to AOD*

Although the effects of trauma on an individual who is recovering from AOD addiction was not an interest of this study, dramatic themes emerged and must be noted. Trauma typically manifests in many ways. Quite often unspeakable events occur that leave victims unable to function properly (Levers, 2002). Many individuals do not immediately identify acts of cruelty inflicted on them, or they have fragmented thoughts of their traumatic experiences. An individual’s lived experience of trauma is frequently very personal and can be subjective (Levers, 2012). As such, it is significant to note that all of the individuals who participated in this study report numerous forms of trauma as a result of childhood abuse.

According to Maslow’s (1970) hierarchy of needs, it is difficult for an individual to progress emotionally through the stages of growth when foundational needs are not met.

Table 16

<table>
<thead>
<tr>
<th>Needs</th>
<th>Basic Needs: food, shelter, water</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physiological Needs</td>
<td>Basic Needs: food, shelter, water</td>
</tr>
<tr>
<td>Safety Needs</td>
<td>Law, order, stability</td>
</tr>
<tr>
<td>Love and Belonging</td>
<td>Friends, affiliations</td>
</tr>
<tr>
<td>Esteem</td>
<td>Confidence, respect, status</td>
</tr>
</tbody>
</table>
As stated previously, all of the participants indicated an interruption in development that has created significant implications in their maturation and emotional growth. Additionally, most of the participants report that they are unable to “turn-off” their response to stress or feelings that trigger painful memories. As one participant stated, “It takes its toll.”

The following is a break-down of the type of trauma experienced by the participants:

Table 17

<table>
<thead>
<tr>
<th>Participant</th>
<th>Physical abuse</th>
<th>Sexual abuse</th>
<th>Emotional abuse</th>
<th>Death</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>X (adult)</td>
<td>X (adult)</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>2</td>
<td>X</td>
<td>X</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>3</td>
<td>X (adult)</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>4</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>6</td>
<td></td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>X</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>8</td>
<td></td>
<td>X</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>9</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>X (adult)</td>
<td></td>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>
Because trauma has played a significant role as a precipitating factor in the participant’s transition into AOD abuse and eventual addiction, an in-depth exploration should occur. The following is a list of significant quotes that emerged from the interviews in regard to a participant’s individual experiences of childhood trauma.

### Table 18: Participant 1

<table>
<thead>
<tr>
<th>Analytical Category</th>
<th>Significant Quote</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ability to make feelings go away</td>
<td>“Once I started getting fucked up nothing mattered.”</td>
</tr>
<tr>
<td>Genetic Indicators</td>
<td>“My Dad drank. I heard that I had uncles and aunts that drank too. My son’s a junkie.”</td>
</tr>
<tr>
<td>Triggers and Cues</td>
<td>“Triggers? They’re everywhere…hard to escape.”</td>
</tr>
<tr>
<td>Realization</td>
<td>“That room blew my mind. The minute I walked in I knew I had been there before…really hit me.”</td>
</tr>
<tr>
<td>Skill Sets</td>
<td>“I figured out how to ignore pipes and shit. Didn’t let needles and straws bug me.”</td>
</tr>
<tr>
<td>Specific Cue Identification</td>
<td>“The plate with the egg, bottle through TV screen, trash, the bed tore up.”</td>
</tr>
<tr>
<td>Fear of Placement</td>
<td></td>
</tr>
</tbody>
</table>
Violence

“I lived with violence the whole time I was using. My old man beat me a lot…in front of my son.”

No Recall

Mandate People to *The Crack Room*

“You should make addicts go in there.”

Table 19: Participant 2

**Participant 2**

<table>
<thead>
<tr>
<th>Analytical Category</th>
<th>Significant Quote</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ability to make Feelings go Away</td>
<td>“Nothing matters when you’re all fucked up. Getting as high as you can…that’s all there is.”</td>
</tr>
<tr>
<td>Genetic Indicators</td>
<td>“I guess it makes sense that I’m a junkie. I used to sit and watch my Pop get drunk and be mean to Nam. He was a nut.”</td>
</tr>
<tr>
<td>Triggers and Cues</td>
<td>“fuck man…they’re everywhere.”</td>
</tr>
<tr>
<td>Realization</td>
<td>“didn’t get it at first.”</td>
</tr>
<tr>
<td>Skill Sets</td>
<td>“I learned to chill the fuck out when I see a needle or something that upsets me.”</td>
</tr>
<tr>
<td>Specific Cue Identification</td>
<td>“The little kid drawing. My sister sent me pictures when I was in jail. Just like that.”</td>
</tr>
</tbody>
</table>

Fear of Placement

Violence

No Recall
**Mandate people to *The Crack Room***

“More junkies need to see that shit hole.”

