# Development of a positive psychology intervention to improve intrinsic motivation for the treatment of substance use disorders

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Mini-dissertation accepted in fulfilment of the requirements for the degree *Masters of Arts in Positive Psychology* at the North-West University

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Graduation: August 2021

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## ACKNOWLEDGEMENTS

I would like to express my deepest gratitude to:

God, for answering many, many spoken and unspoken dissertation-related prayers.

My supervisor, Dr Laura Weiss. Your patience and perseverance are virtues that I deeply appreciate. Thank you for allowing me the freedom to explore my seemingly impossible ideas and guiding me towards the end product. It was a privilege to work with you, and I cannot thank you enough for taking on this particularly challenging research project with me.

My co-supervisor, Prof Marita Heyns. Thank you for always making the time, under very difficult circumstances, to share your experience and knowledge with us. It was invaluable and assisted me in believing that I can make a difference in the lives of people with substance use disorders.

To my beloved Paul Minnaar, thank you for your love, patience, and support. Thank you for assisting me in understanding the life cycle of a sunflower plant to incorporate into my intervention. Your understanding of the long hours I have had to devote to this project is admirable. You have always believed in me, and I am grateful to have you in my life.

My children, Babette and Paul Minnaar. Thank you for being attentive listeners whenever I needed some sympathy, for trying your best to keep the house clean, and for every cup of coffee.

My mom, Rita Carstens, who passed away during this research project. Thank you for your unconditional love and support throughout my life. You are my sunflower. Thank you for teaching me that *those who bring sunshine into the lives of others cannot keep it from themselves.*

A very big thank you to the people with substance use disorders and the experts that participated in the focus group discussions of this research project. It was an honour and privilege to be able to develop this intervention based on your needs.

## PERMISSION TO SUBMIT MINI-DISSERTATION FOR EXAMINATION PURPOSES

Mrs. Nanette Minnaar (11179015) elected to write a mini-dissertation in partial fulfilment of the degree of Masters of Arts in Positive Psychology. As her supervisor, I hereby grant permission for her to submit this mini-dissertation for examination purposes.

Dr L. A. Weiss

Supervisor

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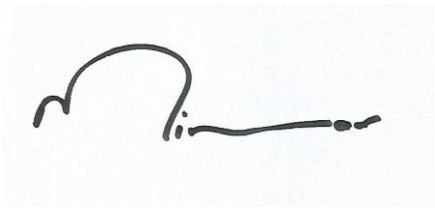
I, Nanette Minnaar, hereby declare that this mini-dissertation, titled *Development of a positive psychology intervention to improve intrinsic motivation for the treatment of substance use disorders*, is my own effort in cooperation with my supervisor, Dr Laura Weiss.

I also declare that all the literary sources used to inform this study have been referenced and acknowledged. This mini-dissertation was proofread and edited by a professional language editor and submitted to Turn-it-in to confirm that no plagiarism had been committed.



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**DECLARATION**

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# ABSTRACT

## Background

People with substance use disorders (SUD) often drop out of treatment. A lack of motivation is one of the most recurrent reasons for treatment dropout, including failure to abide by treatment, relapse, and other negative treatment outcomes. This study aimed to better understand what should be included in a positive psychology intervention (PPI) to increase intrinsic motivation to treat substance use disorders. The development was informed by the self-determination theory (SDT) with a specific focus on using the basic psychological needs as the core of the PPI.

## Methods

This was an exploratory, qualitative study consisting of two parts, before and after intervention development. The first part, developing the initial version of the positive psychology intervention, was informed by inputs from 70 participants from four focus groups. Of those, 37 were people with substance use disorders, and 33 were experts (also future implementers of the intervention) from two in-patient treatment centres in Gauteng, South Africa. The second part, namely the modification of the first draft of the PPI, was also informed by the inputs of these participants from another four focus groups. For the selection of the target group, a homogeneous sampling method was used. The experts were selected using an expert sampling method. Audio recordings of the focus groups discussed were transcribed verbatim by the researcher and an assistant to ensure that the transcriptions could be analysed in detail, linked to analytic notes, and coded. Once the data was captured, thematic analysis was used to examine the findings.

## Results

It was found that people receiving treatment for substance use disorders need support from others (family, staff, people in recovery, other people in treatment, higher power) to feel more *engaged*. They need to have a life purpose, participate in more structured activities and skills development and have more opportunities to become more *competent*. They also need to make their own good choices, feel in control of their own lives, and participate in their own treatment to develop *autonomy*. Furthermore, people with SUD and experts indicated that the first version of the PPI could inspire people to change and motivate people with SUD to continue their treatment. They found it relevant for the target group and appreciated the involvement of the target group in the development thereof. They also identified some suggested additions to include in the PPI to improve it.

## Discussion

The development of the PPI was thoroughly informed by theory (SDT) and research on SUD treatment in South Africa. Basing this PPI development on SDT was valuable in understanding the needs of people with SUD, subsequently enhancing their intrinsic motivation for treatment. The findings indicated that SDT is ideal to use in the development of an intervention for such a vulnerable group. The involvement of people with SUD and future implementers of the intervention in developing this PPI through a participatory approach provided a useful alternative to the conventional research-led approaches. While research-led approaches are inadequately matched to the needs of target users, this study specifically focused on the needs of target users. If participants are asked what would be good for their needs, they knew and expressed specific ideas on improvement. The feedback from people with SUD in active treatment and people working with them (experts) was substantial and led to the intervention's development being based on it, although in combination with the theory. The suggested additions to the first version

of the intervention by people with SUD reflected their accountability for their own recovery. They were included in the final intervention to improve it. Recommendations include that treatment centres consider allowing people with SUD to play a more active role during treatment and connect people with SUD with opportunities to enhance their need-fulfilment. It seems that the currently available treatment of people with SUD does insufficiently address the basic psychological needs and intrinsic motivation for people with SUD. This shows the need for the newly developed Sunflower PPI, which is likely to increase well-being and motivation because all three needs of people with SUD are addressed in concrete ways. Implementing this intervention in support of a current treatment programme may improve intrinsic motivation.

**Conclusion**

This study led to the development of a positive psychology intervention based on theory, namely the self-determination theory, and on the expertise of people with SUD and practitioners working with them. It is, therefore, a promising way to improve the much needed motivation to support the prevention of treatment dropout and the recovery from SUD.

*Keywords:* Substance use disorders, self-determination theory, intrinsic motivation, psychological need satisfaction, autonomy, competence, relatedness, positive psychology intervention

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# CHAPTER 1

# INTRODUCTION

## 1.1 Background

Motivation is considered a crucial factor in the treatment of substance use disorders (SUD). Motivation is assumed to affect treatment retention and behaviour change (Groshkova, 2010). A lack of motivation is one of the most recurrent reasons for treatment dropout, as well as failure to abide by treatment, relapse, and other negative treatment outcomes (Ryan et al., 1995). Higher treatment retention rates are more likely when people with SUD are very motivated, accept help from motivated staff, and are offered longer-term treatment in suitable settings (McKay & Hiller-Sturmhöfel, 2011).

Premature dropout while being treated for substance misuse is possibly the most significant and common problem faced by people with SUD, practitioners, and clinical researchers in the field of addiction. People not completing treatment are at high risk for poor outcomes (Ball et al., 2006). Palmer et al. (2009) found that some of the key reasons for early dropout, with a specific focus on the early therapeutic relationship, were low trust, engagement, and motivation. There is a vital need for the improvement and assessment of approaches to enable commitment to treatment, the prevention of treatment dropout, and the reinstatement of dropout from treatment (Broome et al., 2002).

The main objective of this study was to develop a positive psychology intervention (PPI) to increase motivation for the treatment of SUD through the intervention. A preliminary Nexis[1] database search indicated that no similar interventions exist, focusing on motivation for SUD treatment. It is, therefore, under-explored. This study is subsequently making both a theoretical

[1] Nexis Uni is a user-friendly academic search engine. It provides pertinent content that makes academic research more effective, and it provides personalisation, sighting, and co-operation features that students and universities want in an academic research tool (LexisNexis, n.d.).

and practical contribution to the existing knowledge base. The search also revealed that this study is the first South African sample of focus group discussions with people with SUD in active treatment, addressing one of the most serious challenges in this country's health sector, more specifically, treatment dropout (Lintz et al., 2019). According to Andersson and his team of researchers (Andersson et al., 2018), the role of mental health and intrinsic motivation should be further explored to establish their potential for reducing SUD treatment dropout. They also concluded that these factors could be pursued in future intervention studies (Andersson et al., 2018).

Furthermore, the database search indicated that it is the first time that inputs were obtained from two complementary perspectives – people with SUD and experts. A collaborative approach between multi-disciplinary teams, the target group, academics, and policymakers are needed in the development of interventions (Wight et al., 2016). Wight and colleagues (2016) also state that such a collaborative approach improves the applicability to the target group's identified needs, thus enhancing the intervention's effectiveness.

From a South African perspective, it is evident that the need to develop a PPI focused on motivation for treatment of SUD is crucial, especially if it may enhance treatment retention and consequently prevent dropout.

This report consists of three parts, including the introduction, problem statement and objectives (Chapter 1), an article about the findings (Chapter 2), and the discussion, conclusions, and recommendations (Chapter 3). Each chapter is followed by a reference list. The appendices of each chapter are collated after Chapter 3. This chapter will explore the challenges faced with SUD treatment dropout undercutting treatment effectiveness in South Africa. Clarification of the self-determination theory (SDT), basic psychological needs, and intrinsic motivation in SUD treatment follow. The research objectives and design utilised in conducting the study will also be presented, and the chapter will conclude with an outline of the operationalisation of the study.

## 1.2 Problem Statement

### 1.2.1 Challenges in substance misuse treatment in South Africa

Substance misuse is a universal occurrence distressing millions of people worldwide (United Nations Office on Drugs and Crime [UNODC], 2018). About 275 million people across the world, approximately 5.6% of the global population aged 15-64, used drugs at least once during 2016 (UNODC, 2018). About 31 million people who use drugs suffer from drug use disorders; thus, their drug use is harmful as they may need treatment (UNODC, 2018). Substance misuse has multifaceted challenges around socio-economic issues, health, and crime and has a profoundly negative impact on the social functioning of individuals, families, and communities (Ederies, 2017).

In South Africa, substance misuse is costly. Substance misuse in South Africa is 6.4% of the Global Domestic Product (GDP), costing South Africa almost R 136 380 million each year (Department of Social Development [DSD], 2013).

In South Africa, the segregation of cultural groups and dealing with drugs in previously deprived communities were feebly controlled during the past apartheid regime (Peltzer et al., 2010). Economic and social factors that exacerbate the challenges of substance misuse in these previously deprived communities include high unemployment, gang-related activity, crime, and inadequate access to services (Elderies, 2017). There is, therefore, a vital need for interventions to address substance misuse in South Africa. SUD treatment could be seen as an intervention to decrease the destruction linked with substance misuse (Ederies, 2017).

In South Africa, treatment of SUD demand far exceeds supply (Meyers et al., 2008). Some provinces do not have reasonably priced state-sponsored treatment facilities, and although some private centres provide high-quality care, these are unaffordable by the majority (Pasche & Myers, 2012). Help-seeking is often delayed until substance misuse is critical, resulting in the

types of services that are easily accessible, not being suitable for the severity of the problem (Myers et al., 2010).

When treatment is accessed, early dropout continues to be the central problem undermining the value of treatment. According to Ball and colleagues (2006), first-month dropout rates are generally at least 50% in out-patient and community-based treatment programmes. Ball et al. (2006) assessed the reasons for dropout from treatment from the person with a SUD's perspective. The reasons for dropout were loss of motivation and expectations for change, including relational challenges with treatment staff (Ball et al., 2006). These reasons were also echoed in findings that the lack of coping skills, interpersonal skills and minimal motivation are associated with high-level early dropout rates from SUD treatment (Anderson & Berg, 2001; Broome et al., 2002; Dobkin et al., 2002).

Therefore, one of the recurring themes in the treatment of SUD dropout is lack of motivation. If this lack of treatment motivation could be addressed by developing a PPI supporting an existing treatment programme, it may address this critical gap of client dropout. In return, this may positively impact the financial challenges experienced by both the government and private clinics due to non-completion of treatment and eventually the cost of substance misuse in South Africa because of the possible positive impact on the treatment of SUD retention.

## 1.3 Literature Review

### 1.3.1 The self-determination theory

Self-determination theory (SDT) is a theory that links motivation, personality, and best possible functioning. SDT places its prominence on people's inherent motivational inclinations for learning and growing and how they can be supported (Ryan & Deci, 2020). It hypothesises

that there are two types of motivation – extrinsic and intrinsic, both dominant forces in shaping who we are and how we behave (Deci & Ryan, 2008).

Intrinsic motivation relates to activities done "for their own sake" or for their innate interest and enjoyment (Deci & Ryan, 2000). Play, adventure, and curiosity-spawned activities typify intrinsically motivated behaviours because they are not dependent on external inducements or pressure but rather provide their own satisfactions and delights. Although "fun," such inherent tendencies toward interesting engagement and control are likely responsible for most human learning across a life span, as opposed to externally instructed learning and instruction (Ryan & Deci, 2017). According to Ryan and Deci (2020), external regulation concerns behaviours driven by externally enforced rewards and penalties and is a form of motivation normally experienced as regulated and non-autonomous.

As many of the interventions in SUD treatment are not inherently exciting or pleasant, knowing how to promote more active and purposeful forms of motivation is important for successful treatment of SUD. Within SDT, the Orgasmic Integration Theory (OIT) describes the various types of external motivation and the correlated factors that encourage or impede internalisation and integration of the management of these behaviours (Deci & Ryan, 1985).

**Figure 1**

*A taxonomy of human motivation (Ryan & Deci, 2000)*

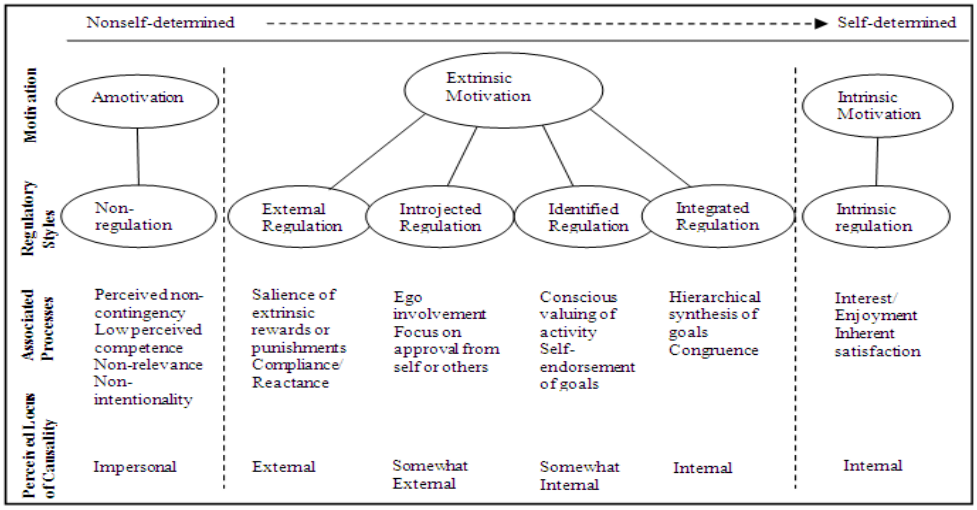

Figure 1 illustrates the OIT taxonomy of kinds of motivations, organised from left to right in terms of the extent to which the motivation for one's behaviour originates from one's self. Far left is *amotivation*, which is the state of lacking an intention to act. When amotivated, a person's behaviour is short of intentionality and a sense of personal causation (Ryan & Deci, 2000).

To the right of amotivation on the OIT taxonomy is an *external motivation*; it represents the least autonomous forms of extrinsic motivation. Externally motivated behaviours are performed to satisfy an external demand or imposed reward contingency (Ryan & Deci, 2000).

Another extrinsic motivation is *introjected regulation.* This form of motivation is still controlling because people carry out such actions with the feeling of pressure to avoid guilt or apprehension or to attain ego-enhancement or pride (Ryan & Deci, 2000). Within the treatment of SUD, people with SUD may be introjectedly motivated on entry to treatment because of social pressures by family and friends.

Following this, is *identification,* which is a more self-directed or independent form of extrinsic motivation. The person has recognised the individual significance of an action and acknowledged its management as their own (Ryan & Deci, 2000). In the treatment of SUD, this may happen during the first three weeks of treatment when people with SUD develop an understanding of their addiction and the devastating effects it had on them.

Finally, *integrated regulation* is the most independent form of extrinsic motivation. Integration occurs when recognised regulations have been completely incorporated by the self. It takes place through introspection and comparing new regulations with the person's other morals and desires (Ryan & Deci, 2000). Upon termination of treatment and during aftercare, people with SUD may be integratedly motivated. Their values and needs are altered away from substance misuse to living a life of sobriety.

At the far-right is intrinsic motivation. It is placed here to highlight that intrinsic motivation is a prototype of a self-determined activity (Ryan & Deci, 2000). However, this does not mean that

as extrinsic principles are adopted, they are converted into intrinsic motivation (Ryan & Deci, 2000). A person does not have to move through each stage of internalisation for a specific regulation. A person can adopt a new behaviour regulation at any point along this continuum upon previous experiences and situational factors (Ryan, 1995). People with SUD may enter treatment while being intrinsically motivated because of a personal decision to get help. They may, however, also become intrinsically motivated during their treatment as a result of the development of a personal need to change (Urbanoski, 2010)

The SDT (Deci & Ryan, 1985) has been used in many areas, such as weight loss, medication adherence, test-taking behaviour, and school-going children. In recent years there has been a significant increase in the number of intervention studies that aim to promote well-being-conducive behaviours (e.g., healthy eating, increased physical activity, abstaining from tobacco use) or boost health treatments (e.g., diabetes self-management, medication adherence) (Ntoumanis et al., 2020). According to Ntoumanis et al. (2020), such intervention studies are necessary, given the trouble people have in starting and maintaining healthy behaviours over time and the startling global statistics on the origins of ill-health. However, the application of the SDT, specifically to substance abuse, has been limited (Ryan et al., 1995; Zeldman et al., 2004). The SDT suggests that persons with higher internal motivation should have better treatment results and that high external motivation in the absence of internal motivation is linked with less positive results (Kennedy & Gregoire, 2009). According to Zeldman et al. (2004), people in a methadone maintenance programme with higher levels of internal motivation had lower relapse rates and higher programme participation than externally motivated clients. Ryan et al. (1995) found a negative correlation with treatment dropout linked to higher internal motivation. Through their research, they noticed that treatment retention was more likely when a person with a SUD had an elevated internal and elevated external motivation (Ryan et al., 1995)—according to Ryan and colleagues (1995), external motivation optimistically compared to results only in the

presence of internal motivation. This therefore means that there would be great potential value in developing of an intervention aimed at increasing internal motivation among those in treatment for substance use disorders.

### 1.3.2 Motivation and positive psychology interventions

The term ‘motivation’ has been part and parcel of the psychology glossary since 1985 through the work of researchers Edward L. Deci and Richard M. Ryan, including the emergence of positive psychology in 2000. It has, however, only recently become a crucial part of the idiom of researchers and professionals in the substance misuse field (O’Leary Tevyaw & Monti, 2004). Motivation is the probability that a person will enrol for and remain in, treatment, as well as keep to a particular transformation strategy (Cahill et al., 2003; Miller & Rollnick, 1991).

In a proof-of-concept trial using a combination of a positive psychology intervention (PPI) and motivational interviewing (MI) for patients with type two diabetes, Celano et al. (2018) found that the intervention may have promise and was linked with increases in well-being, general diabetes self-help, and some health outcomes. They also found that from a health perspective, the pilot study may be of significant value, if included in larger measured studies (Celano et al., 2018). These conclusions support earlier studies of PPI in other health domains that found such PPI to be sound and sometimes improving well-being (Huffman et al., 2011; Ogedegbe et al., 2012; Peterson et al., 2012). In research conducted by Sheeran and a team of researchers (Sheeran et al., 2020) on the effectiveness of health behaviour interventions based on the SDT, they found that the interventions had a significant but small effect on behaviour change.

According to Miller (2000), motivational improvement interventions have struck a chord in the field of addiction because they have the largest effect sizes among all treatments for adult alcohol abuse and dependence (Miller, 2000). Motivational improvement interventions are

adapted typically to the needs and issues of the targeted individual, which might amplify the intervention's appeal. Some studies have utilised motivational improvement following alcohol-related negative events (Monti et al., 2001). Facilitating a motivational intervention following an undesirable incident may enhance the prominence of the incident and the need to not partake in such an incident in the future (Barnett et al., 2002).

People are often motivated by external factors such as their family's opinions or a court procedure to enter treatment for SUD. They are, however, also motivated from within by their values, interests, and curiosity. These intrinsic motivations are not automatically externally reinforced, but they can maintain enthusiasm, creativity, and sustained efforts. The interaction between the extrinsic influences working on individuals and the intrinsic intentions and needs inherent in human nature is the domain of SDT (Ryan & Deci, 2017).

### 1.3.3 Basic Psychological Needs

At the heart of the SDT is the assumption that people have three innate psychological needs: the needs to autonomy, competence, and relatedness (Deci & Vansteenkiste, 2004, Ryan & Deci, 2017). Within SDT, needs are defined as general necessities; they form the nutriments required for pro-activity, best possible development, and psychological health of all people (Deci & Vansteenkiste, 2004). These needs are an inherent aspect of human nature and not learned; they act across culture, gender, and time (Chirkov et al., 2003) to support optimal functioning and prevent weakened functioning (Deci & Vansteenkiste, 2004). If these needs are thwarted, one would expect to find passivity, ill-being, disintegration, and unstable functioning (Deci & Vansteenkiste, 2004).

These basic psychological needs need to be fulfilled to experience ongoing growth and well-being: (1) *autonomy* refers to the need to be the manager of one's own life and make your own choices; (2) *competence* is the need to feel self-assured, capable and valuable in one's actions; (3) the need to *relatedness* encompasses the feeling of being understood and connected to others,

and of encountering a sense of belongingness in caring relationships (Ryan & Deci, 2000). According to Miller and Gramzow (2016), the extent to which people implement these three basic psychological needs significantly affect their well-being. Individuals with high levels of autonomy, competency, and relatedness are inclined to experience more optimistic mental and physical health outcomes (Deci & Vansteenkiste, 2004; Ng et al., 2012; Reiss et al., 2000; Sheldon et al., 2004). According to Ryan and Deci (2000), need fulfilment is conducive towards health and well-being, while need thwarting circumstances play a role in pathology and ill-being.

### 1.3.4 Basic Needs and Intrinsic Motivation

The notion of intrinsic motivation surfaced from the work of Harlow and White in opposition to the behavioural theories that were central at the time, as quoted by Deci and Vansteenkiste (2004). Intrinsically motivated activities were defined as those not energised by physiological forces or the results thereof and for which the incentive is the natural satisfaction associated with the activity itself rather than with effective distinguishable consequences (Deci & Vansteenkiste, 2004). White (1959) suggested that a need for competence inspires intrinsic motivation, that people engage in many activities to experience a sense of effectance and happiness (as cited in Deci & Vansteenkiste, 2004). According to Kowal and Fortier (1999), autonomy is an important forecaster of flow, an example of intrinsic motivation. There is also some evidence (Frodi et al., 1985) that the need for relatedness influences intrinsic motivation. However, it is less vital for supporting intrinsic motivation than the needs for autonomy and competence. Finally, when the environment allows need satisfaction, an individual is more likely to engage in behaviour that is intrinsically motivated. Thus, if the environment fosters these three needs, an individual's behaviour can be expected to be self-motivated (Flannery, 2017).

From the discussion thus far, it seems as though there is a direct correlation between the three basic psychological needs and intrinsic motivation. If one would develop a PPI to assist people

with SUD in satisfying all three of their basic psychological needs, it may stimulate their intrinsic motivation and enhance their motivation for treatment.

## 1.4 Research Questions

### 1.4.1 General Research Question

The general research question in this study was: What should be included in a positive psychology intervention to increase intrinsic motivation for the treatment of substance use disorders, based on the needs and feedback of people with SUD and experts of South African in-patient treatment centres?

### 1.4.2 Specific Research Questions

The specific research questions, according to people with SUD and experts were:

a) What do people with SUD in treatment need to improve psychological need satisfaction?
b) How can people with SUD feel more autonomous, competent, and related during and after substance use disorder treatment?
c) How can the first draft of an intervention be improved with the feedback from people with SUD and experts?

## 1.5. Research Objectives

### 1.5.1 The main research objective

The main objective was the development of a positive psychology intervention to increase intrinsic motivation for treating substance use disorders, based on the needs and feedback of people with SUD and experts of South African in-patient treatment centres.

### 1.5.2 The specific research objectives

The specific objectives from people with SUD and expert perspectives were to:

a) Explore and describe the needs of people with SUD to improve psychological need satisfaction.
b) Explore and describe how people with SUD can feel more autonomous, competent, and related during and after their substance use disorder treatment.
c) Explore and describe the feedback from people with SUD and experts on the first draft of an intervention.

## 1.6 Research Design

### 1.6.1 Qualitative Methods and Intervention Development

This study made use of an exploratory qualitative research design. Exploratory research is performed to clarify the extent of the problem; it is not intended to offer irrefutable proof but contribute to a better understanding of the dilemma (Saunders et al., 2012). Within intervention development, researchers may select qualitative methods to comprehend how individuals or groups experience a motivational development to which they (the people the intervention was developed for) interpret and ascribe meaning to (Pope et al., 2000). It may also help researchers increase their understanding of participants' perceptions about the benefits and restrictions of receiving an intervention (Monaghan et al., 2011). A qualitative research design was chosen for this study as it offered the possibility to enhance the researcher's understanding of the needs of the target group as well as the implementer's understanding of SUD treatment programmes for this new intervention.

This research design was also informed by what McBride (2016) refers to as the *Intervention Research Framework*. This framework is a scientific guide to developing and assessing inventive

and science-based interventions (McBride, 2016). It includes the following four phases: *notification, development, assessment,* and *dissemination*. This study focused on the first two phases, namely *notification* and *development*.

The *notification* of a research issue is informed by epidemiological and aetiological research to detect concerning or significant problems, to explain a distinct research focus (McBride, 2016). Within this research study, the critical gap of treatment dropout has been identified through a literature study of SUD treatment in South Africa.

The *development phase* encompasses developmental intervention research in this study. These developmental methods confirm that an intervention is informed by numerous types of essential feedback (McBride, 2016). This feedback includes preceding studies in the field that has resulted in behavioural change, perceptions from experts, development in collaboration with the key target groups and setting implementers of the intervention (McBride, 2016). It also incorporates regulation from theories and models (self-determination theory) and is pre-tested in the setting before continuing to the assessment phase (McBride, 2016).

Focus group discussions with people with SUD and experts (multi-disciplinary staff) from two in-patient clinics informed the development phase. This ensured that critical inputs from experts in the treatment of SUD informed the development of the PPI; the development of the PPI was also done in conjunction with the key target group (people in treatment for SUD) and the future implementers of the intervention. Furthermore, the development was regulated by the SDT with a specific focus on using the basic psychological needs as the core of the PPI to enhance intrinsic motivation for treatment of SUD.

Focus group discussions were used to gather preliminary data to inform the development of a PPI (Cherry, 2018). A focus group is a group discussion on a specific topic organised for research purposes. This discussion is channelled, monitored, and recorded by a researcher (Kitzinger, 1994; Morgan, 1998). Focus group discussions are used to generate information on

collective views and the meanings behind those views. They are useful in producing a rich understanding of participants' experiences and viewpoints (Morgan, 1998) and were thus ideal to use in this study.

### 1.7 Research Setting and Context

The South African Community Epidemiology Network of Drug Abuse (SACENDU) (2017) provided the following statistics with regards to treatment admissions in 2017: a total of 3870 patients were treated at Gauteng treatment centres during the first half of 2017, compared to 2884 patients during July to December 2010 (SACENDU, 2017). Since there is an increase in drug misuse concerning those entering treatment in the Gauteng Province, the study consequently focused on Gauteng treatment centres. This trend is typical for other treatment centres in South Africa (SACENDU, 2018), making Gauteng an expedient location for this study.

Two in-patient treatment centres in Gauteng participated in the research: The South African National Council on Alcoholism and Drug Dependence (SANCA) Nishtara in Lenasia (township south of Soweto) and SANCA Pretoria in Akasia. All the SANCA clinics are non-government organisations (NGOs) and partially subsidised by the government. People with SUD attending these clinics will either be subsidised by the government or pay for their treatment themselves. Both clinics already have existing treatment programmes focused on cognitive behavioural therapy (CBT). Within substance misuse treatment, CBT methods are centered on the social learning concepts and the values of operant conditioning (Caroll et al., 2004). According to Carroll and Onken (2005), the trademarks of the CBT approach are an operational assessment of the SUD behaviour and training in effective coping skills. These skills assist a person with a SUD in avoiding high-risk situations for substance use or the employment of improved coping skills when such situations cannot be prevented (Carroll & Onken, 2005). In a group format (as it

is used in the participating clinics), CBT may be a source of communal support in recovery from addiction through acceptance and normalisation (Dingle et al., 2009). The PPI that was developed as part of this study will support the existing treatment programmes. SANCA Nishtara and SANCA Pretoria have been selected to participate in the focus group discussions because both clinics have multi-disciplinary teams. Also, they treat the key population on an in-patient treatment basis. Although there are other treatment centres in Gauteng, they do not meet the three criteria needed to partake in the study, namely working within a multi-disciplinary team, admit the key population and have an existing CBT-focused treatment programme.

According to SACENDU (2017), the mean age for persons seen by treatment centres in 2017 was 25 to 33 years and has remained stable since then. According to Brown et al. (2008), late adolescence (aged 16 to 20 years) is a stage characterised by an increase of drinking and alcohol use problems for many and the beginning of an alcohol disorder for some. Brown and colleagues also state that this heightened period of vulnerability is a joint consequence of the continuity of risk from earlier developmental stages and the unique neurological, cognitive, and social changes that occur in late adolescence (Brown et al., 2008). Seligman and Rider (2006) define young adults as an individual aged between 20 and 39 years. This study's key target group was young adults aged 20 to 39 years, to include all the developmental phases of young adulthood and address the mean age for persons in treatment centres in South Africa.

### 1.7.1 Sampling

For selecting the target group, purposive sampling was used, more specifically, a homogeneous sampling method (Etikan et al., 2016). Homogeneous sampling is used because the researcher needs particular participants who have expert knowledge in the field of SUD to gain insight into their experiences about motivation for treatment. Homogeneous sampling is used when the study's objective is to comprehend and explain a distinct group in detail (Cohen & Crabtree,

2006), in this case, people between the ages of 20 and 39 years with a substance use disorder enrolled for in-patient treatment. The researcher first contacted the directors of the clinics (they acted as gatekeepers), who identified a staff member (mediator) in each clinic who informed people with SUD about the study. The mediator then informed the researcher of potential participants. Thereafter, the researcher identified an independent person with no relationship with the participants and no investment in the research project to obtain informed consent from the participants.

An expert sampling method was used, a type of purposive sampling, for selecting the expert group. Expert sampling employs professionals in a distinct field to be the participants of the goal-directed sampling (Etikan et al., 2016). The expert group needed to represent the normal multidisciplinary team members consisting of social workers (programme implementers), healthcare workers (they have daily interactions with people with SUD), religious workers and care workers (implementers of the programme). This assured a variability of inputs, thus enhancing the research trustworthiness.

The researcher aimed to disrupt the normal treatment programme when facilitating the focus group discussions as little as possible. The focus groups were conducted at a place and time most convenient to the participants and did not interfere with the participants' usual activities.

### 1.8 Participants

People with substance use disorders in active treatment participated in the current study, as the intended PPI was specifically aimed to motivate them and keep them motivated during their substance use disorder treatment in order to address the critical gap of treatment dropout. The literature study confirmed that if the motivation for treatment of substance use disorders can be enhanced, it may improve retention and prevent dropout (Ryan et al., 1995).

According to Kennedy and Gregoire's (2009) study on the relationship between the self-determination theory and the trans-theoretical model of change, the source of motivation can predict the trans-theoretical model of change's stage of change. The trans-theoretical model of change has been adapted to behaviours such as substance misuse and consists of four interrelated dimensions of change that include stages of change. These stages include pre-contemplation, contemplation, action, and maintenance stages. Kennedy and Gregoire (2009) found that an approach to change focused on internal motivation (this research study's focus) is a requirement for advancing toward dealing with addiction.

People with substance use disorders enrolling for treatment are in the action stage of the trans-theoretical model of change's stages (behaviour change). Their inputs were, therefore, the most valuable needed for the development of the PPI. People who completed their treatment are in the final maintenance stage (after-behaviour change); they are taking steps to avoid relapse and consolidate their new lifestyle. Their inputs were not as valuable as those receiving active treatment.

Participants that were included in this study consisted of two groups. Firstly, the SUD group came from two clinics in Gauteng, namely SANCA Nishtara and SANCA Pretoria. The following criteria were used for inclusion: Participants older than 19 and younger than 40 were included, from different cultural groups (for validation purposes), misusing either illicit/licit drugs and/or alcohol (the treatment centres do not separate people with SUD according to the substances they misuse and are receiving treatment for; therefore, people misusing illicit/licit drugs and/or alcohol were both included in the study). People with SUD should also have completed their detoxification period as they might have been influenced by the withdrawal symptoms they experienced due to the substances they misused. Finally, they should also not have experienced severe mental health disorders that might have created barriers when participating in group discussions.

During treatment, people with SUD are expected to start with group work sessions only after detoxification. Detoxification is a set of interventions targeted at managing severe intoxication and withdrawal. It represents a clearing of toxins from the body of the patient who is severely intoxicated and/or dependent on substances of abuse. Detoxification seeks to lessen the physical harm caused by substance abuse (Center for Substance Abuse Treatment, 2006). The treatment centre will refer a person struggling with severe mental health disorders for psychiatric treatment. People still busy with detoxification and experiencing severe mental health disorders will normally not participate in group work sessions and subsequently were not included in the focus group discussion.

The second group was experts working in the substance abuse treatment centres. The following criteria were used for inclusion: They needed to have specific experience (more than five years) working directly with people with SUD in in-patient treatment centres because the treatment of SUD is a specialised field, they had to form part of a multi-disciplinary team, and they had to be from different cultural groups.

The expert groups were the same group of people for both focus groups. However, the group for people with SUD differs because the first group of people with substance use disorders completed their treatment and were not in the clinic anymore when the second focus group was conducted. For people with SUD, the following exclusion criteria were used: Participants, 19 years and younger and older than 40; people with behaviour addictions such as gambling and gaming because this study specifically focused on substance use disorders; people in the detoxification period of their treatment because they might have experienced withdrawal symptoms; lastly, people suffering from severe co-occurring disorders (i.e., depression or anxiety). If they experience severe mental health disorders, it may have created barriers when participating in group discussions.

For the expert group, the following exclusion criteria were used: Participants not specialised in SUD in-patient treatment because the treatment of SUD is a specialised field; mediators assisting with the selection of experts were able to identify experts specialised in SUD in-patient treatment.

### 1.9 Data Gathering

The researcher compiled two interview schedules (see Appendix A and B) to ensure consistency when facilitating the focus groups with the experts and the key target group. Each of the interview schedules consisted of initial engagement, exploring and exit questions.

The first focus group, the interview schedule (see Appendix A) for experts and people with SUD, focused on what motivates people with SUD to attend treatment by examining: (a) what helps people with SUD to feel in control during the treatment, (b) what role significant others play in treatment, (c) what skills people with SUD need to stop misusing substances, (d) the issues related to non-completion and treatment dropout, and (e) finally, the requirements for SUD treatment maintenance. The second focus group interview schedule (see Appendix B) focused on experts and people with SUD's opinions regarding the design and layout of the PPI, the content and application for the target audience, additions they would like to suggest, and in what way it may have an impact on treatment motivation.

All people with SUD and experts participating in the research study completed an informed consent form before the research commenced. Within the informed consent, the research participants were informed about their rights, the purpose of the study, the research procedure, and the potential risks and benefits of participation. They were also informed that their participation is voluntary (Shahnazarian et al., 2013). Participants also permitted that the focus group sessions were recorded with an audio recorder.

People with SUD were also asked to provide demographic information, which their treatment centres provided. The demographic information can help others know more about the transferability of the results to other groups and settings. This added to the trustworthiness of the study. It was clearly explained that this information would be given voluntarily. It included birth date, race, gender, marital status, and primary substance of abuse.

Finally, the researcher also developed a guide used during the second focus group discussions when she gave an overview of the PPI and facilitated some teaser activities. The feedback from the second focus group was used to adapt the first version of the intervention to improve it. Afterwards, the audio recordings were uploaded to a password-protected computer and deleted from the audio recorder immediately after each focus group.

## 1.10 Procedure

### 1.10.1 Research Procedure

This research study comprised five phases: (1) first set of focus group discussions with people with SUD and experts (multi-disciplinary staff) to inform the development of positive psychology intervention; (2) capturing and interpretation of data (3) development of a positive psychology intervention; (4) development in collaboration with the key target group and experts: presentation of the developed PPI to the key target group and experts followed by the second set of focus group discussions and (5) adaptation of positive psychology intervention using collaborative development feedback.

### 1.10.2 Recruitment and Data Collection

*Phase 1: First set of focus group discussions with people with SUD and experts to inform the development of PPI.*

Ethical approval (NWU-0049-19-A1) was obtained from the North-West University Health Research Ethics Committee (NWU-HREC) (see Appendix C). Formal permission to conduct the two focus groups was provided by the directors (gatekeepers) of the clinics. Mediators (as selected by the directors of the clinics) conducted the selection of both the target and expert groups with the assistance of the multidisciplinary staff. This was based on the inclusion criteria. The participants were given one week to decide if they want to participate in the study. If interested, they privately contacted the mediator in each clinic to confirm their participation. The mediator finalised the participant recruitment and invited them to discuss the informed consent that was conducted by an independent person. The researcher trained an independent person to obtain informed consent. The independent person informed the participants about the research aim and objectives, as well as their rights. He/she also explained that the research study would be conducted under ethical practices. The participants received their informed consent document from the independent person (administrator at the clinic) and had time to read the form and ask questions. The independent person asked them to sign the consent form when they were ready. They were allowed to keep the part that included more information about the study. The independent person informed both groups of the time and venue for the focus group discussions and indicated who would form part of each focus group.

The four focus group discussions, two with the target group and two with experts, were conducted on four separate days and facilitated by the researcher at the two clinics. The focus group sessions took place in a private room in the clinics. Each session was approximately 90 minutes and audiotaped (with the participants' permission).

*Phase 2: Capturing and interpretation.*

The focus group audio-recording was transcribed verbatim and interpreted (see analysis). These critical inputs were incorporated into the intervention framework that informed the development of the PPI.

*Phase 3: Development of a positive psychology intervention.*

An intervention framework was created based on research in the field of SUD treatment, as well as basic psychological needs. The critical inputs received from the target and expert groups in relation to motivation for treatment were incorporated into the framework that informed the intervention development. The PPI consisted of seven distinct workshops themed: *1) play to your strengths, 2) my best possible self, 3) learn to be kind, 4A) an attitude of gratitude, 4B) gratitude visit, 5) hope and recovery, and 6) rise and shine.* Each of these seven workshops comprised a three-hour session facilitated in a way that will complement the already existing treatment programmes. The aim was to facilitate it over three consecutive weeks, twice per week, to ensure that it does not disrupt the already existing treatment programmes but rather complement it.

*Phase 4: Development in collaboration with the key target group and experts, presenting the developed PPI to the key target groups and experts, followed by the second set of focus group discussions.*

Once the first draft of the PPI was developed, the researcher presented it to people with SUD (21 participants) and experts (16 participants) in the same clinics where the first focus groups took place. The experts were the same participants, but the people with SUD were different because the people with SUD who participated in the first focus groups completed their treatment. An overview of the draft of the PPI was given during the focus group session, as well as some teaser activities to allow the people with SUD and experts to experience the look and

feel of the intervention. This gave the people with SUD and experts the opportunity to make suggestions of how the first draft of the PPI could be improved. The people with SUD and experts were asked, in separate focus groups, to comment on the design, layout, and content of the intervention and its applicability to the target audience. They were also asked what else they would include in the intervention, and if they thought the intervention would impact treatment motivation.

*Phase 5: Adaptation of a positive psychology intervention using collaborative development feedback.*

The focus group data was captured and interpreted (see data analysis). It was used to improve the first version of the PPI. The critical inputs from the key target group and insights from experts were compared with theories and models that informed the development before adaptations were made to the developed intervention.

### 1.11 Data Analysis

Audio recordings of the focus group discussions were transcribed verbatim by the researcher and an assistant to ensure that the transcripts could be analysed in detail, linked with analytic notes, and coded (Bailey, 2008). Once the data was captured, *thematic analysis* was used to examine the findings. Thematic analysis is a method used within qualitative data to detect patterns and themes (Maguire & Delahunt, 2017). Maguire and Delahunt (2017) state that the goal of thematic analysis is to find themes in the data that are valuable or of interest. Subsequently, these themes are used to address the research question (Maguire & Delahunt, 2017).

The researcher employed Braun and Clarke's (2006) six-phase model for the data analysis.

1) *Phase 1: Familiarisation with the data.* The researcher started by reading and re-reading the transcribed data to properly familiarise herself with all the data (Braun & Clarke, 2006)
2) *Phase 2: Generate initial codes.* The researcher started to organise the data in meaningful ways through coding. The researcher used a theoretical thematic analysis (the theoretical focus of the study is the SDT) to address the specific research question. The research was, therefore, deductive in nature; the researcher used previous research discoveries and theories regarding motivation for treatment (Mayring, 2000). The researcher coded segments of the data relevant to the research question (Braun & Clarke, 2006). During this phase, the researcher created a very comprehensive table that included the main codes, subcodes, and quotes.
3) *Phase 3: Search for themes.* The researcher inspected the codes and combined some into themes. By the end of this step, the codes were organised into broader themes relevant to the research question (Braun & Clarke, 2006).
4) *Phase 4: Review themes.* The researcher reviewed and adapted the initial themes. The researcher reflected on whether the themes work in the context of the complete data set (Braun & Clarke, 2006).
5) *Phase 5: Define the themes.* The researcher refined the themes to identify what each theme is really about (Braun & Clarke, 2006). Finally, the researcher recognised overarching themes engrained in the other themes (Braun & Clarke, 2006). During this phase, the researcher also made use of an independent co-coder to analyse the results.
6) *Phase 5: Write-up.* Lastly, each theme was described and supported with multiple data excerpts. The results compiled the final codes in a cohesive manner that best represented the story the data tells across the themes in relation to the research question.

The analysed data were subsequently used to inform the development of the first version of the PPI.

For the second set of focus group discussions, the researcher also employed *thematic analysis*. The only difference was that during the first focus group discussions, she used the themes to identify interventions to include in the development of the PPI, and in the second set of focus group discussions, she used the themes to adapt the already developed PPI.

### 1.12 Ethical Considerations

All research must adhere to ethical guidelines mainly to add value to the field of study and to ensure that no harm will be done to anyone participating in the study. The research proposal was approved by the Optentia Research Focus Area's Scientific Committee. Ethical approval (NWU-0049-19-A1) was obtained from the North-West University Health Research Ethics Committee (NWU-HREC) (see Appendix C).

#### 1.12.1 Data storage

Only the researcher, research supervisor, data transcriber, and co-coder had access to the data files. Both the data transcriber and co-coder signed confidentiality agreements. Audio files and transcribed data were stored on the researcher's personal computer for the duration of the study and were password-protected. The data transcriber and co-coder only had access to the audio and data files while transcribing and coding. Their personal computers were also password-protected.

All audio files were deleted once the files were transcribed. The parts where participants may be identified (e.g., names, locations) was not transcribed. The data transcriber and co-coder deleted all audio and data files from the audio recorder and their personal computers after completing the transcribing and coding. All data files were transported using USB-sticks. The

researcher will keep the research data on a password-protected computer for five years. No hard copy versions of the data were used.

### 1.12.2 Remuneration of participants

The in-patient clinics where the study took place did not allow any remuneration for people with SUD or staff members. However, the researcher provided refreshments for both the target and expert groups after the focus group discussions as a form of appreciation. The two treatment centres provided tea and coffee. There were no direct research-related expenses for the target or expert group.

### 1.12.3 Risks inherent in the study

Research participants were informed about the topics that were discussed and who participated in the focus group by the mediators to ensure that they could have made informed decisions to participate beforehand. This was especially important for the target group. The target group attended group work sessions daily in the treatment centre with other people with SUD. The focus groups were a familiar environment for them as they already knew the people and shared personal information with them before. The researcher created group rules and obtained verbal consent before the focus group session commenced. She reminded participants to keep the information discussed during the focus groups, private. This lowered the possible psychological and social risk that may be ascended when participating in the focus groups and addressed partial confidentiality (each participant's contributions will be shared with the others in the group and the researcher; therefore, confidentiality was only partial). However, if they felt vulnerable or experienced any discomfort, they would have been referred to their personal social worker in the case of the people with SUD or the onsite psychologist in the case of the expert group.

Research participants were also informed that the focus group session was audio-recorded only for data analysis purposes and that the audio files would be deleted once they were transcribed. Furthermore, they were informed that only the researcher, research supervisor, data transcriber, and co-coder would view the files. The only person who knew their names was the mediator at their treatment centre; a staff member they already knew. The privacy, confidentiality, and anonymity of the participants were ensured as the researcher did not use any identification of participants during the focus group discussions. The research participants were given code names, and any information that could be traced back to them during the transcription was deleted.

### 1.12.4 Benefits to the participants

There were no direct benefits for participants. There were, however, general benefits for people partaking in substance abuse treatment. Taking part in the research study may contribute to the motivation for treatment of other people with SUD in the future and may impact treatment dropout. It may also be interesting for the target group to realise what motivated other participants and themselves to go for in-patient treatment. It may have exercised their autonomy, and they may have felt that they took an active role in society. Experts may have found it beneficial to hear about good practices and creative ways of working with people with SUD.

If the lack of treatment motivation could be addressed through the development of a PPI in support of an existing treatment programme, it may address the critical gap of client dropout. This may enhance knowledge regarding motivation for the treatment of SUD. These could be some of the indirect benefits of the study.

### 1.12.5 Dissemination of data back to participants

Research participants may request a summary of the results (the outcomes of the research explained in an understandable manner, fitted to the research group) or the full dissertation, which would be given to the treatment centre's directors. The researcher does not have any contact details of the research participants to protect their identities. Participants who were interested gave their contact details to their mediators, who can send it to everyone who indicated they were interested once the directors received the results. The researcher will deliver hard copies to the two participating clinics, as well as a pdf-document that the clinics can provide to the participants. This will be done on completion of the study.

### 1.12.6 Privacy and Confidentiality

Privacy of the participants was ensured as only the researchers, mediators, and multi-disciplinary staff members involved in assisting with the research study in the two identified clinics knew who participated in the study. Focus group sessions took place in a closed, private room. The confidentiality and anonymity of the participants were assured as the researcher did not use any identification of participants during the focus group discussions. The research participants were given code names, and any information that could be traced back to them during the transcription was deleted. All audio-data files were deleted after transcription. Demographic information was only used to ensure the reliability of the study and was given voluntarily. This included birthdate (to ensure that they were within the targeted age group), ethnic group (to ensure that all cultures were represented), gender (to ensure that all genders were included), marital status (being in a relationship plays a role in motivation and it forms part of one of the three psychological needs, namely engagement) and primary substance of abuse (to ensure that people with SUD misusing different types of substances were included in the study).

## 1.13 Chapter Organisation

This mini-dissertation will, in addition to the preceding introductory chapter, be organised as follows:

Chapter 2: Research article: “Sunflower: a positive psychology intervention to improve intrinsic motivation for the treatment of substance use disorders.”

Chapter 3: Discussion, strengths, and limitations, and recommendations are made specifically for SUD treatment centres for future research. Lastly, the conclusion is given.

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# CHAPTER 2

# SUNFLOWER: A POSITIVE PSYCHOLOGY INTERVENTION TO IMPROVE INTRINSIC MOTIVATION FOR THE TREATMENT OF SUBSTANCE USE DISORDERS


## Abstract

### Background

People with substance use disorders (SUD) often drop out of treatment. A lack of motivation is one of the most recurrent reasons for treatment dropout, including failure to abide by treatment, relapse, and other negative treatment outcomes. This study aimed to better understand what should be included in a positive psychology intervention (PPI) to increase intrinsic motivation of participants through the intervention. The development was informed by the self-determination theory (SDT) and specifically focused on using the basic psychological needs as the core of the PPI.

### Methods

This was an exploratory, qualitative study consisting of two parts, before and after intervention development. The first part, namely developing the initial version of the positive psychology intervention, was informed by inputs from 70 participants from four focus groups. A total of 37 were people with substance use disorders, and 33 were experts (also future implementers of the intervention) from two in-patient treatment centres in Gauteng, South Africa. The second part, the modification of the first draft of the PPI, was also informed by the inputs of these participants. For the selection of the target group, a homogeneous sampling method was used. The experts were selected using an expert sampling method. Audio recordings of the focus groups discussed were transcribed verbatim by the researcher and an assistant to

ensure that the transcriptions could be analysed in detail, linked to analytic notes, and coded. Once the data was captured, thematic analysis was used to examine the findings.

**Results**

It was found that people in treatment for substance use disorders need support from others (family, staff, people in recovery, other people in treatment, higher power) to feel more *engaged*. They need to have a life purpose, participate in more structured activities and skills development, and have more opportunities to feel more *competent*. They also need to make their own choices, feel in control of their own lives, and participate in their treatment to develop *autonomy*. People with SUD and experts expressed that the first version of the PPI inspired people to change and motivated people with SUD to continue their treatment. They found it relevant for the target group and appreciated the involvement of the target group in the development thereof. They also identified some suggested additions to include in the PPI to improve it.

**Discussion**

The development of the PPI was thoroughly informed by theory (SDT) and research on SUD treatment in South Africa. Basing the development of this PPI on SDT was valuable in understanding the needs of people with SUD, thus possibly enhancing their intrinsic motivation for treatment. The findings indicated SDT is ideal for the development of an intervention for such a vulnerable group. The involvement of people with SUD and future implementers of the intervention in developing this PPI through a participatory approach provided a useful alternative to the conventional research-led approaches. While research-led approaches are inadequately matched to the needs of target users, this study specifically focused on their needs. Participants were able to express what is good for their needs and had specific ideas on improvement. The feedback from people with SUD in active treatment and people working with them (experts) was substantial enough that the intervention's development could be based on it, combined with the

theory. The suggested additions to the first version of the intervention by people with SUD reflected their accountability for their own recovery and were included in the final intervention to improve it. Recommendations include that treatment centres may consider allowing people with SUD to play a more active role during treatment and connect people with SUD with opportunities to enhance their need-fulfilment. It seems that the currently available treatment of people with SUD does insufficiently address the basic psychological needs and intrinsic motivation for people with SUD. This shows the need for the newly developed Sunflower PPI, which is likely to increase well-being and motivation because all three needs of people with SUD are addressed in concrete ways. Implementing this intervention in support of a current treatment programme may improve intrinsic motivation.

**Conclusion**

This study led to the development of a positive psychology intervention based on theory, specifically self-determination theory, and the expertise of people with SUD and practitioners working with them. It is, therefore, a promising way to improve the much needed motivation to support the prevention of treatment dropout and the recovery from SUD.

*Keywords:* Substance use disorders, self-determination theory, intrinsic motivation, psychological need satisfaction, autonomy, competence, relatedness, positive psychology intervention

## 2.1 Introduction

Substance use disorders are multifaceted and highly prevalent communal health problems amongst both youth and adults globally (Groenewald & Bhana, 2018). In South Africa, substance misuse is especially prevalent and adds to the problems the country is already battling with, as it paves the way to unemployment, crime, and limited access to services, thus crippling the economy, breaking up families, and devastating communities (Ederies, 2017). The cost of the misuse of substances in South Africa is 6.4% of the GDP, or R 136 380 million annually ($ 9001, 08 million dollars) (Department of Social Development [DSD], 2013). There is a critical need for interventions to address substance misuse in South Africa, but the demand for such treatment far exceeds supply (Ederies, 2017; Meyers et al., 2008).

One of the biggest threats to treatment effectiveness is premature dropout. A study by Andersson et al. (2018), which included 454 patients from five in-patient SUD centres, found that approximately one-quarter of patients dropped out of in-patient SUD treatment. Ball et al. (2006) found that the reasons for dropout from treatment from the person with a SUD's perspective were loss of motivation and expectations for change, including relational challenges with treatment staff. However, these studies were conducted in Northern Europe and the United States of America. These reasons supported findings that the lack of coping skills, interpersonal skills, and minimal motivation are associated with high-level early dropout rates from SUD treatment (Anderson & Berg, 2001; Broome et al., 2002; Dobkin et al., 2002). Motivation is especially considered a crucial factor in the treatment of SUD as it is assumed to affect treatment retention and behaviour change (Groshkova, 2010). Studies regarding alcohol and abuse dependence confirmed that motivational improvement interventions have the largest effect size among all treatments (Miller, 2000).

One of the most important theories in the field of human motivation, the self-determination theory (SDT), emerged from the work of psychologists Edward Deci and Richard Ryan. They

first introduced their theory in their 1985 book *Self-Determination and Intrinsic Motivation in Human Behaviour*. The research on intrinsic and extrinsic motivation, however, already started in the 1970s (Deci, 1971). The SDT places its prominence on people's innate motivational inclinations for edification and development and how they can be endorsed (Ryan & Deci, 2020). It hypothesises that there are two types of motivation – extrinsic and intrinsic; both prevailing influences in determining our identity and behaviour (Deci & Ryan, 2008). According to Deci and Ryan (1985), extrinsic motivation is a drive to act in a certain way that comes from outer sources and results in external rewards. These sources include awards and praises, respect and appreciation of others, scoring systems, and evaluations. Intrinsic motivation, on the other hand, comes from within. There are internal forces that motivate people to act in confident ways, which include their core values, interests, and personal set of principles (Deci & Ryan, 2008).

As many of the interventions in the treatment of SUD are not inherently interesting or pleasant, knowing how to promote more energetic and volitional forms of motivation is important for successful treatment of SUD. SDT has been used in many areas, but its application to the treatment of SUD is limited (Ryan et al.,1995; Zeldman et al., 2004). However, evidence shows higher levels of internal motivation with lower relapse rates, higher programme participation, and a negative correlation with treatment dropout (Ryan et al., 1995; Zeldman et al., 2004). Thus, the question arises of what should be included in an intervention for people in treatment for a SUD to increase intrinsic motivation of participants through the intervention.

The answer lies in exploring the preconditions that allow people to be intrinsically motivated. At the heart of the SDT is the assumption that people have three innate psychological needs. These include: The need for autonomy (to be the director of one's own life and make your own choices), competence (to feel self-assured, capable, and valuable in one's actions), and relatedness (to feel understood and connected to others and encountering a sense of belongingness in caring relationships) (Deci & Ryan, 2000; Deci & Vansteenkiste, 2004). Within

SDT, needs are defined as general necessities; they form the nutriments required for pro-activity, best possible development, and psychological health of all people (Deci & Vansteenkiste, 2004). These needs are an inherent aspect of human nature and not learned; they act across culture, gender, and time (Chirkov et al., 2003) to support optimal functioning and prevent weakened functioning (Deci & Vansteenkiste, 2004). If these needs are thwarted, passivity, ill-being, disintegration, and unstable functioning could occur (Deci & Vansteenkiste, 2004).

People who report greater autonomy, competency, and relatedness tend to experience more optimistic mental health outcomes, as well as more optimistic physical health outcomes (Deci & Vansteenkiste, 2004; Ng et al., 2012; Reiss et al., 2000; Sheldon et al., 2004). These claims have been empirically endorsed across different life spheres, including healthcare (Van der Kaap-Deeder et al., 2014), education (Tian et al., 2014), sports (Gagne 2003), work (Van den Broeck et al., 2016), and parenting (Mabbe et al., 2018). The SDT is therefore well evaluated throughout the world. It is, however, not the case in other theories. According to Ryan and Deci (2000), the fulfilment of all three needs is conducive to health and well-being, while need thwarting circumstances play a role in pathology and ill-being.

If the lack of treatment motivation could be addressed through the development of a PPI in support of the existing treatment programme, it may address this critical gap of client dropout. In return, this may have a positive impact on the financial challenges experienced by both the government- and private clinics because of the non-completion of treatment. It could also lower the cost of substance misuse in South Africa because of the possible positive impact on the treatment of SUD retention. This study, therefore, focused on the development of a new PPI, the Sunflower PPI, that aspires to improve intrinsic motivation of people in treatment for SUD through the intervention, and is designed to address the critical gap of treatment dropout.

A preliminary Nexis[2] database search indicated that there are no similar interventions focusing on motivation for SUD treatment; it is therefore under-explored. This study is subsequently making both a theoretical and practical contribution to the existing knowledge base. The search also revealed that this study is the first South African sample of focus group discussions with people with SUD in active treatment, addressing one of the most serious challenges in the health sector of this country and, more specifically, treatment dropout. This study is based on the findings of Andersson and a team of researchers (2018), indicating that the role of mental health and intrinsic motivation should be further explored to establish their potential for reducing SUD treatment dropout. They also concluded that these factors be pursued in future intervention studies (Andersson et al., 2018).

The database search also indicated that it is the first time that inputs were obtained from two complementary perspectives, namely people with SUD and experts. A collaborative approach between multi-disciplinary teams, the target group, academics, and policymakers is needed to develop interventions (Wright et al., 2016). According to Wright and colleagues (2016), such a collaborative approach improves the applicability to the target group's identified needs, thus enhancing the intervention's effectiveness.

From a South African perspective, it is evident that the need for the development of a PPI focused on motivation for treatment of SUD is crucial, especially if it may enhance treatment retention and prevent dropout. This study focused on gaining a better understanding of what should be included in a positive psychology intervention (PPI) to increase intrinsic motivation for the treatment of substance use disorders. The development was also regulated by the self-determination theory (SDT), with a specific focus on using the basic psychological needs as the core of the PPI.

[2] Nexis Uni is a user-friendly academic search engine. It provides pertinent content that makes academic research more effective, and it provides personalisation, sighting, and co-operation features that students and universities want in an academic research tool (LexisNexis, n.d.).

## 2.2 Method

### 2.2.1 Research Design

This study made use of an exploratory qualitative research design to analyse the outcome of the focus groups. Exploratory research is conducted to determine the nature of the problem. It is not intended to provide conclusive evidence but assists in a better understanding of the problem (Saunders et al., 2012). Within intervention development, researchers may select qualitative methods to comprehend how individuals or groups experience a motivational development to which they (the people the intervention was developed for) interpret and ascribe meaning to (Pope et al., 2002). It may also assist researchers in increasing their understanding of participants' perceptions about the benefits and restrictions of receiving an intervention (Monaghan et al., 2011). A qualitative research design was chosen for this study as it offered the possibility to enhance the researcher's understanding of the needs of the target group as well as the implementer's understanding of SUD treatment programmes for this new intervention.

This research design was also informed by what McBride (2016) refers to as the *Intervention Research Framework*. This framework is a scientific guide to inventive and evidence-based intervention development, including the evaluation of these interventions. It includes the following four phases: *notification, development, assessment,* and *dissemination*. This study focused on the first two phases only, namely *notification* and *development*.

The *notification* of a research issue is informed by epidemiological and aetiological research to detect concerning or significant problems, to explain a distinct research focus (McBride, 2016). Within this research study, the critical gap of treatment dropout has been identified through a literature study of SUD treatment in South Africa.

The *development phase* encompasses developmental intervention research in this study. These developmental methods confirm that numerous types of essential feedback inform an

intervention (McBride, 2016). This feedback includes preceding studies in the field that have resulted in behavioural change, perceptions from experts, development in partnership with the key target groups and setting implementors of the intervention (McBride, 2016). It furthermore incorporates regulation from theories (self-determination theory) and is piloted in the site before continuing to the Assessment phase (McBride, 2016).

Focus group discussions with people with SUD and experts (multi-disciplinary staff) from two in-patient clinics informed the development phase. This ensured that critical inputs from experts in the treatment of SUD informed the development of the PPI; also done in conjunction with the key target group (being people in treatment for SUD) as well as the future implementers of the intervention (social workers). Furthermore, the development was regulated by the SDT with a specific focus on using the basic psychological needs as the core of the PPI to enhance intrinsic motivation for treatment of SUD.

#### 2.2.1.1 Setting

Two in-patient treatment centres in Gauteng participated in the research, namely The South African National Council on Alcoholism and Drug Dependence (SANCA) Nishtara in Lenasia (township south of Soweto) and SANCA Pretoria in Akasia. All the SANCA clinics are non-government organisations (NGOs) and partially subsidised by the government. People with SUD attending these clinics are thus either subsidised by the government or pay for their own treatment. Both clinics already have existing treatment programmes focused on cognitive behavioural therapy (CBT). CBT approaches to substance misuse treatment are centered on the social learning theories and the values of operant conditioning (Carroll et al., 2004). The trademarks of the CBT approach are a functional analysis of the addictive behaviour and skills training, in which the individual acquires the skills to avoid high-risk situations for substance use or to use improved coping strategies when such situations cannot be avoided (Carroll & Onken,

2005). CBT in a group format (as it is used in the participating clinics) may provide a foundation of normalisation and de-stigmatisation of individual experiences and a source of social support in early recovery from addiction (Dingle et al., 2009). The PPI that was developed as part of this study will support the existing treatment programmes.

SANCA Nishtara and SANCA Pretoria have been selected to participate in the focus group discussions as both clinics have multi-disciplinary teams and treat the key population on an in-patient treatment basis. Although there are other treatment centres in Gauteng, they do not meet the three criteria needed to participate in the study, namely working within a multi-disciplinary team, admit the key population, and have an existing CBT-focused treatment programme.

#### 2.2.1.2 Participants

People with substance use disorders in active treatment participated in this research as the intended PPI was specifically aimed at motivating substance use disorder treatment to address the critical gap of treatment dropout. The literature study confirmed that if the motivation for treatment of substance use disorders can be enhanced, it may improve retention and prevent dropout (Ryan et al., 1995).

Kennedy and Gregoire (2009) conducted a study on the relationship between the self-determination theory and the trans-theoretical model of change and found that the source of motivation can predict the trans-theoretical model of change's stage of change. The trans-theoretical model of change has been adapted to behaviours such as substance misuse and consists of four interrelated dimensions of change that include stages of change. These stages include precontemplation, contemplation, action, and maintenance stages. Kennedy and Gregoire (2009) also found that an internally motivated approach to change (the focus of this research study) is a prerequisite for progressing toward taking action in addiction.

People with substance use disorders enrolling for treatment are in the action stage of the trans-theoretical model of change's stages (behaviour change). Their inputs were, therefore, the most valuable inputs needed for the development of a PPI. People who completed their treatment are in the final maintenance stage, after behaviour change, thus taking steps to avoid relapse and consolidate their new lifestyle. Their inputs were therefore not as valuable as people in active treatment.

Participants included in this study consisted of two groups. Firstly, the people with SUD from two clinics in Gauteng (SANCA Nishtara and SANCA Pretoria). The following criteria were used for inclusion: Participants older than 19 and younger than 40, from different cultural groups (for validation purposes), misusing either illicit/licit drugs and/or alcohol (the treatment centres do not separate people with SUD according to the substances they receive treatment for), people with SUD who completed their detoxification period as they might have been influenced by the withdrawal symptoms they experienced as a result of their substance misuse, and people without severe mental health disorders that might have created barriers when participating in group discussions.

During treatment, people with SUD should start with group work sessions after detoxification. According to the Center for Substance Abuse Treatment (2006), detoxification is a group of actions targeted at coping with severe SUD and withdrawal. It represents the removal of contaminants from the body of the person with a SUD, and aims to reduce the physical damage caused by the misuse of substances (Center for Substance Abuse Treatment, 2006). The treatment centre will refer a person struggling with severe mental health disorders for psychiatric treatment. People undergoing detoxification and experiencing severe mental health disorders will not participate in group work sessions and subsequently were not included in the focus group discussion.

The second group was experts working in the substance abuse treatment centres. The following criteria were used for inclusion: They needed to have specific experience working directly with people with SUD in in-patient treatment centres because the treatment of SUD is a specialised field, they had to form part of a multi-disciplinary team, and had to be from different cultural groups.

The expert groups were the same group of people for both focus groups. However, the group for people with SUD differed, as the first group of people with substance use disorders completed their treatment and were not in the clinic when the second focus group was conducted.

For people with SUD, the following exclusion criteria were used: Participants younger than 19 years and older than 40, people with behaviour addictions such as gambling and gaming as this study specifically focuses on substance use disorders, people in the detoxification period of their treatment because they might have experienced withdrawal symptoms, and people suffering from severe co-occurring disorders such as depression or anxiety (if they experience severe mental health disorders it may have created barriers when participating in group discussions).

For the expert group, the following exclusion criteria were used: Participants not specialised in SUD in-patient treatment because the treatment of SUD is a specialised field, mediators assisting with selecting experts were able to identify experts specialised in SUD in-patient treatment.

In total, 70 people participated in eight focus group discussions. People with SUD (37 participants) from two in-patient treatment centres in Gauteng, South Africa, participated in four of these focus groups. The majority of the people with SUD were male (n=34), only three were female; this correlates with how groups are normally divided in treatment centres. People with SUD had a mean age of 29,5 years, ranging from 20 to 39 years. All participants reported substance misuse as their main addiction problem. People with behaviour addictions (non-

substance addictions such as gambling addiction) were not included in the focus group discussions. The majority, almost a third of the participants, reported a combination of three or more different substances as their main addiction. More than 20% reported amphetamines as their main addiction, followed by heroin, cannabis, and alcohol. Concerning marital status, more than 80% were single. As far as cultural groups were concerned, almost two-thirds were Black, less than 20% Coloured, about 14% Indian, and just over 8% White. Table 1 provides more details on the characteristics of the participants with SUD.

**Table 1**

*Demographic Characteristics of People with SUD*

| | **First focus group before development** | | **Second focus group before development** | | **First focus group after development** | | **Second focus group after development** | | **Full Sample** | |
|---|---|---|---|---|---|---|---|---|---|---|
| | *(n=9)* | | (*n=7)* | | *(n=12)* | | *(n=9)* | | *(n=37)* | |
| **Gender** | | | | | | | | | | |
| Female | 0 | 0 | 1 | 14,29 | 0 | 0 | 2 | 22,22 | 3 | 8,11 |
| Male | 9 | 100 | 6 | 85,71 | 12 | 100 | 7 | 77,78 | 34 | 91,89 |
| **Birth Year** | | | | | | | | | | |
| 1981- 1990 | 6 | 66, 67 | 4 | 57,14 | 7 | 58,88 | 3 | 33,33 | 20 | 54,05 |
| 1991- 2000 | 3 | 33,33 | 3 | 42,86 | 4 | 33,33 | 6 | 66,66 | 16 | 43,25 |
| 2001- 2010 | | | | | 1 | 8,33 | | | 1 | 2,70 |
| **Culture Group** | | | | | | | | | | |
| Black | 6 | 66,67 | 2 | 28,57 | 11 | 91,97 | 3 | 33,33 | 22 | 59,46 |
| Indian | 0 | 0,00 | 4 | 57,14 | | | 1 | 11,11 | 5 | 13,51 |
| Coloured | 1 | 11,11 | 1 | 14,29 | | | 5 | 55,56 | 7 | 18,92 |
| White | 2 | 22,22 | | | 1 | 8,33 | | | 3 | 8,11 |
| **Marital Status** | | | | | | | | | | |
| Married | | | 3 | 42,86 | 1 | 8,33 | | | 4 | 10,81 |
| Single | 9 | 100 | 4 | 57,14 | 10 | 83,34 | 8 | 88,89 | 31 | 83,79 |

| | First focus group before development (n=9) | | Second focus group before development (n=7) | | First focus group after development (n=12) | | Second focus group after development (n=9) | | Full Sample (n=37) | |
|---|---|---|---|---|---|---|---|---|---|---|
| Engaged | | | | | 1 | 8,33 | | | 1 | 2,70 |
| In a relationship | | | | | | | 1 | 11,11 | 1 | 2,70 |
| **Primary Substance of Abuse** | | | | | | | | | | |
| Amphetamines Cat | 2 | 22,22 | 1 | 14, 29 | 1 | 8,33 | 4 | 44,44 | 8 | 21,62 |
| Cocaine | 1 | 11,11 | | | 1 | 8,33 | | | 2 | 5,41 |
| Cannabis | 1 | 11,11 | | | | | | | 1 | 2,70 |
| Heroin | 1 | 11,11 | | | 4 | 33,30 | | | 5 | 13,51 |
| Nyaope | 4 | 44,45 | | | | | 2 | 22,22 | 6 | 16,21 |
| Alcohol | | | | | 2 | 16,67 | | | 2 | 5,41 |
| Combination of 3 or more different substances | | | | | 2 | 16,67 | 1 | 8,33 | 3 | 8,11 |
| | | | 6 | 85,71 | 2 | 16,67 | 2 | 22,22 | 10 | 27,03 |

Experts (33 participants) from the same treatment centres participated in another four focus group discussions. They had more than five years' experience working in a substance use disorder treatment centre, worked as part of a multidisciplinary team, and usually work with an already existing SUD treatment programme.

### 2.2.2 Data Gathering

The researcher compiled two interview schedules (see Appendix A and B) to ensure consistency when facilitating the focus groups with the experts and the key target group. Each of the interview schedules comprised initial engagement, exploring and exit questions.

The first focus group, the interview schedule for experts and people with SUD (see Appendix A), focused on what motivates people with SUD to attend treatment by examining the following: (a) what helps people with SUD to feel in control during the treatment, (b) what role significant others play in treatment, (c) what skills people with SUD need to stop misusing substances, (d) the issues related to non-completion and treatment dropout, and (e) the requirements for SUD treatment maintenance. The second focus group interview schedule focused on experts and people with SUD's opinions around the design and layout of the PPI, the content and application for the target audience, additions they would like to suggest, and in what way it may have impacted treatment motivation (see Appendix B).

All people with SUD and experts participating in the research study completed an informed consent form before the research commenced. Within the informed consent, the research participants were informed about their rights, the purpose of the study, the research procedure, and the potential risks and benefits of participation. They were also informed that their participation is voluntary (Shahnazarian et al., 2013). Participants also permitted the audio-recording of the focus group discussions.

People with SUD were also asked to provide some demographic information, which the researcher received from their treatment centres. The demographic information can help others know more about the transferability of the results to other groups and settings. It was clearly explained that this information would be given voluntarily. It included birth date, race, gender, marital status, and primary substance of abuse.

The researcher used a coding scheme and kept a codebook, which was developed while scoring. Finally, the researcher also developed a guide used during the second focus group discussions when she provided an overview of the PPI and facilitated some teaser activities. The feedback from the second focus group was used to adapt the first version of the intervention to improve it.

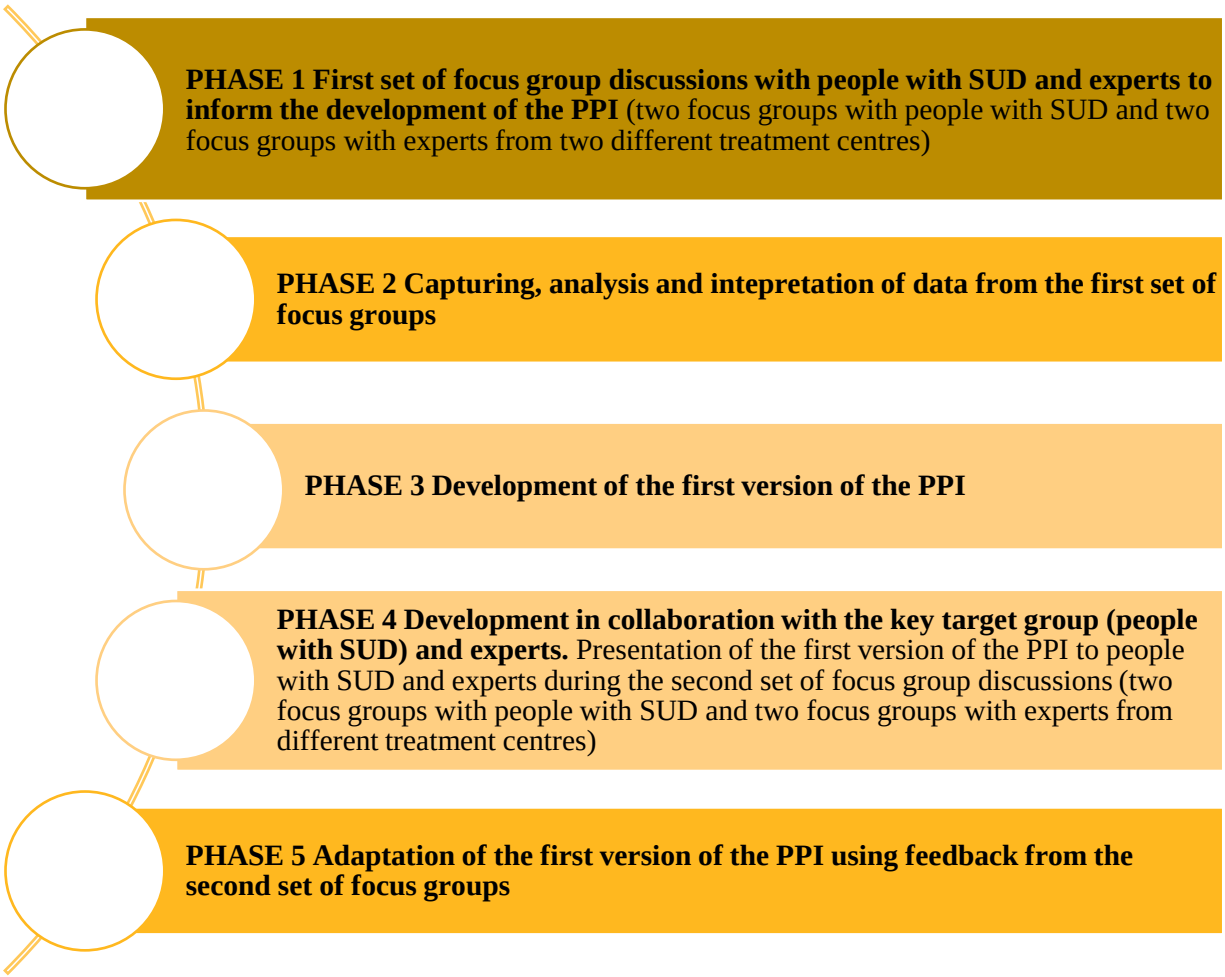
The focus group sessions were audio recorded. The audio recordings were uploaded to a password-protected computer and deleted from the audio recorder immediately after each focus group.

### 2.2.3 Research Procedure

This research study consisted of five phases, as illustrated by Figure 1: (1) first set of focus groups discussions with people with SUD and experts (multi-disciplinary staff) to inform the development of positive psychology intervention, (2) capturing and interpretation of data from the first set of focus groups, (3) development of the first version of the positive psychology intervention based on the feedback, (4) development in collaboration with the key target group and experts: presentation of the first version of the developed PPI to the key target group and experts followed by the second set of focus group discussions, and (5) adaptation of the first version of the PPI using the feedback from the second set of focus groups.

**Figure 2**

*Graphical Representation of the Research Procedure*




### 2.2.3.1 Recruitment and Data Collection

*Phase 1: First set of focus groups discussions with people with SUD and experts to inform the development of PPI.*

Ethical approval (NWU-0049-19-A1) was obtained from the North-West University Health Research Ethics Committee (NWU-HREC) (see Appendix C). Formal permission to conduct the two focus groups was provided by the clinics' directors (gatekeepers). Mediators (as selected by the clinics' directors) conducted the selection of both the target and expert groups with the

assistance of the multidisciplinary staff. This was based on the inclusion criteria. The participants were given one week to decide if they wanted to participate in the study. If interested, they privately contacted the mediator in each clinic to confirm their participation. The mediator finalised the participant recruitment and invited them to discuss the informed consent that an independent person conducted. The researcher trained an independent person to obtain informed consent. The independent person informed the participants about the research aim and objectives as well as their rights. He/she also explained that the research study would be conducted according to ethical practices. The participants received the informed consent form from the independent person (administrator at the clinic) and had time to read the form and ask questions. The independent person asked them to sign the consent form when they were ready. They could keep the part with the information about the study. The independent person informed both groups of the time and venue for the focus group discussions and who would form part of each focus group.

The four focus group discussions, two with the target group and two with experts, were conducted on four separate days and facilitated by the researcher at the two clinics. The focus group sessions took place in a private room in the clinics. Each of the sessions took approximately 90 minutes and was audiotaped with the permission of the participants.

*Phase 2: Capturing and interpretation.*

The focus group audio-recording was transcribed verbatim, analysed and interpreted (see data analysis). These critical inputs were incorporated into the intervention framework that informed the development of the PPI.

*Phase 3: Development of the first version of the PPI.*

An intervention framework was created based on research in the field of SUD treatment as well as basic psychological needs. The critical inputs received from the target and expert groups

in relation to motivation for treatment were incorporated into the framework that informed the intervention development. The PPI consisted of seven distinct workshops themed: *1) play to your strengths, 2) my best possible self, 3) learn to be kind, 4A) an attitude of gratitude, 4B) gratitude visit, 5) hope and recovery, and 6) rise and shine.* Each of these seven workshops comprised a three-hour session facilitated to complement the already existing treatment programmes. The aim was to facilitate it over three consecutive weeks, twice per week, to ensure that no disruption in the already existing treatment programmes occur but rather complement it.

*Phase 4: Development in collaboration with the key target group and experts, presentation of the first version of the developed PPI to key target groups and experts followed by the second set of focus group discussions.*

After developing the first version of the PPI, the researcher presented it to people with SUD (21 participants) and experts (16 participants) in the same clinics where the first focus groups took place. The experts were the same participants, but the people with SUD differed because the people with SUD who participated in the first focus groups completed their treatment. An overview of the draft of the PPI was given during the focus group session, as well as some teaser activities to allow the people with SUD and experts to experience the look and feel of the intervention. This allowed the people with SUD and experts to make suggestions of how the first draft of the PPI could be improved. The people with SUD and experts were asked, in separate focus groups, to comment on the design, layout, and content of the intervention, as well as its applicability to the target audience. They were also asked what else they would include in the intervention and if they thought the intervention would impact treatment motivation.

*Phase 5: Adaptation of the positive psychology intervention using feedback from the second set of focus groups.*

The focus group data was captured and interpreted (see data analysis), and used to improve the first version of the PPI. The critical inputs from the key target group and insights from experts were compared with theories and models that informed the development before adaptations were made to the developed intervention.

### 2.3 Data analysis

Audio recordings of the focus group discussions were transcribed verbatim by the researcher and an assistant; the transcripts were analysed in detail, linked with analytic notes, and coded (Bailey, 2008). Once the data was captured, *thematic analysis* was used to examine the findings. Thematic analysis is a method used within qualitative data to detect patterns and themes (Maguire & Delahunt, 2017). Maguire and Delahunt (2017) state that thematic analysis aims to find themes in the data that are valuable or of interest. These themes are then used to address the research question (Maguire & Delahunt, 2017).

The researcher employed Braun and Clarke's (2006) six-phase model for the data analysis.

1) *Phase 1: Familiarisation with the data.* The researcher started by reading and re-reading the transcribed data to ensure very good familiarisation with all the data (Braun & Clarke, 2006).
2) *Phase 2: Generate initial codes.* The researcher organised the data in meaningful ways through coding. The researcher used a theoretical thematic analysis (the theoretical focus of the study is the SDT) to address the specific research question. The research was, therefore, deductive in nature because the researcher used previous research discoveries and theories regarding motivation for treatment (Mayring, 2000). The researcher coded segments of the data relevant to the research question (Braun & Clarke, 2006). During this phase, the researcher created a very comprehensive table, which included the main codes, subcodes, and quotes.

3) *Phase 3: Search for themes.* The researcher inspected the codes and fitted some into themes. Thereafter, ordering the codes into broader themes related to the research question (Braun & Clarke, 2006).
4) *Phase 4: Review themes.* The researcher reviewed and adapted the initial themes. The researcher also reflected on whether the themes work in the context of the complete data set (Braun & Clarke, 2006).
5) *Phase 5: Define the themes.* The researcher refined the themes to identify what each theme is really about (Braun & Clarke, 2006). Finally, the researcher recognised overarching themes engrained in the other themes (Braun & Clarke, 2006). During this phase, the researcher also made use of an independent co-coder for the analysis of the results. This co-coder signed a confidentiality agreement before the research commenced.
6) *Phase 6: Write-up.* Lastly, each theme was described and supported with multiple data excerpts. The results compiled the final codes in a cohesive manner that best represented the story the data tells across themes in relation to the research question (Braun and Clarke, 2006).

The analysed data were used to inform the development of the first version of the PPI. For the second set of focus group discussions, the researcher also employed *thematic analysis*. The only difference was that during the first focus group discussions, she used the themes to identify interventions to include in the development of the PPI. In the second set of focus group discussions, she used the themes to adapt the already developed PPI.