---

**Table 20: Participant 3**

<table>
<thead>
<tr>
<th>Analytical Category</th>
<th>Significant Quote</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ability to make Feelings go Away</td>
<td>“I was raped over and over again. How do you escape that? How do you forget?”</td>
</tr>
<tr>
<td>Genetic Indicators</td>
<td>“My entire family was nuts. Everybody used one way or another.”</td>
</tr>
<tr>
<td>Triggers and Cues</td>
<td>“Dude. I get triggered every day.”</td>
</tr>
<tr>
<td>Realization</td>
<td>“You walk in there and you’re like…WHOA…then it make sense.”</td>
</tr>
<tr>
<td>Skill Sets</td>
<td></td>
</tr>
<tr>
<td>Specific cue Identification</td>
<td>“Straws, pill powder on CD cover. Trash and pizza boxes.”</td>
</tr>
<tr>
<td>Fear of Placement</td>
<td></td>
</tr>
<tr>
<td>Violence</td>
<td>“Anger and flipping the fuck out was what I was known for. The holes in the walls kinda got to me.”</td>
</tr>
<tr>
<td>No Recall</td>
<td>“It’s weird. I didn’t remember living like that at first. Guess I blocked it out.”</td>
</tr>
<tr>
<td>Mandate People to <em>The Crack Room</em></td>
<td>“A lot of fuckers need to go in there.”</td>
</tr>
</tbody>
</table>
Table 21: Participant 4

<table>
<thead>
<tr>
<th>Analytical Category</th>
<th>Significant Quote</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ability to Make Feelings go Away</td>
<td>“I was beat… I was raped… what do you expect? You’d get high too.”</td>
</tr>
<tr>
<td>Genetic Indicators</td>
<td>“I don’t know anything but using.”</td>
</tr>
<tr>
<td>Triggers and Cues</td>
<td>“I can’t walk down the street without wanting to go get drunk. Bars are everywhere, and you see beer cans on the road every five feet.”</td>
</tr>
<tr>
<td>Realization</td>
<td>“That room (laughs) it’s messed up in a Way, but it really makes you think.”</td>
</tr>
<tr>
<td>Skill Sets</td>
<td>“I guess I learned to talk to myself. I learned to talk myself out of using, I guess.”</td>
</tr>
<tr>
<td>Specific Cue Identification</td>
<td></td>
</tr>
<tr>
<td>Fear of Placement</td>
<td>“I’m not going back to lock up, man”</td>
</tr>
<tr>
<td>Violence</td>
<td></td>
</tr>
<tr>
<td>No Recall</td>
<td>“I kinda forgot about that part of my life. I guess maybe I blocked it out, huh?”</td>
</tr>
<tr>
<td>Mandate People to The Crack Room</td>
<td></td>
</tr>
</tbody>
</table>

Table 22: Participant 5

<table>
<thead>
<tr>
<th>Analytical Category</th>
<th>Significant Quote</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ability to make Feelings go Away</td>
<td>“A lot of people died in my life, family, friends, a girlfriend. It’s hard.”</td>
</tr>
<tr>
<td>Genetic Indicators</td>
<td>“Being a dick runs in my family…family trait to party.”</td>
</tr>
<tr>
<td>-----------------------------</td>
<td>----------------------------------------------------------</td>
</tr>
<tr>
<td>Triggers and Cues</td>
<td>“What everyone calls triggers is like a fat chick seeing cake everywhere. Not to be rude…but that’s what it’s like.”</td>
</tr>
<tr>
<td>Realization</td>
<td>“You really get to see where you were.”</td>
</tr>
<tr>
<td>Skill Sets</td>
<td>“The room helps you not go nuts when you see needles or spoons…stuff you use to get high.”</td>
</tr>
<tr>
<td>Specific Cue Identification</td>
<td>“No sheets on the mattress.”</td>
</tr>
<tr>
<td>Fear of Placement</td>
<td></td>
</tr>
<tr>
<td>Violence</td>
<td></td>
</tr>
<tr>
<td>Mandate People to <em>The Crack Room</em></td>
<td>“I think probation should make their people go in there.”</td>
</tr>
</tbody>
</table>

Table 23: Participant 6

### Participant 6

<table>
<thead>
<tr>
<th>Analytical Category</th>
<th>Significant Quote</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ability to Make Feelings go Away</td>
<td></td>
</tr>
<tr>
<td>Genetic Indicators</td>
<td>“Fuck man, we’re all drunks and junkies.”</td>
</tr>
<tr>
<td>Triggers and Cues</td>
<td>“I can’t even eat a bowl of soup without wanting to get high. Spoons…ya know?”</td>
</tr>
<tr>
<td>Realization</td>
<td>“Thought it was fucked up to go in there. I wondered what the fuck my counselor was doing. I get it now. It helped me.”</td>
</tr>
<tr>
<td>Skill Sets</td>
<td></td>
</tr>
<tr>
<td>Specific cue Identification</td>
<td>“The pillow, pill bottles, the smell of the room. The whole vibe.”</td>
</tr>
</tbody>
</table>
Fear of Placement

“Fuck going back to jail. I’m a little guy man…I don’t do good in there.”