## 2.4 Results

### 2.4.1 Development of the Sunflower PPI

One main objective of this study was developing a PPI to increase motivation for the treatment of people with SUD through the intervention. Four steps were followed during this study to develop the Sunflower PPI: *Step 1:* Needs assessment to inform the development of the PPI framework, *Step 2*: Development of workshops based on the seven identified themes, *Step 3:* Development of the PPI in collaboration with people with SUD and experts, and *Step 4*: Adaptation of the PPI using the collaborative development feedback.

#### 2.4.1.1 Step 1: Needs-assessment to inform the development of the PPI framework

During the needs-assessment, the first set of focus group discussions, two with people with SUD and two with experts (programme implementers) from two treatment centres, were conducted to identify their needs concerning motivation for treatment. Following the generative process of data analysis, themes (consisting of main- and subcodes) were produced based on the needs of both the target group and experts. These themes assisted the researcher in answering the research question and generating an intervention framework that informed the development of the first draft of the PPI. Overarching themes were identified in support of each of the three basic psychological needs.

##### 2.4.1.1.1 Relatedness

The main themes generated during the course of the analysis on relatedness indicated that family, other people, religion and staff support play a vital role in the treatment of people wit SUD.

#### 2.4.1.1.1.1 Family

Most of the reports from people with SUD and experts during the focus groups focused on others' role in their motivation for treatment, and specifically to **undergo treatment for their family (sub theme).** From the people with SUD's perspective, they showed an understanding of the pain they have caused their family: *'I'd say family you know, out of everything else family the ones that hurt the most because a lot of substance abuse.'* They also acknowledged that their family plays an important role in relapse prevention, thus maintaining their sobriety: '*So, my family right now is motivation so that I don't relapse.'* They also felt that they wanted to make their family proud: '*I want to make them proud.'* Feeling proud creates a great sense of self-worth for people with SUD and is essential in recovering from SUD.

Experts' feedback supported the important role of the family during treatment. They acknowledged the importance of rebuilding and restoring broken relationships while people are in treatment for SUD: '*[…] they (people with SUD) more trying to do it for the loved ones because they want to re-build relationships or restore relationships […]'*

Furthermore, the importance of **family participation (sub theme)** in the treatment process was also emphasised by experts and people with SUD's reports. People with SUD admitted that they need support from their family to stay sober: *'The family plays a crucial role because they have to walk this road of recovery with the patient to prevent relapses […].'* They also realised that their disorder affected their family, who evidently need to participate in the treatment process: '*[…] and also on the other side, they've been affected as well by the behaviour.'* Experts acknowledged this: *'[…] for family support to be a critical part of the programme so that family members themselves, they may not be directly affected by the substances, but they have been indirectly affected.'*

The feedback from both people with SUD and experts concurred that family plays a vital role in the treatment of SUD and that family participation in treatment is essential. Family (including

significant others and friends for people with SUD who do not have any family support) was incorporated into three workshops of the Sunflower PPI. In Workshop 2, themed *My Best Possible Self*, an activity was included named *'Letter of Atonement'*. Part of recovery is understanding and acknowledging the pain that people with SUD may have caused through their substance misuse (as already mentioned by people with SUD). People with SUD were allowed to decide if they wanted to write a letter of atonement, which may or may not be read or given to the person (or people) they have hurt. A structure was provided to make it easier for them to write their letters, and their individual social workers were also asked to assist them if they struggle in any way. In Workshop 4 (a) (theme: *An attitude of Gratitude),* people with SUD familiarised themselves with the power or gratitude and practicing gratitude during their treatment and recovery. One of the activities in this workshop was to write a *letter of gratitude* to a person they wanted to thank for assisting them with their recovery. Workshop four (b) (theme: *Gratitude Visit*) was developed to incorporate a visit from family (including significant others or friends) to the treatment centre. During this visit, the gratitude letters could be shared within a circle dialogue setting to create a safe space. Once the gratitude letters were shared, the people with SUD received private family time to share their *letters of atonement* if they wanted to do so.

#### 2.4.1.1.1.2 Other People

People with SUD and experts' reports also focused on the importance of being motivated by **people in recovery (sub theme)** (former substance users). People with SUD felt that people in recovery would motivate them to be sober. One person with SUD stated: *'[…] I think for me, like meeting people like [name of person in recovery], who are clean for maybe sometime will keep me going.'* The participant further stated: *'He's like my role-model here. If he's done it, why not me?'* Therefore, people in recovery may be encouraged by former substance users and be motivated to change through the example they set.

The feedback from experts supported this notion. One expert mentioned: *'[…] there's other people that are further on into recovery, and they look excited about it, they are progressing in life, and it motivates you know, the person who's coming in earlier on to say that if he's done it then perhaps I can also do it.'*

People in recovery from SUD play an important role in the treatment of SUD, as confirmed by both people with SUD and experts. Therefore, connecting with people in recovery was included in the Sunflower PPI in Workshop 2 (theme: *My Best Possible Self*). People in recovery were invited to participate in an activity named *connecting with a person in recovery*. This person should preferably be from the same treatment centre where the PPI would be implemented. This person could share their recovery story with the people with SUD before creating *Best Possible Self Hats* through a creative arts activity. This activity might motivate them to focus on what they can become and achieve in the near future.

**Support from fellow group members (sub theme*)*** (people in treatment for SUD) was mentioned by both experts and people with SUD. In the treatment centres, the treatment programmes are delivered through group and individual sessions. Therefore, people with SUD are spending a lot of time with other people with SUD in treatment. People with SUD felt they motivated each other while in treatment and, in particular, to stay sober. They also related to one another because they learned from each other's experiences. One person with SUD mentioned: *'[…] So, I think we all motivate each other. So ja, I think it's in the support that we have with each other, and we motivate each other to move forward. That's the biggest motivation because we relate to each other and we see where we came from and how others are moving forward motivates us to also move in that step.'*

The feedback from experts supported the encouragement given to one another by people in treatment of SUD: '*Okay, I'd say when we admit patients, you'll find that there's somebody who's been here for quite some time with the same problem that the new one comes with. And*

*now when they start to feel like the programme is difficult, they can't do it, then the next person would say "you know what, I've been here, I've been through the thing that you are feeling."*

The identification with one another, encouragement, and motivation from other people in treatment for SUD play a significant role in learning to relate to other people, thus enhancing relatedness during treatment. It was incorporated into the methodology of the Sunflower PPI and formed part of each workshop. All seven workshops were delivered in a group format, although there were a few individual activities. In each workshop, there were group activities and discussions that allowed participants to interact and share their own experiences. There were also opportunities during *check-in* (participants gathered in a circle and checked in with the social worker or facilitator and shared one thing they needed from the group to enable them to participate unreservedly) and *check-out* (within a circle, people with SUD were allowed to appreciate another person based on their participation during the workshop) activities for participants to learn to relate to each other.

#### 2.4.1.1.1.3 Religion

Within South African treatment centres, religion is another significant connection and support structure that assists people with SUD to stop using substances. This was emphasised by one of the people with SUD: '*And also coming to find your higher power. It's the most important. Without our higher power, we have no support, and without support, there is no recovery.'* The people with SUD participating in the focus group discussions felt supported by their higher power, and it seemed that having a relationship with God is a significant connection they need during treatment as mentioned by a person with SUD: '*So, I would say the God of your understanding is the best support you can have, and with building that relationship with Him, would be the best thing.'*

Religion was therefore included in the Sunflower PPI to enhance the need for relatedness. A specific section was included in Workshop 5 (theme: *Hope and Recovery*), which focused on *leaning on a higher power* and understanding how *hope is the foundation upon which you build your recovery*. The researcher did however take into consideration that not all people with SUD may be religious and their religious beliefs may differ. The researcher therefore assured that the rest of workshop 5 focused on a general approach to hope and recovery.

#### 2.4.1.1.1.4 Staff Support

People with SUD and experts also emphasised the importance of staff support with specific reference to support from social workers in the treatment centre. The care and support given by staff members and the treatment centre remain important for people with SUD. One person with SUD mentioned: '*That "we care about you, we here, you not just a number or a stat by us, we want to make an impact on your life". So, I think that is crucial that comes from the environment [treatment centre] again and the staff members.'* Having a supportive relationship with staff members is essential for people with SUD. This was also highlighted by an expert: *'So, once they trust you, like they can share anything with you and then they will change themselves.'* Building a trustworthy relationship with people with SUD will assist them in making themselves vulnerable and, in return, result in behaviour change.

If staff support can bring about behaviour change among people with SUD, it was essential to include it in the Sunflower PPI. Staff support was incorporated into three of the seven workshops. In Workshop 1 (theme: *Play to your Strengths*), people with SUD identified their character strengths through a *Via Strength Art Gallery* activity. These character strengths were discussed with their social workers (each person with SUD had an individual social worker when in treatment). More specifically, they discussed how they could use these strengths during their treatment and recovery. Workshop 3 (theme: *Learn to be Kind*) was developed to enhance

relatedness between staff members (all treatment staff) and people with SUD. It focused on the importance of spreading kindness in the treatment centre. It included a *sweet appreciation* activity where people with SUD and staff praised each other while eating sweets. It also included a group activity focused on the *love languages*; each participant discovered their primary love language, and everyone was motivated to 'speak' each other's love language in the treatment centre. Workshop 4 (b) (theme: *Gratitude Visit*) ended with a certificate presentation after the gratitude visit from family. Staff members presented certificates of appreciation to the people with SUD (template for these certificates is provided in the trainer guide).

#### 2.4.1.1.2 Competence

The prominent themes generated during the course of the analysis were that competence would be satisfied if people with SUD could develop a life purpose, engage in more activities, developing skills, and have more opportunities during treatment.

##### 2.4.1.1.2.1 Develop a Life Purpose

During treatment, *'[…] it's very important to have a* sense of purpose (expert), which also acts as a protective factor because it reduces the potential for substance misuse as verified by one of the people with SUD: '*If I wake up in the morning with a sense of purpose it creates meaning in my life, and if I live a meaningful life there is no place for addiction.'*

If a sense of purpose acts as a protective factor to reduce substance misuse and creates meaning in the lives of people with SUD, it needed to be included in the Sunflower PPI. A warm-up activity was included in Workshop 5 (theme: *Hope and Recovery*) on developing a personal purpose statement, combining their character strengths (identified in Workshop 1), what they wished to achieve during their recovery, and what they find meaningful about their journey of recovery.

#### 2.4.1.1.2.2 More Activities

More activities is needed in support of the SUD treatment programme to keep people with SUD busy during their free time. These activities should be stimulating enough for them to enjoy and lift their mood. During the focus group discussions, a person with SUD confirmed: '*There should be more activities, Mam, I don't want to lie. I really appreciate what they've done here, but it feels like we in school. Some people get bored with that.'*

People with SUD identified the need for more structured activities to enhance their competence. A specific section was created within the Sunflower PPI called *Bloom with Grace.* This is a section with some structured activities to assist people with SUD to internalise newly learned skills. Also included in this section of the PPI was positive journaling about each workshop. This provided people with SUD some time for personal reflection. All the *Bloom with Grace* activities were voluntary, and people with SUD could complete it in their free time. The need for more structured activities was built into the additional *guidelines for treatment centres* because these activities refer to activities that people with SUD participate in during their free time and over weekends. It is suggested that people with SUD skills should be identified during house meetings (meetings to discuss rules and regulations in the treatment centre), and they should be empowered to assist with activities within the clinic, particularly after hours and over weekends (e.g., having a talent show on a Saturday evening, sport activities such as volleyball, and singalongs hosted by the people with SUD).

#### 2.4.1.1.2.3 Skills Development

A further theme identified by people with SUD to enhance their competence was skills development. During the focus group discussions, people with SUD stated: '*We should also spend time in here focusing on the development of our skills and abilities.'*

The development of people with SUD's skills was therefore incorporated into the development of the Sunflower PPI to enhance competence. The identification and utilisation of the character strengths were incorporated into the first workshop, as already mentioned.

Skills development was, however, also incorporated into every workshop through the '*Choose to be brave'* activity at the start of each workshop. Participants were given a choice of five roles they would like to engage with during the workshop, specifically focusing on the enhancement of their basic psychological needs. Examples of two of these roles included w*rap-up times three* (three different participants identified an activity during the workshop where they practiced each of the three basic psychological needs) and *introduced others in a creative way* (one participant took the lead in creatively introducing fellow participants (e.g., two claps, two snaps with fingers, two stomps with their feet, two winks and a *"Go Peter (name of the person)!"*). These small activities were playful and fun and incorporated into the Sunflower PPI to enhance all three basic psychological needs but, more specifically, competence.

#### 2.4.1.1.2.4 More Opportunities during Treatment

During the focus group discussions, a person with SUD stated: '*If people could give us that opportunity to show that we can do it, we can make it, it would be great for us you know because always people think "Ai this guy's a user, he's a user, he's a user."'.* Therefore, people with SUD need to have more opportunities to **prove that they can do something for themselves (sub theme)** and not always feel ostracised as substance users. This was also reiterated by an expert*: 'But most of them will say "but I have a computer certificate. I have this certificate. Give me a job. Give me an opportunity."'* In the focus groups, it was mentioned that people with SUD need a chance to show that people recovering from SUD can make it.

If more opportunities for people in treatment for SUD can assist people with SUD not to feel ostracised as substance users, it is an important need that should be incorporated within the treatment process. However, it was included in the *guidelines for treatment centres*

(recommendations) because it could not be built into the PPI. It is suggested that treatment centres focus on creating networking opportunities with local businesses for people with SUD, create *gateway* projects where they mentor people in recovery for the first few months during early recovery while they are working, and create 'give back' projects where they can engage in community projects while in recovery.

#### 2.4.1.1.3 Autonomy

The main themes generated on autonomy were that people with SUD's autonomy would be enhanced if they are allowed to make their own good choices, be in control of their own lives, and be allowed to get involved in their own treatment.

##### 2.4.1.1.3.1 Make their Own Good Choices

The people with SUD felt that their social workers allowed them to make their own choices and not directing them to what they should or should not be doing. One person with SUD mentioned*: 'Most therapists focus on what are you going to do for yourself instead of just sort-of directing you "do it like this for yourself, this might work for you."'* As part of the treatment programme, people with SUD are thus assisted in making their own choices about their treatment and recovery.

##### 2.4.1.1.3.2 Being in Control of their Lives

During the focus group discussions, a person with SUD mentioned the following about being in control of their own lives : *'I'd say to maybe get back into a routine. You notice how babies love routine? So routine is good.'* During active addiction, a person with SUD has no routine; their life is focused on getting their next high. Therefore, it is not surprising that people with SUD feel more in control when they follow a daily routine. Doing things for themselves and not

relying on other people also help people with SUD to gain control of their lives: *'[…] being able to live a clean and sober life for myself.'*

#### 2.4.1.1.3.3 Play and Active Part in their Treatment

During the focus group discussions, one person with SUD stated: '*And also, what makes us feel more in control is actually to work in the programme.'* It was also acknowledged by an expert: '*So, I think they must be involved in everything. That will immediately make them feel "I'm in charge of this programme."* People with SUD need to play an active part in their treatment to be in control of their own lives.

A very practical way of assisting people with SUD to be in control of their own lives, making good choices, and play an active role in their own treatment and recovery can be to maintain a daily routine, as mentioned by one of the people with SUD during the focus group discussions. This was included in the Sunflower PPI in Workshop 6 (theme: *Rise and Shine*). In this last workshop of the Sunflower PPI, people with SUD were empowered to develop their own daily routine for their recovery plan when they have completed their treatment. Making choices was also built into the methodology of the Sunflower PPI. One example is positive journaling that forms part of their free time activities called '*Bloom with Grace.'* Participants reflected on the workshops in any way they liked; they could also decide if they wanted to complete the '*Bloom with Grace'* activities. Participants had a choice to participate in the '*Choose to be Brave'* roles during each workshop. These activities were specifically developed to enhance autonomy.

#### 2.4.1.2 Step 2: Development of workshops based on the seven identified themes

##### 2.4.1.2.1 PPI Methodology

Although the Sunflower PPI includes deficit-based elements (i.e., developing skills to reduce the misuse of substances), the aim and focus of the intervention were building up positive capabilities to create positive results rather than 'fixing' what is wrong (Waters, 2020). This is evident when using the "Sunflower" metaphor in this intervention to assist people with SUD to flourish and grow through learning to focus on and use their basic psychological needs while in treatment and during recovery. Metaphors can be vital instruments in the healing process, as it presents the therapist with a method of conveying possible intricate mental notions and principles to participants partaking in the change process (Killick et al., 2016). The Sunflower PPI is a multi-component positive psychology intervention (MPPIs), as it consists of three positive psychology exercises that are used in the following ways: i) savouring (increasing and lengthening temporary gratifying experiences); ii) articulating gratitude (by contemplation and representation); iii) practising kindness; iv) encouraging positive associations; v) endorsing denotation and determination (Hendriks et al., 2020). Furthermore, it is delivered as a group intervention that includes individual sessions.

##### 2.4.1.2.2 Development of Workshops for the PPI

Three-hour workshops were developed based on each of the seven themes which emerged from the findings. Each workshop was structured using the three drama therapy stages, namely warm-up, development, and closure (Langley, 2006). Drama therapy is the deliberate use of drama toward the psychotherapeutic goals of symptom relief, emotional and physical assimilation, and personal development (Johnson, 1982). The researcher selected a drama therapy structure for the development of the intervention as drama therapy is useful in the

prevention and treatment of substance use disorders, depression, anxiety, and other conditions; it encourages positive changes in empathy, attitudes, and emotions (North American Drama Therapy Association, n.d.).

The Sunflower workshop structure consists of the following three stages that were linked to the "Sunflower" metaphor (this structure is used in each of the seven workshops):

*Preparing and planting stage (warm-up stage)*

- Workshop quote – this is a quote used to set the scene for the workshop and is linked to the workshop theme.
- Workshop chant – repetition of sounds, words, and movement are useful for creating boundaries and providing a safe treatment environment (Langley, 2006). Participants recite the workshop chant together while standing in a circle. This activity will satisfy the need for relatedness and competence.
- Choose to be brave – participants are given a choice of roles they would like to play during the workshop, which specifically focuses on the enhancement of their basic psychological needs. An example of such a role is: *'Wrap-Up Times Three'*. At the end of each workshop, three volunteers need to identify an activity where they practiced each of the three basic psychological needs, namely autonomy, competence, and relatedness. This activity, therefore, enhances all three needs.
- The check-in – participants will gather in a circle and check-in with the social worker or facilitator and share one thing they will need from the group to enable them to participate unreservedly. This activity enhances the need for relatedness, autonomy, and competence.

- The warm-up – the warm-up activity energises the participants and unlocks their creativity; it should get everyone engaged. It is also designed to create positive emotions that thwart negative emotions and broaden people's customary modes of thinking and build their personal resources for surviving (Fredrickson, 2000). Participants are expected to complete the activity with other participants in a small or large group, and the activity is aimed to enhance relatedness.

*Germination and rooting stage (development stage)*

- The main activity is the largest section of the workshop and the focus of the therapeutic work for the day. It includes various activities such as individual, small- and large group activities facilitated in a group setting. It mostly includes the following: *group nourishing activities* (didactic information linked to the workshop theme and building competence within the group), *individual nourishing activities* (didactic information linked to workshop theme and building individual competence), *personal reflection* (positive journaling about the theme of the day to further reflect on newly learned skills to build competence; this activity is completed during participants' own free time and not in a group format), *group nourishing activities* (a collective activity where groups members co-operate and support each other, thus enhancing relatedness) and *personal nourishing activities* (participants are supported in exploring their own identity and purpose through individual activities while being in the group with other participants).

*Growing stage (closure stage)*

- Wrap-up times three – allow volunteers (as identified at the beginning of the workshop) to identify an activity during the workshop where they practiced each of the three basic psychological needs. This activity assists participants in identifying with all three needs.

- Conclusion – summary of the workshop by the facilitator after the volunteers completed the wrap-up activity.
- Check-out – participants gather in a circle and are given the opportunity to appreciate another person based on their participation during the workshop, thus developing relatedness.
- Bloom with grace – these are individual activities developed for the participants to reflect on and appreciate what they have learned during the workshop, thus supporting the feeling of competence through self-appreciation. It includes positive journaling and more structured activities reflecting on the workshop. Each participant gets the opportunity to select a journal (thus supporting autonomy) before the Sunflower PPI commences that they will use to complete these activities. Participants complete the *bloom with grace* activities voluntarily and in their own time, they may choose to do what they feel comfortable doing, thus enhancing their autonomy.

It takes approximately 30 minutes to facilitate the *preparing and planting (warm-up stage)*, two hours to facilitate the *germination and rooting stage (development stage)*, and another 30 minutes to close the session with the *growing stage (closure stage).* The intervention could be facilitated in two sections with a break in-between or as needed by the treatment centres implementing the intervention in the future.

All the workshops include appropriate, innovative, and evidence-based individual, small, and large group activities. Age-appropriate and culture-sensitive content was researched and developed to be included in the PPI based on the intervention framework.

The first version of the seven workshops of the Sunflower PPI was incorporated into a trainer guide.

#### 2.4.1.3 Step 3: Development in collaboration with people with SUD and experts

Hard copies of the trainer guide were printed and provided to people with SUD and experts during the second set of four focus groups (two focus groups with people with SUD and two with experts from two treatment centres). Furthermore, a short presentation of 30 minutes on the development of the Sunflower PPI was conducted by the researcher and some teaser activities from the Sunflower PPI. People with SUD and experts were asked to provide their input and share their insights on the first draft of the PPI.

A number of overarching themes emerged from the analysis of data received during the second set of focus groups focused on feedback concerning suggested adaptations to the first draft of the PPI. These were centered on: *The design, layout, and structure of the PPI; The involvement of the target group in the development of the PPI; Content of the PPI; Applicability for the target group; Extra inclusions in the intervention; and The impact on motivation for treatment.*

##### 2.4.1.3.1 Design and layout of the PPI

The design and layout of a PPI are the first connection that the participants make with the intervention. It, therefore, needs to excite them to participate in the intervention. During the focus groups discussions it seemed as though the people with SUD positively connected with the "Sunflower'' metaphor and also experienced a sense of togetherness. One person with a SUD stated: *'... It shows there is positiveness in the program. So, anybody that will be looking at it as an addict, they would already be attracted to the program to say "okay now there it looks like there's hope for us. You know, let's choose sunflower! So, for me it's just that it shows a lot of positiveness and like they mentioned, you know, connection. Standing together…'*

Experts identified with the example the "Sunflower" set for people with SUD*: 'I think it's a majestic flower. So, it's always standing upright and high above others. So, then it's like you can*

*achieve, and you can become that.'* Experts also referred to how the "Sunflower" inspires people with SUD to change: '*So, because you down and fallen and whatever and everybody looks down on you now, but you can rise to that level then.'*

#### 2.4.1.3.2 Involvement of the target group in the development of the intervention

Experts and people with SUD also appreciated the involvement of the target group in the development of the intervention and adhering to their needs. During the focus group discussions, one person with SUD stated: *'[…] You understand, and for a change, it's refreshing to have a part to play in your own recovery because I think that's only your basic instincts like you still want the best for yourself regardless of all the contradictory actions and your multiple behaviour that you might be […] (inaudible).'* People with SUD felt it is important to be able to participate in their own recovery.

People with SUD also valued being involved in the intervention's development: '*So, to have gone through all this effort, I think really involving addicts in developing this. I think it's only going to result in great approval.'* This notion was also supported by the feedback from experts during the focus group discussions*: 'I think the practical, the fact that you heard from the patients themselves it makes such a huge difference.'* Experts also mentioned: '*Often, we have all of these ideas, but to actually go to them and to identify a few things that they need and that they would want, and then in a practical way to address that need. I think that's really good. Positive.'* During the focus group discussions, both experts and people with SUD valued the involvement of people with SUD in developing the intervention.

#### 2.4.1.3.3 Content of the PPI

One person with SUD mentioned the following about the content of the PPI during the focus group discussions: *'[…] this can be like a starter guide, and then when you ready for that step work (treatment programme), you can now bring that upon yourself because now you really*

*know your strengths, you know who you are. So now it would be much easier for you to be able to do the step work (treatment programme) because you won't get so lost in doing it.'* This person felt that the intervention could be used at the beginning of their treatment to prepare them for their treatment programme. They also mentioned that the PPI could assist them in identifying their strengths and help them with self-knowledge. Another person with SUD mentioned: '*[…] but the thing is when you are in active addiction or when you are an addict, there's feelings and things that you still need to work through and find out about yourself why do you use drugs in the first place before you can come to the sunshine part of it. Do you understand? This can be the happy part of your recovery. This programme can be used to guide us further in our recovery after going through the step programme.'* This person felt that the Sunflower PPI could rather be used towards the end of their treatment and during recovery. According to the feedback of people with SUD, the Sunflower PPI can subsequently be used at the beginning or towards the end of their treatment and recovery.

During the focus group discussions, one of the experts had the following view on the intervention: '*For me, I think that it, it's filling the gap that was already there. You know, we've already identified. So, it's talking to the treatment programme, enhancing it, you know, and in a much more positive way, it's also meeting the needs of the clients.* This expert felt the intervention could support the already existing treatment programme and even enhance it in a more constructive way. The expert stated: '*Like you said, you now identified their needs. So, I think it's something that can be used in different levels of the treatment programme. We can use it with our adolescents, with our adults, with our families.'* The expert, therefore, felt the intervention could be used in different levels of the treatment programme and with people in different stages of development.

During the focus group discussions, one of the people with SUD stated that the intervention made them feel enthusiastic about their recovery: '*You took us through the book briefly with a*

*small explanation, but I, from inside, I can tell you that I feel so positive and happy about this, like you excited about your recovery. It's a good thing. It's something you are looking forward to.*'

Another person with SUD mentioned the following about the teaser activity they participated in: *'Okay, you know what? Before you came in here, I was still like confused with my strengths, and just by looking at these cards, I could identify my strengths!* This person also found that the activities used in the intervention were easy to relate to, thus on the level of the people with SUD. People with SUD may therefore find it easy to engage with the content of the PPI.

#### 2.4.1.3.4 Applicability of the PPI

As far as the applicability of the PPI is concerned, one person with SUD stated: *'[…] it is great to have a programme that is active in helping to reintegrate us back into it and helping us to stand on our feet again because you know, a sense of self-worth means everything in times like this.'* This person felt that the intervention would help them even after they have completed their treatment. It would also help them to be in control of their own lives, feel good about themselves and respect themselves.

*'Some of us haven't heard compliments in such a long time that we've painted pictures of ourselves that are just negative because that's all you've ever hear from other people and you start to believe it because you take that and you compare it with the things you've done in relation to the. But then we tend to forget to listen, you will do 99 good deeds, and the world will remember the one bad one* (Person with a SUD)*.'* People with SUD specifically mentioned the intervention activities that focus on complimenting each other in Workshop 3 (theme: *Learn to be Kind*). The reason may be that they enjoyed the activity because they never receive a compliment.

Many of the *suggested additions to the intervention* mentioned by people with SUD and experts were already included in the PPI. However, participants overlooked them, as there was

not enough time to browse through the full intervention during the focus group discussions. During the focus group discussions, one of the people with SUD suggested adding a glossary in each workshop to simplify the English in the PPI for people who may not be fluent in English: *'[…] I was gonna refer also to the inner depth of the phrasing of words. Some of them are just too Encyclopaedish, deep English, ja. So just simplify it a bit. I don't know, but not throughout the whole thing as a book, but if only the English was that much simpler cause some of them aish […]. Where it shows you a bit more of the word. So, for some people who are struggling with English.'* Subsequently, a glossary was added to the final intervention.

People with SUD also suggested adding a personal contract at the beginning of the PPI; a sort of agreement with yourself: *'[…] at the beginning of the book, gives you like a small summary what the book is about, you sign the book. It's like signing an agreement with yourself. "I'm gonna try and achieve these goals, and I'm trying to establish this in my life […].'* This may give the people with SUD a sense of ownership.

When focusing on the intervention's facilitation, during the focus group discussion with people with SUD, one participant mentioned: *'This programme requires like someone who has been into drugs and went out of drugs […].'* This person felt that a person in recovery (former substance user) could be a good peer coach for this intervention. This person continued saying: *'[…] and learned something through the entire programme on how to stay sober.'* This person with SUD felt that the peer coach should also have participated in the intervention.

Lastly, the people with SUD also wanted to have a self-appreciation activity included at the end of each workshop to celebrate their personal achievements during the workshop. One of the people with SUD stated: *'Like you know, in the book, whereas like you can write down like at the end of every day some kind of a pat on the back for something good that you did today instead of focusing on something or on the bad. Even if it's the smallest thing, but it's good then you can write it down.'*

#### 2.4.1.3.5 Motivates people with SUD to maintain their treatment

During the focus group discussions, both experts and people with SUD agreed that the intervention motivates people with SUD to maintain their treatment**.** One expert in the focus group stated*: '[…] if this person (person with a SUD) knows that this programme involves family and involves staff members and they have a say in your own treatment, if they know all these things it will motivate them to complete their treatment […]* Another expert agreed: '*Yes, sustain their recovery once they have completed their treatment.'*

They also felt that the intervention would prepare them for reintegration; after completion of their treatment, one person with SUD mentioned: *'[…] You groom us as well for the outside world, whereas when we go for a job and things, you guys help us with that as well and what is most important, you know, it gives us hope, like you said about the routine.'* This person also mentioned that the intervention imparts a sense of hope and assists them with their daily routine. On motivation for treatment, one of the experts in the focus group stated: *'They here because they just have to be here. So, they not really motivated. They want to just finish it; they not gonna RHT (note from the author: refuse hospital treatment – drop-out of treatment) because there might be other consequences for them. "So, let me just finish from here, but maybe this motivation thing can be something that will really turn them around.'* This expert felt that this motivational intervention might stop a person with SUD from dropping out of treatment.

### 2.4.1.4 Step 4: Adaptation of the PPI using the collaborative development feedback

All the additional inclusions, as suggested by the people with SUD and experts during the focus group discussions, were incorporated into the Sunflower PPI. The second draft of the PPI was finalised (see Appendix D) and *Step 5: Dissemination and Assessment* ready to be implemented.

As already mentioned, this step was not included in this study due to the large scope of disseminating and assessing the intervention.

### 2.5 Overview of the Sunflower PPI

The Sunflower PPI was developed to complement the already existing treatment programmes. The aim was to facilitate it over three consecutive weeks, twice per week, ensuring that it did not disrupt the already existing treatment programmes but rather complement it. It would, however, depend on what would best work for each treatment centre. The intervention consisted of seven workshops.

Workshop 1: Play to your strengths. This workshop focused on strengths and how people with SUD can start practicing their signature strengths while in treatment and during recovery to enhance their competence (Quinlan et al., 2012). An overview of the 24 strengths was provided, and participants were assisted in selecting their top five strengths using posters developed for each of the 24 strengths (This was done in the form of a '*strength art gallery'* activity). Following this, participants were given time to reflect on how they can use their top five strengths during recovery, specifically during treatment. As part of their '*bloom with grace'* activity, they had the option to discuss this with their therapist during an individual session.

Workshop 2: My best possible self. The focus of this workshop was for participants to find the best version of themselves and leaving behind the mask of substance misuse, thus enhancing their autonomy and competence. According to Malchiodi (2010), mask-making has been around since early times and has been used in storytelling, ceremonies, and dramatic enactment. By making a mask, the person with SUD can see his dilemma more clearly. Through creative arts activities, participants created a mask representing their substance misuse and shared their story through scriptwriting. They also created a best-possible-self-hat, representing the best version of themselves once they removed the mask of substance misuse (Altintas et al., 2020). As part of the '*bloom with grace'* activity, the participants had time to reflect on their masks and best-

possible-self-hats. They were allowed to complete a more structured activity around visualising and reflected on their best possible selves. The final activity forming part of '*bloom with grace'* was a letter of atonement. Part of recovery is to understand the hurt that people with SUD may have caused through their substance misuse that became evident when they made their masks. They had the opportunity to decide (autonomy) if they wanted to write a letter of atonement that may or may not be read to the person (or people) they have hurt. A structure was provided to make it easier for them to write their letters. Their therapists also assisted them if they struggled in any way.

Workshop 3: Learn to be kind – this workshop is for people with SUD and treatment staff and aimed to enhance relatedness between people with SUD and staff members in the treatment centre. The workshop started by focusing on the importance of spreading kindness, followed by a '*sweet appreciation'* group activity where people with SUD and staff praised each other while eating sweet treats. The workshop attended to self-appreciation linked to positive self-talk followed by a group activity focused on love languages where each participant discovered their primary love language. These love languages were shared in a circle, and participants attempted to *speak* the other participant's primary love language in the treatment centre. As part of the '*bloom with grace'* activity, the participants could reflect on the workshop through positive journaling. Lastly, they were given a structured activity about the '*circle of control'* to enhance their autonomy.

Workshop 4A: An attitude of gratitude. The workshop aimed to understand the power of gratitude and how to practice gratitude during treatment and recovery, thus enhancing competence. The workshop started with discussing the importance of living a life of gratitude, followed by a personal activity focused on how to be more grateful. Participants engaged in a pair-up activity regarding '*benefit finding'* to identify what part of their life of substance misuse they should be grateful for. The final activity was a personal activity where they wrote a letter of

gratitude to someone they wanted to thank. As part of the '*bloom with grace'* activity, the participants reflected on the workshop through positive journaling. They also selected a gratitude stone to use during their treatment and recovery.

Workshop 4B: Gratitude visit. This workshop involved family, significant others, friends, staff, and people with SUD. People that the person with SUD wanted to share their gratitude letters with were invited to come for a gratitude visit at a time that suited the treatment centre. This enhanced the people with SUD's autonomy, competence, and relatedness. Everyone present started by engaging in a '*gratitude tree'* activity where participants wrote things that they were grateful for on already cut-out leaves, which hung on a tree branch that was put in a vase with stones supporting it. Everyone could share what they were grateful for before hanging their leaves on the tree. Once done, they could reflect on the activity. Letters of gratitude were shared within a circle dialogue, and time for identification and appreciation for the letters were provided. Private family time was also given after the circle dialogue for people with SUD to share their letters of atonement. Family, significant others, and friends, for example, could take the letters home to read in their own time. The final activity was a certificate presentation. Staff members presented certificates of appreciation to each of the people with SUD (a template for these certificates is provided in the trainer guide). As part of the '*bloom with grace'* activity, the participants had the opportunity to reflect on the gratitude visit through positive journaling.

Workshop 5: Hope and recovery – this workshop centered on hope in recovery, focusing on developing a personal purpose statement and understanding the importance of hope in recovery. There is a specific section allocated to '*leaning on a higher power'* in this workshop that links to developing relatedness. The workshop started with a warm-up activity for participants focused on developing a personal purpose statement for their treatment and recovery. This may address the need for autonomy because the participants choose what their purpose is. It may also satisfy the need for competence because participants exercise the capacity to construct a way forward.

This was followed by an information session about the importance of hope in recovery. Participants engaged in a '*life spiral exercise'* to identify three trigger experiences that shaped their life story. They also wrote about the lessons learned in each stage. If willing, they could choose a friend to share it with. The workshop ended with a '*goal setting and hope'* personal activity in the form of a visualisation. Following this, the participants had time to evaluate the exercise. As part of the '*bloom with grace'* activity, the participants reflected on the workshop through positive journaling. Participants were also allowed to '*plant hope.'* They received instructions and equipment (e.g., a container and seeds) to plant sunflower seeds. These skills aimed to teach people with SUD responsibility and consistency (competence). They may to take their sunflower plant with them once they have completed their treatment.

Workshop 6: Rise and shine. This is the last workshop of the PPI and focuses on the importance of having a daily routine when recovering from SUD. Both competence and autonomy were enhanced through this workshop. It started with creating an understanding of the importance of having a healthy daily routine in recovery. They engaged in a personal activity reflecting on their day's achievements by asking themselves: '*What good have I done today?'* This was followed by creating a daily routine for their recovery using a template provided. As part of the '*bloom with grace'* activity, the participants reflected on the workshop through positive journaling. The intervention ended with a personal activity: '*I am poem'* (reflecting on skills learned during the Sunflower PPI). The participants received the outline of an '*I am poem'* that they could populate. They could also choose not to use the given structure and write their own poem. This was, in essence, their own evaluation of their personal growth during the Sunflower PPI and a celebration of their achievements. They could also use it to reflect on during their recovery.

## 2.6 Discussion

This study's objective was to gain a better understanding of what should be included in a positive psychology intervention (PPI) that aspires to improve intrinsic motivation for the treatment of substance use disorders through the intervention. The development was informed by the self-determination theory (SDT) with a specific focus on using the basic psychological needs as the core of the PPI.

People with SUD and experts had concrete ideas on how to improve need fulfilment during treatment. They were also able to make additional suggestions for inclusions in the PPI that would improve the intervention. These findings support Yardley and colleagues' (2015) conclusions regarding the client-centered approach, which focuses on developing interventions based on an in-depth understanding of the viewpoints and context of users of the intervention that are acquired through comprehensive qualitative research. The findings also confirm that obtaining and addressing the needs and views of the intended intervention user (in this study, people with SUD in active treatment) is a particularly important part of intervention development that ensures that the intervention is valid and engaging (Baker et al., 2014; Pagliari, 2007; Van Gemert-Pijnen et al., 2011). Therefore, this intervention may be useable and appealing to people with SUD, as it was specifically developed based on needs, as identified and confirmed by people with SUD and experts during the focus group discussions.

Another interesting finding was that people with SUD and experts' needs might have been fulfilled by the participatory process used in developing the intervention. Participatory approaches appreciate that communities and people should be the focus of social and health care systems and should have an influential role in identifying needs and the development of services and policies (Department of Health, 2006). Having the opportunity to suggest new additions allowed participants to take charge and make autonomous choices. People need to feel in control of their own behaviour (Deci & Ryan, 2008), and people with SUD subsequently gave their input

and made suggestions. They displayed being accountable for their own recovery. Therefore, their need for autonomy may be satisfied, and they may experience a sense of integrity as their thoughts, feelings, and actions are self-endorsed and true (Vansteenkiste et al., 2020). This participator process could also have improved people with SUD's *competence.* They shared their knowledge around what they would need to motivate them for treatment, and it informed the development of the PPI. They also made suggestions for adaptations to the PPI to improve it. Their need for competence may be satisfied because they were capable of identifying what additional activities could be included in the PPI using their skills and expertise (Vansteenkiste et al., 2020). Being in a group, working on a shared goal may also have had an impact on the people with SUD's *relatedness.* It could have resulted in people with SUD experiencing a sense of belonging, warmth, and care during the focus group discussions that could have signified relatedness, as confirmed by Vansteenkiste and & Mouriatidis (2016).

The participation of a vulnerable group in active treatment in the focus group discussions was substantial enough that it informed the development of the intervention. Involving vulnerable groups as participants in research allow them to experience the benefits of participating in research (Pyer & Campbell, 2012). If people with SUD were not included in this research, the findings could not have applied to people with SUD, thus excluding them from the benefits of improved treatment (Pyer & Campbell, 2012). With this study, people with SUD used the opportunity to reflect their needs through the focus group discussions, and it informed the development of an intervention. Other people with SUD and perhaps even themselves may benefit from this intervention in the future.

The involvement of experienced experts from multi-disciplinary teams added additional value to the research study. The advantage of multidisciplinary teams in practice is that the discussion can be extended, issues resolved, and outcomes can be identified quicker due to a wide range of team members working together (Meier, 2020). Furthermore, professional inputs from people

from different backgrounds (i.e., religious workers, social workers, nurses, and caregivers) provided feedback from diverse vantage points in this research. This was especially important when experts evaluated the first draft of the intervention as the researcher could improve the intervention based on their knowledge and experience in the field of SUD treatment and the facilitation of treatment programmes.

Basing the development of this PPI on theory (SDT) assisted the researcher in understanding the needs of people with SDT that subsequently enhanced their intrinsic motivation for treatment. This supports French and colleagues' (2012) findings that theory can be used to recognise the factors that could impact the behaviour change being targeted. They also state that understanding these factors may help underpin feasible activities that might be used to change substance misuse behaviour. Evidence from theory can also inform which behaviour could be changed and which interventions and modes of delivery may be effective (French et al., 2012). This intervention was developed based on theory and feedback from people with SUD and experts. Each activity in the intervention links with a need (SDT) identified and was confirmed by people with SUD and experts.

This study is, however, not free from limitations. One of the limitations may be that, for the vulnerable group of people with SUD suffering from feelings of guilt and shame, using focus group discussions may not have been the best way to fully and openly participate. Although focus groups offer a caring environment to participants, the group context may create a sense of open vulnerability (Sim & Waterfield, 2019). However, focus groups have the advantage that they are useful in producing a rich understanding of participants' experiences and viewpoints (Morgan's (1997) study as cited in Sim & Waterfield, 2019) and were therefore used in this study. Individual interviews, on the other hand, are intimate and private and protect participants' vulnerability (Ransome, 2013). For future research, it would be ideal to combine focus groups and individual interviews {i.e., talking to people who did not speak up during the focus groups}.

Furthermore, the participants may not have had ample time to look at and engage with the PPI when the researcher went back to evaluate the PPI. The researcher did not want to request more time from the participants as it would have impacted their treatment programme. It would have been ideal if a copy of the PPI could have been given to them before the focus group discussion to prepare. In future studies, it would be useful to provide enough time for the participants to evaluate the PPI in their own time.

The transferability of the findings of this study is limited. Most qualitative studies do not aim to generalise but rather provide an in-depth, contextualised understanding of a specific form of human experience through the rigorous study of specific cases (Polit & Beck, 2010). Within this study, where evidence to improve treatment motivation was especially important, the transferability in relation to knowledge claims deserves careful attention (Polit & Beck, 2010). The findings in this study are only based on the experiences of a limited group of people with SUD and experts. They were from two in-patient centres and one province in South Africa. However, the target group (people with SUD) included different culture groups, age groups, genders, and people in treatment for various substances. Expert groups consisted of different role payers within the multidisciplinary team (e.g., social workers, religious workers, medical staff members, caregivers). The treatment centres included in the study were from a large city and situated in a rural area, respectively. It would, however, be valuable to extend the scope to other clinics and people with SUD in different provinces in South Africa.

It would also have been ideal if the Sunflower PPI could be assessed and disseminated to other treatment centres. The research design used in this study was informed by what McBride (2016) refers to as the Intervention Research Framework. This framework is a scientific guide to inventive and evidence-based intervention development and is used to evaluate these interventions. It includes the following four phases: notification, development, assessment, and dissemination. This study focused on the first two phases only, namely notification and

development. It would consequently be important to also include the last two phases to ensure an adequate understanding of the PPI's feasibility in relation to the enhancement of intrinsic motivation for the treatment of SUD. This could inform future studies that are utilising the Intervention Research Framework.

This study has implications for theory and practice.

From a practical perspective, based on the research findings, there are several recommendations for treatment centres. Involving people admitted for treatment of SUD (those whose behaviour change is the focus of attention) in the development and evaluation of the intervention may provide insight into the data that are collected as well as the viability of the intervention. Another practical contribution is that this study resulted in the development of a new PPI. This intervention was created during the course of the study.

Furthermore, using the triangulation method, by designing in conjunction with both the target group and experts (setting implementors of the intervention), may alleviate bias, support social change, and reach data saturation through these multiple sources.

Also, based on the feedback received during the focus group discussions, treatment centres may consider allowing people with SUD to play a more active role during treatment. This may enhance their fulfilment of autonomy and competence (e.g., choosing to play different roles during group work sessions), opening and closing the session or appreciation of participation, and their free time (organising structured after-hour activities coordinated by people with SUD) in the treatment centres.

Treatment centres can also assist people in treatment by connecting them with opportunities that will enhance their need-fulfilment. This can include finding work, mentoring people in recovery while working, upskilling them (e.g., computer skills and creating opportunities to volunteer in their communities), thus satisfying their need for competence.

Treatment centres may also want to consider implementing creative ways to celebrate people with SUD's sobriety. This may fulfil their need for competence and consist of, for example, giving out badges, tokens, or certificates for the number of days being sober. People with SUD may also be given a choice about how they would like to celebrate their sobriety, thus satisfying their need for autonomy.

Having a support group for family members and significant others running concurrent to the SUD treatment programme may assist the family in understanding SUD and reconnect with people with SUD, thus fulfilling the need for relatedness.

During the focus group discussions, the feedback from people with SUD and experts revealed how their current treatment could be improved. Given the findings, it appears that the current treatment in the clinics insufficiently addresses basic psychological needs fulfilment and intrinsic motivation for people with SUD. This supports Philips and Wennberg's (2014) findings on therapy motivation for patients with SUD. Their study indicated that amotivation is a risk factor for treatment dropout, and they recommend that more effort should be directed at preparation for treatment through enhancing motivation (Philips & Wennberg, 2014). The Sunflower PPI is likely to increase well-being and motivation because all three needs of people with SUD are addressed in concrete ways. Implementing this intervention in support of a current treatment programme may therefore improve intrinsic motivation.

## 2.7 Conclusion

During this research, both experts and people with SUD were able to express how their basic psychological needs of autonomy, competence, and relatedness can be improved during treatment of SUD. The researcher was able to develop a comprehensive intervention based on the findings. By going back to the clinics for evaluation after developing the PPI, the

intervention was subsequently adapted and further improved based on the participants' suggestions and additions.

This intervention has the potential to increase well-being and motivation (SDT), as all three needs are addressed in concrete ways. These needs were identified, confirmed, and improved by experts and people with SUD.

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# CHAPTER 3

# DISCUSSION, STRENGHTS, LIMITATIONS, RECOMMENDATIONS AND CONCLUSION

This chapter includes a discussion about the findings in the literature and the study's strengths and limitations. Recommendations are made specifically for SUD treatment centres and future research. Lastly, the conclusion is given.

## 3.1 Discussion

The self-determination theory (SDT) assumes people are intrinsically motivated towards psychological development and integration, and thus towards connection with others, being in control, and learning. Nonetheless, these positive human tendencies are not regarded as certain – they require supportive environments to be healthy (Ryan & Deci, 2020). This study looked at SDT in the context of treatment for people with SUD.

This study's objective was to gain a better understanding of what should be included in a positive psychology intervention (PPI) that aspires to improve intrinsic motivation for the treatment of substance use disorders through the intervention. In this study, people with SUD and experts from two treatment centres were asked to identify what they would need to increase their motivation for treatment in focus group discussions.

First, it was found that experts, and more specifically people with SUD, felt that all needs were important, which is in line with the Basic Psychological Needs Theory (Centre for Self-Determination Theory, n.d.). Participants had concrete ideas on how to improve need fulfilment during treatment.

### 3.1.1 Relatedness

Among the goals of effective SUD treatment are abstaining or controlling substance use, developing a steady support system, developing and improving social skills, including refusal skills, and attaining secure and supportive family relationships (Goodwin, 2015). Therefore, it was not surprising that ***undergoing treatment for their family*** and ***family participation*** were two of the themes reported by people with SUD and experts during the focus group discussions. People with SUD showed an understanding of the pain they have caused their family and acknowledged the important role their families play in maintaining their sobriety. Experts mentioned the importance of rebuilding broken relationships while people receive treatment for SUD.

Literature supports this finding. According to Daley (2013), family sessions during SUD treatment can help families address their uncertainties and change the way they engage and communicate within their families. Family members can receive support regarding their own personal problems and behaviours that can impede the treatment of the person with SUD (Daley, 2013). Daley (2013) also mentioned that interventions could be delivered through individual family sessions or family support groups, which offer a caring atmosphere for families to communicate their shared encounters and fears. Families can connect and learn from each other during family sessions (Daley, 2013). In the development of the Sunflower PPI, the plan was to offer sessions with family members and significant others.

From the focus group feedback on the needs assessment, people with SUD were also motivated for treatment by ***people in recovery***. People with SUD felt that people in recovery might encourage them to be sober by the example they set. Cabral and Smith (2011) confirmed this, as their study showed that employing individuals from parallel demographic backgrounds who have gone through the recovery process themselves can improve people with SUD's willingness to participate in treatment, trust, engagement, and retention.

Peer recovery coaches (PRCs), who are individuals with lived experiences with SUD, may be uniquely positioned and experientially qualified to assist people with SUD with their treatment programme. PRC interventions have been linked with reduced substance misuse, decreased SUD relapse rates, increased treatment retention, enhanced social support, improved relationships with treatment staff, and greater treatment satisfaction (Bassuk et al., 2016; Reif et al., 2014). PRC will therefore participate in the Sunflower PPI by sharing their success stories with people in SUD treatment.

Another important need identified by people with SUD was ***religion***. According to Chan and colleagues (2019), religion serves as a form of spiritual support to which people with SUD can connect to find psychological support to resist the misuse of substances. People with SUD supported this notion and mentioned that having a relationship with God is a very important connection they need during their treatment for SUD. Spirituality has an important role in substance misuse self-help programmes, such as Alcoholics Anonymous (AA) and other 12-step treatment programmes (Martin et al., 2011).

This finding, based on feedback from two South African SUD treatment centres, also provided knowledge specific to the African population. Beraldo and colleagues (2019) found that spirituality is essential for interest groups such as African-American, Latino and American-Indian populations. These interest groups' traditional beliefs, which are usually deeply founded in religion and spirituality, may greatly support people trying to recover from SUD (Beraldo et al., 2019).

Hendriks and colleagues' (2019) bibliometric analysis on PPIs revealed that positive psychology was until lately culturally biased due to the bulk of randomised controlled trials (RCTs) on the efficacy of PPIs derived in Western countries. However, there was a distinct rise in non-Western countries' publications since 2014, representing one-third of the studies (Hendriks et al., 2019). Hendriks and colleagues (2019) recommend that more studies on PPI's

efficacy in non-Western countries are needed. The future dissemination and assessment of the Sunflower PPI may contribute to studies from an African perspective.

Hendricks et al.'s (2019) analysis revealed that life review and spiritual activities were the most used activities in non-Western countries. It is thus evident that spirituality and religion may support recovery from SUD, especially since it forms part of the African population's traditional beliefs. Spirituality was, therefore, included in the Sunflower PPI.

People with SUD and experts also emphasised the importance of ***staff support***, with specific reference to support from social workers in the treatment centre. They stated that the care and support received from social workers and the treatment centre are central to their progress. A good relationship with the social worker seems to influence substance misuse. In addition, Gibbons et al. (2010) found during a brief behavioural treatment that cannabis use decreased as the therapeutic alliance increased. Crits-Christoph et al. (2013) also concurred that positive therapeutic alliances were related to a reduction in cocaine use. Furthermore, Urbanoski et al. (2012) found that improved therapeutic alliances were linked with better process outcomes in residential substance misuse treatments, including decreases in emotional distress. Other studies corresponded with the finding that positive therapeutic relationships lead people with SUD to engage in less drinking and substance misuse; the people with SUD also remain abstinent for a longer period and are more involved in their treatment than those with weaker associations (Connors et al., 1997; McKay et al., 2009). Experts participating in the focus group discussions agreed. They found that building a trustworthy relationship with people with SUD will assist them in making themselves vulnerable, and in return, this will result in behaviour change.

According to people with SUD, the ***support from fellow group members*** plays a vital role in motivation for treatment. They shared that the identification with one another, encouragement, and motivation from other people in treatment play a significant role in learning how to relate to other people. Von Greiff and Skognes (2017) agree that group members that are further along in

the recovery process bring experience to the group and can serve as motivation for other group members. Research has shown that group cohesion is one of the crucial aspects that improve a person with SUD's chances to change (Greenfield et al., 2013; Pooler et al., 2014).

### 3.1.2 Competence

People with SUD stated that waking up with a ***sense of purpose*** creates meaning in their lives, and when they live a meaningful life, there is no place for substance misuse. According to Weinstein et al. (2012), meaningfulness is connected to doing activities that are self-chosen and compatible with one's personal acceptance. Competence is satisfied when a person is effective in these activities (Baumeister & Vohs, 2002). The Sunflower PPI, therefore, includes activities to build a sense of purpose for people with SUD to live a more meaningful life that may result in feeling more competent.

During the feedback, people with SUD stated that they need ***more activities*** to keep them busy during treatment as boredom can be a trigger to start using substances again. They also mentioned that activities should be on the education level of the people with SUD. Thus, the people with SUD felt that activities are on a level that does not match their interests.

Legault (2017) states that the need for competence promotes determination, awareness, and sustained effort. Subsequently, people enjoy tasks that are stimulating rather than easy and boring (Legault, 2017). When people, therefore, participate in activities that are challenging, their need for competence is satisfied.

According to The National Institute of Drug Abuse (2015) in the United States, people with SUD are more likely to suffer from mood disorders such as depression and anxiety than people in general. Good-humoured activities involving amusement and drama might increase ambiance and be effective healing tools for people in SUD treatment (Ramseur & Wiener, 2003). Settings must accommodate the requirements of varied groups at different stages of recovery but need to

be focused enough to promote meaningful activities (Bustos et al., 2016). Therefore, interventions with people with SUD should be well-structured, though playful and fun to ensure that people with SUD do not become uninterested. Structured, fun, and playful activities were included in all the workshops of the Sunflower PPI.

When focusing on the ***development of skills*** for people with SUD, Bonanno and Burton (2013) found that individuals with adequate skills may be better equipped to face high-risk situations. These individuals have a wider variety of choices besides misusing a substance when confronted with a demanding situation (Roos & Witkiewitz, 2016). An effective skillset may also promote a bigger capability to resist misusing substances in high-risk situations (Marlatt & Gordon, 1985). During the focus group discussions, people with SUD concurred that more time should be spent on developing their skills and abilities during treatment. Skills development is an essential tool during recovery and should form part of treatment interventions, and thus, the researcher included it in the general guidelines for treatment centres.

During the focus group discussions, people with SUD and experts felt that people with SUD ***need more opportunities*** to prove themselves and not always feel not accepted as substance users. McKay (2017) argues that motivation for treatment can be sustained to the degree that the person in recovery keeps believing that staying sober will be worth the effort it entails. Unfortunately, many people with SUD do not have a lot of natural reinforcers for sustained recovery. For many, lack of education and job skills makes possibilities bleak for meaningful employment that provides a decent income (Henkel, 2011). The need for competence refers to the individual's desire to influence the environment and reach desired results (Deci & Ryan, 2000). This need is articulated by a person's inclination to engage in specific activities that will allow them to develop their skills and new abilities (Deci & Ryan, 2002). Therefore, when one feels capable enough to carry out a task to the best of their ability, their need for competence is satisfied, making it more likely to reach one's goals (Deci & Ryan, 2000, 2002). When people

with SUD mentioned that they need more opportunities to prove themselves, they may want to have a job to feel capable enough to care for their families and themselves. They would then also be able to influence their environment by providing for their family, something they were lacking when still actively misusing substances.

It would, therefore, be a valuable contribution to the normal programme for treatment centres (included in the recommendations for practice) to create networking opportunities with local businesses for people with SUD seeking employment. They may also consider creating projects where they mentor people in recovery during the first few months when they are in early recovery and allow people with SUD to volunteer to participate in community projects to engage with their communities while in recovery. This may result in them finding a job and proving that they can still provide for their families and themselves, thus enhancing their need for competence.

### 3.1.3 Autonomy

If the structural value of people with SUD is not recognised, there is no space for the fulfilment of autonomy (Lago et al., 2020). According to Lago et al. (2020), people with SUD lose the skills to govern their own lives during the progression of their illness. They feel it is particularly important for treatment staff to share responsibility with the person with SUD within the therapeutic process to allow the person with a SUD to develop much needed autonomy (Lago et al., 2020). During the focus group sessions, people with SUD and experts agreed that people with SUD want to ***play an active role in their treatment***. Experts and people with SUD felt that people with SUD need to take responsibility for their own recovery and be vigorously involved in their own treatment. People with SUD also mentioned during the focus groups that their social workers allowed them to ***make their own choices*** and not direct them to what they should or should not be doing. The social workers working in the treatment centres where the study was conducted created a space to fulfill autonomy as they allowed people with SUD to share

responsibility and decision-making during treatment. This may be because the social workers respect people with SUD by employing empathy, thus trying to understand their emotions and experiences. Entwistle and colleagues (2010) confirmed that professions working with people with SUD not only demonstrate respect for the person with SUD as a person but also enhance the autonomous capacity of people with SUD. The Sunflower PPI, therefore, includes a variety of activities that allow people with SUD to make their own decisions and take responsibility for their recovery to enhance their already existing autonomy.

Lastly, people with SUD mentioned that they ***want to be in control of their own lives***; they said that a daily routine would assist them to feel in control of their lives again. Oliver (2019) confirmed that in an attempt to manage their recovery better, it is crucial to begin developing routines early in the process. During treatment, people with SUD are expected to adhere to the structure of the treatment process within the treatment centres, which entails participating in the daily routine as set out by the treatment centre. Many people with SUD do not have well-structured routines before treatment and find themselves with ample free time as they get sober. Developing a routine can provide comfort and structure to reduce restlessness and stress (Oliver, 2019), especially when they have completed their in-patient treatment. Developing a daily routine was thus incorporated into the Sunflower PPI.

SDT focuses on people's innate motivational inclinations for education and flourishing and how it can be maintained (Ryan & Deci, 2020). The basic psychological needs of relatedness, competence, and autonomy is associated with psychological well-being, which is a major occupant of SDT (Flannery, 2017). When the social context aids these three basic needs, a person is more likely to engage in intrinsically motivated behaviours. Therefore, if the environment fosters these three needs, then an individual's behaviour can be expected to be self-motivated (Flannery, 2017). As shown in the previous discussion, experts and people with SUD

felt that all needs were essential, and they were able to identify what they would need to feel better.

According to Flannery (2017), relatedness is one of the basic needs of intrinsic motivation and refers to the need for secure and close personal relationships. People with SUD and experts felt that *relatedness* could be stimulated by incorporating sessions with family during treatment of SUD. This could offer a supportive environment in rebuilding broken relationships and maintaining sobriety. They also want to be encouraged by people who have already gone through the recovery process. This may further result in enhanced social support and improved relationships with treatment staff, thus improving the need for relatedness. According to people with SUD and the experts, religion will further enhance relatedness because people with SUD can find psychological support through their connection with a higher power. A reduction in substance misuse can result from a positive therapeutic relationship, also mentioned as a necessity that will enhance relatedness.

Finally, the close relationships with fellow group members during treatment may improve relatedness because it teaches people with SUD how to relate to others through identification, encouragement, and motivation.

*Competence* is the need to feel self-assured, capable, and valuable in one's actions (Ryan & Deci, 2000). People with SUD and experts felt that *competence* could be enhanced during treatment if people with SUD can have a sense of purpose that creates meaning in their lives. Meaningfulness is connected to doing activities that are self-chosen and support self-acceptance. Competence will be satisfied when a person is effective in these activities. Participants also felt that their activities during their treatment should be more challenging to satisfy their need to feel capable. People with SUD and experts mentioned that if more time is spent on developing their skills and abilities during treatment, it will promote their self-efficacy, thus resulting in a higher level of competence. Finally, the participants felt that there should be more opportunities for

people with SUD to prove themselves. They may want to have a job to feel capable enough to take care of their families and themselves. They would also be able to influence their environment by providing for their family, something they were lacking when still actively misusing substances.

Flannery (2017) states that strategies that support *autonomy* include acknowledging feelings, giving people choices, and providing patients with the ability to self-determine their behaviour. The research participants felt that their autonomy would be enhanced if they play an active role in their treatment by taking responsibility for their treatment and making their own decisions. Finally, people with SUD felt that having a daily routine may assist them in being in control of their own lives. A daily routine will provide people with SUD the ability to self-determine their daily activities and thus support their autonomy.

If activities aimed at fulfilling these identified needs are incorporated in a PPI, it may satisfy the basic psychological needs, thus igniting the intrinsic motivation of people with SUD for their treatment.

### 3.1.4 Discussion on feedback from second set of focus groups

Next, the focus will be on the main findings that were produced in relation to suggested adaptations to the first draft of the PPI.

A number of overarching themes were identified which centered on the design, layout, and structure of the PPI, the involvement of the target group in the development of the PPI, the content of the PPI, applicability for the target group, extra inclusions in the intervention, and the impact on motivation for treatment.

#### 3.1.4.1 The design, layout, and structure of the PPI

People with SUD and experts were able to relate to the ‘Sunflower’ metaphor used in the PPI in a very positive way during the focus group discussions. They felt that it could inspire people with SUD to change. Metaphors can be vital instruments in the healing process, presenting the therapist with a method of conveying possible intricate mental notions and principles to participants partaking in the change process (Killick et al., 2016). Also, the ‘Sunflower’ metaphor may assist people with SUD to be encouraged to change.

#### 3.1.4.2 Appreciation of the involvement of the target group in the development of the intervention

The feedback from people with SUD and experts concurred with the ideas of people with SUD that it is inspirational to play a role in their own recovery, and it also made them feel more in control. A collaborative approach between multi-disciplinary teams, the target group, academics, and policymakers is needed to develop interventions (Wright et al., 2016). Wright and colleagues (2016) further state that such a collaborative approach improves the applicability to the target group's identified needs, thus enhancing the effectiveness of the intervention. This collective development process stimulated the people with SUD’s psychological need for autonomy, competence, and relatedness and subsequently enhanced their intrinsic motivation.

#### 3.1.4.3 The content of the Sunflower PPI

During the feedback from participants, it was found that the content of the PPI ignited positive emotions among the people with SUD, and they were able to relate to the content. The ignition of positive emotions supports Fredrickson’s (2013) broaden-and-build theory that suggests positive emotions develop a person’s reasoning to nurture personal strengths. The people with SUD and experts may be relating to the content of the PPI positively because their

needs, as identified by people with SUD and experts during the first set of focus group discussions, were incorporated into the development of the first draft of the ‘Sunflower’ PPI.

Experts and people with SUD also reported that the Sunflower PPI compliments the current treatment programme and can be used to support this programme and people in different stages of development. Boiler et al. (2013) found that PPI can be used as complementary approaches within mental health interventions.

#### 3.1.4.4 The applicability of the PPI

People with SUD appreciated the PPI's applicability to assist people with SUD with reintegration back into society and to be in control of their own lives. Literature confirms that normally, people with SUD lose the skills to govern their lives during the development of their SUD (Lago et al., 2020). Therefore, they need assistance in reintegrating back into their communities after completing their in-patient treatment. Developing these much needed skills may also assist them in developing self-worth and being in control of their own recovery, thus enhancing their autonomy.

During the focus groups, people with SUD identified with activities where the participants complemented each other. These activities may instill the skill to empathise, which is dependent on a person’s ability to feel their own feelings and identify with them (Attar & Chandramani, 2012). Kiosses and colleagues (2016) found that people who demonstrate empathy also identify with others' feelings. These activities may therefore satisfy the need for relatedness.

#### 3.1.4.5 Suggested additions to the intervention

People with SUD identified some suggested additions to the Sunflower PPI during the focus group discussions. These included a personal contract at the beginning of the PPI, a glossary to explain some of the English in the PPI, and an extra self-appreciation activity to be included at

the end of each workshop to celebrate their achievements. All these additions support people with SUD's autonomy. They chose to include these extra additions to enable them to be accountable for their own recovery. Deci and Ryan (2008) agree that people need to feel that they have at least some control over their lives and, more specifically, that they are in control of their own behaviour. People with SUD were, therefore, able to identify ways to gain back their autonomy in future intervention. By including these into the PPI, other people with SUD may benefit even more from the Sunflower PPI, and these addictions may satisfy their need for autonomy.

People with SUD finally felt that the intervention could be facilitated by someone in recovery. They further felt that this person should have participated in the intervention and should be living a sober life because of something they have learned by participating in the intervention. This notion supports the work of Cabral and Smit (2011) that found that peer recovery coaches (PRCs), who are individuals with lived experiences with SUD, have a unique skill set to assist people with SUD with their treatment programme; it can also improve retention (Cabral & Smith, 2011). There should be a strict selection criterion in place, and therefore proper training should be provided. These PRCs need to work under the supervision of an expert in the field of SUD and Positive Psychology.

#### 3.1.4.6 The impact on motivation for treatment

Both experts and people with SUD agreed that the PPI would motivate people with SUD to maintain their treatment by assisting them with the following: reintegration and giving them hope (competence), helping them to relate with family members and staff (relatedness), and provide them with the opportunity to participate in their own treatment (autonomy). It is evident that they believe the Sunflower PPI will assist people with SUD in satisfying all three of their basic psychological needs. It may result in enhancing their intrinsic motivation and motivate

them to complete their treatment. Although SDT's applicability in the field of SUD is limited, there is evidence that higher levels of internal motivation had lower relapse rates, higher programme participation, and a negative correlation with treatment dropout (Ryan et al., 1995; Zeldman et al., 2004). The Sunflower PPI may therefore motivate people with SUD to maintain treatment and subsequently address the high levels of treatment dropout.

During the focus group discussions, the feedback from people with SUD and experts revealed how their current treatment could be improved. Given the findings, it appears that the current treatment in the clinics insufficiently addresses basic psychological needs fulfilment and intrinsic motivation for people with SUD. This supports Philips and Wennberg's (2014) findings on therapy motivation for patients with SUD. Their study indicated that amotivation is a risk factor for treatment dropout and they recommend that more effort should be directed at preparation for treatment through enhancing motivation (Philips & Wennberg, 2014). The Sunflower PPI is likely to increase well-being and motivation because all three needs of people with SUD are addressed in concrete ways. Implementing this intervention in support of a current treatment programme may therefore improve intrinsic motivation.

#### 3.1.4.7 Participatory approach to the development of PPI

An unexpected outcome of the study was that by the mere participation in the development of the intervention, people with SUD's basic psychological needs might have been satisfied. Through the intervention development process, people with SUD could have enhanced their *autonomy*. Being allowed to suggest new additions, they were motivated to take charge and make autonomous decisions, and they used the chance to make suggestions. These inclusions are related to them being accountable for their own recovery. People need to feel that they are in control of their behaviour (Deci & Ryan, 2008). It appears as though the development process allowed people with SUD to play an active role in their own treatment, thus feeling that they can

contribute something. Their need for autonomy may therefore be satisfied, and they may experience a sense of integrity as their thoughts, feelings, and actions are self-endorsed and true (Vansteenkiste et al., 2020).

The intervention development process also improved people with SUD's *competence*. People with SUD shared their knowledge about what they would need to motivate them for treatment, which informed the development of the PPI. They were also able to make suggestions as to what should be included in the Sunflower PPI. These suggestions would make it more relevant for them, especially if activities could be included that will help to appreciate what they have learned while participating in some of the activities in the intervention, such as celebrating their achievements. Their need for competence may have been satisfied because they were capable of identifying what additional activities could be included in the PPI using their skills and expertise (Vansteenkiste et al., 2020).

Furthermore, the intervention development process may have improved people with SUD's need for *relatedness.* During the focus groups, people with SUD stated that their identification with one another, encouragement, and motivation play a significant role in learning how to relate to other people. Being in a group, working on a shared goal may have impacted their relatedness. This may have resulted in people with SUD experiencing a sense of belonging, warmth, and care during the focus group sessions that could have signified relatedness, as confirmed by Vansteenkiste and Mouriatidis (2016).

It appears as though the people with SUD's needs may have been fulfilled by the participatory process used in the development of the intervention. Participatory approaches to attain better health outcomes are used to manage chronic conditions, reducing unsafe behaviours such as substance misuse and smoking, and healthy eating (Hibbard & Greene, 2013). Participatory approaches appreciate that communities and people should be the focus of social and health care systems and should have an influential role in identifying needs and the development of services

(therefore also interventions) and policies (Department of Health, 2006). This approach is compatible with participatory research methodologies, such as action research, which acknowledge the significance of 'users' in the research process (Morton et al., 2017). Using a participatory approach in the development of a PPI may therefore be considered by other researchers.

### 3.2 Strengths, Limitations, and Future Research

When focusing on the study's strengths, a clear strength, according to a preliminary Nexis[3] search, is that this is the first South African sample addressing one of the most serious challenges in the health sector of this country, namely treatment dropout. The LexisNexis search also indicated that no similar interventions focus on motivation for SUD treatment, and it is thus under-explored. This study is subsequently making both a theoretical and practical contribution to the existing knowledge base.

Another strength is that data were collected from both experts (multidisciplinary team) and people with SUD. According to Wight et al. (2016), interventions are best developed through cooperation between interdisciplinary teams of experts, the target population, researchers, and legislators. Muller and colleagues (2019) added that patient and public involvement for the development of health interventions provides a valued alternative to the conventional researcher-led approaches, which can be inadequately matched to the needs of target users.

The involvement of experienced experts from multi-disciplinary teams added additional value to the research study. This supports Meier's (2020) view that multidisciplinary teams are important. One can extend the discussion, resolve issues, and identify outcomes quicker if one brings a wide range of team members together (Meier, 2020). According to Distefano (2017),

[3] Nexis Uni is a user-friendly academic search engine. It provides pertinent content that makes academic research more effective, and it provides personalisation, sighting, and co-operation features that students and universities want in an academic research tool (LexisNexis, n.d.).

each professional, multidisciplinary team member is essential in the recovery of a person with SUD. Professional inputs from different backgrounds (e.g., religious workers, social workers, nurses, and caregivers) provided feedback from diverse vantage points. This was especially important when experts evaluated the first draft of the intervention because the researcher could improve the intervention based on their suggested additions. It also increased the transferability of the findings, and thus likely the intervention.

Furthermore, the target group (people with SUD) participated in the research that informed the development of the PPI. Inputs from target groups form part of the development phase of McBride's (2016) Intervention Research Framework used in this study. This framework integrates developmental intervention research (McBride, 2016). According to McBride (2016), these developmental processes confirm that numerous types of essential input from the key target group inform the intervention. The development and design were done with both the experts, who work with people with SUD on a daily basis, and the people admitted for treatment of SUD (McBride, 2016).

An additional strength is that a very vulnerable, hard-to-reach group was involved in the study. People with SUD in active treatment participated in the focus group discussions. According to Freedman (2018), people with SUD have the additional burden of disgrace, guilt complex, stigma, and blame, which impacts them seeking help and conforming with treatment. She also mentions that a person with SUD attempts to escape the wider world, only focusing on their substance of choice resulting in them living their lives in isolation (Freedman, 2018). The American Psychiatric Association (2013) states that to recover, a person with SUD needs to connect to the world (as cited in Freedman, 2018). This is what happened during the research, specifically in the focus group discussions. The feedback from people with SUD was very significant and informed the development of the intervention. Also, they were inspired to provide

complimentary additions to the first draft of the intervention that focused on their accountability for their own recovery.

The fact that the researcher went back to the same clinics for evaluation after the first draft of the Sunflower PPI, may also be seen as a strength of the study. Based on the suggested additions from the people with SUD and experts, the researcher adapted the PPI to improve the intervention. This supports Muller and colleagues' (2019) results that promote using qualitative research together with patient and public involvement at all phases of the intervention design, development, and evaluation.

Another strength refers to the development of the PPI being thoroughly informed by theory (SDT) and research on SUD treatment in South Africa. Gander and colleagues (2016) state that interventions developed and evaluated thus far do not clearly refer to a theoretical framework or candidly target different elements of a well-being theory as the case was with this study. If interventions are developed on a well-being theory, they benefit that hypotheses can be drawn from the theory, and results can be translated within the theory (Michie et al., 2007).

The researcher also made use of an independent co-coder for the analysis of their results. Good inter-rater reliability was found between the researchers (Elliott, 2018). This indicated that the research findings are reliable and not only the product of one single researcher.

Lastly, this intervention is likely to improve well-being and motivation (SDT) because all three needs are addressed in concrete ways that were identified, confirmed, and favoured by experts and people with SUD.

This study, however, also includes limitations. One of the limitations may be that, for the especially vulnerable group of people with SUD that might be suffering from feelings of guilt and shame, using focus group discussions may not have been the best way for participants to open up fully. Although focus groups offer a caring environment to participants, the group context may create a sense of open vulnerability (Sim & Waterfield, 2019). However, focus

groups have the advantage that they are useful in producing a rich understanding of participants' experiences and viewpoints (Morgan's study (1998) as cited in Sim & Waterfield, 2019) and were thus used in this study. However, individual interviews are intimate and private and protect participants' vulnerability (Ransome, 2013). For future research, it would be ideal to combine focus groups and individual interviews (e.g., talking to people who did not speak up during the focus groups).

Furthermore, the participants may not have had ample time to look at and engage with the PPI when the researcher went back to evaluate the PPI. The researcher did not want to use more time of the participants because it would have impacted their treatment programme. It would have been ideal if a copy of the PPI could have been given to them before the focus group discussion to prepare. In future studies, it would be useful to provide enough time for the participants to evaluate the PPI in their own time.

The transferability of the findings of this study may also be limited. Most qualitative studies aim not to generalise but rather to provide a deep, contextualised understanding of a specific form of human experience through the rigorous study of specific cases (Polit & Beck, 2010). Within this study, where evidence to improve motivation for treatment was especially important, the transferability in relation to knowledge claims deserves careful attention (Polit & Beck, 2010). However, the findings in this study are only based on the experience of a limited group of people with SUD and experts. They were from two in-patient centres and only one province in South Africa. The target group (people with SUD) included different culture groups, age groups, genders, and people in treatment for different substances. Expert groups consisted of different role payers within the multidisciplinary team such as social workers, religious workers, medical staff members, and caregivers. Included treatment centres were also from both a large city and rural area. It would be valuable to extend the scope to other clinics and people with SUD in different provinces in South Africa.

Finally, it would be ideal if the Sunflower PPI could be assessed and disseminated to other treatment centres. The research design used in this study was informed by what McBride (2016) refers to as the Intervention Research Framework. This framework is a scientific guide to inventive and evidence-based intervention development and is used to conduct evaluative research of these interventions. It includes the following four phases: notification, development, assessment, and dissemination. This study focused on the first two phases, namely notification and development. It would consequently be important to also include the last two phases to ensure an adequate understanding of the PPI's feasibility in relation to the enhancement of intrinsic motivation for the treatment of SUD. This may also inform future studies that are utilising the Intervention Research Framework.

### 3.3 Recommendations

This study has implications for theory and practice. It is essential to base the intervention development process on theory. The SDT is the most important theory the researcher focused on. The satisfaction of all three needs (autonomy, competence, and relatedness) is necessary for good well-being. Participants would know what would be good for their needs if asked. Incorporating the mini-theory in the development of the PPI for people in treatment of SUD may result in them being self-motivated through fostering these three needs. It appeared as though the SDT is an ideal theory to use in the development of an intervention for such a vulnerable group. The feedback from people with SUD was significant and informed the development of the intervention. They were inspired to also provide complimentary additions to the first draft of the intervention that focused on their accountability for their own recovery.

From a practical perspective, based on the research findings, there are several recommendations for treatment centres. Involving people admitted for treatment of SUD (those

whose behaviour change is the focus) in the development and evaluation of the intervention may provide insight into the data that are collected as well as the viability of the intervention.

Furthermore, using the triangulation method in our study, by designing in conjunction with both the target group and experts (setting implementors of the intervention) may alleviate bias, support social change, and data saturation could be reached through these multiple sources.

Based on the feedback received during the focus group discussions, treatment centres may consider allowing people with SUD to play a more active role during treatment. This may enhance their fulfilment of autonomy and competence, for example, choosing to play different roles during group work sessions (opening and closing the session or appreciation of participation) and their free time (organising structured after-hour activities coordinated by people with SUD) in the treatment centres.

Treatment centres can also assist people in treatment by connecting them with opportunities, which will enhance their need-fulfilment. This can include finding work, mentoring people in recovery while working, upskilling them (e.g., computer skills and creating opportunities to volunteer in their communities), thus satisfying their need for competence.

Treatment centres may want to consider implementing creative ways to celebrate people with SUD's sobriety. This may fulfil their need for competence and comprise of, for example, giving out badges, tokens, or certificates for the number of days being sober. People with SUD may also be given a choice about how they would like to celebrate their sobriety, thus satisfying their need for autonomy.

Having a support group for family members and significant others running concurrent to the SUD treatment programme may assist the family in understanding SUD and reconnect with people with SUD, thus fulfilling the need for relatedness.

Finally, the Sunflower PPI may also assist in contributing to studies on PPIs from an African perspective, especially if the intervention can be disseminated and assessed by different treatment centres.

### 3.4 Conclusion

During this research, both experts and people with SUD were able to express how their basic psychological needs of autonomy, competence, and relatedness can be improved during treatment of SUD. The researcher was able to develop a comprehensive intervention based on the findings. The researcher also went back to the same clinics and target groups for evaluation after developing the PPI. The PPI was subsequently adapted and further improved based on the participants' suggestions and complementary additions. A participatory approach is very useful when developing an intervention, even for such a vulnerable group.

This intervention has the potential to increase well-being and motivation (SDT) because all three needs are addressed in concrete ways. These needs were identified, confirmed, and improved by experts and people with SUD.

This study allowed the researcher to develop a positive psychology intervention based on theory, specifically the SDT, and the expertise of people with SUD and practitioners working with them. It is, therefore, a promising way to improve the much needed motivation to enable people to recover from SUD and to prevent treatment dropout.

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## APPENDIX A

Focus group questions for phase one (focus group discussions with the target group and experts to inform the development of a positive psychology intervention) of the study.

**Initial Engagement Questions: (same for target group and experts)**

What motivates you to get up every morning?

**Exploring Questions:**

Experts

1. What, based on your experience, normally motivates people with SUD to attend in-patient substance use disorder treatment?
2. What do you think help people with SUD to feel in control during their treatment?
3. What role do people, inside and outside the clinic, play in people with SUD's treatment?
4. What skills do people with SUD need to help them to stop using drugs?
2. What is the main reason for non-completion of treatment?
3. What do you think will decrease treatment drop-out?
4. What would people with SUD require to maintain their sobriety during and after completion of their treatment?

Target group

1. What are your expectations of this in-patient substance use disorder treatment?
2. What motivates you to stop using drugs?

3.1. What would help you to feel in control during your treatment?

3.2. What role do other people, inside and outside the clinic, play in your treatment?

3.3. What skills do you think you would need to stop using drugs?

4. Which of your own strengths, skills or talents could help you during treatment?
5. What do you think you would require to maintain your sobriety during and after completion of your treatment?

**Exit Question: (same for multi-disciplinary team and clients)**

Is there anything else you would like to add in relation to motivation for substance use disorder treatment and the things we talked about?

## APPENDIX B

Focus group questions for phase three (development and design in collaboration with the target group and experts: presentation of the developed PPI to key target groups followed by a focus group discussion) of the study.

**Initial Engagement Question: (same for the target group and experts)**

What are your thoughts about the newly developed Positive Psychology Intervention?

**Exploring Questions:**

Experts

1. How do you feel about the design, layout and structure of the intervention?
2. What is your opinion about the content of the intervention?
3. How applicable do you think the intervention would be for the target group?
4. What else would you like us to include or exclude as part of this intervention aimed to enhance motivation for treatment?
5. In what way could this intervention have an impact on treatment motivation?
6. Would you be willing to be trained in using this intervention as part of your treatment programme in the future?

Target group

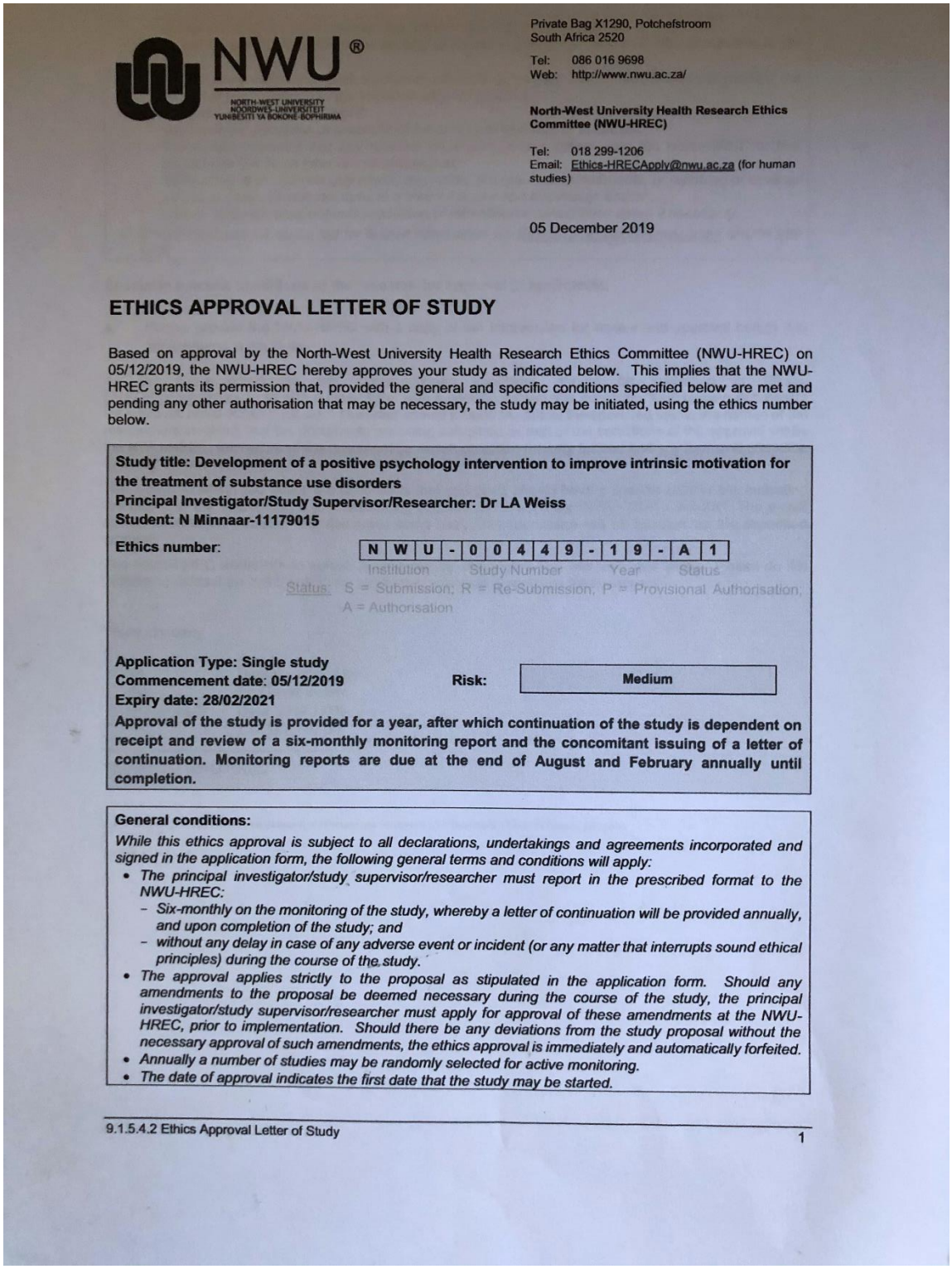
1. How do you feel about the design and layout of the intervention?
2. What is your opinion about the content of the intervention?
3. How do you think you will benefit from this intervention?
4. In what way could this intervention have an impact on your motivation for treatment?
5. What else would you like us to include as part of this intervention aimed to enhance motivation for treatment?
6. What parts would you like us to exclude?
7. Would you be willing to participate in this intervention as part of your treatment programme?