Violence

No Recall

Mandate People to The Crack Room

Table 24: Participant 7

Participant 7

Analytical Category

Significant Quote

Ability to Make Feelings go Away

“My parents was always upset. Booze were the only thing that made me feel good.”

Genetic Indicators

“I guess we had trouble way back when. Heard I get it honest.”

Triggers and Cues

“My buddies. They come to the house all drunked up. Bugs me.”

Realization

“I know how things would get if the wife ‘aint around to clean. She keeps the house pretty good.”

Skill Sets

“Learned how to keep away from getting upset when I see something.”

Specific Cue Identification

“A lot of garbage everywhere. It smelled bad too. Music playing.”

Fear of Placement

Violence

No Recall

Mandate People to The Crack Room
<table>
<thead>
<tr>
<th>Analytical Category</th>
<th>Significant Quote</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Participant 8</strong></td>
<td></td>
</tr>
<tr>
<td>Ability to Make Feelings go Away</td>
<td>“When my Dad died, shit got weird…bad.”</td>
</tr>
<tr>
<td>Genetic Indicators</td>
<td>“I heard stories about uncles and stuff. drinkers mostly.”</td>
</tr>
<tr>
<td>Triggers and Cues</td>
<td>“Everything makes a junkie want to get high.”</td>
</tr>
<tr>
<td>Realization</td>
<td>“The Crack Room is intense. Puts you back to how bad things were.”</td>
</tr>
<tr>
<td>Skill Sets</td>
<td>“Talked a lot. Talked about how to not Jones when you see things that make you want to catch one.”</td>
</tr>
<tr>
<td>Specific cue Identification</td>
<td>“Smell, seeing the filth, posters on the wall. I could smell urine.”</td>
</tr>
<tr>
<td>Fear of Placement</td>
<td></td>
</tr>
<tr>
<td>Violence</td>
<td>“You know. I did State time. It’s not worth it. Can’t get high in prison anyhow. Not unless you have a shit load of money.”</td>
</tr>
<tr>
<td>No Recall</td>
<td></td>
</tr>
<tr>
<td>Mandate People to <em>The Crack Room</em></td>
<td></td>
</tr>
</tbody>
</table>

Table 26: Participant 9

<table>
<thead>
<tr>
<th>Analytical Category</th>
<th>Significant Quote</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Participant 9</strong></td>
<td></td>
</tr>
<tr>
<td>Ability to Make Feelings go Away</td>
<td>“I got beat a lot. It wasn’t good.”</td>
</tr>
<tr>
<td>Genetic Indicators</td>
<td>“My Moms drank a lot. So did her friends.”</td>
</tr>
<tr>
<td>Triggers and Cues</td>
<td>“It’s not hard to see or smell something that brings back those memories and makes you want to use.”</td>
</tr>
<tr>
<td>------------------</td>
<td>--------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Realization</td>
<td>“The biggest thing is that the room makes you remember…makes you realize what happened to you with drugs.”</td>
</tr>
<tr>
<td>Skill Sets</td>
<td>“I was taught how to let go of all the stress I felt when I saw paraphernalia. Made it not matter as much as it used to.”</td>
</tr>
<tr>
<td>Specific Cue Identification</td>
<td>“The beer bottle in the TV screen.”</td>
</tr>
<tr>
<td>Fear of Placement</td>
<td>“Next time I’ll go upstate.”</td>
</tr>
<tr>
<td>Violence</td>
<td>“I got mean. I’m so ashamed of that now.”</td>
</tr>
<tr>
<td>No Recall</td>
<td></td>
</tr>
<tr>
<td>Mandate People to The Crack Room</td>
<td>“You should do this more often. Make kids go in there. It’s a good idea.”</td>
</tr>
</tbody>
</table>

Table 27: Participant 10

<table>
<thead>
<tr>
<th>Analytical Category</th>
<th>Significant Quote</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ability to Make Feelings go Away</td>
<td>“Getting high was the only thing that ever made me feel better.”</td>
</tr>
<tr>
<td>Genetic indicators</td>
<td>“I have a lot of family who are dope heads, pot heads, drunks, you name it. We got it.”</td>
</tr>
<tr>
<td>Triggers and Cues</td>
<td>“Trigger? They’re all over the place. Most people don’t even notice them.”</td>
</tr>
<tr>
<td>Realization</td>
<td>“The thing about the room is that you get to see it when you’re straight. It means more when you’re straight.”</td>
</tr>
<tr>
<td>Skill Sets</td>
<td>“I needed to learn all that stuff years ago… how to talk yourself out of being weirded out by seeing needles and spoons.”</td>
</tr>
<tr>
<td>---------------</td>
<td>------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Specific Cue Identification</td>
<td>“Smell I’d say. My room always had a musty smell that grossed me out.”</td>
</tr>
<tr>
<td>Fear of Placement</td>
<td>“Psych wards…jails…I don’t want anything to do with those places anymore.”</td>
</tr>
<tr>
<td>Violence</td>
<td></td>
</tr>
<tr>
<td>No Recall</td>
<td></td>
</tr>
<tr>
<td>Mandate People to <em>The Crack Room</em></td>
<td></td>
</tr>
</tbody>
</table>

**Supportive Factors in Recovery**

When discussing examples of factors that relate to continued recovery, some of the participants were clear in their assessment of elements that contribute in a positive way. Once again, this topic was not an interest of the study; however, a discussion seems to be significant. Just as certain factors precipitated one’s involvement in AOD use, other elements help them to manage his or her recovery. Two of the participants cited their connectedness to others who had previous experience in *The Crack Room*.