**Exit Question: (same for multi-disciplinary team and clients)**

Is there anything else you would like to add in relation to the Positive Psychology Intervention?

# APPENDIX C

## Ethics Approval Letter



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**North-West University Health Research Ethics Committee (NWU-HREC)**

Tel: 018 299-1206
Email: Ethics-HRECApply@nwu.ac.za (for human studies)

05 December 2019

**ETHICS APPROVAL LETTER OF STUDY**

Based on approval by the North-West University Health Research Ethics Committee (NWU-HREC) on 05/12/2019, the NWU-HREC hereby approves your study as indicated below. This implies that the NWU-HREC grants its permission that, provided the general and specific conditions specified below are met and pending any other authorisation that may be necessary, the study may be initiated, using the ethics number below.

**Study title: Development of a positive psychology intervention to improve intrinsic motivation for the treatment of substance use disorders**
**Principal Investigator/Study Supervisor/Researcher: Dr LA Weiss**
**Student: N Minnaar-11179015**

**Ethics number:** N W U - 0 0 4 4 9 - 1 9 - A 1
Institution Study Number Year Status
Status: S = Submission; R = Re-Submission; P = Provisional Authorisation; A = Authorisation

**Application Type: Single study**
**Commencement date: 05/12/2019** **Risk:** **Medium**
**Expiry date: 28/02/2021**
**Approval of the study is provided for a year, after which continuation of the study is dependent on receipt and review of a six-monthly monitoring report and the concomitant issuing of a letter of continuation. Monitoring reports are due at the end of August and February annually until completion.**

**General conditions:**
*While this ethics approval is subject to all declarations, undertakings and agreements incorporated and signed in the application form, the following general terms and conditions will apply:*

- *The principal investigator/study supervisor/researcher must report in the prescribed format to the NWU-HREC:*
  - *Six-monthly on the monitoring of the study, whereby a letter of continuation will be provided annually, and upon completion of the study; and*
  - *without any delay in case of any adverse event or incident (or any matter that interrupts sound ethical principles) during the course of the study.*
- *The approval applies strictly to the proposal as stipulated in the application form. Should any amendments to the proposal be deemed necessary during the course of the study, the principal investigator/study supervisor/researcher must apply for approval of these amendments at the NWU-HREC, prior to implementation. Should there be any deviations from the study proposal without the necessary approval of such amendments, the ethics approval is immediately and automatically forfeited.*
- *Annually a number of studies may be randomly selected for active monitoring.*
- *The date of approval indicates the first date that the study may be started.*

9.1.5.4.2 Ethics Approval Letter of Study 1

- *In the interest of ethical responsibility, the NWU-HREC reserves the right to:*
  - *request access to any information or data at any time during the course or after completion of the study;*
  - *to ask further questions, seek additional information, require further modification or monitor the conduct of your research or the informed consent process;*
  - *withdraw or postpone approval if:*
    - *any unethical principles or practices of the study are revealed or suspected;*
    - *it becomes apparent that any relevant information was withheld from the NWU-HREC or that information has been false or misrepresented;*
    - *submission of the six-monthly monitoring report, the required amendments, or reporting of adverse events or incidents was not done in a timely manner and accurately; and/or*
    - *new institutional rules, national legislation or international conventions deem it necessary.*
- *NWU-HREC can be contacted for further information via Ethics-HRECApply@nwu.ac.za or 018 299 1206*

**Special in process conditions of the research for approval (if applicable):**

a. Please provide the NWU-HREC with a copy of the intervention for review and approval before it is implemented in the study

As the study progresses the aforementioned conditions should be submitted to Ethics-HRECProcess@nwu.ac.za with a cover letter with a specific subject title indicating "Outstanding documents for approval: NWU-XXXXX-XX-XX." The letter should include the title of the approved study, the names of the researchers involved, that the documents are being submitted as part of the conditions of the approval set by the NWU-HREC, the nature of the document i.e. which condition is being fulfilled and any further explanation to clarify the submission.

The *e-mail*, to which you attach the documents that you send, should have a *specific subject line* indicating the nature of the submission e.g. "Outstanding documents for approval: NWU-XXXXX-XX-XX". The e-mail should indicate the nature of the document being sent. This submission will be handled via the expedited process.

The NWU-HREC would like to remain at your service and wishes you well with your study. Please do not hesitate to contact the NWU-HREC for any further enquiries or requests for assistance.

Yours sincerely,

Bester

Digitally signed by
Prof Petra Bester
Date: 2019.12.05
13:43:46 +02'00'

Chairperson NWU-HREC

Current details:(23239522) G:\My Drive\9. Research and Postgraduate Education\9.1.5.4 Templates\9.1.5.4.2_NWU-HREC_EAL.docm
20 August 2019

File Reference: 9.1.5.4.2

## APPENDIX D

**The Sunflower PPI attached as a separate pdf file.**

# Sunflower

A POSITIVE PSYCHOLOGY INTERVENTION

TRAIN THE TRAINER GUIDE

I think the most beautiful thing in the world is watching the light come on in someone's eyes when they've been lost in the dark so long.

Unknown

# GLOSSARY

- **Resilience** – the capacity to recover quickly from difficulties; toughness.
- **Autonomy** – freedom from external control or influence; independence.
- **Competence** – the ability to do something successfully or efficiently.
- **Relatedness** – the state or fact of being related or connected.
- **Vulnerability** – the quality or state of being exposed to the possibility of being attacked or harmed, either physically or emotionally.
- **Atonement** – the action of making amends for a wrong or injury.
- **Affirmation** – emotional support or encouragement.
- **Bloom** – the state or period of greatest beauty, freshness, or vigour.
- **Assimilate** – become absorbed and integrated into a society or culture.
- **Accountability** – the fact or condition of being accountable; responsibility.
- **Stanza** – a group of lines forming the basic recurring metrical unit in a poem; a verse.

# SUNFLOWER PERSONAL CONTRACT

*Complete your Personal Sunflower Positive Psychology Intervention Contract. Sign the contract at the bottom to affirm your commitment to making a healthy change and ask a friend to witness it.*

My behaviour change will be: _____

My long-term goal for this behaviour change is: _____

These are three obstacles to change (things that I am currently doing or situations that contribute to this behaviour or make it harder to change):

1._____

2._____

3._____

**The strategies I will use to overcome these obstacles are:**

1._____

2._____

3._____

**Resources I will use to help me change this behaviour include:**
1.Friend/partner/relative/staff member/God or Higher Power that can assist me:
_____

2. Skills I have that can assist me with this behaviour change:
_____

_____

3. Choices I have that I can make to assist with this behaviour change:
_____

_____

**In order to make my goal more attainable, I have devised these short-term goals:**

1.Short-term goal target date reward
_____

2. Short-term goal target date reward
_____

3. Short-term goal target date reward
_____

When I make the long-term behaviour change described above, my reward will be:

_____Target date: _____

I intend to make the behaviour change described above. I will use the strategies and skills learned in the Sunflower PPI to achieve the goals that will contribute to a healthy behaviour change.

Signed: _____Witness: _____

# WORKSHOP 1

Play to your strengths

Sunflower

A POSITIVE PSYCHOLOGY INTERVENTION

# TABLE OF CONTENTS

# INTRODUCTION

Welcome to the 'Sunflower' intervention. This intervention's aim is to assist people with substance use disorders to improve their motivation for treatment. It is rooted in the Self-determination Theory and develops basic psychological needs. The Sunflower metaphor also represents resiliency. The sunflower is a flower that grows towards the light and the sun. It can withstand all kinds of weather, even drought and it pushes its stem up through the soil wherever the seeds are planted or dropped to the ground.

## Self-determination Theory and Addiction Recovery

Richard M. Ryan and Edward I. Deci developed a theory of well-being called Self Determination Theory (SDT) three decades ago. Over the years, this theory has been expanded upon and fine-tuned by scholars and researchers throughout the world. The thinking behind SDT is that we are organisms with an inclination towards growth. We grow as we master life's challenges and integrate learnings into a comprehensible sense of who we are. That said, we do not live in a controlled environment. Whether or not we develop our natural tendencies depends upon the world in which we operate.

SDT advocates that we have basic psychological needs. These include:

- **A need for autonomy** – a sense that we have a choice and some control over our lives and environment;
- **A need for competence** – a feeling of self-worth derived from knowing we can make a contribution; and
- **A need for relatedness** – a feeling of connection with others because we feel cared for.

When the conditions in which we work and live support these basic needs, we flourish and grow. When the conditions thwart these needs, we will not thrive and function effectively. When people are challenged by a substance use disorder (SUD) their circumstances do not always support these basic needs and they do not function effectively. The metaphor of a Sunflower is used in this intervention to assist people with SUD to flourish and grow through learning to focus on and use their basic psychological needs whilst in treatment and during recovery.

## How Resilience Can Play a Role in Addiction Recovery

Resiliency allows people to step back briefly, regroup and move forward. No matter how long you stay away from harmful substances, there may be some unexpected surprises. While these surprises can lead to stress, they do not have to result in a return to using if you have developed some useful emotional wellness tools.
Some of the ways to build resilience in recovery include:

- **Learn from the past:** Experience is an amazing teacher. Use your insight to look back at how you handled past situations either successfully or poorly. Let this guide your future behaviour. Also, do not forget all of the triumphs in addiction recovery that you have experienced.
- **Accept that change will happen:** Change can be difficult, but it is inevitable in life. Resiliency involves being able to adapt more quickly to changing conditions.
- **Have a support system:** People are usually stronger in numbers. You can develop a support system and use it to help you get through difficult times. You might find that you can handle anything when this group has your back.
- **Emphasize self-care:** Skimping on self-care during a crisis would be a mistake. In recovery, you can learn to take care of your own needs first by eating and sleeping right and building resilience through such things as daily routine and exercise.
- **Be grateful:** Instead of focusing on something stressful, remember everything that is wonderful about your life now. Learn to practice gratitude.

**The 'Sunflower' intervention message is:**

Stand tall and develop the skills to follow your dreams, make good choices everyday to be in control of your recovery and learn to connect and relate to others because you can not recover on your own!

**The intervention consists of the following workshops:**

- Workshop 1: Play to your strengths
- Workshop 2: My Best Possible Self
- Workshop 3: Learn to Be Kind
- Workshop 4A: An Attitude of Gratitude
- Workshop 4B: Gratitude Visit
- Workshop 5: Hope & Recovery
- Workshop 6: Rise & Shine

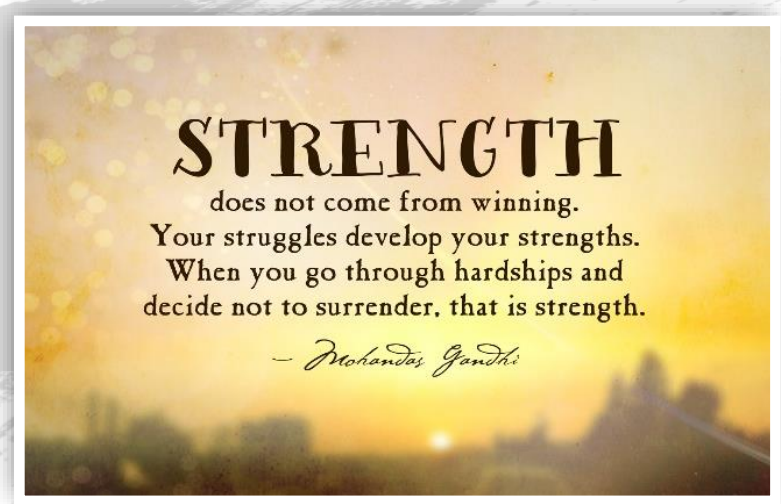
Today's workshop will focus on discovering your strengths and learning to use it in your recovery.

## 1. PREPARING AND PLANTING PHASE *(Preparation Phase)*

### 1.1 Workshop Quote

**FACILITATOR**

*Share the workshop quote with the participants. Let them reflect on the quote by writing in their personal journals. Ask for voluntary feedback.*




### 1.2 Program Chant

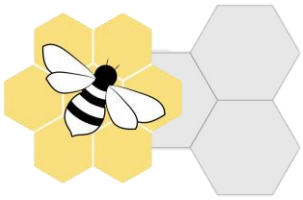
**FACILITATOR**

*Let all the participants gather in a circle. Let them first read and then recite the program chant together.*

*As participants in the 'Sunflower' programme*
*Always remember...*
*we are braver than we believe*
*smarter than we think*
*and twice as beautiful as we ever imagined!*

## 1.3 Choose to be brave

(Participants can practice competence, autonomy and relatedness within this workshop)



**FACILITATOR**

*Before starting the workshop ask participants to choose which of the following roles they would like to play during the workshop (keep record of the names of these participants):*

- *Timekeeper (Keep time during activities)*
- *Wrap-Up Times Three (Three volunteers each need to identify an activity during the workshop where they practiced each of the three basic psychological needs: autonomy [people are empowered when they feel a sense of choice and endorsement in a task], competence [individuals seek control to allow them to experience mastery over a task] and relatedness [individuals have a need to interact with others]).*
- *Introduce others in a creative way (One person takes the lead in introducing fellow participants in a creative way, i.e. two claps, two snaps, two stomps with their feet, two winks and a "Go Peter" (name of person).*
- *Appreciate with love (One person takes the lead by appreciating participants who shared by clapping X 2 and showering them with love by moving their hands in the form of a heart)*
- *Kibata! ('Kibata' is a loud clap followed by moving the one hand away from the other when done. One participant takes the lead in appreciating a participant who discovered an aha-moment, shared something profound or made themselves vulnerable. This needs to be an incredibly special moment)*

## 1.4 Check-in

**Materials needed:**

- Open space
- Talking piece (bean bag)

***INSTRUCTIONS***

*Let participants gather in a circle. Using a talking piece let each participant share one thing they will need from the group that day to enable them to participate unreservedly. It may be support, encouragement, being non-judgmental, etc.*

*Once a participant has shared the group will respond by saying:*

*"Thabo (name of participant), nothing for us, without us!*

## 1.5 Warm-Up Activity

### *Group Map*

**Materials needed:**

- Open space

Time: 15 Minutes

***INSTRUCTIONS***

*A great way to get to know each other is to have participants place themselves on an imaginary map laid out in the room. Each person should place themselves on the imaginary map according to where they grew up. Ask them to share one strength (hope, fairness, love etc.) they got from that place, and why that is important for them. Encourage people to share a short story if they want to. Sharing customs and values from your childhood can create more understanding and help form stronger bonds.*

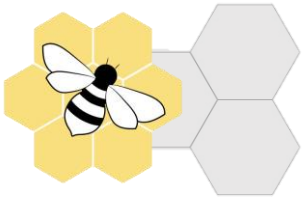

**FACILITATOR**

*In recovery, you will discover and develop strengths you didn't even know you had. These strengths have been within you all along, but they have been waiting for their moment to shine. Without the battles you've been through, these strengths may have remained hidden. A few examples of personal strengths you can find within you during the recovery process include perseverance, bravery, curiosity and leadership. It could be beneficial for you and your journey to document the strengths you have and the strengths you find during the recovery process. Be proud of the strengths you have and begin to focus on these strengths to assist yourself through the ups and downs of getting sober and staying sober.*

## 2. GERMINATING AND ROOTING PHASE *(Educational and Skills Development Phase)*

### 2.1 Group Nourishing Session

***The Importance of Strengths***

**FACILITATOR**
*Use the information provided to clearly explain the importance of strengths*

People tend to be happier and more content in their lives when using their "strengths" on a regular basis.

The 'Positive Psychology' movement, started by Professor Martin Seligman, highlights things like abilities, potential and values, in contrast to the traditional medical model's affinity to pathologize. So, if you're looking to make some changes in your life, you may want to start here, by discovering and reflecting on your core strengths as a person.

Led by Martin Seligman and Neal Mayerson, the VIA (values in action) Institute on Character identifies 24 character strengths that all people have, with the acknowledgment that some of these are more evident or developed in some versus others.

Each character strength falls under one of these six broad virtue categories, which are universal across cultures and nations.


**The 24 Character Strengths from Positive Psychology**
***The character strengths are classified into 6 categories:***

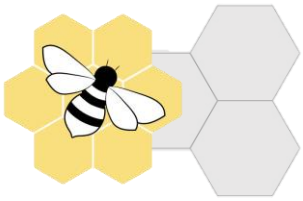
1. **Wisdom & Knowledge:** creativity, curiosity, judgment, love of learning, perspective
2. **Courage:** bravery, perseverance, honesty, zest
3. **Humanity:** love, kindness, social intelligence
4. **Justice:** teamwork, fairness, leadership
5. **Temperance:** forgiveness, humility, prudence, self-regulation
6. **Transcendence:** appreciation of beauty & excellence; gratitude; hope; humour; spirituality

## 2.2 Individual Nourishing Session

### *VIA Strength Art Gallery*


**Materials needed:**

- 24 X A4 VIA Strength posters
- Prestik
- Large room with walls

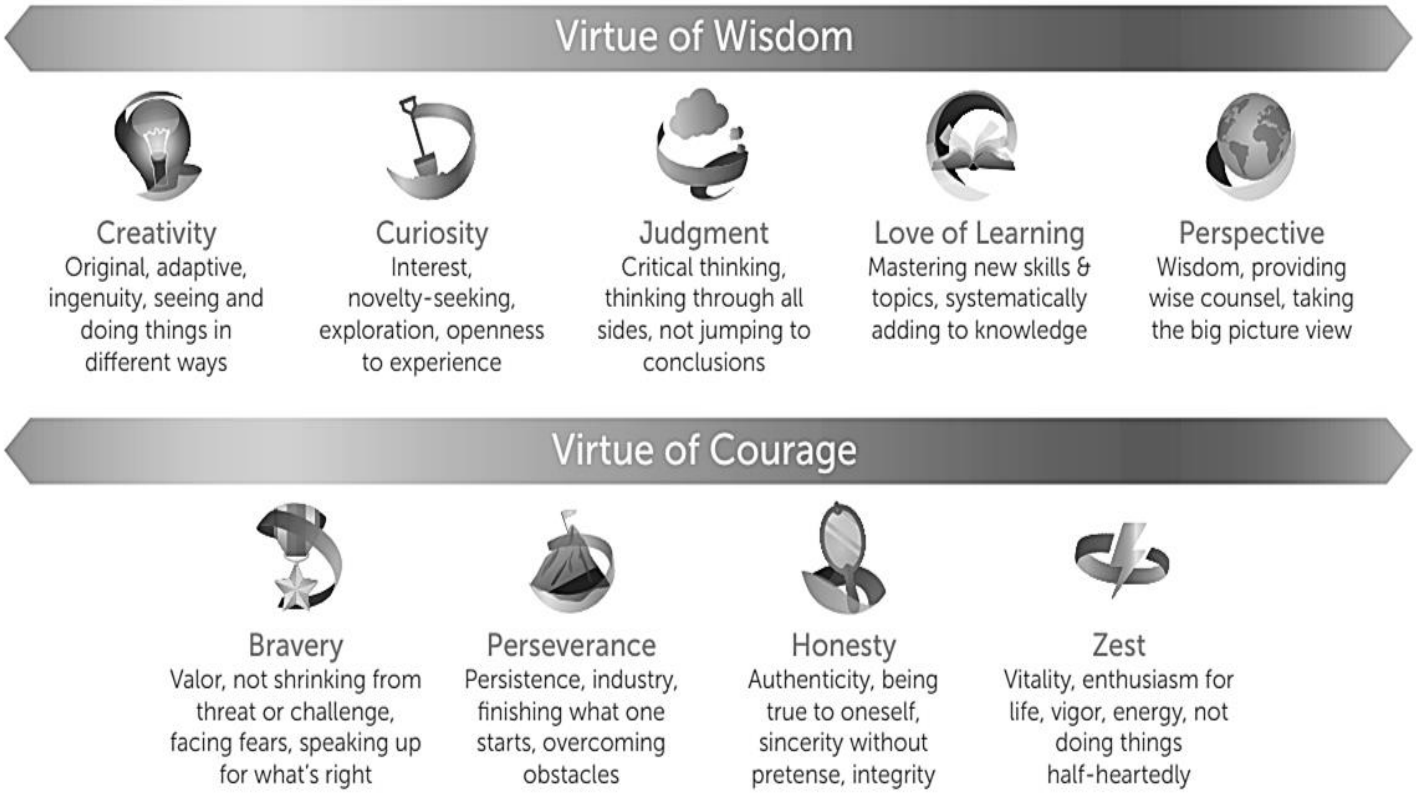


**FACILITATOR**

*Before the session commences, paste the strength posters (attachment 1) on the walls of the room to create an art gallery using the 24 strengths.*

*Ask participants to browse through the 24 pieces of art. They can look at the image, the name of the piece of art and also read the explanation of each strength.*

*Using their 'Bloom with Grace' journals they need to try and select their top 5 strengths.*



## Virtue of Humanity

**Love**
Both loving and being loved, valuing close relations with others, genuine warmth

**Kindness**
Generosity, nurturance, care, compassion, altruism, doing for others

**Social Intelligence**
Aware of the motives and feelings of oneself and others, knows what makes others tick

## Virtue of Justice

**Teamwork**
Citizenship, social responsibility, loyalty, contributing to a group effort

**Fairness**
Adhering to principles of justice, not allowing feelings to bias decisions about others

**Leadership**
Organizing group activities to get things done, positively influencing others

## Virtue of Temperance

**Forgiveness**
Mercy, accepting others' shortcomings, giving people a second chance, letting go of hurt

**Humility**
Modesty, letting one's accomplishments speak for themselves

**Prudence**
Careful about one's choices, cautious, not taking undue risks

**Self-Regulation**
Self-control, disciplined, managing impulses, emotions, and vices

## Virtue of Transcendence

**Appreciation of Beauty & Excellence**
Awe and wonder for beauty, admiration for skill and moral greatness

**Gratitude**
Thankful for the good, expressing thanks, feeling blessed

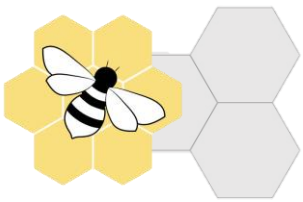
**Hope**
Optimism, positive future-mindedness, expecting the best & working to achieve it

**Humour**
Playfulness, bringing smiles to others, lighthearted – seeing the lighter side

**Spirituality**
Connecting with the sacred, purpose, meaning, faith, religiousness

### 2.3 Pair-Up

***Sharing***

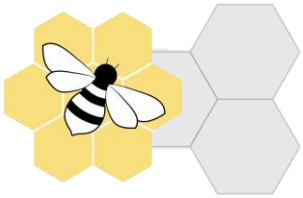



**FACILITATOR**

*Let participants select a partner to discuss their top 5 strengths with. They can start by sharing and comparing their Character Strengths. Once done they can share a story of when they used one of these strengths in the past and how it made them feel. After sharing they can now share another story of when they wanted to use one of their top 5 strengths but didn't and share how that made them feel. Once done have an open discussion of the significance of using their strengths.*

## 2.4 Personal Reflection Session

### *Positive Journaling*



Time: 15 Minutes

**FACILITATOR**

*Ask participants to journal about how they can use their Character Strengths during recovery and more especially whilst in treatment, i.e. take the lead over weekends re sport and recreation activities, assist fellow people with SUD, take responsibility to open and lock gates etc.*

*Allow time for voluntary feedback. Ask participants to share this with their individual counsellors and try to start using their character strengths during their treatment.*

## 3. GROWING PHASE *(Summary and Termination Phase)*

### 3.1 Wrap-Up Times Three

Allow three volunteers (as identified in the beginning of the workshop) to identify an activity during the workshop where they practiced each of the three basic psychological needs: autonomy (people are empowered when they feel a sense of choice and endorsement in a task), competence (individuals seek control to allow them to experience mastery over a task) and relatedness (individuals have a need to interact with others).

### 3.2 Conclusion

Just like you set recovery goals, set strength goals. Using your top 5 strengths will be a walk in the park for you. Just look at what you have already accomplished in your recovery. One day, when a person just starting out in their recovery asks you how you became so successful, you can start them on their strengths journey, which will be yet another strength for you.

### 3.3 Check-out

***Watering the flowers (Practising Relatedness)***

***INSTRUCTIONS***

*Let participants gather in a circle. Ask them to appreciate the person on their right-hand side based on their participation during the session i.e.: "Ntebo, I want to thank you for being a good listener." End the session with everyone reciting the Sunflower Chant:*

# Bloom with GRACE

**Wherever life plants you, bloom with grace**.

You have each selected your own "Bloom with Grace" journal. During your treatment you can use this journal to reflect on what you have learned in each of the Sunflower workshops.

To practice newly learned skills, you will be expected to complete some assignments. Before speaking to anyone about today's workshop please use the space provided to journal about it. You may want to investigate your thoughts and feelings after the workshop. Perhaps you can also think about the choices you have been given during the workshop and your interaction with your fellow participants. Maybe you also want to journal about new skills you may have learned or want to develop after the workshop.

Finally, you can also write about something that you appreciate about yourself after the workshop. Once done you may want to read what you have written and reflect on it, sum up your takeaway in one or two sentences, starting with statements like: "As I read this, I notice…; "I am aware of…", or "I feel…"

## Journaling

- **Flower 1: Using your character strengths during treatment**
  Discuss how you can start using your character strengths during your treatment and recovery with your individual counsellor. Give feedback on your discussion below:

_____
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- **Flower 2: Using your character strengths at home**
  Think of ways you can start using each of your five character strengths at home after you have completed your treatment.

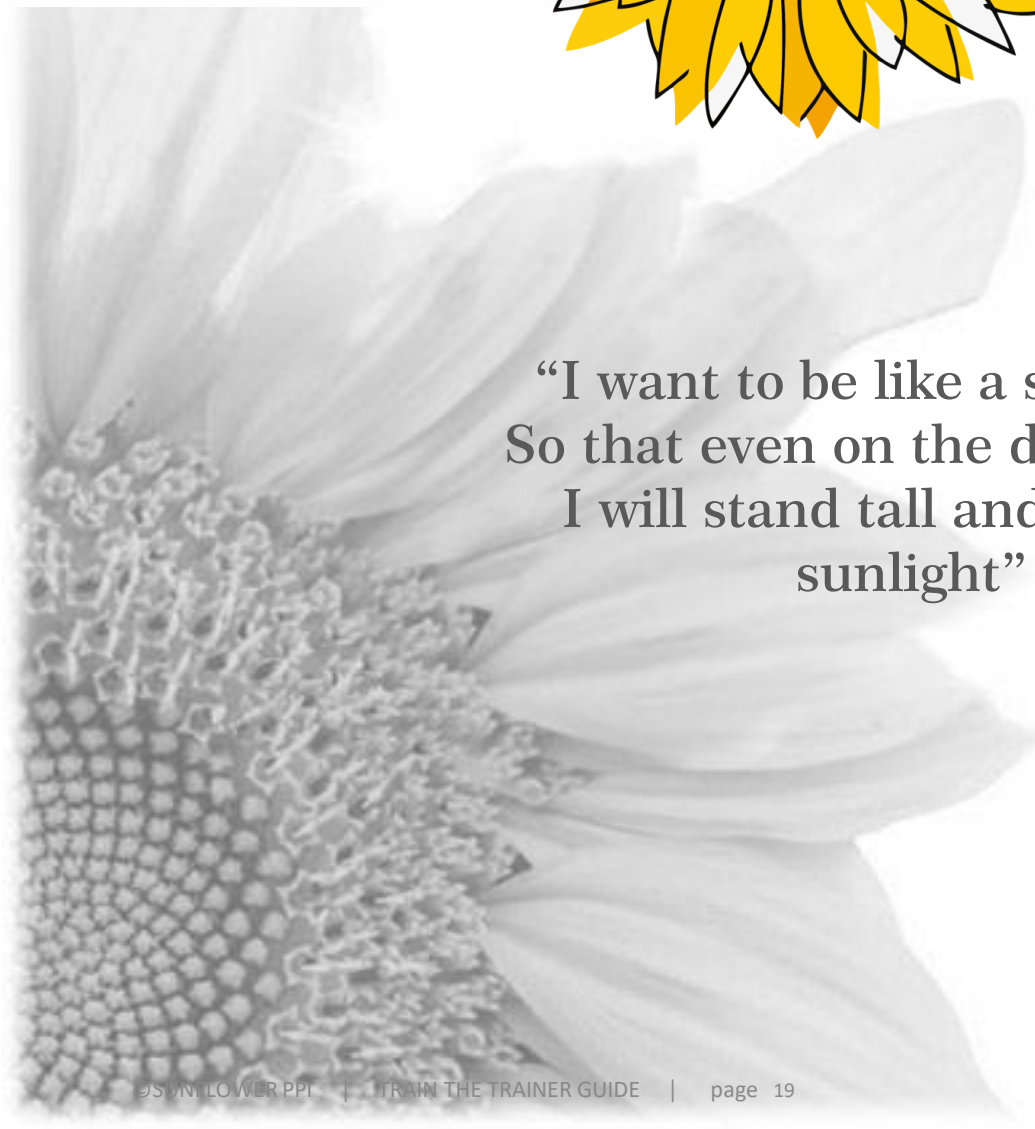
  - Strength 1:
  - Strength 2:
  - Strength 3:
  - Strength 4:
  - Strength 5:

# WORKSHOP 2

My best possible self

Sunflower

A POSITIVE PSYCHOLOGY INTERVENTION



"I want to be like a sunflower;
So that even on the darkest days
I will stand tall and find the
sunlight"

- M.K

# TABLE OF CONTENTS

**Toolkit:**

- Hand Mirror for every participant
- Sessions songs from the Sunflower Playlist: “Baby can I hold you” and “For the first time”
- Device to play the session song with
- Art Material: (different coloured board, glue, pastels, scissors, glitter, etc.)
- String
- Stapler with staples
- Talking piece (bean bag)
- Invite a person in recovery (more than 5 years sober) to share their story with the group

## INTRODUCTION

People are difficult to know because they wear masks all the time. They are not what they appear to be. The masks which they wear protect them from the judgment and condemnation of others and from their own judgment. It also provides others who interact with them with an opportunity to adjust their own masks and matching behaviour. Because of this, people are deprived of many opportunities to know others or form healthy relationships.

Because of the conditioning and the weight of social pressure to which we are all subject, they become so immersed in the ritualistic and superficial behaviour that they cannot ascertain who their true friends are and with whom they should establish trustworthy relationships.

In the process, most relationships at some point hurt them and consume their peace of mind. Many relationships fail when the masks gradually wear off, and people bare their true selves. By that time, the damage must have already been done to the psyche of those who were attracted to their public persona.

Those who surrender to the initial charm and surface impressions often pay a heavy price and find it hard to recover from the hopelessness that follows.

When battling with addiction, wearing your mask becomes part of the defence mechanism you use to cope with a life of addiction. You may become a person you do not even know anymore.

*Today's session is about finding the best version of you and leaving behind the mask of addiction.*

Be the best version of you

## 1. PREPARING AND PLANTING PHASE *(Preparation Phase)*

### 1.1 Workshop Quote

**FACILITATOR**
*Share the workshop quote with the participants. Let them reflect on the quote by writing in their personal journals. Ask for voluntary feedback.*

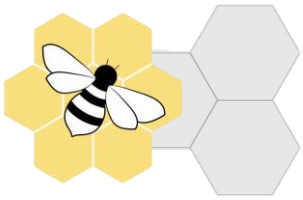

### 1.2 Program Chant

**FACILITATOR**
*Let all the participants gather in a circle. Let them first read and then recite the program chant together.*

*As participants in the 'Sunflower' programme*
*Always remember...*
*we are braver than we believe*
*smarter than we think*
*and twice as beautiful as we ever imagined!*

## 1.3 Choose to be brave

(Participants have the opportunity to practise competence, autonomy, and relatedness within this workshop)



**FACILITATOR**

*Before starting the workshop ask participants to choose which of the following roles they would like to play during the workshop (keep record of the names of these participants):*

- *Timekeeper (Keep time during activities)*
- *Wrap-Up Times Three (Three volunteers each need to identify an activity during the workshop where they practiced each of the three basic psychological needs: autonomy [people are empowered when they feel a sense of choice and endorsement in a task], competence [individuals seek control to allow them to experience mastery over a task] and relatedness [individuals have a need to interact with others]).*
- *Introduce others in a creative way (One person takes the lead in introducing fellow participants in a creative way, i.e. two claps, two snaps, two stomps with their feet, two winks and a "Go Peter" (name of person).*
- *Appreciate with love (One person takes the lead by appreciating participants who shared by clapping X 2 and showering them with love by moving their hands in the form of a heart)*
- *Kibata! ('Kibata' is a loud clap followed by moving the one hand away from the other when done. One participant takes the lead in appreciating a participant who discovered an aha-moment, shared something profound or made themselves vulnerable. This needs to be an incredibly special moment)*

## 1.4 Check-in

**Materials needed:**

- Open space
- Talking piece (bean bag)

***INSTRUCTIONS***

*Let participants gather in a circle. Using a talking piece let each participant share one thing they will need from the group that day to enable them to participate unreservedly. It may be support, encouragement, being non-judgmental, etc. Give time for voluntary feedback on the participants' 'Bloom with Grace' assignments.*

*Once a participant has shared the group will respond by saying:*

*"Thabo (name of participant), nothing for us, without us!*

## 1.5 Workshop Poem

***The Mask***


***INSTRUCTIONS***

*Ask participants to open their "Bloom with Grace" Journals at the "The Mask". Give time for the participants to read the poem a few times. Let them reflect and discuss the meaning of the poem after writing about it in their journals.*

# The Mask

***(Crosskill Longanbach, 2015)***

I have so many different masks.
I wear them one by one.
I see them in a pile
When my day is finally done.

There's one for when I'm happy
And one I wear when sad.
There's one for when I'm pensive
For all that I have had.

I try not to hide behind them,
To just let my sunshine glow.
I've learned from you, "Just be yourself,
And no one else will know."

"You had so much and lost it,
And you tried to get it back.
It may take some time! Be patient!
It's just confidence you lack!"

If I stay true and honest,
There will be no need to wear
These masks I see at bedtime
That are lying on my chair

## 1.6 Warm-Up Activity

### *Dialogue with the back*


***INSTRUCTIONS***

*In this exercise, the goals are to break the ice between group members, provoke a range of emotions, and warm the group up for interactions. The group should be split up into pairs, with each person standing back to back with their partner. The facilitator will read out instructions like:*

*"Imagine your backs are speaking to each other about trivial, everyday life matters. You exchange ideas, make light jokes about things, share experiences, etc. ,*

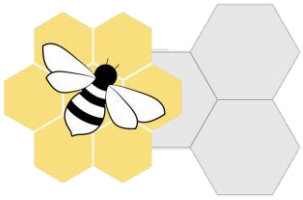
*Eventually, a mild discrepancy between you arises which increases gradually into a discussion. An intense conflict is revealed which turns into an angry argument. You both hold to your positions: it is a matter of principle and you are not willing to give up! Finally, you realize that it was all a misunderstanding, a big mistake. You just didn't understand or hear each other properly. Now everything is mended, you explain yourselves to one another, you make up. You're just two loving, caring human beings." (Pendzik, n.d.).*

*Next, the fun part! The participants will act out the instructions from the facilitator, but only using movements of the back. They cannot speak or turn to look at each other, raise their arms or use their legs and feet to nudge one another; they can only use their backs.*

## 2. GERMINATING AND ROOTING PHASE *(Educational and Skills Development Phase)*

### 2.1 Large Group Nourishing Session


***Finding your Addiction Self***



**FACILITATOR**

*Use the information to discuss finding your Addiction Self*

The Addiction Self is the image of power hiding an image of inadequacy underneath. It is that part of our imagination that we use to control others to get what we want in support of our addiction. When we use drugs, we deny our true selves so that we can control others.

When we create an image of our Addiction Self, we identify a role that we usually try to keep secret from ourselves. This helps us to identify our process of addiction as well as the way we hurt people to support our SUD.

Some of the pattern we use when wearing our addiction self-masks are:

**Denial** – refusing to see your addiction or its impact on other

**Minimizing** – making the impact of your addiction seem less than it really is

**Blaming** – always finding the fault in others

**Colluding** – glorifying and hiding behind – or joining with – others who support you in your addiction

**Controlling** – getting what you want through verbal, emotional, and physical force

**Coercing** – forcing people to do things they do not want to do

**Setting up an emotional hide and seek** – emotional withdrawal and expecting the answers to come from others or expecting people to run after you

## 2.2 Personal Nourishing Activity

### *Making Contact with Your Mask of Addiction*


*You may now make contact with your Addiction Self and create your Mask of Addiction and complete the script.*

**Materials needed:**

- Small hand mirrors
- Song from Sunflower Playlist: Baby can I hold you
- Device to play the song with
- Art Material (different coloured board, glue, scissors, glitters, etc.)
- String

***INSTRUCTIONS***

- *Provide every participant with a hand mirror*
- *Instruct participants to look in the mirror whilst the song is playing, they must try and keep looking into their own eyes throughout the song*
- *When done they have to start creating their Mask of Addiction using the page provided*
- *Once done they have to complete their Mask of Addiction script*

## Baby Can I Hold you

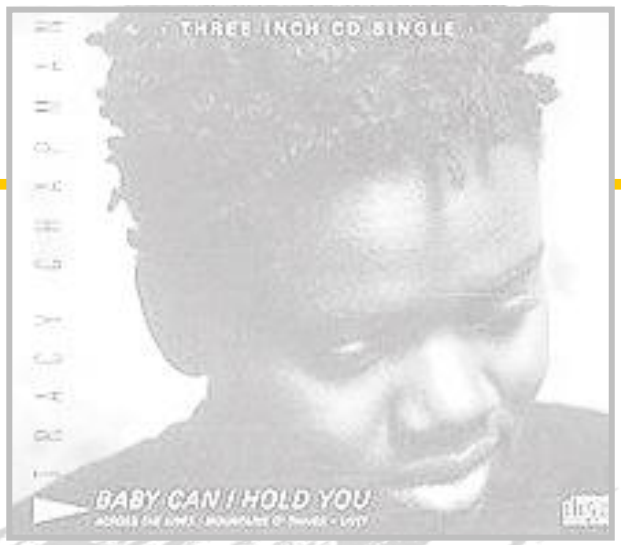
***Tracy Chapman***

*Sorry*
*Is all that you can't say*
*Years gone by and still*
*Words don't come easily*
*Like sorry like sorry*

*Forgive me*
*Is all that you can't say*
*Years gone by and still*
*Words don't come easily*
*Like forgive me forgive me*

*But you can say baby*
*Baby can I hold you tonight*
*Maybe if I told you the right words*
*At the right time you'd be mine*

*I love you*
*Is all that you can't say*
*Years gone by and still*
*Words don't come easily*
*Like I love you I love you*



# MY MASK OF ADDICTION

**(Use this space to create ideas for your mask)**

## MASK OF ADDICTION SCRIPT

**(After you have completed your mask, write the answers to these questions. It may help to put your mask on and look in the mirror before you start answering the questions)**

**The name of this mask is…**

**The role it represents is…**

**The colours and symbols represent…**

**These eyes have seen…**

**This mouth has…**

**I first remember wearing this mask when…**

**What I discovered while making this mask is…**

**What scares / surprises / pleases me most about this mask is…**

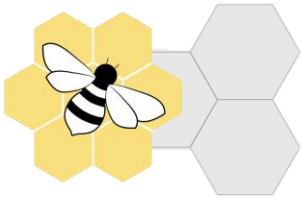
**What this mask would like to say is…**

**What I would like to say to this mask is…**

**How this mask can stop drugging is…**

## 2.3 Circle Dialogue

### *Introduce your Mask*

**FACILITATOR**

*After the participants have completed their Addiction Self Masks, let volunteers wear their masks and share their scripts. The masks may also want to share their story. Create a circle dialogue to assure a safe space for participants to share.*

***INSTRUCTIONS***

1. *Ensure that everyone has completed their masks and scripts.*
2. *Start the first circle dialogue by doing a safety check, let everyone just say what they would need from the other participants to feel safe enough to make themselves vulnerable.*
3. *Ensure that everyone understands the rules of the circle dialogue:*

    - *The person holding the talking piece is talking and the others are listening.*
    - *Once the circle is open, no one is to leave the circle until it is closed.*
    - *Everyone needs to listen with a 100% attention.*
    - *Listen for the seed of truth in someone else's story or sharing (What in their story is also true for me)*
    - *No questions or arguments allowed whilst the circle is open.*

4. *Open the circle with the following theme: This is my Mask… Put the talking piece in the centre of the circle, anyone who feels ready to share can take the talking piece and start. Once they are done, they can put the talking piece back for the next person to share. Close the circle after 45 minutes.*
5. *Give everyone a body break of only 5 minutes*
6. *Open another circle where you give everyone the opportunity to appreciate someone for sharing or identify with someone who shared. This is an essential step in the process because it gives the people who didn't share the opportunity to share. It also assists the participants who made themselves vulnerable because they do not feel alone and they can feel accepted by the group.*
7. *Close the circle dialogue session with everyone reciting the following chant:*

Achieving true sobriety
goes beyond abstinence. it's
also about healing your
soul, apologizing for
damage you did to other,
and seeking forgiveness.