I’ll be at a meeting and someone mentions *The Crack Room*. I’ll go up to them at the end of the meeting and I’ll be like…hey dude. You did it too. Then we talk, and it’s a link…a bond.

**Lived Space: Replication**

Traditional AOD therapy often relies on 12-step programs and behavior-based interventions (Taleff, 1997). One of the findings of this study was the idea that *The Crack Room* can be an effective addition to treatment modalities. Because *The Crack Room*
replicates a drug-using environment, and all of the participants reported an inability to combat cues in society, a marriage of traditional treatment and The Crack Room seems logical.

*Lived Body: Feeling Worthwhile*

Four participants reported feeling objectified by counselors during traditional therapy sessions. One expressed opinion by saying:

> All they do is paperwork. Counselors don’t hardly have time to talk to you… too busy writing stuff. I think they call it document. At least when I was in The Crack Room the counselor paid a lot of attention to me. It was like I was more than a way to make money…like he really cared about me and what I was thinking.

One of the most damaging experiences for a consumer is to feel ignored or unimportant. For the individuals who received therapeutic simulation, it appeared as though they “mattered” when therapy occurred in The Crack Room. I can safely speculate that consumers who are happy with their intervention will report a sense of satisfaction and feel that their time in therapy is well-spent.

*Lived Time: A Sense of Loss*

Finally, several participants reported feelings of loss or a lack of achievement. Lived time is described as time that is reportable as a feeling, rather than time that is determined by a clock (van Manen, 1997). One individual stated, “I just let life go by.” Another participant reported their feelings of loss as it applies to The Crack Room. “I wasted so much time in places like that. Sitting in dirt and garbage while other people my age were making careers…had lives…real lives.” It may behoove counselors to become
aware of these feelings, thus creating an opportunity to discuss one’s use of AOD, while focusing on future choices and behaviors.

Implications

The findings of this study have implications for individuals who are in recovery from addiction to AOD, when faced with drug-related cues. This investigation, specifically, was focused on individuals who previously received therapeutic simulation in *The Crack Room*. It is important that, as the researcher, I look at the meaning of these experiences as well as how the findings can be used in therapy. The bioecological model of development guided much of this study, as well as van Manen’s (1997) ideas of lived space, lived body, and lived time. As such, I will discuss and reflect on the meanings behind the findings of this research.

Implications for Counselors

Counselors are an important participant in an individual’s recovery. Rather than simply treating one’s abuse or addiction, other elements of an individual’s mental health need to be incorporated to enhance successful sobriety and healing. As stated previously, numerous themes relating to this topic emerged in the analysis of data. Specifically, childhood unrest was reported to be a significant factor in a participant’s decision to engage in prolonged AOD use.

Implications of Trauma

Trauma is experienced in many ways. The result of traumatic events is personal and depends on numerous factors that reflect highly subjective and personal realities. The emotional fall-out of trauma can be seen as an aspect of terror and disconnectedness (Herman, 1992, 1997). Likewise, Courtois (1988, 2004) explains traumatic experiences
as shattered trust. All of the participants engaging in this inquiry reported various forms of trauma, specifically in childhood. Reportedly, early maltreatment can develop serious implications for future psychopathology (Levers, 2012). Risk factors may include the individual’s age at the time of the event, whether or not the perpetrator was a friend, family member, or a stranger, and the support available to the victim (Levers, 2012). Most of the participants in this investigation report having been abused by a family member in their childhood. Additionally, in all of these cases the abuse was never reported and the survivors never received much-needed intervention and support.

When psychological needs are met humans move toward self-motivated behavior. Environmental factors can either delay or strengthen one’s attempt to grow (Ryan & Deci, 2000). Professionals in the helping disciplines acknowledge the effect of mistreatment and trauma on one’s mind, body, and spirit. Herman (1992, 1997) describes the arousal that is symptomatic of trauma as being on “permanent alert” (p. 35). This includes intrusive and constrictive symptoms of PTSD. Intrusive indicators comprise of agitation and anxiety, while constrictive symptoms may include depression (Herman, 1992, 1997). This fact can be confusing when attempting to understand the behaviors and motivation behind addiction to AOD. Levers (2012) stated this eloquently when she said:

I recall thinking about the cubist paintings that I had seen in European museums, perceiving the trauma experience through the disciplinary lens of my undergraduate work in literature and art history. Focusing on the deconstructed images in the Cubist paintings, like those of Picasso, for example assisted me to comprehend, even in a limited fashion, the fragmentation that traumatized clients had experienced and tried to share with me (p. 8).
Trauma makes individuals question the very foundation of human relationships, impairs the ability to make decisions, and shatters their ability to trust and love (Herman, 1997). Specifically trauma can cause feelings of blame, guilt, and safety, and creates undesignated fears, depression, AOD disorders, eroded self-esteem, numbed responsiveness, and expectations of danger (Mojab & McDonald, 2001). Chronic use of AOD is often a way to manage these emotions (Sebold, 1989). As one participant stated, “It’s a lot easier to be delusional and forget about your past when you’re high.” Counselors should remain mindful of the emotional implications of trauma and become proficient in the multiple areas of care that are available to the consumer. Having said that, counselors should a) become aware of biases, stereotypes, and certain belief systems, b) become knowledgeable about the diverseness of the consumer, and c) understand and remain aware of treatment options and interventions that are appropriate to meet the needs of the consumer. This study creates new ideas for therapy for individuals who are struggling with abuse of or addiction to AOD.

**Hypotheses**

A hypothesis has been generated as a result of this investigation. Most of the supposition is related to the themes that composed the results of the investigation. Other hypotheses about broader themes relating to factors that precipitated an individual’s journey into AOD addiction and personal feelings about *The Crack Room* also surfaced. Some important ideas were generated: a) there are four factors that precipitated abuse of, or addiction to AOD; b) other themes emerged that discuss an individual’s experience in *The Crack Room*; c) a few minor themes resulted from this inquiry and included ideas for
future use of *The Crack Room*; and d) trauma appears to play a role in one’s addiction to AOD.

The following information emerged from the interviews and observations:
a) factors that precipitated addiction to AOD remain an important and key issue for individuals who maintain successful recovery; b) drug-related triggers and cues are found in abundance throughout society, often resulting in relapse or difficult emotional situations; c) individuals who engage in therapeutic simulation in *The Crack Room* report a realization or awareness of how their lives had been affected by AOD use (this awakening occurs through visual, auditory, and olfactory stimulation while the consumer is sober and not impaired by AOD); d) individuals develop a set of self-talk skills and become calloused to a triggers ability to impact their emotions in a negative way; e) specific cues in *The Crack Room* invoked very personal emotions; f) the risk of placement in jails, prisons, or psychiatric units help individuals to maintain sobriety; g) individuals in recovery from or currently addicted to AOD form a sense of belonging with one another; h) individuals report a thread of violence that is common in the drug culture; i) quite often, individuals forget the depths of despair that accompany addiction to AOD; and j) more individuals should be mandated into treatment in *The Crack Room*.

*Limitations*

Investigations often include limitations. In this particular study, some of the limitations were related to personal issues I faced as the only researcher. Some of these limitations involved time constraints and emotional and psychological energy. Sample size also became an issue and affected the ultimate findings. A small sample size in qualitative inquiry has certain constraints, sometimes limiting a researcher’s ability to
generalize findings back to the larger population. Therefore, the results of this study cannot be used to make generalized statements about individuals who are addicted to AOD when faced with drug-related cues. Additionally, the goal of this research was to understand the meaning of an individual’s experience in *The Crack Room*. Sadly, the experiences of minority groups were absent from the findings. From the start of this study, one of the most significant limitations was an inability to achieve results from a diverse group of participants. While variation in age did not appear to be much of a problem, nine participants were Caucasian, while only one individual was African-American. No other ethnic or racial groups were represented. Likewise, the participants did not represent an appropriate cross-section of socio-economic or financial status. The relatively homogenous sample population of this study limits the ability to understand the interaction between one’s experience in *The Crack Room* and the way other groups may respond to therapeutic simulation. Additionally, due to university and IRB restraints, the sample population was derived only from individuals who attend AA or NA meetings and individuals who were no longer on state parole or county probation. This limited the diversity of the sample population and, ultimately, the results of the inquiry.

*Recommendation for Further Investigation*

A strong recommendation for further research emerged from the findings of this study. Specifically, how can the therapeutic simulation techniques of *The Crack Room* be used to assist individuals who are receiving therapy for addiction to AOD? Further inquiry could examine the nuances of an individual’s experience and pose questions about the counselor’s involvement and effectiveness during sessions in *The Crack Room*. 
Several of the participants discussed the effectiveness of therapeutic simulation when support from a counselor is a prominent feature:

It was weird. You go into this fucked-up room and it scares the shit out of you. Then your counselor starts talking to you about how you’re feeling and what you think about this and that. A couple times in there and pipes don’t make you want to climb the walls. Vodka bottles don’t make you freak the fuck out. I guess you learn how to keep your shit together. You learn how to keep your sanity when you see that shit.

The following questions may provide direction for continuing the exploration of the factors that enhance as well as thwart an individual’s success in recovery from addiction to AOD: a) What effect do cues and triggers have on an individual who is in recovery? b) What can counselors do to provide therapy that is appropriate for consumers on an individual and personal level? c) Can therapeutic simulation provide effective intervention? d) What effect would *The Crack Room* have with minority groups or groups that do not match socioeconomic categories? Further examination of these questions will help to ensure that individuals who are in recovery from addiction to AOD can take advantage of a full range of therapeutic services and techniques.

*Interpretation and Analysis*

The original design of *The Crack Room* was to assist consumers who are in treatment for addiction to AOD in minimizing their startle response to drug-related stimuli. When *The Crack Room* was in its infancy, I believed that exposing select individuals to a realistic drug-using environment would help them to manage the rush of
emotions that are common when one is faced with drug-related stimuli. The room has been used by Two Roads Counseling Services for more eight years.

The results of this investigation seem to indicate that this hypothesis was indeed correct. With the assistance of a therapist who guides all of the sessions in The Crack Room, consumers are able to reframe their thoughts and emotions to a more appropriate or “safer” reaction. Numerous participants in this inquiry indicated that they have successfully used the knowledge acquired in The Crack Room in their everyday lives and have been triumphant in combating their desires to use AOD. As one participant indicated, “I’m not afraid to see pipes or razor blades anymore. I just sorta put my mind to other things. I use what I learned in The Crack Room and talk myself out of using.”

As stated previously, one of the most important findings indicated that individuals who enter The Crack Room are reminded of uncomfortable situations in their past of being active in their addiction. One participant demonstrated this by saying:

I picture that fucking room and the last thing I want to do is go out and get high. I lived like that. I actually lived like that. It seems unbelievable. I know that if I start using again I’ll be right back there. I don’t want that. I want to keep caring about myself. No. I don’t want to use anymore.

This finding was unexpected but adds another layer to the ways in which The Crack Room can be used in therapeutic situations.

Additional comments made by the participants indicate that The Crack Room also allows the counselors involved in therapeutic simulation to spend more time focusing on the consumer. One participant stated, “It was like me and my counselor were really
connected in the room. Don’t get me wrong. He was a good counselor but it felt different in there. Like he was really locked on me and interested in me.”

As drug use in the United States continues to reach epidemic proportions, the concerns for assisting individuals in maintaining successful recovery from addiction to AOD becomes increasingly important. This investigation provides evidence that therapeutic simulation provided in *The Crack Room* is a beneficial and viable option for anyone who is battling addiction to AOD.

**Conclusion**

The intent of this study was to ask: What is the experience of individuals in recovery from addiction to AOD, who previously received therapeutic simulation in *The Crack Room*? To answer this question, I conducted individual interviews and researcher observations with 10 individuals who volunteered for participation. Participants represented, to the best of my ability, the general population of individuals who are in recovery from addiction to AOD. All of the volunteers previously had engaged in therapeutic simulation in *The Crack Room* and were able to reflect on their experiences.

Findings emerged and, discussed, were precipitating factors that hastened an individual’s involvement in AOD use. The findings also illuminated themes that disclosed participants’ feelings of realization, the development of skills used to combat triggers, and specific cue identification and perceptions within *The Crack Room*. Another thematic pattern surrounded memories of violence in the past, individuals who did not initially recall experiencing rooms similar to the design of *The Crack Room*, and the notion that others who may struggle with addiction should be offered the opportunity to
receive therapy in *The Crack Room*. These factors seem to indicate that *The Crack Room* is, in fact, a viable intervention.
References


development: School development: Based countermeasures. *Journal of Children & Poverty, 8*(1), 5-44.


APPENDIX A
Protocol Questions

The following semi-structured questions represent the types of question that was posted to the informants. These questions were designed to be open ended in order to allow for additional probes, depending upon the specific information that each volunteer provided.

1. Tell me about your experiences in The Crack Room.

2. Did The Crack Room represent an accurate representation of triggers common in AOD abuse and addiction?
   How?

3. What were some of the keys factors in this experience?

4. Has anything changed for you since your participation in The Crack Room?

5. What strategies have you developed to maintain sobriety? Have they changed since participating in The Crack Room?

6. How do you manage triggers on a daily basis?

7. Has The Crack Room helped you to combat desires to use AOD?
   If yes, how? If not, why?

8. Please share with me the top three factors that were important to you during your experience in The Crack Room.

9. Please share with me anything that you feel is important about your experience in The Crack Room.

10. Please discuss anything you would like to add.
RESEARCHER OBSERVATIONS

Participant number: _____

Date: _____  Session length: _____

Observation:
APPENDIX C
CONSENT TO PARTICIPATE IN A RESEARCH STUDY

TITLE: The Crack Room: A Study of the Lived Experience of Individuals, and Their Response to Drug-related Stimuli, and Therapeutic Simulation

INVESTIGATORS: Hallie Smith Carlton, M.Ed., CAC, LPC, ICADC Director, Two Roads Counseling Services
100 Foundry Street
Punxsutawney, PA 15767
814-938-6473