Lou Gramm

## 2.4 Large Group Nourishing Session

### *Connecting with your Best Possible Self*


***Connecting with a person in recovery.***
*Invite a person in recovery (preferably from the same clinic the program is being implemented at) to share their recovery story with the participants before they create their Best Possible Self Hats. This will motivate them to focus on what they can become and achieve in the near future.*

Awaiting you in your near future is your Best Possible Self. Your Best Possible Self holds your real feelings and reality after you have put down your Addiction Self mask. Your Best Possible Self is authentically you. It is that part of you that is deep feeling, intuitive, responsible and multi-levelled and has spontaneity like an innocent child. It is that part of you that experiences joy and love and has needs and feelings. Often, we do not acknowledge our best possible self. This part of us is lost, disowned, and left behind when growing up in abusive situations. We abandon our real feelings in order to protect ourselves. If we continually live a life of fear and survival, then we forget that we have another part of our true-self that needs us –our Best Possible Self.

**BEST POSSIBLE SELF PATTERNS**

- Nurture and take care of self and others
- Give love to self and others
- Ask for help when in need
- Be accountable and trustworthy
- Make decisions about ways to improve your life that do not include addiction
- Practice Ubuntu
- Look for meaning in day to day living
- Is grateful for what you have
- Is optimistic about the future

## *The person behind the mask*


*Is vulnerability the same as weakness? "In our culture," teaches Dr. Brené Brown, "we associate vulnerability with emotions we want to avoid such as fear, shame, and uncertainty. Yet we too often lose sight of the fact that vulnerability is also the birthplace of joy, belonging, creativity, authenticity, and love."*

*On The Power of Vulnerability, Dr. Brown offers an invitation and a promise - that when we dare to drop the armour that protects us from feeling vulnerable, we open ourselves to the experiences that bring purpose and meaning to our lives. Here she dispels the cultural myth that vulnerability is weakness and reveals that it is, in truth, our most accurate measure of courage. When you take of your Addiction Self mask you may feel very vulnerable because you have been wearing your mask for a long time. You may not even recognize the image staring back at you in the mirror. You need to find something that will allow you to connect with the best version of yourself. Something that can protect you from your Addiction Self.*

*This protection comes in the form of your Best Possible Self Hat. We all wear hats to protect ourselves from the sun and falling objects like on a construction site. Hats also give us an identify like a police hat, a beautiful elegant hat for a lady or a Panama hat. By creating your Best Possible Self Hat, you will connect to your true-self/authentic self that will be able to protect you from your Addiction Self.*

**Materials needed:**

- Art Material
- Small hand mirrors
- Song from STV Playlist: For the first time
- Device to play the song with
- Art Material (different coloured board, glue, pastels, scissors, glitter, etc.)
- String
- Stapler with staples

***INSTRUCTIONS***

- *Provide every participant with a hand mirror*
- *Instruct participants to look in the mirror while the song is playing ("For the first time"), they must try and keep looking into their own eyes throughout the song.*
- *When done they have to start creating their Best Possible Self Hats.*
- *Once done they have to complete the Best Possible Self script*

## BEST POSSIBLE SELF SCRIPT

**Write the answers to these questions:**

**The name of this hat is…**

**The role it represents is…**

**The colours and symbols represent…**

**The one thing this hat wants to see is …**

**This one thing this hat wants to say is…**

**I want to start wearing this hat…**

**What I discovered while making this hat is…**

**What scares / surprises / pleases me most about this hat is…**

**What this hat would like to say is…**

**What I would like to say to this hat is…**

**This hat protects me through…**

## 2.5 Circle Dialogue

### *Introduce your Best Possible Self Hat*


**FACILITATOR**

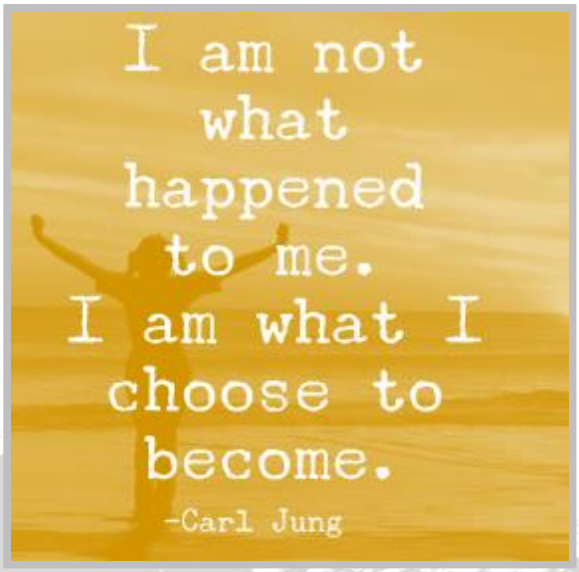
*After the participants have completed their Best Possible Self Hats, let volunteers wear their hats and share their scripts. The hats may also want to share their story. Create a circle dialogue to assure a safe space for participants to share.*

***INSTRUCTIONS***

1. *Ensure that everyone has their completed their hats and scripts.*
2. *Start the first circle dialogue by doing a safety check, let everyone just say what they would need from the other participants to feel safe enough to make themselves vulnerable.*
3. *Ensure that everyone understands the rules of the circle dialogue:*

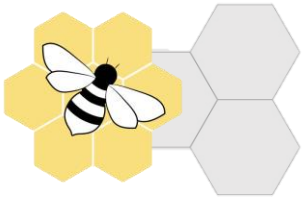
    - *The person holding the talking piece is talking and the others are listening.*
    - *Once the circle is open, no one is to leave the circle until it is closed.*
    - *Everyone needs to listen with a 100% attention.*
    - *Listen for the seed of truth in someone else's story or sharing (What in their story is also true for me)*
    - *No questions or arguments allowed whilst the circle is open.*

4. *Open the circle with the following theme: This is my Best Possible Self Hat… Put the talking piece in the centre of the circle, anyone who feels ready to share can take the talking piece and start. Once they are done, they can put the talking piece back for the next person to share. Close the circle after 45 minutes.*
5. *Give everyone a body break of only 5 minutes*
6. *Open another circle where you give everyone the opportunity to appreciate someone for sharing or identify with someone who shared. This is an essential step in the process because it gives the people who didn't share the opportunity to share. It also assists the participants who made themselves vulnerable because they do not feel alone and they can also feel accepted by the group.*
7. *Closing the circle dialogue session with everyone reciting the following chant:*



## 2.6 Large Group Activity

### *Cleansing Ritual*



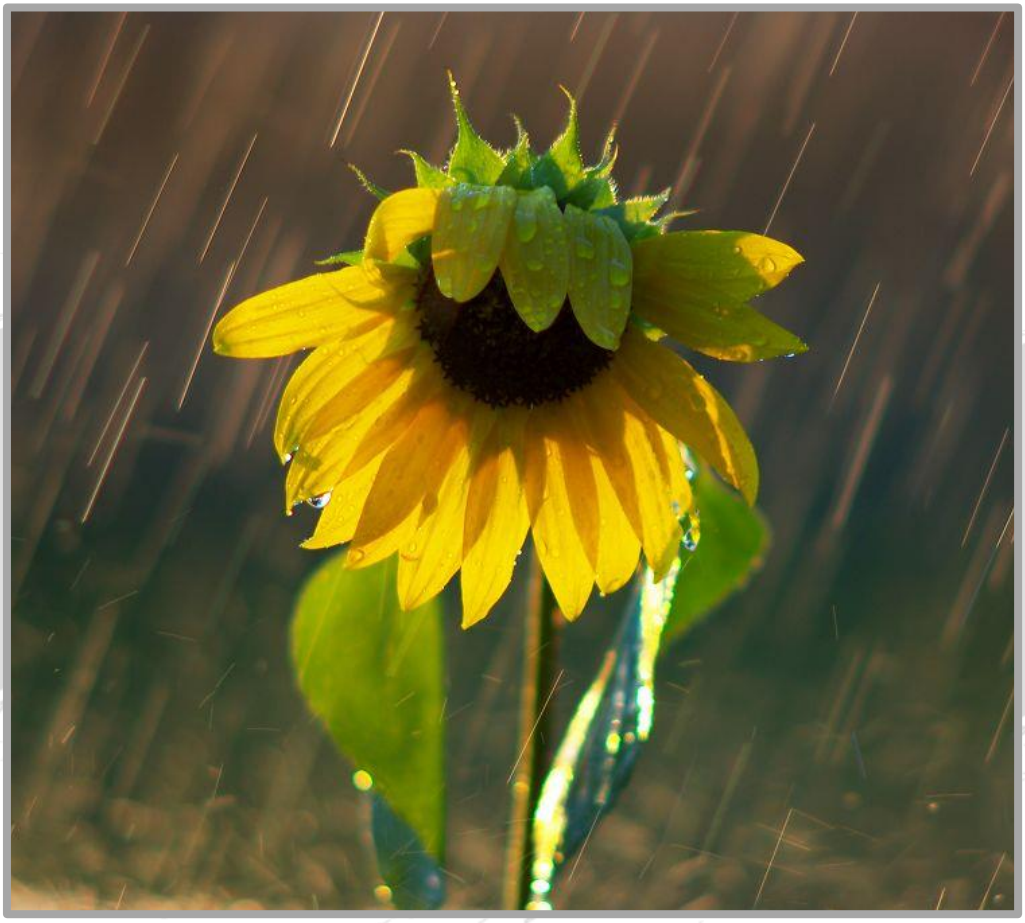
Time: 10 Minutes

**FACILITATOR**

*Let all the participants stand in a circle.*
*Do a few stretches and shake out what people want to leave behind from that day.*

*Ask people to mention a few things that they want to shake out and leave behind.*
*Then ask people what they want to take with them from that day.*

*Scoop this from the circle of the room and let the participants place it in their hearts or wherever they feel they want to put it.*



## 3. GROWING PHASE *(Summary and Termination Phase)*

### 3.1 Wrap-Up Times Three

Allow three volunteers (as identified in the beginning of the workshop) to identify an activity during the workshop where they practiced each of the three basic psychological needs: autonomy (people are empowered when they feel a sense of choice and endorsement in a task), competence (individuals seek control to allow them to experience mastery over a task) and relatedness (individuals have a need to interact with others).

### 3.2 Conclusion

By thinking about your best possible future self, you can learn about yourself and what you want in life. This way of thinking can help you restructure your priorities in life in order to reach your goals. Additionally, it can help you increase your sense of control over your life by highlighting what you need to do to achieve your dreams.

### 3.3 Check-out

***Watering the flowers (Practicing Relatedness)***

***INSTRUCTIONS***

*Let participants gather in a circle. Ask them to appreciate the person on their right-hand side based on their participation during the session i.e.: "Ntebo, I want to thank you for being a good listener." End the session with everyone reciting the Sunflower Chant:*

Before speaking to anyone about today's workshop please use the space provided to journal about it. You may want to investigate your thoughts and feelings after the workshop. Perhaps you can also think about the choices you have been given during the workshop and your interaction with your fellow participants. Maybe you also want to journal about new skills you may have learned or want to develop after the workshop. Finally, you can also write about something that you appreciate about yourself after the workshop. Once done you may want to read what you have written and reflect on it, sum up your takeaway in one or two sentences, starting with statements like: "As I read this, I notice…; "I am aware of…", or "I feel…"

## Journaling

- **Flower 1: My Best Possible Self**
  - Take a few minutes to select a future time period (e.g., 6 months, 1 year, 5 years from now) and imagine that at that time you are expressing your best possible self strongly. You are wearing and using your Best Possible Self Hat. Visualize your best possible self in a way that is very pleasing to you and that you are interested in.
  - Imagine in vivid detail that you have worked hard and succeeded at accomplishing your life goals. You might think of this as reaching your full potential, hitting an important milestone, or realizing one of your life dreams. The point is not to think of unrealistic fantasies, but rather, things that are positive and attainable within reason.
  - After you have a fairly clear image, write about the details. Writing about your best possible self helps to create a logical structure for the future and can help you move from the realm of foggy ideas and fragmented thoughts to concrete, real possibilities.
  - Be sure to write about strengths that you are using to be your best possible self.

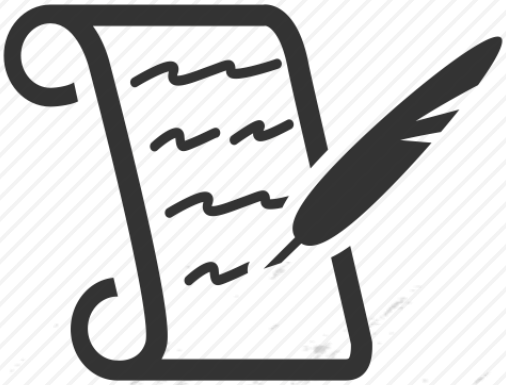
- **Flower 2: Letter of Atonement (Amends)**

  Part of recovery is to understand the hurt that you have caused through your addiction. Today you have created your Addiction Self mask and you realized some of the hurt you have caused the people you love. An effective way to build understanding is by writing a letter of atonement which may or may not ultimately be read to the person (or people) you have harmed.

  **Letters of atonement are relatively short. In these letters you do the following:**

  1. *Give and apology*
  2. *Describe exactly what you did in general, non-graphic terms*
  3. *Explain how you are responsible for what you did, meaning the people/person you acted out with are not responsible, nor are your parents, your spouse, your siblings, your friends, etc.*
  4. *Explain your current understanding of why you did what you did – without minimizing your actions, blaming another person or blaming your addiction.*
  5. *Explain that the person you are writing this letter to is in no way at fault, nor did he/she influence your decision to act out at any time.*
  6. *Describe the ways in which you have blamed or put down the person you are writing this letter to in order to hide and/or justify what you were doing.*
  7. *Describe the ways in which you caused the recipient to doubt himself/herself as a way to cover your tracks and avoid getting caught.*
  8. *Acknowledge the reality of his/her thoughts and feelings, which may include hate, disgust, anger, betrayal, rejection, etc.*
  9. *Accept responsibility for the emotional, financial and other burdens and losses your behaviour has created.*
  10. *Accept responsibility for how your behaviours isolated you from him/her and also isolated him/her from family, peers, community, etc.*
  11. *Describe what you have learned from your behaviours and what your commitments are in terms of changing those behaviours.*

  Write a letter of atonement to your spouse/ parents/ sibling/ any other significant other or person you have most deeply hurt.



Dear

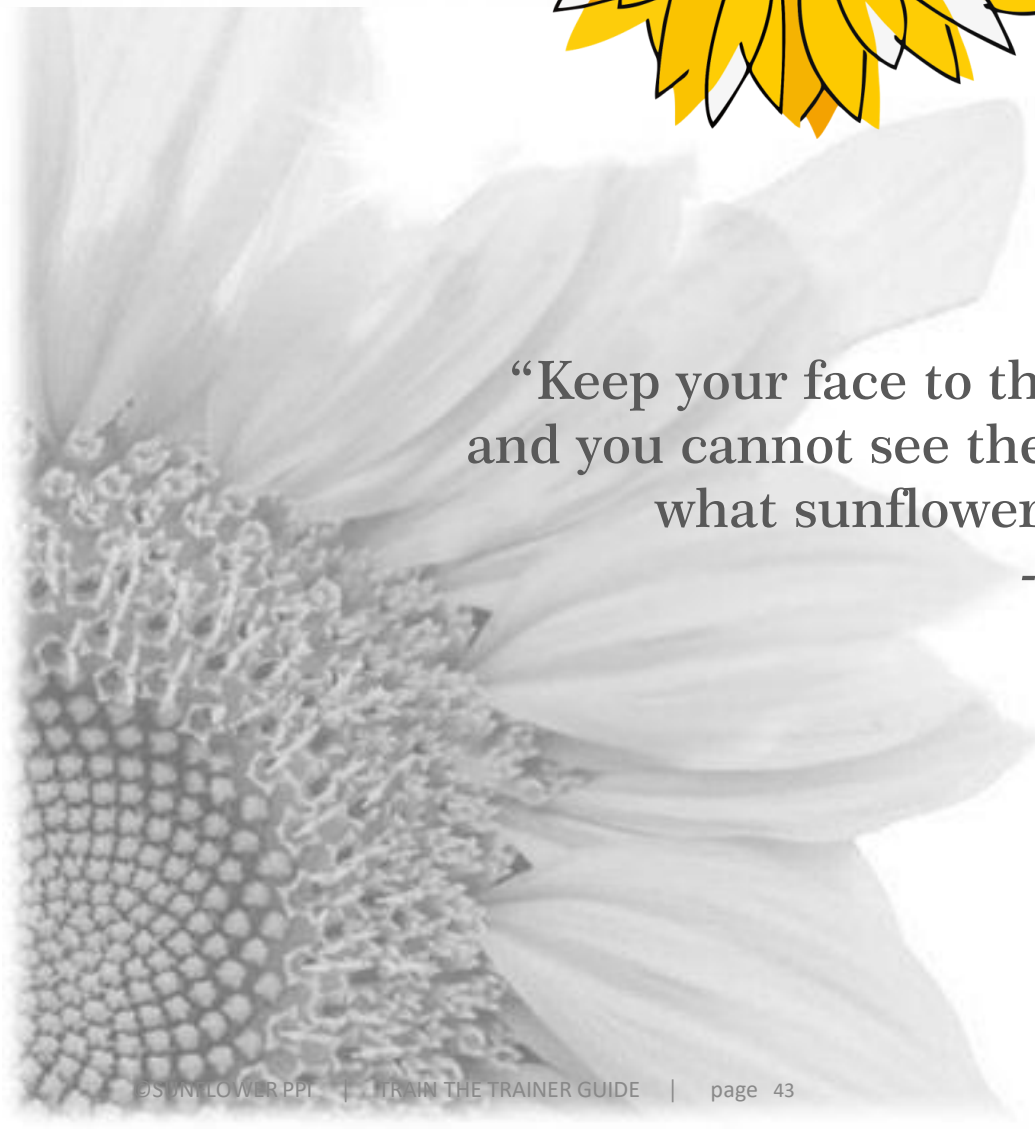
# WORKSHOP 3

## Learn to be Kind

*(A session for staff and people with SUD)*

Sunflower

A POSITIVE PSYCHOLOGY INTERVENTION



"Keep your face to the sunshine and you cannot see the shadow. It's what sunflowers do"

*- Helen Keller*

## INTRODUCTION

***Kindness*** is being nice to others.
***Kindness*** is being generous with others, giving your time, money, and ability to support those who are in need.
***Kindness*** is being considerate, which means to really be there for someone, listening intently to their suffering or just sitting with them and silently assisting them.

Such compassion involves a deep concern for the welfare of others. Kindness is also being supporting and caring to others — to enjoy helping others and to do good deeds.

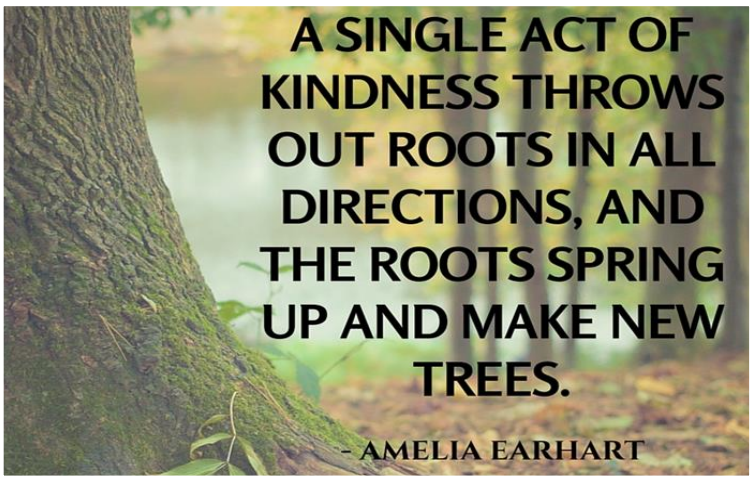
This session of the Sunflower PPI focuses on understanding what kindness is and starting to practice kindness in your treatment center and during your recovery.

## 1. PREPARING AND PLANTING PHASE *(Preparation Phase)*

### 1.1 Workshop Quote

**FACILITATOR**

*Share the workshop quote with the participants. Let them reflect on the quote by writing in their personal journals. Ask for voluntary feedback.*




### 1.2 Program Chant

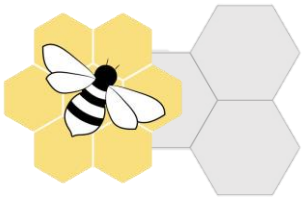
**FACILITATOR**

*Let all the participants gather in a circle. Let them first read and then recite the program chant together.*

*As participants in the 'Sunflower' programme*
*Always remember...*
*we are braver than we believe*
*smarter than we think*
*and twice as beautiful as we ever imagined!*

## 1.3 Choose to be brave

(Participants can practise competence, autonomy, and relatedness within the workshop)



**FACILITATOR**

*Before starting the workshop ask participants to choose which of the following roles they would like to play during the workshop (keep record of the names of these participants):*

- *Timekeeper (Keep time during activities)*
- *Wrap-Up Times Three (Three volunteers each need to identify an activity during the workshop where they practiced each of the three basic psychological needs: autonomy [people are empowered when they feel a sense of choice and endorsement in a task], competence [individuals seek control to allow them to experience mastery over a task] and relatedness [individuals have a need to interact with others]).*
- *Introduce others in a creative way (One person takes the lead in introducing fellow participants in a creative way, i.e. two claps, two snaps, two stomps with their feet, two winks and a "Go Peter" (name of person).*
- *Appreciate with love (One person takes the lead by appreciating participants who shared by clapping X 2 and showering them with love by moving their hands in the form of a heart)*
- *Kibata! ('Kibata' is a loud clap followed by moving the one hand away from the other when done. One participant takes the lead in appreciating a participant who discovered an aha-moment, shared something profound or made themselves vulnerable. This needs to be an incredibly special moment)*

## 1.4 Check-in

**Materials needed:**

- Open space
- Talking piece (bean bag)

***INSTRUCTIONS***

*Let participants gather in a circle. Using a talking piece let each participant share one thing they will need from the group that day to enable them to participate unreservedly. It may be support, encouragement, being non-judgmental, etc. Give time for voluntary feedback on the participants' 'Bloom with Grace' assignments.*

*Once a participant has shared the group will respond by saying:*

*"Thabo (name of participant), nothing for us, without us!*

## 1.5 Warm-Up Activity

### *Good Things*


**FACILITATOR**

*Instruct each participant to turn to one of their neighbours and tell him or her something good. Participants can use one of these prompts:*

- *One good thing in my life is . . .*
- *Something good that happened is . . .*

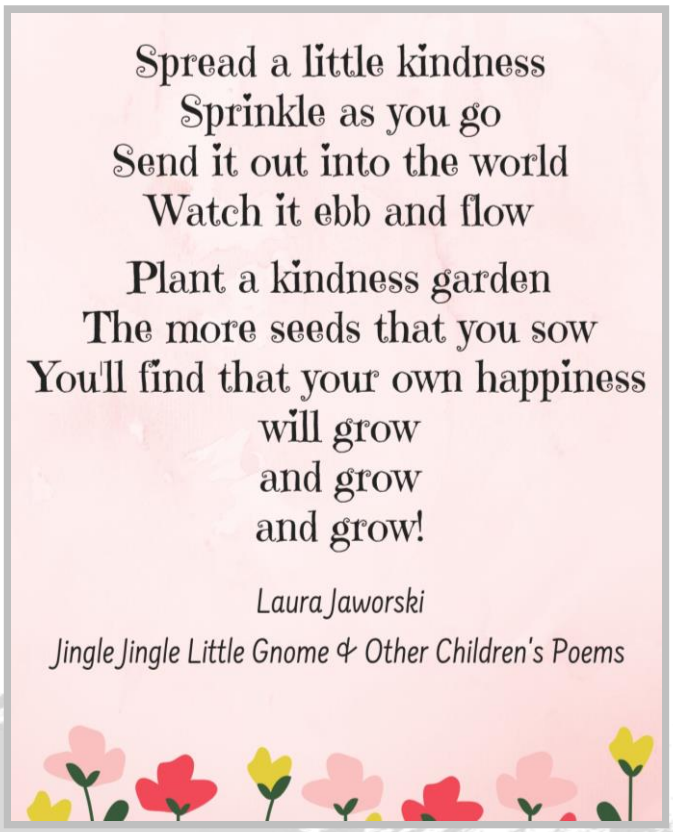
*Encourage the participants to be creative with their "good thing," but if they are having trouble coming up with something, assure them that the good thing can be as small as eating something they liked or seeing something that is beautiful.*

## 1.6 Session Poem

### *Spread a little kindness*


***INSTRUCTIONS***

*Let participants open the journals at the poem: "Spread a little kindness". Give time for them to read the poem and journal about it. Allow voluntary feedback from participants.*



## 2. GERMINATING AND ROOTING PHASE *(Educational and Skills Development Phase)*

### 2.1 Group Nourishing Session

***In a world trying to make you heartless, be kind***


**FACILITATOR**

*Use the information provided to motivate the participants to start spreading kindness every day.*

**In a world trying to make you believe that it is better to mean, be nice. Be respectful.**

Be compassionate. Be the bigger person. Be tolerant. Be stronger than your heartbreak, your past and your pain. Be someone who knows how to love no matter how many times love has failed you. Be someone who knows how to be kind to a world that is known for being heartlessly unkind.

**In a world trying to make you feel like you must do everything alone, learn how to share.**

Learn how to give, learn how to be a better friend, a better parent or partner, learn how to surround yourself with people who make you happy. Learn how to ask for help or ask someone for assistance. Learn how to be someone others can rely and depend on. Remember the heart you used to have before it got broken.

**In a world teaching you how to be aloof, uncommitted, and distant, be brave, vulnerable, and thoughtful.**

Be the one who cares more. Be the one who says 'I love you' first. Be the one who tries instead of the one who wonders what could have been. Be the one who knows how to live with a few bruises from getting knocked down instead of the one who fears getting hurt and misses out on all the fun.

**In a world telling you that you cannot have it all, dare to dream, dare to believe.**

Dare to look at those living the life you have always dreamed of and have faith that you can have that kind of life too. Life is tough but it can also be easy. In a world trying to tell you to look at the glass half-empty, look at it half-full or even better – start topping-up your own glass.

**In a world trying to tell you to live a lie, live the truth.**

Life gets easier when you accept yourself and know who you really are, with your mistakes and your imperfections. It gets easier when you stop living conferring what the world wants and start living according to what you want.

**In a world trying to change your heart, learn how to fight for it.**

Learn how to keep increasing kindness, learn how to love harder because when this world ends, you will not remember the days you were harsh or heartless or scared. You'll remember the times you fell in love, the memories that made you smile, the people who were there for you and the people you moved and motivated and loved along the way. So, spread a bit of kindness every day! (Naim, 2017)

## 2.2 Group Nourishing Activity


### *Sweet Appreciation*

**Materials needed:**

- Pack of sweets
- A chair for each participant

***INSTRUCTIONS***

*Let participants and staff members gather in a circle. Ensure that every participant has their own chair. Everyone will get the opportunity to sing someone's praise after handing them a sweet. The facilitator needs to make sure that everyone's praise has been sung.*

## 2.3 Personal Nourishing Activity


### *Don't forget yourself!*

**Materials needed:**

- Sticky Notes
- Markers

***INSTRUCTIONS***

*Ask participants to notice any negative self-talk they might do that makes them feel not so good about themselves. Give them sticky notes and markers and have them write a positive affirmation to combat each negative thought. For example, "I'm not smart enough" can become "I am always learning new things!" Then, instruct them to post the sticky notes in places where they are likely to see them every day, such as the bathroom mirror — and whenever the negative thought creeps in, replace it with the positive one!*

## 2.4 Treatment Center Challenge

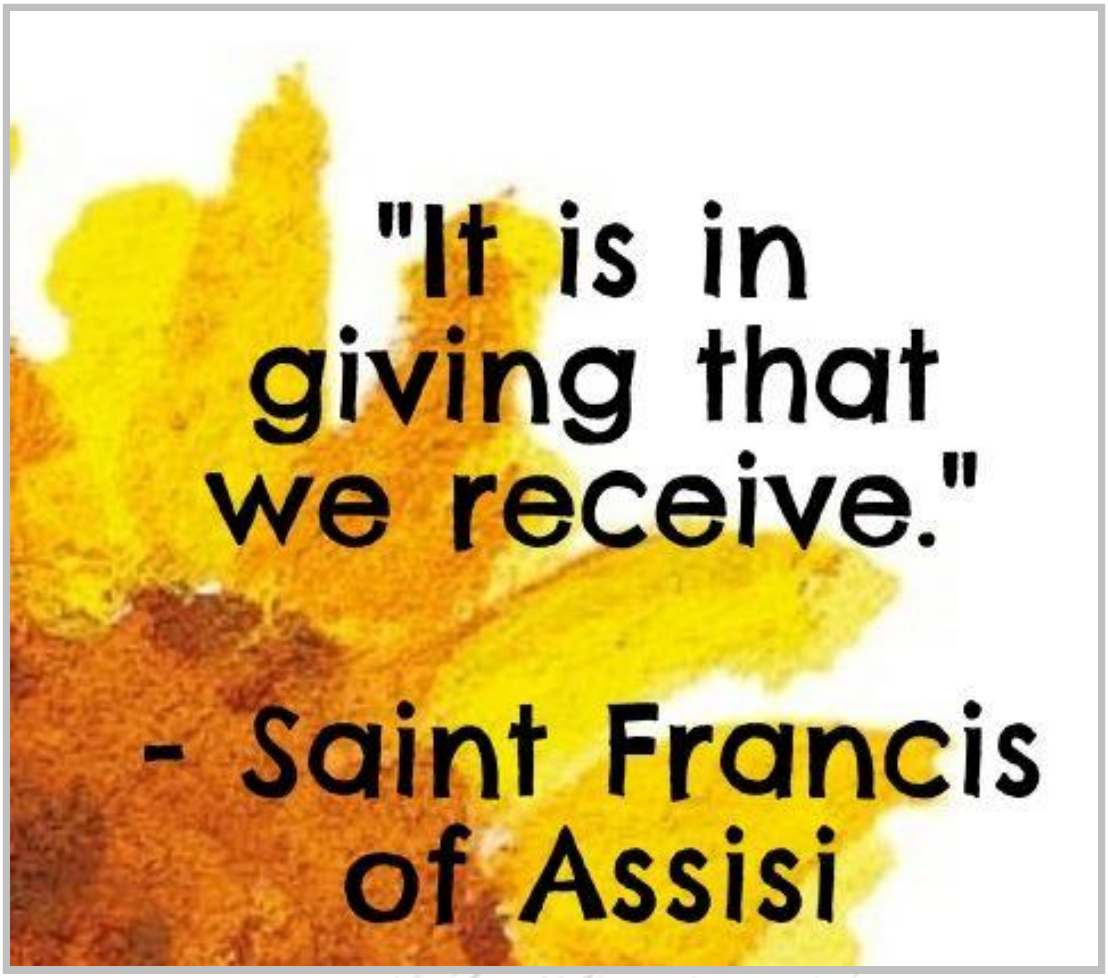
***Thank You for Being Kind!***

**Materials needed:**

- Sticky notes
- Markers
- Bullet board

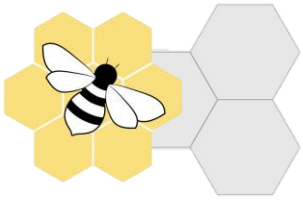
***INSTRUCTIONS***

*Tell staff members and people with SUD to be on the lookout for random acts of kindness. When they see someone doing something nice for someone else, have them write the person's name on a sticky note along with the kind deed. Tell everyone to paste the sticky notes on an identified bulletin board titled: "Thank You for Being Kind!". Identify a time, once a week, for everyone to read the sticky notes and collect sticky notes with their name on it from the bulletin board.*



## 2.5 Group Nourishing Activity

### *Languages of Love*

**FACILITATOR**

*Use the information provided on Languages of Love to explain the Five Languages of Love.*

*Dr Gary Chapman popularized the love languages in his famous book, The Five Languages of Love more than 10 years ago. According to him, taking time to learn and understand a person's primary love language, which is often different from your own, can improve communication and strengthen your bond with that person. But what are these five different love languages and what do they look like in practise?*

### *Words of affirmation*

*According to Chapman, people with this love language need to hear their family or friend say, "I love you." Even better is including the reasons behind the love through leaving them a voice message or a written note or talking to them directly with sincere words of kindness and affirmation.*

### *Quality time*

*This language, says Chapman, is all about giving your partner your undivided attention. That means no TV, no chores, no cell phone — just giving each other your undivided attention. Take time every day to do this.*

### *Receiving gifts*

*The person who loves this language thrives on the love, thoughtfulness, and effort behind the gift. In short, actions speak louder than words. Think about finding a gift that someone has been asking for or would enjoy receiving and plan for a special way of giving it; make it a surprise.*

### *Acts of service*

*This language includes anything you do to ease the burden of responsibility, like vacuuming the floors, going grocery shopping, or sending thank-you notes. Chapman suggests asking the person to give ideas for things they'd like you to do that would make their life easier and make a schedule to get them done.*

### *Physical touch*

*People who speak this love language thrive on any type of physical touch: hand-holding, hugs and pats on the back. Be intentional about finding ways to express your love using physical touch: giving hugs or touching their arm or hand during a conversation (Hogan, 2020).*

## *The 5 Languages Quiz*

**FACILITATOR**

*Let staff and people with SUD complete the 5 Languages Quiz.*


## The Five Love Languages Quiz

Two phrases will presented to you at a time. Select the one that best describes you right now. Mark your selection to the right of the sentence by circling the letter in that block.

| | | |
|---|---|---|
| 1. | I like to receive notes of affirmation. | A |
| | I like to be hugged. | E |
| | | |
| 2. | I like to spend one-to-one time with a person who is special to me. | B |
| | I feel loved when someone gives practical help to me. | D |
| | | |
| 3. | I like it when people give me gifts. | C |
| | I like leisurely visits with friends and loved ones. | B |
| | | |
| 4. | I feel loved when people do things to help me. | D |
| | I feel loved when people touch me. | E |
| | | |
| 5. | I feel loved when someone I love or admire puts his or her arm around me. | E |
| | I feel loved when I receive a gift from someone I love or admire. | C |
| | | |
| 6. | I like to go places with friends and loved ones. | B |
| | I like to high-five or hold hands with people who are special to me. | E |
| | | |
| 7. | Visible symbols of love (gifts) are very important to me. | C |
| | I feel loved when people affirm me. | E |
| | | |
| 8. | I like to sit close to people whom I enjoy being around. | E |
| | I like for people to tell me I am beautiful/handsome. | A |
| | | |
| 9. | I like to spend time with friends and loved ones. | B |
| | I like to receive little gifts from friends and loved ones. | C |
| | | |
| 10. | Words of acceptance are important to me. | A |
| | I know someone loves me when he or she helps me. | D |

| | | |
|---|---|---|
| 11. | I like being together and doing things with friends and loved ones. | B |
| | I like it when kind words are spoken to me. | A |
| | | |
| 12. | What someone does affects me more than what he or she says. | D |
| | Hugs make me feel connected and valued. | E |
| | | |
| 13. | I value praise and try to avoid criticism. | A |
| | Several small gifts mean more to me than one large gift. | C |
| | | |
| 14. | I feel close to someone when we are talking or doing something together. | B |
| | I feel closer to friends and loved ones when they touch me often. | E |
| | | |
| 15. | I like for people to compliment my achievements. | A |
| | I know people love me when they do things for me that they don't enjoy doing. | D |
| | | |
| 16. | I like to be touched as friends and loved ones walk by. | E |
| | I like it when people listen to me and show genuine interest in what I am saying. | B |
| | | |
| 17. | I feel loved when friends and loved ones help me with jobs or projects. | D |
| | I really enjoy receiving gifts from friends and loved ones. | C |
| | | |
| 18. | I like for people to compliment my appearance. | A |
| | I feel loved when people take time to understand my feelings. | B |
| | | |
| 19. | I feel secure when a special person is touching me. | E |
| | Acts of service make me feel loved. | D |
| | | |
| 20. | I appreciate the many things that special people do for me. | D |
| | I like receiving gifts that special people make for me. | C |
| | | |

| | | |
|---|---|---|
| 21. | I really enjoy the feeling I get when someone gives me undivided attention. | B |
| | I really enjoy the felling I get when someone helps me make decisions. | D |
| | | |
| 22. | I feel loved when a person celebrated my birthday with a gift. | C |
| | I feel loved when a person celebrates my birthday with meaningful words. | A |
| | | |
| 23. | I know a person is thinking of me when he or she gives me a gift. | C |
| | I feel loved when a person helps with my chores. | D |
| | | |
| 24. | I appreciate it when someone listens patiently and doesn't interrupt me. | B |
| | I appreciate it when someone remembers special days with a gift. | C |
| | | |
| 25. | I like knowing loved ones are concerned enough to help with my daily tasks. | D |
| | I enjoy extended trips with someone who is special to me. | B |
| | | |
| 26. | I enjoy kissing or being kissed by people with whom I am close. | E |
| | I enjoy receiving a gift given for no special reason. | C |
| | | |
| 27. | I like to be told that I am appreciated. | A |
| | I like for a person to look at me when we are talking. | B |
| | | |
| 28. | Gifts from a friend or loved one are always special to me. | C |
| | I feel good when a friend or loved one touches me. | E |
| | | |
| 29. | I feel loved when a person enthusiastically does some task I have requested. | D |
| | I feel loved when I am told how much I am needed. | A |
| | | |
| 30. | I need to be touched every day. | E |
| | I need words of encouragement daily. | A |

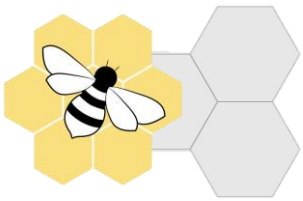
**Totals:** **A:** **B:** **C:** **D:** **E:**

Count the number of A's, B's, C's, D's and E's you have circled, and record them below. The highest total will show you what your 'love language' is.

- ☐ A = Words of Affirmation
- ☐ B = Quality Time
- ☐ C = Receiving Gifts
- ☐ D = Acts of Service
- ☐ E = Physical Touch

**Group Share Session**

***Primary Love Language***

**FACILITATOR**

*Let participants gather in a circle. Give everyone the opportunity to share their primary love language and why they can identify with their love language.*

*Once done ask participants to try and 'speak' each other's love language when engaging with one another in the treatment center.*

*Provide people with SUD and staff member with a name tag identifying their primary love language i.e. Nokothula – Acts of Service.*

## 3. GROWING PHASE *(Summary and Termination Phase)*

### 3.1 Wrap-Up Times Three

Allow three volunteers (as identified in the beginning of the workshop) to identify an activity during the workshop where they practiced each of the three basic psychological needs: autonomy (people are empowered when they feel a sense of choice and endorsement in a task), competence (individuals seek control to allow them to experience mastery over a task) and relatedness (individuals have a need to interact with others).

### 3.2 Conclusion

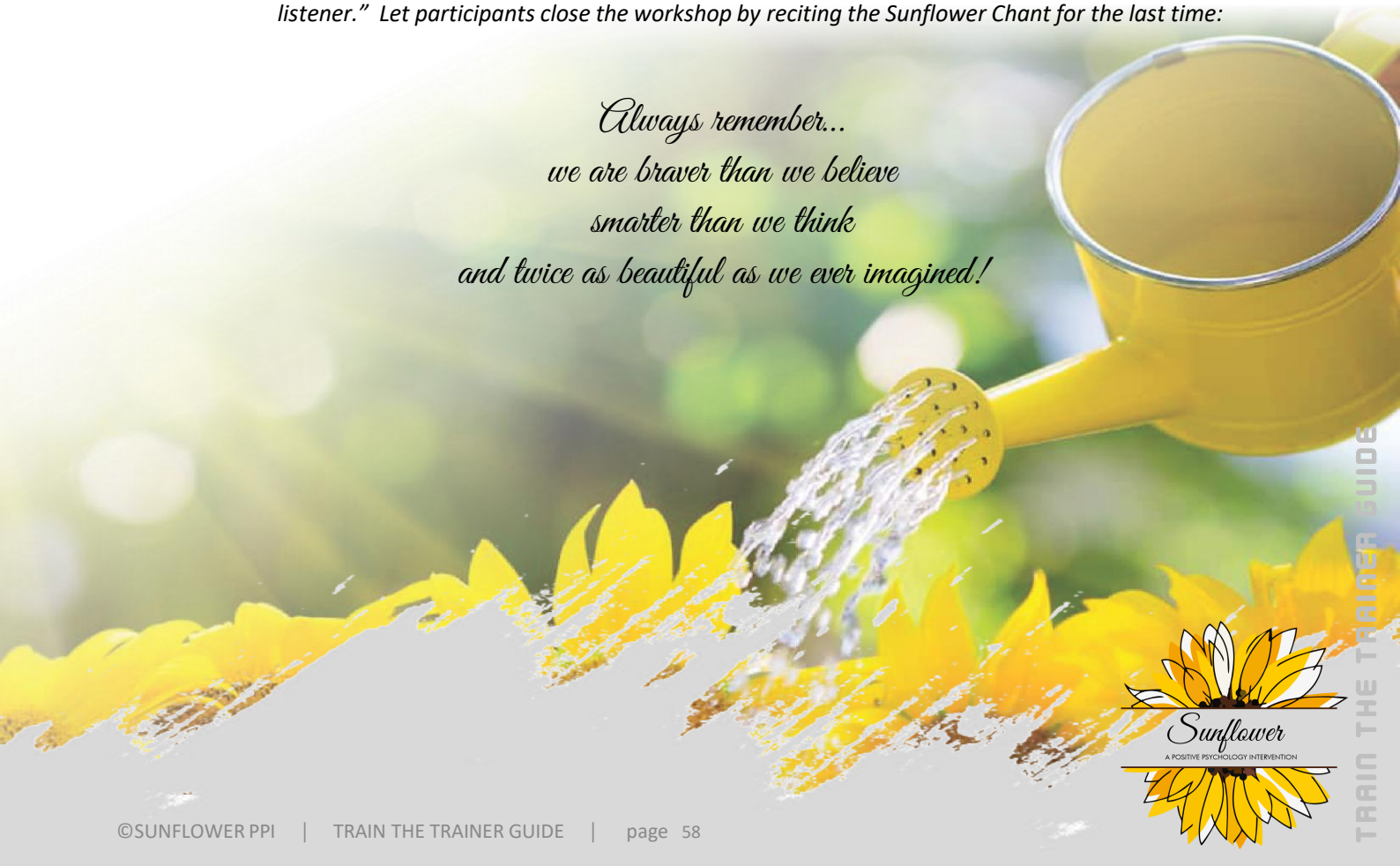
Being kind may boost your mood, but research has also shown that being in a good mood can make you more kind. This makes it a wonderful two-way relationship which just keeps giving. Kindness also creates much needed social connections during recovery.

### 3.3 Check-out

***Watering the flowers (Practising Relatedness)***

***INSTRUCTIONS***

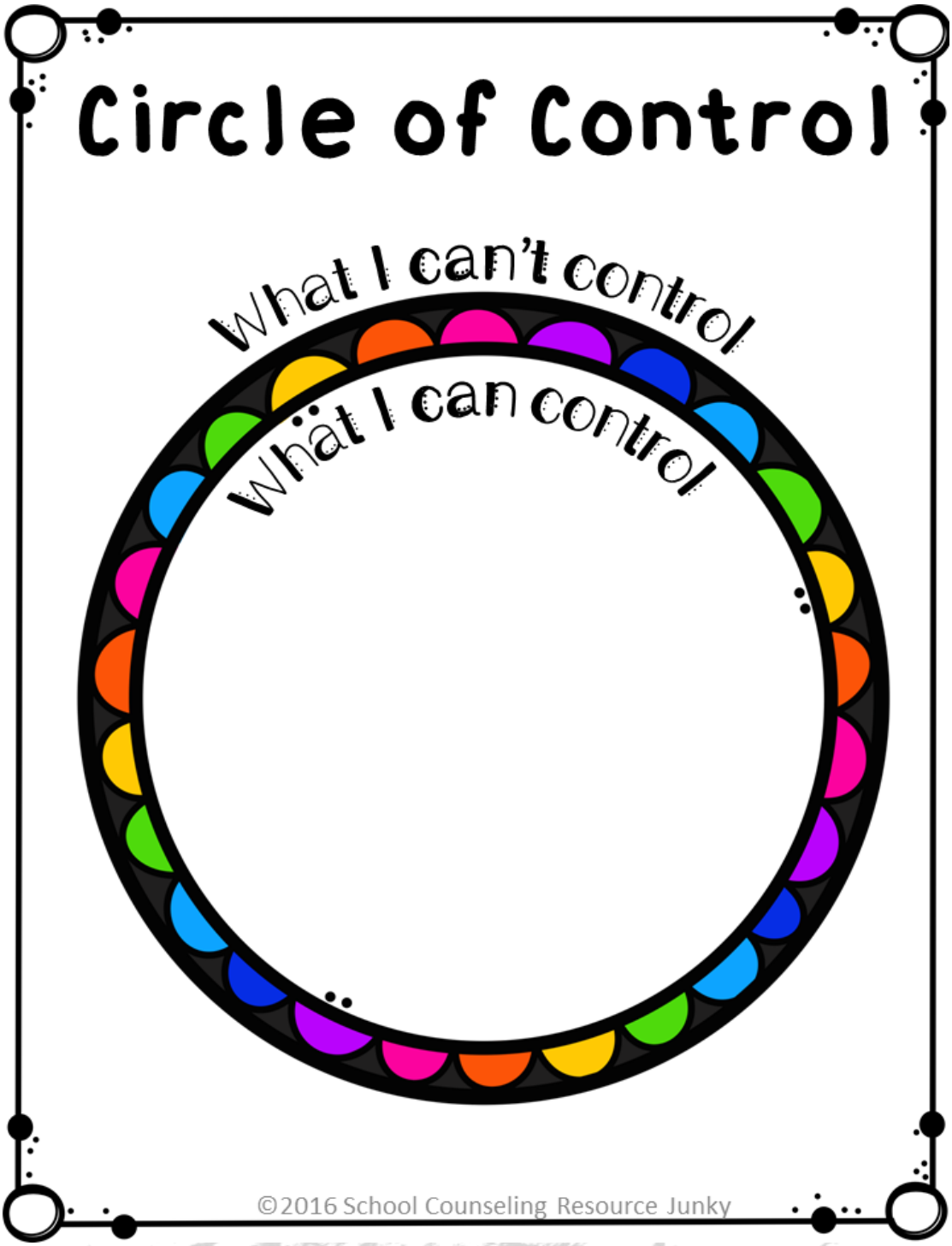
*Let participants gather in a circle. Ask them to appreciate the person on their right-hand side based on their participation during the session i.e.: "Ntebo, I want to thank you for being a good listener." Let participants close the workshop by reciting the Sunflower Chant for the last time:*



Before speaking to anyone about today's workshop please use the space provided to journal about it. You may want to investigate your thoughts and feelings after the workshop. Perhaps you can also think about the choices you have been given during the workshop and your interaction with your fellow participants. Maybe you also want to journal about new skills you may have learned or want to develop after the workshop. Finally, you can also write about something that you appreciate about yourself after the workshop. Once done you may want to read what you have written and reflect on it, sum up your takeaway in one or two sentences, starting with statements like: "As I read this, I notice…; "I am aware of…", or "I feel…"

## Journaling

- **Flower 1: Circle of Control**
  - Use the Circle of Control below to identify what you can currently control i.e. your drug intake, your recovery, your temper, etc. as well as what you cannot control i.e. others people's actions, the weather, inflation etc.

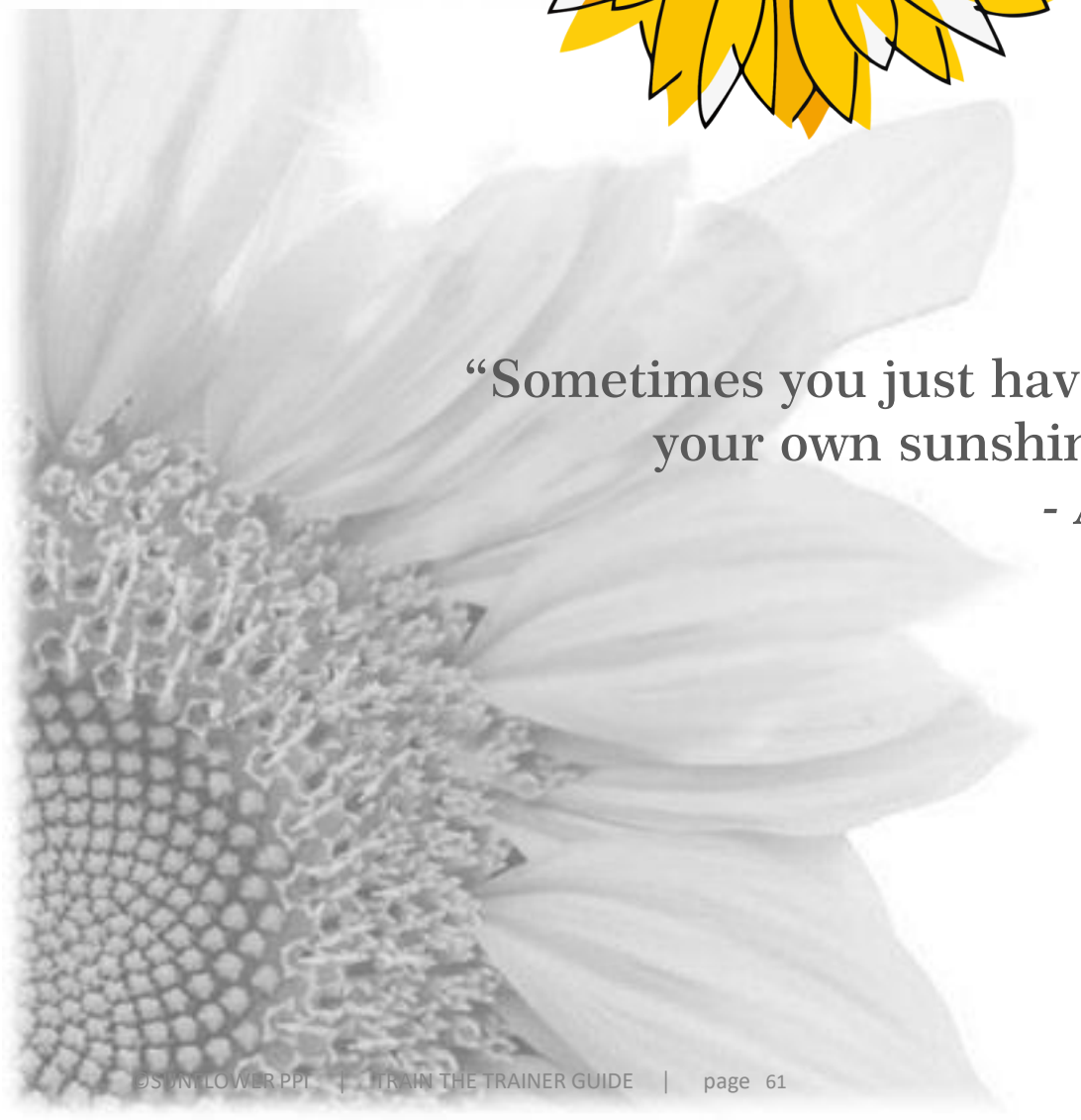


# WORKSHOP 4A

An Attitude of Gratitude!

Sunflower

A POSITIVE PSYCHOLOGY INTERVENTION



"Sometimes you just have to create your own sunshine"

*- Amulya Gs*

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## INTRODUCTION

People can use gratitude to form new social relations or to strengthen current ones.

Acts of gratitude can be used to apologize, make amends and help solve other problems. Alternatively, people may feel gracious because it can be an intrinsically rewarding process.

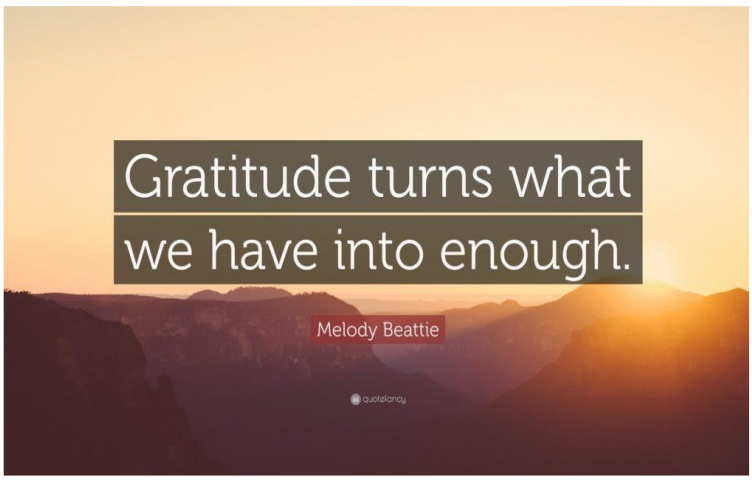
Simply being grateful for being alive is a great way to motivate oneself to seize the day.

The idea that tomorrow is not guaranteed is a strong motivator for some people to be their "best self" today. Today's workshop will focus on understanding the power of gratitude and starting to practise gratitude during recovery.

## 1. PREPARING AND PLANTING PHASE *(Preparation Phase)*

### 1.1 Workshop Quote

**FACILITATOR**
*Share the workshop quote with the participants. Let them reflect on the quote by writing in their personal journals. Ask for voluntary feedback.*



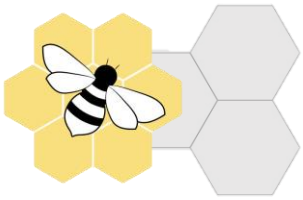

### 1.2 Program Chant

**FACILITATOR**
*Let all the participants gather in a circle. Let them first read and then recite the program chant together.*

*As participants in the 'Sunflower' programme*
*Always remember...*
*we are braver than we believe*
*smarter than we think*
*and twice as beautiful as we ever imagined!*

## 1.3 Choose to be brave

(Participants can practise competence, autonomy, and relatedness within the workshop)



**FACILITATOR**

*Before starting the workshop ask participants to choose which of the following roles they would like to play during the workshop (keep record of the names of these participants):*

- *Timekeeper (Keep time during activities)*
- *Wrap-Up Times Three (Three volunteers each need to identify an activity during the workshop where they practiced each of the three basic psychological needs: autonomy [people are empowered when they feel a sense of choice and endorsement in a task], competence [individuals seek control to allow them to experience mastery over a task] and relatedness [individuals have a need to interact with others]).*
- *Introduce others in a creative way (One person takes the lead in introducing fellow participants in a creative way, i.e. two claps, two snaps, two stomps with their feet, two winks and a "Go Peter" (name of person).*
- *Appreciate with love (One person takes the lead by appreciating participants who shared by clapping X 2 and showering them with love by moving their hands in the form of a heart)*
- *Kibata! ('Kibata' is a loud clap followed by moving the one hand away from the other when done. One participant takes the lead in appreciating a participant who discovered an aha-moment, shared something profound or made themselves vulnerable. This needs to be an incredibly special moment)*

## 1.4 Check-in

**Materials needed:**

- Open space
- Talking piece (bean bag)

***INSTRUCTIONS***

*Let participants gather in a circle. Using a talking piece let each participant share one thing they will need from the group that day to enable them to participate unreservedly. It may be support, encouragement, being non-judgmental, etc. Give time for voluntary feedback on the participants' 'Bloom with Grace' assignments.*

*Once a participant has shared the group will respond by saying:*

*"Thabo (name of participant), nothing for us, without us!*

## 1.5 Warm-Up Activity

### *I am Grateful for*

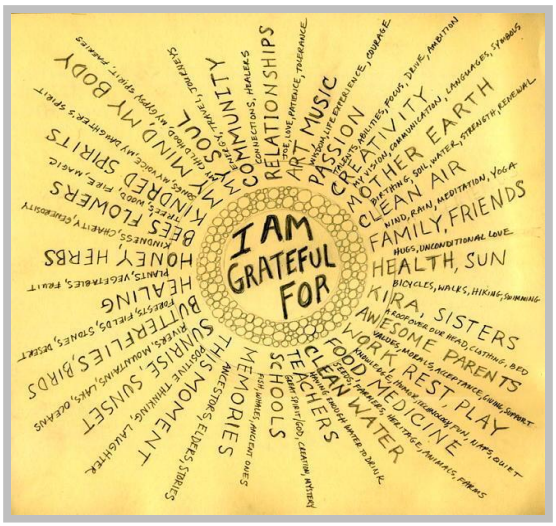
Time: 15 Minutes

**Materials needed:**

- Large coloured cardboard with circle drawn in the centre as on example above
- Coloured pens or pencils
- Prestik

***INSTRUCTIONS***

- *Put a large sheet of cardboard on the wall with Prestik.*
- *Ensure there is enough space for the participants to move.*
- *Ask all the participants to write what they are grateful for around the circle in the centre as illustrated in the image below.*
- *Once done let the participants reflect on what they have written.*




**FACILITATOR**

*Start by asking the participants how they are feeling after they have done this activity. Most of them will be happy and smiling. Gratitude is a selfless act. Its acts are done unconditionally, to show to people that they are appreciated. "A gift that is freely given" is one way to understand what these acts are like. For example, if someone is sad and you write them a note of appreciation, you are likely not asking for something in return from this person; instead, you are reminding them of their value, and expressing gratitude for their existence. In that moment, you are not waiting for a "return note" from this person. Even when we do not expect a return, sometimes they happen. Gratitude can be contagious, in a good way. In the previous example, maybe when you are down, this person will write you a note too.*

## 1.6 Workshop Song

### *Thank U*

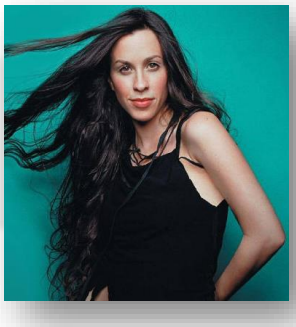

**Materials needed:**

- 'Thank U' song to play from Sunflower Playlist
- Speaker or Radio to play the song
- My "Bloom with Grace" Journal

***INSTRUCTIONS***

*Ask participants to open their journals on the page with the "Thank U" song. Play the song twice: the first time, let them just listen and the second time let them follow the words in their journals. When finished let them reflect on the song by writing in their journals. Once finished let them share what they feel comfortable sharing.*

**Thank U**
*Alanis Morisette*



*Thank you India*
*Thank you terror*
*Thank you disillusionment*
*Thank you frailty…*
*How 'bout getting off these antibiotics*
*How 'bout stopping eating when I'm full up*
*How 'bout them transparent dangling carrots*
*How 'bout that ever elusive kudo*
*Thank you India*
*Thank you terror*
*Thank you disillusionment*
*Thank you frailty*
*Thank you consequence*
*Thank you thank you silence*
*How 'bout me not blaming you for everything*
*How 'bout me enjoying the moment for once*
*How 'bout how good it feels to finally forgive you*
*How 'bout grieving it all one at a time*
*Thank you India*
*Thank you terror*
*Thank you disillusionment*
*Thank you frailty*
*Thank you consequence*

*Thank you India*
*Thank you providence*
*Thank you disillusionment*
*Thank you nothingness*
*Thank you clarity*
*Thank you thank you silence*
*Thank you thank you silence*
*The moment I let go of it was the moment*
*I got more than I could handle*
*The moment I jumped off of it*
*Was the moment I touched down*
*How 'bout no longer being masochistic*
*How 'bout remembering your divinity*
*How 'bout unabashedly bawling your eyes out*
*How 'bout not equating death with stopping*

## 2. GERMINATING AND ROOTING PHASE *(Educational and Skills Development Phase)*

### 2.1 Group Nourishing Session

***The Power of Gratitude***


**FACILITATOR**

*Use the information to discuss the importance of living a life of gratitude*

### *Gratitude*

Science tells us that an "attitude of gratitude" is a good health choice. Being more grateful more often makes us happier and more optimistic. But gratitude also adds to the bottom line - in very real ways. And the best news about gratitude is that it requires little time and no money.

**Here are five reasons gratitude improves your productivity and results:**

**Gratitude attracts what we want.** The universal law of attraction says that we will attract into our life the things we think about and focus on. Since this is true, wouldn't you want more of what you are thankful for? (I think I know the answer to that!) Remember that when you are consciously aware of your blessings, and are grateful for them, you are focusing more clearly on what you do want in your life - and are attracting more of those things into your life.

**Gratitude improves relationships.** We learn the importance of saying "thank you" as little children. We are taught that habit because it is "good manners." This childhood lesson is extremely powerful. Think about those people that you know who are most appreciative of you - and let you know it. How do you feel about them? Does their appreciation positively impact your relationship with them? Of course it does! Be grateful for people, their contributions, their talents and their actions - and make sure you let them know how you feel.

**Gratitude reduces negativity.** It is hard to be negative about your situation when you are thinking about things for which you are grateful. One of the fastest ways to improve your mood or outlook is to count your blessings.

**Gratitude improves problem solving skills.** Too often we look at problem solving with a very jaded view. "Something is wrong. We have barriers in our way. Then, we have to put in effort to fix it." Conversely, when we think about what we are grateful for we open our minds up to new possibilities and connections. We also enter a problem solving situation with a perspective of improvement and opportunity rather than challenge or issue.

**Gratitude helps us learn.** Every dark cloud has a silver lining. Behind every problem lies an opportunity. Being grateful for our situation - even if we don't like everything about it - allows us to be thankful for the opportunity to learn something new.

## 2.2 Personal Nourishing Activity

### *How to be more grateful*


*1. Using your journals make a list of five things you are grateful for right now. These can be big things (like your family) or little things (like the fact that someone held the door open for you this morning).*

_____

_____

_____

_____

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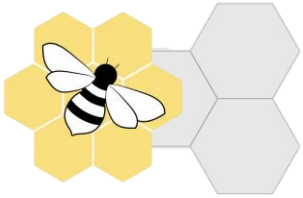
_____

*2. Reflect on your list and allow yourself to feel good about these things.*
*3. If there is a person you can thank or show your appreciation to, do that now too (a quick call or email is a good start!).*

You can do this exercise anytime, and you don't have to stop at five things. In fact, it is a great idea to keep a running list in your Journal, planner or notebook - this way you can return to your list anytime you wish, reinforcing your gratitude. But at any moment you can make a list, bask in those thoughts, and share that thankfulness with others.

You've probably thought of being thankful as a good thing to do or the right thing to do. But now hopefully you see it can be even more powerful than "right."

Gratitude is an attitude. Gratitude is a choice. And gratitude is a habit. When we consciously practice being grateful for the people, situations and resources around us we begin to attract better relationships and results. The habit will be strengthened as you make the choice each day.



**FACILITATOR**
*Give an opportunity for voluntary feedback.*

## 2.3 Pair-Up Sharing Activity

### *Benefit Finding*


**FACILITATOR**

*Use the information provided below to explain ''benefit finding'':*

Benefit finding involves thinking through and mentally listing all the positive things related with a situation. For example, let's say I lose my job. Although there may be negatives linked with this, there are also likely to be positives. I may have not really liked my boss or maybe now I can finally engage in another interest that I have been wanting to pursue.

There will be many times in life when we experience challenging situations and tough emotions. When we find the benefits in these situations we can make them a bit more bearable and may even be able to grow and learn new things we never could have dreamed of. Often it is life's challenges that lead to truly gratifying opportunities. When we remind ourselves of this we become capable of experiencing happiness, even when we are battling.

**FACILITATOR**

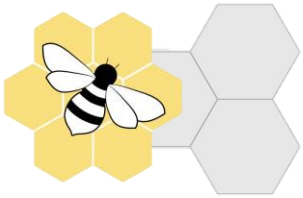
*Let participants select someone to pair up for this activity. Ask each pair to discuss any benefit they can identify because of their addiction? This can be that they realized who the people are that absolutely love and support them. Give an opportunity for voluntary feedback.*

***End the session by discussing the following question:***

- ***Is there now something about your SUD that you are grateful for?***

## 2.4 Personal Nourishing Activity

### *Letter of Gratitude*



Time: 30 Minutes

**FACILITATOR**

*Use the information provided to explain ways to express gratitude.*

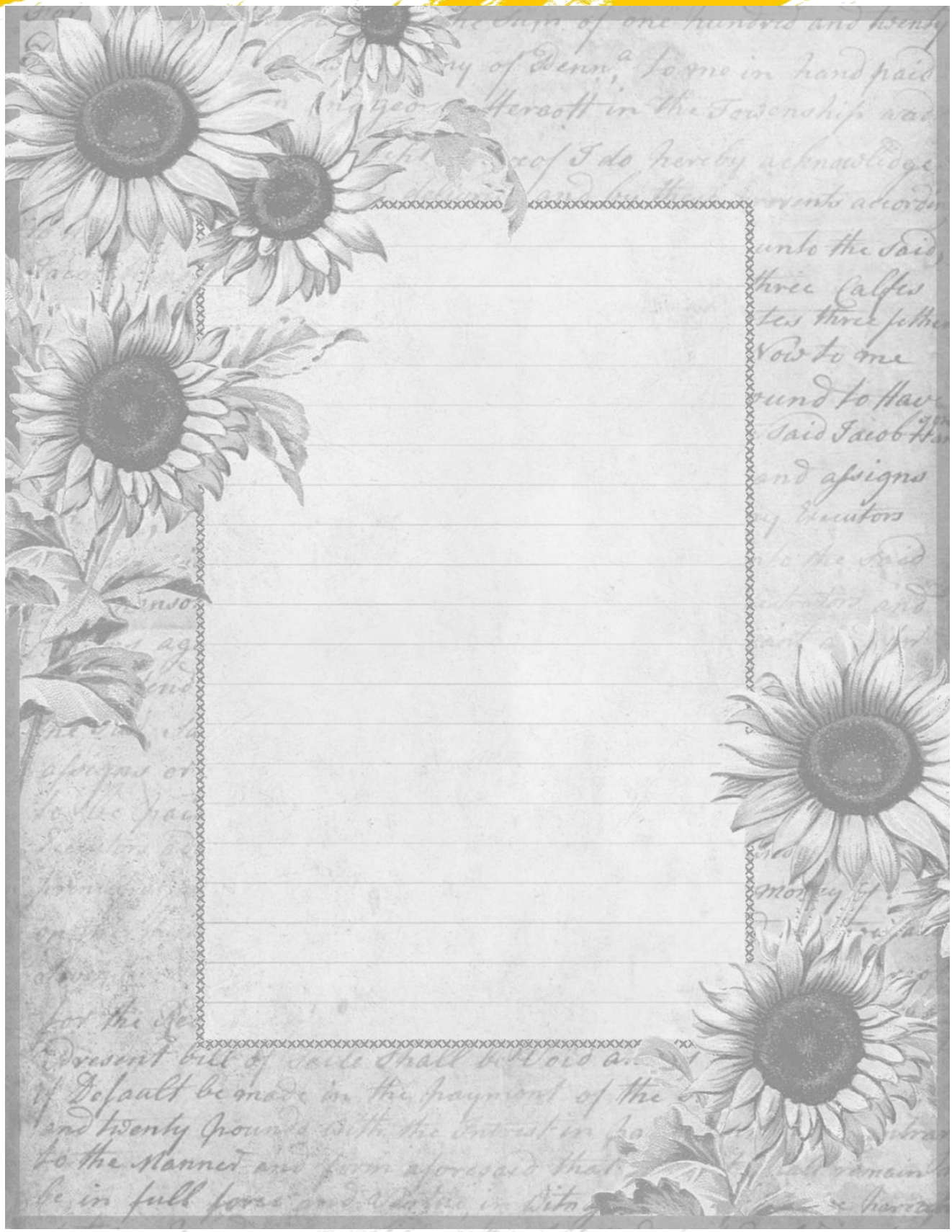
In positive psychology research, gratitude is strongly and constantly associated with greater happiness. Gratitude helps people feel more positive emotions, appreciate good experiences, improve their health, deal with hardship, and build strong relationships.

People feel and express gratitude in various ways. They can apply it to the past (retrieving positive memories and being thankful for elements of childhood or past blessings), the present (not taking good fortune for granted as it comes), and the future (maintaining a hopeful and positive attitude). Regardless of the innate or current level of someone's gratitude, it's a quality that individuals can successfully develop further.

## Research on gratitude

Dr. Martin E. P. Seligman, a psychologist at the University of Pennsylvania, tested the impact of various positive psychology interventions on 411 people, each compared with a control assignment of writing about early memories. When their week's assignment was to write and personally deliver a letter of gratitude to someone who had never been appropriately thanked for his or her kindness, participants immediately displayed a huge increase in happiness scores. This impact was greater than that from any other intervention, with benefits lasting for a month.

Part of the treatment of SUD is to re-build broken relationships with the people we love. To assist you in making this happen we would like you to write a letter of gratitude to someone you want to thank for their support during your addiction. This can be family, a friend, someone you work with, someone from church or your community, it may also be a person who passed away. You will get an opportunity to read these letters to the people you would like to thank during a gratitude visit organised by your treatment center. Using the template in your “Blooming with Grace” journals you can now write your letter of gratitude.



## 3. GROWING PHASE *(Summary and Termination Phase)*

### 3.1 Wrap-Up Times Three

Allow three volunteers (as identified in the beginning of the workshop) to identify an activity during the workshop where they practiced each of the three basic psychological needs: autonomy (people are empowered when they feel a sense of choice and endorsement in a task), competence (individuals seek control to allow them to experience mastery over a task) and relatedness (individuals have a need to interact with others).

### 3.2 Conclusion

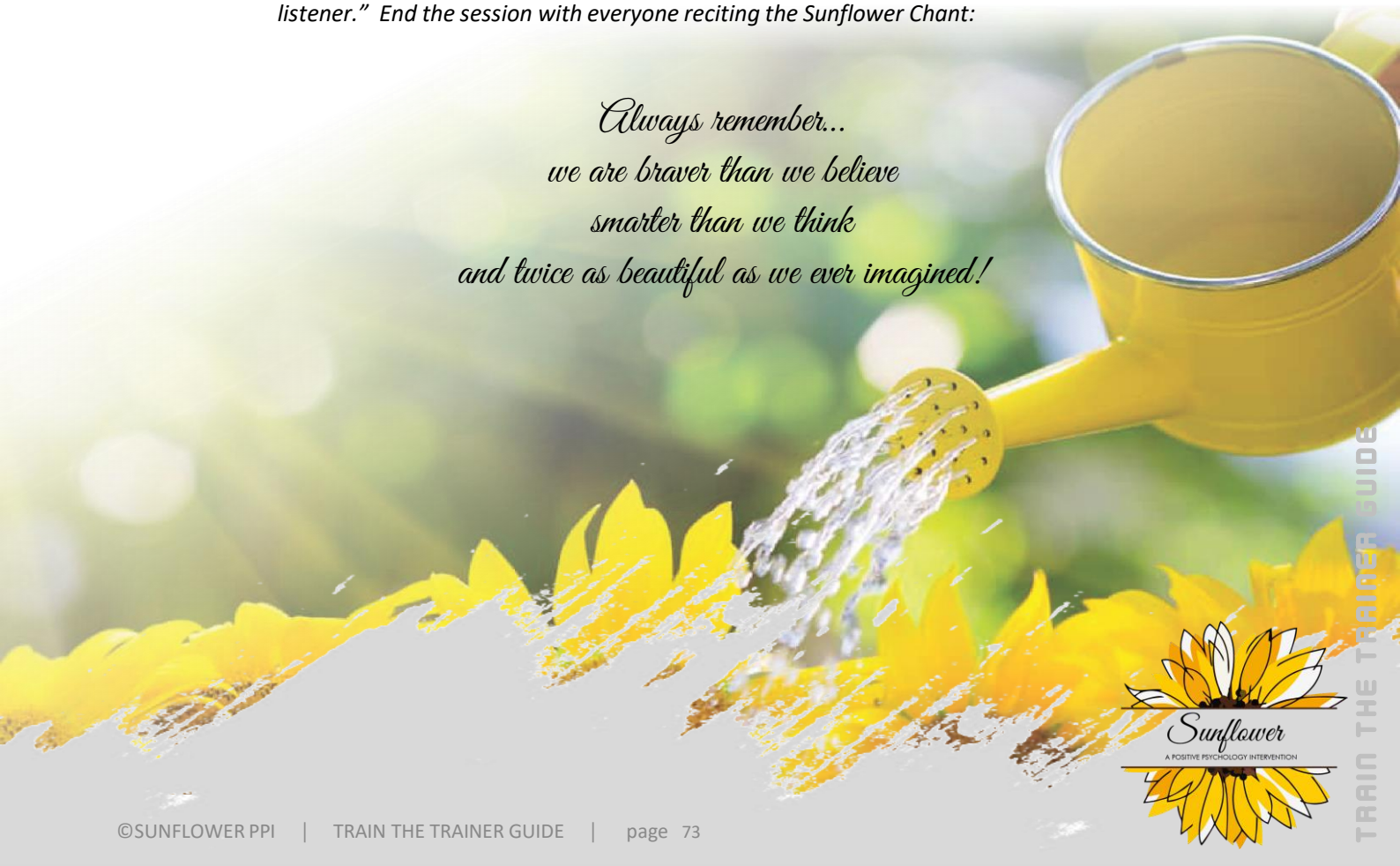
Consciously utilizing Gratitude is not only an important life skill to learn and master, it's an extremely important aspect of consciously and consistently attracting to yourself the Abundance and Happiness that we all desire, aspire toward and without exception deserve to experience in life.

### 3.3 Check-out

***Watering the flowers (Practising Relatedness)***

***INSTRUCTIONS***

*Let participants gather in a circle. Ask them to appreciate the person on their right-hand side based on their participation during the session i.e.: "Ntebo, I want to thank you for being a good listener." End the session with everyone reciting the Sunflower Chant:*



Before speaking to anyone about today's workshop please use the space provided to journal about it. You may want to investigate your thoughts and feelings after the workshop. Perhaps you can also think about the choices you have been given during the workshop and your interaction with your fellow participants. Maybe you also want to journal about new skills you may have learned or want to develop after the workshop. Finally, you can also write about something that you appreciate about yourself after the workshop. Once done you may want to read what you have written and reflect on it, sum up your takeaway in one or two sentences, starting with statements like: "As I read this, I notice…; "I am aware of…", or "I feel…"

## Journaling

**Materials needed:**

- Box of garden stones (available at any nursery)

- **Flower 1: Gratitude Stones**

  Your facilitator will provide you with a box of stones. Please select a stone, one that feels good when you hold it in your hand.

  Gratitude stones are basically a simple way to remind yourself to be grateful for what you have in your life. The idea is that you put a stone in your pocket and throughout the day you keep finding it there. When you do, it reminds you to be grateful of all you have in your life. It serves as a reminder so you can keep your spiritual focus.

  These days in the hustle and bustle of modern life we tend to forget about how good our life is, how lucky we are. Perhaps you are waiting at a bus stop on a cold and wet day, thinking what a horrible day it is. Then you by chance put your hands in your pocket and find the gratitude stone. Instantly this will remind you how lucky you are. You could be starving or homeless, but no – you have a good life.

  We want to ask you to start using your gratitude stone whilst in treatment. Each morning you can take your stone and just make a mental list of the things you are grateful for, you can even thank God or your Higher Power or you can write it down. You can repeat this activity before you go to bed.

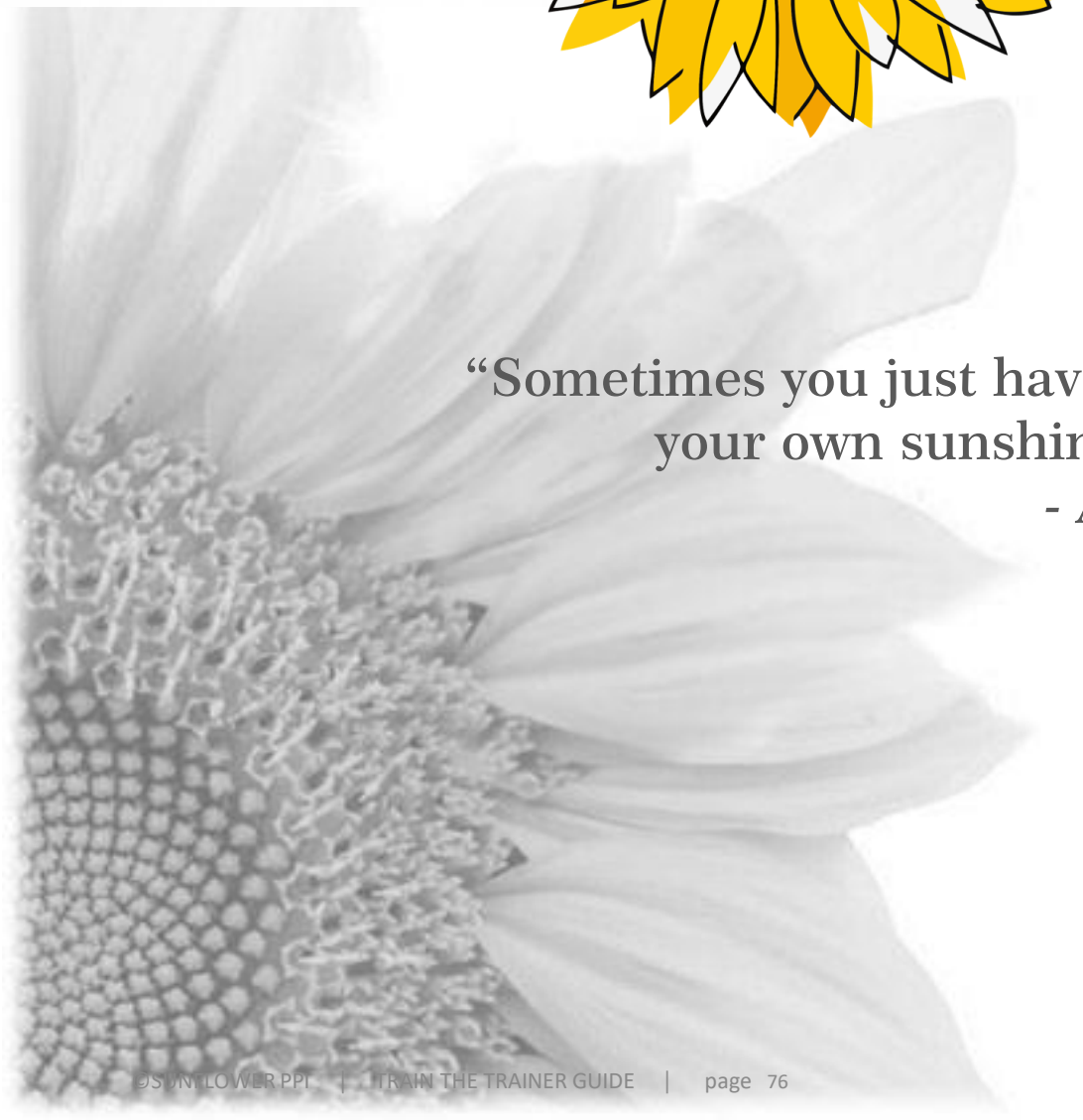
# WORKSHOP 4B

## Gratitude Visit

*(Workshop for Family, Significant Others, Staff and People with SUD)*

Sunflower

A POSITIVE PSYCHOLOGY INTERVENTION



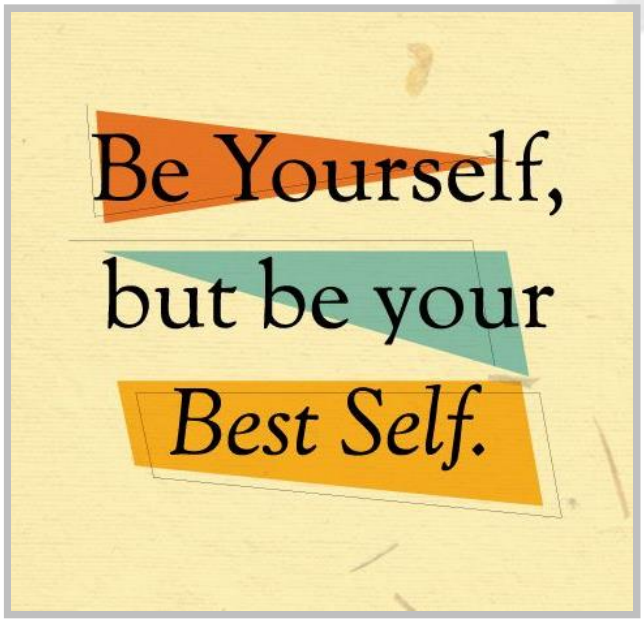
"Sometimes you just have to create your own sunshine"

*- Amulya Gs*

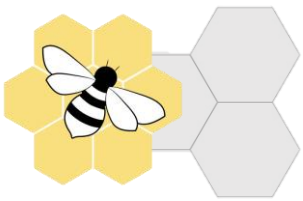
**Table of contents**

## INTRODUCTION

People can use gratitude to form new social relations or to strengthen current ones. Acts of gratitude can be used to apologize, make amends and help solve other problems. Alternatively, people may feel gracious because it can be an intrinsically rewarding process. Simply being grateful for being alive is a great way to motivate oneself to seize the day. The idea that tomorrow is not guaranteed is a strong motivator for some people to be their "best self" today.