Professor Lisa Lopez Levers, Ph.D., PCC-S, LPC, CRC, NCC Rev. Francis Philben, C. S. Sp. Endowed Chair in African Studies Professor of Counselor Education & Supervision
School of Education/Department of Counseling, Psychology, & Special Education
Duquesne University
600 Forbes Avenue
209-A Canin Hall
Pittsburgh, PA 15282
412-396-6009

SOURCE OF SUPPORT:

This study is being performed as a partial fulfillment of the requirements for the degree of Doctor of Philosophy, Department of Counseling, Psychology, and Special Education, at Duquesne University.
PURPOSE AND BACKGROUND:

You are being asked to participate in a research project that seeks to understand the experiences of individuals who previously have received therapeutic simulation in *The Crack Room*. You will be asked to participate in a 1-hour interview discussing previous experiences in this room. Reactions and comments will be observed and documented for this study. Methods of collecting information will include an interview and researcher observations of your responses.

Participation in this study is completely voluntary and will not include individuals who were mandated into treatment, those who are on county probation or state parole, or individuals who have been on our therapeutic caseload. Individuals who received therapy in *The Crack Room* less than 1 year prior to the beginning of this study will not be included. In addition, volunteers will not have been on Hallie's therapeutic caseload at any time in the past or present, nor will they be on our therapeutic caseload in the future. You are free to cease participation in this study at any time, and for any reason.

PROCEDURES

By agreeing to voluntarily participate in this research, the following will occur:

1. You will be asked to participate in an individual interview that will last for approximately hour, to discuss your previous experience in *The Crack Room*.
2. Throughout this study your reactions and responses will be observed by the researchers. Notes regarding the interview will be made, and will be used solely for research.
3. You are free to review all materials. You may do this by contacting the researchers.
4. You will have the opportunity to review a copy of the interview transcript, in a private setting. You will be able to check the transcript for accuracy, and you will have an opportunity to clarify or add information at this time.
5. You must be free from AOD for 1 year.
6. You may cease participation at any time.

RISKS AND BENEFITS:

Please note that participation is voluntary and that your name and identity will not be released to other individuals or agencies. In addition, your name and identity will not appear on written materials. You also will be given a private code number to ensure anonymity. No identifying information will be exposed in the data, and you will have the opportunity to investigate your transcript to ensure that all information is free of identifying factors. Should you choose to review the contents of your study-related documents, you only will need to contact the researchers and schedule a time and date to review information that is pertinent to your participation. Due to the sensitivity of this study, any decision to decline or end participation will be accepted without question. Please note that data collected for this study only will be used for research, and any identifying information will be deleted from all written materials. Research information
will be stored in a locked file cabinet and will be destroyed 6 years after completion of this exploration. Audio tapes will be destroyed immediately upon completion of the transcription process. The investigators will be the only individuals with access to the file cabinet, research files, correspondences, written materials, and audiotapes.

An indirect benefit of participation in this study is that you will be assisting the researchers in understanding your experiences in *The Crack Room*. You also will be able to express your ideas and the coping techniques you may use when combating drug-related cues. By helping the researchers understand emotional responses to drug-specific triggers, you will be playing an important role in better understanding the needs of individuals in recovery who may feel anxious when faced with physical cues.

While participating in this research you will be asked to recall potentially painful memories of your experiences in *The Crack Room*. If you become uncomfortable, you may end the interview at any time, simply by telling the researchers to stop. If you have a negative emotional experience during the interview, or after, the researchers are prepared to refer you for immediate counseling, by a third party, with whom tentative arrangements have been made prior to the research.

**COMPENSATION:**

There will be no compensation for participation in this study. Participation, however, will not cost you anything.

**CONFIDENTIALITY:**

Your name will not appear on documents, forms, or research materials. However, your signature must be present on several documents required by the Duquesne University IRB. Forms or documents containing your signature will be stored separately from other research materials. The researchers will be the only individuals with access to the research materials. You will not be seen by, or required to speak with other individuals who have volunteered for this study.

Audio-taped, written materials and consent forms will be locked in a file cabinet. Immediately upon completion of the transcription process, the researchers will pull the tape from its housing and demolish the plastic casings. All loose tape will be shredded. Likewise, after a period of 6 years, remaining forms, documents, and research notes will be removed from the locked file cabinet and will be shredded. The researchers are the only individuals who will have access to this file cabinet, and will be the only individuals with the key to the cabinet.

During the transcription process, only the researchers will listen to tapes in order to identify important information and key words or phrases. The researchers will listen to tapes only under conditions that ensure complete privacy and in which there is no possibility that anyone else can hear the tapes.

Interviews will be held at the researcher's private office. You will be given a choice of when you would like the interview to occur. All precautions will be taken to protect your confidentiality.
RIGHT TO WITHDRAW:

Participation in this research is completely voluntary. You are under no obligation and may "withdraw" your consent to participate at any time. Should you choose to end participation in this study any information already collected immediately will be destroyed. To withdraw from this study, you may contact the researchers by confidential e-mail, through the researcher's confidential cellular phones.

SUMMARY OF RESULTS:

Upon your request, a summary of the results of this study will be provided to you at no cost.

VOLUNTARY CONSENT:

I have read and understand the statements above. I also understand the requirements of this study and realize that I am free to withdraw at any time and for any reason. I certify that I am willing to participate in this research.

I also understand that should I have questions or concerns, I may contact Hallie Smith Carlton, Co-investigator, at 814-952-8446, by confidential e-mail at carltonha@duq.edu or Lisa Lopez Levers, Principal Investigator, at 412-396-1871 or at levers@duq.edu or Dr. Joe Kush, Chair of the Duquesne University Review Board, at 412-396-6326 or at kushj@duq.edu.

I have read the above information and have declined/accepted a copy of this form (circle one).

Participant signature                                       Date

Researcher signature                                       Date
Hallie Smith Carlton
Two Roads Counseling Services

Lisa Lopez Levers
Professor, Counselor Education & Supervision
CONSENT TO USE INFORMATION IN A STUDY

We are conducting a study that examines the experiences of individuals who previously have received therapeutic simulation in *The Crack Room*.

Your thoughts, memories, feelings, and perceptions will be of specific interest. You will be given a numeric code, and all identifying information will remain confidential in my written and taped materials. In addition, we will be the only individuals with access to this information.

By signing this form, you are agreeing to allow us to use all of the information to complete this investigation. We specifically request your consent for the following:

1. Consent to Audio-tape Interviews
2. Consent to Observe
3. Consent to Transcribe Interviews and Observation Notes
4. Consent to Use Transcriptions in a Written Product

Yes, you may use the above information that is listed in bold type.

No, you may not use the above information that is listed in bold type.

I have read the above statements and have declined/accepted a copy of this form (please circle one).

Participant signature: __________________________ Date: __________

Researcher signature __________________________ Date: __________
Hallie Smith Carlton
Director, Two Roads Counseling Services

Researcher signature __________________________ Date: __________
Lisa Lopez Levers
Professor, Counselor Education & Supervision

Duquesne University
IRB - Protocol 12-142
Approval Date: October 2012
Expiration Date: October 2013
APPENDIX E
RECRUITMENT LETTER/STUDY DESCRIPTION

Dear Potential Participant,

We are writing to tell you about a research study being conducted by Dr. Lisa Lopez Levers, and Hallie Smith Carlton. We are inviting individuals who previously received therapy in The Crack Room at Two Roads Counseling, who have remained AOD free for at least 1 year, who are over the age of twenty-one, who are not currently in probation or parole, who were not in Hallie’s client caseload or had any ancillary contact with her, and who did not receive therapy in The Crack Room less than 1 year prior to this study, to join in this research.

We are studying the experience of individuals who previously have received therapy in The Crack Room. The focus of this study is to understand your current and previous thoughts, feelings, perceptions, and recollections regarding this intervention. The types of questions that we will ask include requesting information about your experience of the intervention, maintaining sobriety, and managing triggers.

This is a completely voluntary investigation which will require you to participate in a 1-hour interview with the researchers. Observations of your responses, feelings, and perceptions will be used to understand your experience of The Crack Room. You will not be asked to do anything disrelated to this study. You may choose not to participate, or to cease participation at any time. It must be noted that if you attend the interview while under the influence of a mind-altering substance, or if you have not been AOD free for one year, you will be asked to withdraw from the study, and another respondent will be contacted for participation.

There are no personal benefits for your participation in this study. However, this investigation will help us to better understand your experience and the possible benefits of participation in The Crack Room. Even though we are asking you to recall potentially painful memories of your experience in The Crack Room that could be stressful, as a voluntary participant in this study, you will be able to end the study at any time.

If you would like to learn more about this study, please contact Hallie at her confidential cellular phone at 812-396-1871, or at levers@dshs.edu. Participation is voluntary. Thank you.

Sincerely,

Hallie Smith Carlton, L.Ed.
Director, Two Roads Counseling Service

Lisa Lopez Levers, PhD., PCC-S, LPC, CRC, NCC
Professor, Counselor Education & Supervision
Rev. Francis Philben, D. S. Sp. Endowed Chair in African Studies
APPENDIX F
Thank You Letter to Potential Participants

Dear Respondents,

Thank you for your willingness to volunteer for this research that will investigate the experiences of individuals who previously have received therapeutic simulation in *The Crack Room*. However, through the selection process, you have not been chosen for participation. If you have any questions about this selection process, please feel free to contact Hallie at her confidential cellular phone at 814-552-8446, through confidential e-mail at carltosh@duq.edu; or contact Dr. Lisa Lopez Leves, Principal Investigator, at 412-396-1871, or at levrs@duq.edu. Once again, thank you for your willingness to volunteer for this study.

Sincerely,

Hallie Smith Cadton, M.Ed.
Director, Two Roads Counseling Services

Lisa Lopez Leves, Ph.D., PCC-S, LPC, CRC, NCC
Professor, Counselor Education & Supervision
Rev. Francis Philton, C. S. Sp. Endowed Chair in African Studies