### 1.1 Program Chant



**FACILITATOR**

*Let all the participants gather in a circle. Let them first read and then recite the program chant together.*

*As participants in the 'Sunflower' programme*
*Always remember...*
*we are braver than we believe*
*smarter than we think*
*and twice as beautiful as we ever imagined!*

## 1.2 Warm-Up Activity

### *Gratitude Tree*

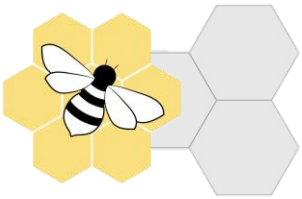
Time: 30 Minutes

**Materials needed:**

- Cut out leaves (See template attached as annexure 1)
- String or Ribbon
- Tree branch or twig in a vase with stones
- Pens and coloured pencils

***INSTRUCTIONS***

- *The gratitude tree is a great activity for adults who are open to experiencing a childlike sense of fun and wonder.*
- *Step 1: Cut out enough leaves for everyone present using the template provide.*
- *Step 2: Punch a hole at the top of each leaf, and loop your string or ribbon through each hole.*
- *Step 3: Put the stones or marbles into a vase and stick the tree branch or twig in the middle.*
- *Step 4: Let each participant write things that they are grateful for on the leaves and decorate it with the coloured pencils.*
- *Step 5: Hang the leaves from the branches, and behold your gratitude tree!*
- *Step 6: Allow some Family and SO to share what they are grateful for.*
- *This activity is easy and results in a pretty reminder of the things that bring your family members and yourself joy throughout your daily life.*



**FACILITATOR**

*Start by asking the participants how they are feeling after they have done this activity. Most of them will be happy and smiling. Gratitude is a selfless act. Its acts are done unconditionally, to show to people that they are appreciated. "A gift that is freely given" is one way to understand what these acts are like". For example, if someone is sad and you write them a note of appreciation, you are likely not asking for something in return for this person; instead, you are reminding them of their value, and expressing gratitude for their existence. At that moment, you are not waiting for a "return note" from this person. Even when we do not expect a return, sometimes they happen. Gratitude can be contagious, in a good way, For example, if someone is sad and you write them a note of appreciation, you are likely not asking for something in return for this person; instead, you are reminding them of their value, and expressing gratitude for their existence. At the moment, you are not waiting for a "return note" from this person. Even when we do not expect a return, sometimes they happen. Gratitude can be contagious, in a good way. In the previous example, maybe when you are down, this person will write you a note too.*

## 1.3 Circle Dialogue

### *Letters of Gratitude*

Time: 60 Minutes

**Materials needed:**

- Beanbag as a Talking Piece
- Chairs for everyone to sit on
- People of SUD's Gratitude Letters

***INSTRUCTIONS***

1. *Assure that all the people with SUD have their gratitude letters. If there are participants who do not have letters they can just listen to what the other participants are sharing because most of it will be relevant to them.*
2. *Let everyone (including family, friends and SO) gather in a large circle.*
3. *Start the first circle dialogue by doing a safety check, let everyone just say what they would need from the other participants to feel safe enough to make themselves vulnerable.*

    - *Assure that everyone understands the rules of the circle dialogue:*
    - *The person holding the talking piece is talking and the others are listening.*
    - *Once the circle is open, no one is to leave the circle until it is closed.*
    - *Everyone needs to listen with a 100% attention.*
    - *Listen for the seed of truth in someone else's story or sharing (What in their story is also true for me)*
    - *No questions or arguments allowed whilst the circle is open.*

4. *Open the circle with the following theme: Reading/sharing your gratitude letters. Put the talking piece in the centre of the circle, anyone who feels ready to share can take the talking piece and start. Once they are done they can put the talking piece back for the next person to share. Close the circle after 45 minutes.*
5. *Give everyone a body break of only 5 minutes*

    - *Open another circle where you give everyone the opportunity to appreciate someone for sharing or identify with someone who shared. This is an essential step in the process because it gives the people who didn't share the opportunity to share. It also assists the participants who made themselves vulnerable because they do not feel alone and they also feel accepted by the group.*
    - *Close the circle dialogue session with everyone reciting the serenity prayer below. Assure to give family, friends and SO a copy of the prayer (attached as annexure 2).*
    - *Allow some time for Family and SO to mingle. Participants may ask their family and SO if they would like to read their letters of atonement. They may also take the letters with them to read at home.*

## 1.4 Certificate Presentation


**FACILITATOR**

*End the session with a certificate presentation. Staff members will prepare a certificate of appreciation for each person with a SUD (Template attached as annexure 3). Staff will present these certificates to the people with SUD in front of their family and SO.*

***Optional – provide refreshments for everyone.***

## 1.5 Conclusion

Addiction is a chronic disease that has the potential to negatively affect a person's life and health. One of the casualties of a battle with addiction is the trail of damaged relationships it leaves in its wake. With the right kind of help, repairing relationships after addiction is possible. This gratitude evening is one way of starting to heal the wounds of the past.

## 1.6 Check-out

***Watering the flowers (Practising Relatedness)***

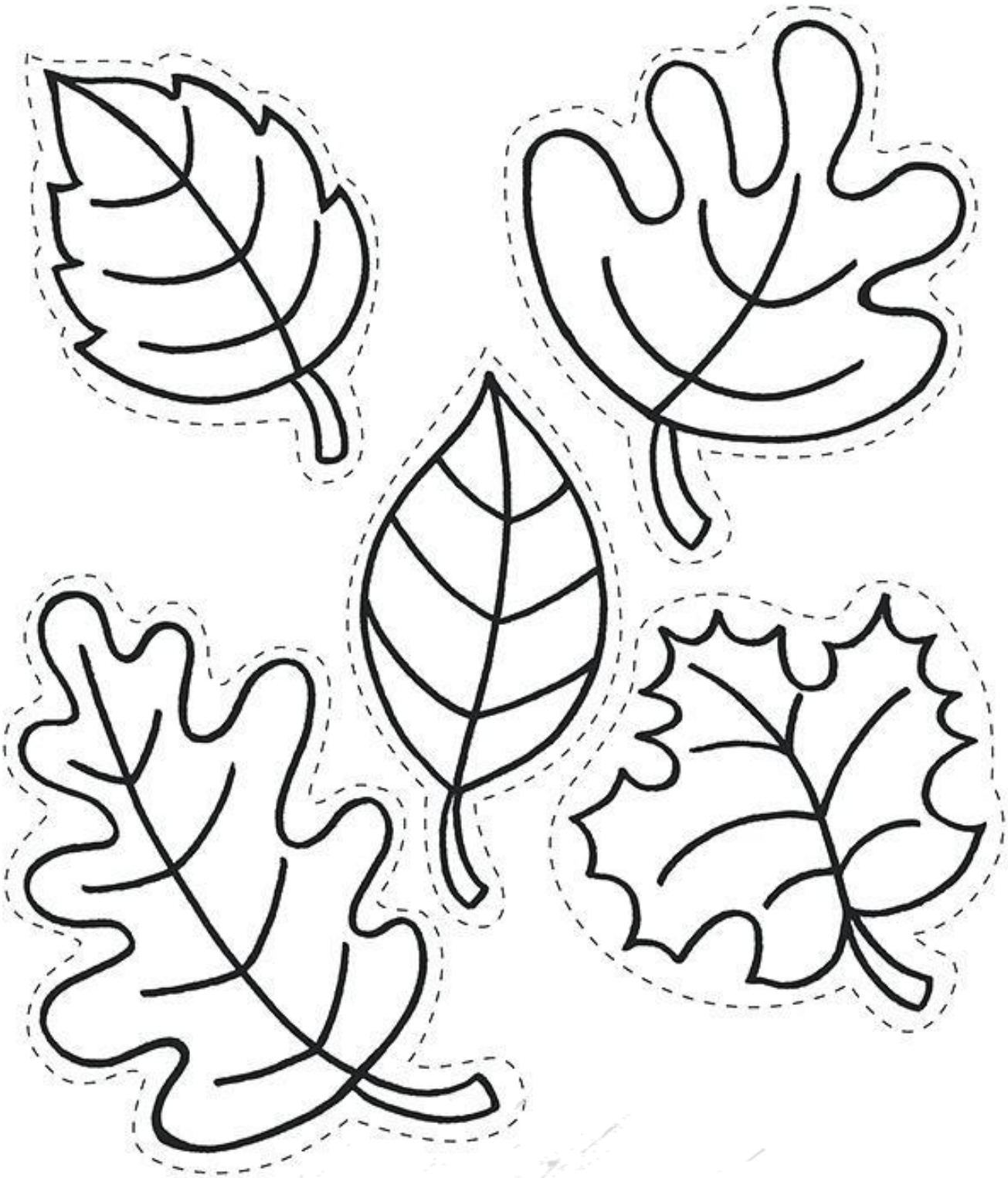
***INSTRUCTIONS***

*Let participants gather in a circle. Ask them to appreciate the person on their right-hand side based on their participation during the session i.e.: "Ntebo, I want to thank you for being a good listener." End the session with everyone reciting the Sunflower Chant:*

- **Flower 1: Gratitude Visit**
  - Use the space provide to journal about the gratitude visit. Try to focus on the best part of the visit. Write about your feelings and the reaction of your family and SO. When done try to reflect on what you think you have learned through this experience.

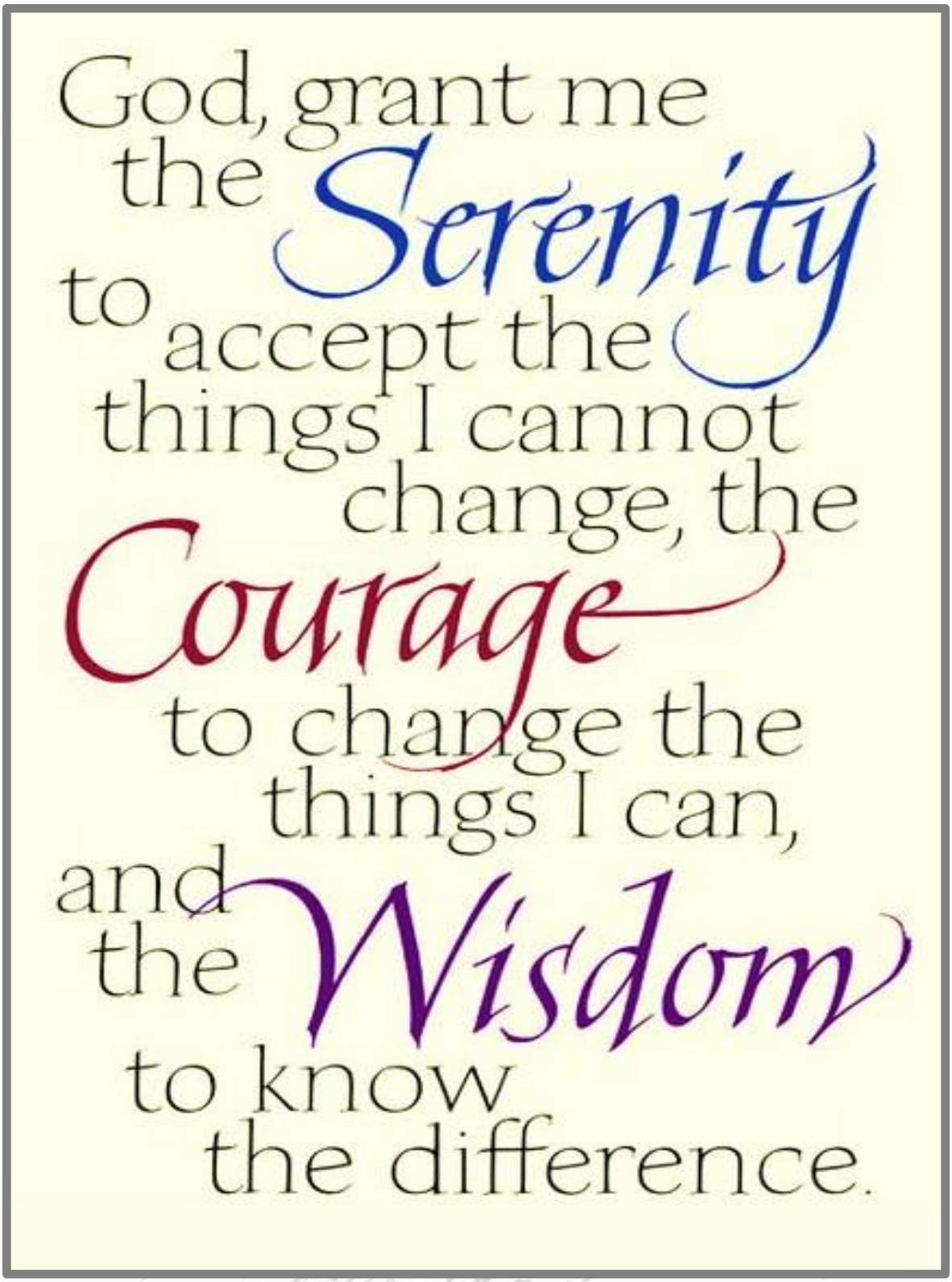
# ANNEXURE 1

## Gratitude Tree – Leaves



# ANNEXURE 2

## The Serenity Prayer



# ANNEXURE 3

## Certificate of Appreciation

# WORKSHOP 5

## Hope & Recovery

Sunflower

A POSITIVE PSYCHOLOGY INTERVENTION

O God, grant me the Serenity
to accept the things I cannot change,
the Courage to change the things
I can, and the Wisdom
to know the difference.

*- Reinhold Niebbur*

FACILITATOR GUIDE

## INTRODUCTION

Addiction recovery is about more than just the absence of drugs in your system.

Recovery from drug and alcohol addiction is a complex process and journey – and while the road may be in the right direction, it can often be filled with bumps, twists and turns.

There are hardships and heartaches, obstacles, and opinionated people along the way. However, it's a journey that everyone recovering from addiction must travel in order to move forward towards health and freedom.

Therefore, recovery from substance addiction doesn't just start with abstinence; it starts with hope.

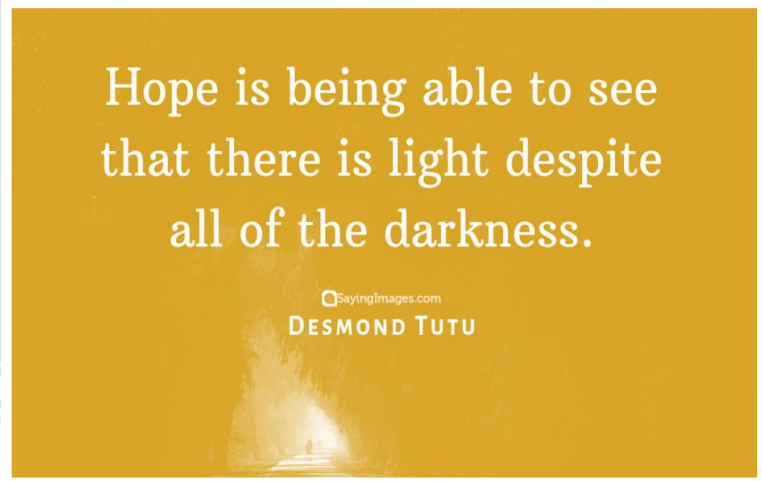
This workshop of the Sunflower PPI focuses on Hope in Recovery.

## 1. PREPARING AND PLANTING PHASE *(Preparation Phase)*

### 1.1 Workshop Quote

**FACILITATOR**

*Share the workshop quote with the participants. Let them reflect on the quote by writing in their personal journals. Ask for voluntary feedback.*




### 1.2 Program Chant

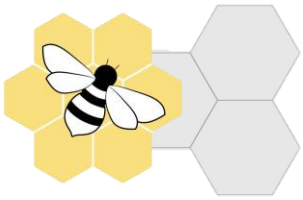
**FACILITATOR**

*Let all the participants gather in a circle. Let them first read and then recite the program chant together.*

*As participants in the 'Sunflower' programme*
*Always remember...*
*we are braver than we believe*
*smarter than we think*
*and twice as beautiful as we ever imagined!*

## 1.3 Choose to be brave

(Participants can practise competence, autonomy, and relatedness within the workshop)



**FACILITATOR**

*Before starting the workshop ask participants to choose which of the following roles they would like to play during the workshop (keep record of the names of these participants):*

- *Timekeeper (Keep time during activities)*
- *Wrap-Up Times Three (Three volunteers each need to identify an activity during the workshop where they practiced each of the three basic psychological needs: autonomy [people are empowered when they feel a sense of choice and endorsement in a task], competence [individuals seek control to allow them to experience mastery over a task] and relatedness [individuals have a need to interact with others]).*
- *Introduce others in a creative way (One person takes the lead in introducing fellow participants in a creative way, i.e. two claps, two snaps, two stomps with their feet, two winks and a "Go Peter" (name of person).*
- *Appreciate with love (One person takes the lead by appreciating participants who shared by clapping X 2 and showering them with love by moving their hands in the form of a heart)*
- *Kibata! ('Kibata' is a loud clap followed by moving the one hand away from the other when done. One participant takes the lead in appreciating a participant who discovered an aha-moment, shared something profound or made themselves vulnerable. This needs to be an incredibly special moment)*

## 1.4 Check-in

**Materials needed:**

- Open space
- Talking piece (bean bag)

***INSTRUCTIONS***

*Let participants gather in a circle. Using a talking piece let each participant share one thing they will need from the group that day to enable them to participate unreservedly. It may be support, encouragement, being non-judgmental, etc. Give time for voluntary feedback on the participants' 'Bloom with Grace' assignments.*

*Once a participant has shared the group will respond by saying:*

*"Thabo (name of participant), nothing for us, without us!*

## 1.5 Warm-Up Activity

### *Your Personal Purpose Statement*


***INSTRUCTIONS***

1) *Review your character strengths again. Look at your top 5 strengths from workshop 1 and write them down.*

*1.*_____
*2.*_____
*3.*_____
*4.*_____
*5.*_____

2) *What do you hope to achieve with your treatment and recovery?*

_____

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3) *What do you find most interesting and meaningful about your journey of recovery?*

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FACILITATOR GUIDE

*Connect those three things and write down your Personal Purpose Statement in your journal. For example: "In my recovery, I want to use my personal strengths of perseverance and self-regulation to strive towards a life of sobriety. I hope this will assist me in re-building broken relationships and be in control of my own life. I want to use what has happened to me to motivate me to appreciate what I have, keep on making the right choices and be healthy and happy."*

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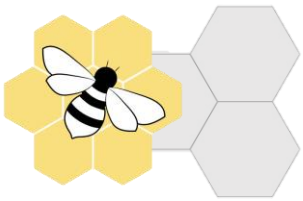


**FACILITATOR**

*Let volunteers share their Personal Purpose Statements*

## 1.6 Workshop Song

***One Moment in Time***


***INSTRUCTIONS***

*Ask participants to open their journals to the page with the song: "One Moment in Time." Play the song twice, the first time the participants can just listen to the song and the second time they can sing along. Give them some time to journal about the song. When done give time for voluntary feedback.*

## One Moment In Time
*Whitney Houston*

*Each day I live*
*I want to be*
*A day to give*
*The best of me*
*I'm only one*
*But not alone*
*My finest day*
*Is yet unknown*

*I broke my heart*
*Fought every gain*
*To taste the sweet*
*I face the pain*
*I rise and fall*
*Yet through it all*
*This much remains*

*I want one moment in time*
*When I'm more than I thought I could be*
*When all of my dreams are a heartbeat away*
*And the answers are all up to me*
*Give me one moment in time*
*When I'm racing with destiny*
*Then in that one moment of time*
*I will feel*
*I will feel eternity*

*I've lived to be*
*The very best*
*I want it all*
*No time for less*
*I've laid the plans*
*Now lay the chance*
*Here in my hands*

*Give me one moment in time*
*When I'm more than I thought I could be*
*When all of my dreams are a heartbeat away*
*And the answers are all up to me*
*Give me one moment in time*
*When I'm racing with destiny*
*Then in that one moment of time*
*I will feel*
*I will feel eternity*

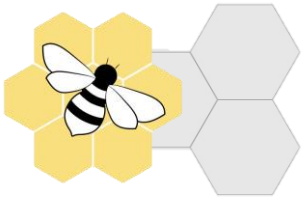
*You're a winner for a lifetime*
*If you seize that one moment in time*
*Make it shine*

*Give me one moment in time*
*When I'm more than I thought I could be*
*When all of my dreams are a heartbeat away*
*And the answers are all up to me*
*Give me one moment in time*
*When I'm racing with destiny*
*Then in that one moment of time*
*I will be*
*I will be*
*I will be free*
*I will be*
*I will be free*

## 2. GERMINATING AND ROOTING PHASE *(Educational and Skills Development Phase)*

### 2.1 Group Nourishing Session

***The Importance of Hope in Addiction Recovery***

**FACILITATOR**

*Use the information provided to explain the importance of hope in recovery from addiction.*

***"Everything that is done in the world is done by hope"***

***- Martin Luther***

Recovering from an addiction is an intricate process. The road is never smooth. In fact, you will probably encounter obstacles, hardships, and heartaches. But it is a journey that everyone hoping to recover from addiction must make. It is the only way to move from a life of devastation to life of joy, health, and wellness.

**While there are many paths to recovery, there is one constant-and that's hope. But why is hope so important in recovery?**

Hope is more than mere wishful thinking; it is the foundation upon which you build your recovery. Without hope, or a yearning to recover, there would be no motivation to get better. With no motivation, there would be truly little meaningful action. Finally, with appropriate action comes improvement through a series of steps leading to a plan for recovery and working the plan for years to come.

**What is 'hope'?**
Each of us defines hope differently. But hope is the belief that things in the future will be better; knowing that the sun will shine again. Relating to addiction recovery, hope becomes a foundation and the energy that drives us to find a way to get better and heal. It keeps us strong when we face challenges. And hope gives us a sense of joy and peace, knowing that a better tomorrow exists.

**Finding Hope**
When caught up in active addiction, it not always easy to see a life beyond the addiction, beyond the pain, chaos, and suffering. But hope can be found. There is no right or wrong way to find hope. Sometimes it comes easy, and sometimes we need to work to find hope.

**Leaning on a Higher Power**
Many find hope by reaching for a higher power. This could be through spirituality, philosophy, or religion. Reaching to a higher power is Step 2 in the 12-Step Process, "Come to believe that a power greater than ourselves could restore us to sanity". Simplified this reads as 'There is help for my problem and I believe I can address it'.

**Accept Your Current Situation**
For someone it may be hard to accept that they are currently in a terrible place. But the bravery of acceptance is the first step in yearning for a better future (i.e. hope). Acceptance helps us realise that our current situation is not where we want to be and helps us develop a dream of where we want to be. Without acceptance, we cannot take control of our destiny to reach a better tomorrow.

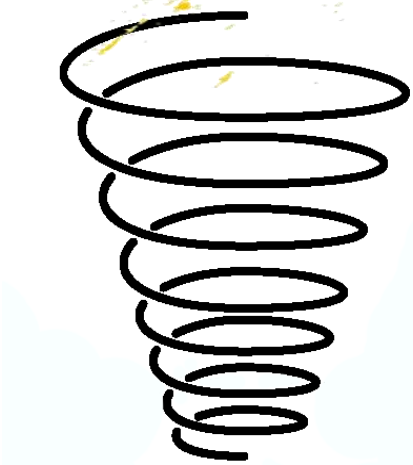
**Have a Realistic and Meaningful Plan**
It is action that makes hopes come true. By developing a plan for a better future you will build hope. The more you plan, with firm action steps and dates, the more you will come to realise that your dream is truly achievable (Ratnanather, 2014).

## 2.2 Personal Nourishing Activity

### *Life Spiral Exercise*


***INSTRUCTIONS***
*Ask participants to open their journals the "Life Spiral Exercise." Ask them to use the metaphor of a spiral. At the bottom of the spiral they write the age they think they will live to be. They then have to mark the place on the spiral which represents their current age. They now have to reflect on how far along they are in this life and feelings it evokes. Next they have to identify three trigger experiences that shaped their life story. These could be any major life events, breakdowns, such as weddings, divorces, moves, losses, career changes, etc. They have to write down the age each trigger took place as well as the lesson learned in each stage. Now they have to focus on each life lesson – what did it teach them, and how did it change them. They also need to try and gauge from this exercise where they are in their life today and where they would like to be by the end of it. What would a life well lived look like? Seeing their life in this broader perspective can help identify what is meaningful and valuable to them.*

## Life Spiral Exercise



Trigger #1 _____

Age _____

Life lesson learned?

_____

_____

Trigger #2 _____

Age _____

Life lesson learned?

_____

_____

Trigger #3 _____

Age _____

Life lesson learned?

_____

_____

## Pair-Up Share Session


***INSTRUCTIONS***

*Ask participants to select someone to pair up for the sharing session. Participants can share what ever they feel comfortable sharing about their Life Spiral Exercise.*

## 2.3 Personal Nourishing Activity

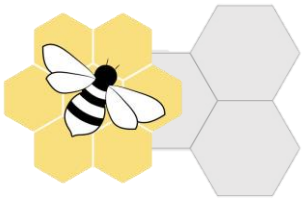
## *Goal Setting and Hope*


*(Adapted from Heyns, 2019)*

***Note to facilitator:***

*You may want to make a recording of you reading the instructions for this activity before the workshop. You can then just let the participants listen to the recording.*

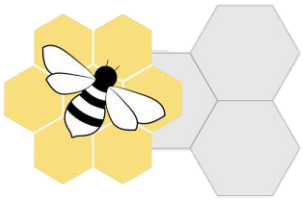
***Step 1: Visualisation***



**TRAINER**

*To begin, take a moment to get comfortable in your seat, and gently close your eyes. Take a few deep, slow breaths, and allow yourself to relax. I'm going to speak to you for the next little while, and all you need to do is listen, and imagine. Do your best to avoid falling to sleep. Simply relax and imagine. OK, I'd like you to think about a goal that you want to accomplish in the next year of your life. This might be a relationship goal, an educational goal, a personal goal, or a work-related goal. Take a moment to bring this goal forward and visualise it in your mind's eye. (30 secs)*

*Now, with this personal goal in mind, I would like you to imagine yourself going forward in time, into the future... going forward one week... two weeks... three weeks.... And four weeks… it's now one month into the future, and you have started working towards achieving your goal - you are on the road to success. What decisions have you made? What actions have you taken? And how does it feel to be on this road to success? (30 secs). Now, using your imagination, continue going forward in time... until you are 6 months into the future. You are significantly closer to achieving your goal. You are starting to feel the benefits of all of your efforts.*



*What is this like? How does it feel to be this much closer to your goal? Allow yourself to notice any feelings or emotions tied to this moment. (30 secs)*

*Now, I would like you to continue going forward in time, until you reach one year from now. Here, you have fully accomplished your goal. You have achieved success! Visualise yourself in your mind. Where are you, and what are you doing?*

*Who are you with, if anyone? What are people saying to you? And what are you saying to them. (15 secs)*

*And how does reaching your goal feel? What emotions are tied to this achievement? Perhaps there are feelings of pride, joy, contentment, or satisfaction. (30 secs)*

*Now, I would like you to look back on your journey. Look back on the process of achieving this goal. Look back on all of your hard work and effort, and consider how you reached your goal, step-by-step. What were the little things you did, day-by-day, to achieve success? What did you do at work? What did you do in your relationships? (15 secs)*

*And what did you do internally to achieve success? How did you manage difficult thoughts, and emotional obstacles? What coping strategies did you use? Take a moment to consider all the things that helped you manage the personal challenges that appeared along the way. (30 secs)*

*Good. Now, as the exercise comes to an end, take a deep, slow breath. And when you are ready, gently open your eyes.*

***Step 2: Evaluate the exercise***

How was it to do this visualisation? Is there anything you learned from this exercise?

Are there any insights that you can use to move closer to your goals? If so, list them below:

_____

_____

_____

_____

_____

*Give an opportunity for voluntary feedback.*

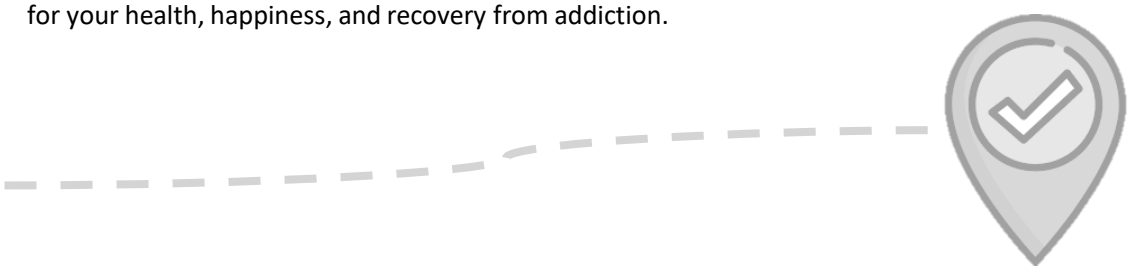
## 3. GROWING PHASE *(Summary and Termination Phase)*

### 3.1 Wrap-Up times three

Allow three volunteers (as identified in the beginning of the workshop) to identify an activity during the workshop where they practiced each of the three basic psychological needs: autonomy (people are empowered when they feel a sense of choice and endorsement in a task), competence (individuals seek control to allow them to experience mastery over a task) and relatedness (individuals have a need to interact with others).

### 3.2 Conclusion

The road to recovery won't be easy – but with hope, it becomes brighter and more meaningful. With hope, you will find a way to keep going, to keep striving, and keep fighting for your health, happiness, and recovery from addiction.

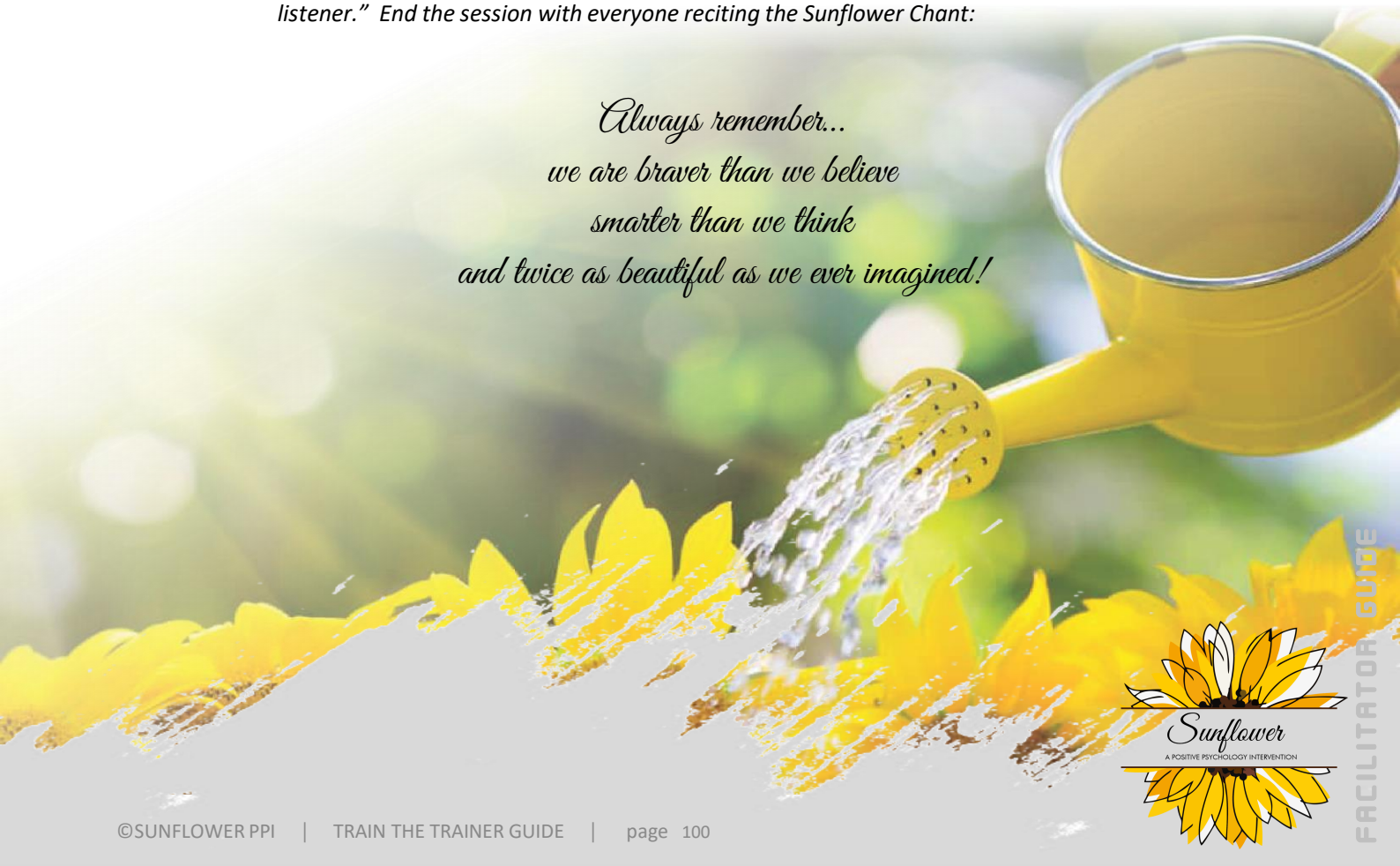


### 3.3 Check-out

***Watering the flowers (Practising Relatedness)***

***INSTRUCTIONS***

*Let participants gather in a circle. Ask them to appreciate the person on their right-hand side based on their participation during the session i.e.: "Ntebo, I want to thank you for being a good listener." End the session with everyone reciting the Sunflower Chant:*



Before speaking to anyone about today's workshop please use the space provided to journal about it. You may want to investigate your thoughts and feelings after the workshop. Perhaps you can also think about the choices you have been given during the workshop and your interaction with your fellow participants. Maybe you also want to journal about new skills you may have learned or want to develop after the workshop. Finally, you can also write about something that you appreciate about yourself after the workshop. Once done you may want to read what you have written and reflect on it, sum up your takeaway in one or two sentences, starting with statements like: "As I read this, I notice…; "I am aware of…", or "I feel…"

## Journaling

- **Flower 1: Planting Hope!**

There's something especially magical about planting a seed and seeing that first green shoot pop out of the soil. Caring for a seed also gives you an opportunity to practice important life skills, including responsibility and consistency. Even better, taking care of plants is something that people of all ages can do!

**What you'll need:** (Treatment centers to provide the materials needed)

- Small containers (egg cartons, yogurt cups, plastic pots, etc.)
- Lightweight soil-less potting mix
- Seeds (sunflowers, zinnias, cosmos, radishes, lettuces, and dill all grow quickly)
- Spray bottle
- Craft sticks
- Plastic wrap

**What to do:**

1. Make sure your containers are clean and dry. Poke a hole in the bottom for drainage.
2. Moisten the potting mix. If you squeeze a clump and water comes out, add more mix. It should be damp but not soaked. Be sure to avoid using outdoor garden soil to start your seeds. The soil-less mix is sterilized (so there's less chance of germs hurting the baby plants) and it provides good drainage.
3. Fill up your containers, leaving about half an inch or so at the top. Gently tap the container to settle the mix; don't compress it.
4. Read the seed packet to determine how deep to plant them. For a small pot, you can plant five seeds: one at the top, bottom, left, right and middle.
5. Mist the top with a spray bottle (this will keep the seeds moist without drowning them). Write the name of the seed on the craft stick, place it in the soil, then lightly cover the top of the pot with plastic. This will help keep them from drying out and keep them warm.
6. Place them in a warm, sunny spot, then let the magic happen! Remember to check and mist the soil regularly so it does not dry out.
7. Remove the plastic once the seedlings emerge and rotate the pot every couple of days, so they don't bend toward the light. To water now, place them in a tray and water them from the bottom. This will help the plant grow stronger roots.
8. Once the seedlings have two or three leaves and have grown a few inches tall, transplant them to bigger container

**Remember to take care of yourself just like you are taking care of your seedlings. Celebrate your own recovery and enjoy the happiness sobriety brings.**

# WORKSHOP 6

Rise & Shine

Sunflower

A POSITIVE PSYCHOLOGY INTERVENTION

"Advice from a sunflower:
Be bright, sunny and positive.
Spread seeds of happiness.
Rise, shine and hold your head high."

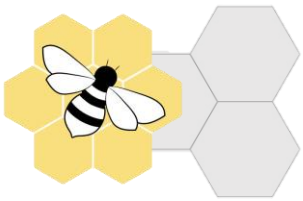
- Unknown

## INTRODUCTION

While enrolled for drug and alcohol treatment, you probably became accustomed to waking up early, having breakfast, meditating and attending daily support groups. These things all became a part of your routine. But when you're out of rehab and living life on your own again, it can be a challenge to maintain that routine without the accountability provided by your peers and counsellors. A healthy routine will aid in lifelong recovery. Today's workshop fucuses on the importance of having a daily routine when recovering from a SUD.

## 1. PREPARING AND PLANTING PHASE *(Preparation Phase)*

### 1.1 Workshop Quote



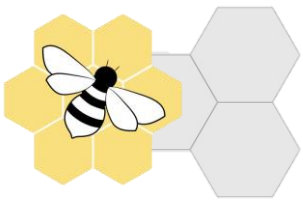
**FACILITATOR**

*Share the workshop quote with the participants. Let them reflect on the quote by writing in their personal journals. Ask for voluntary feedback.*

You will never change your life until you change something you do daily. The secret of your success is found in your daily routine.

John C Maxwell

### 1.2 Program Chant



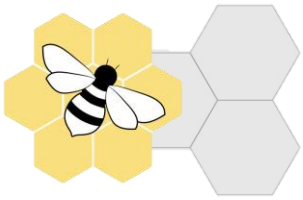
**FACILITATOR**

*Let all the participants gather in a circle. Let them first read and then recite the program chant together.*

*As participants in the 'Sunflower' programme*
*Always remember...*
*we are braver than we believe*
*smarter than we think*
*and twice as beautiful as we ever imagined!*

## 1.3 Choose to be brave

(Participants can practise competence, autonomy, and relatedness within the workshop)



**FACILITATOR**

*Before starting the workshop ask participants to choose which of the following roles they would like to play during the workshop (keep record of the names of these participants):*

- *Timekeeper (Keep time during activities)*
- *Wrap-Up Times Three (Three volunteers each need to identify an activity during the workshop where they practiced each of the three basic psychological needs: autonomy [people are empowered when they feel a sense of choice and endorsement in a task], competence [individuals seek control to allow them to experience mastery over a task] and relatedness [individuals have a need to interact with others]).*
- *Introduce others in a creative way (One person takes the lead in introducing fellow participants in a creative way, i.e. two claps, two snaps, two stomps with their feet, two winks and a "Go Peter" (name of person).*
- *Appreciate with love (One person takes the lead by appreciating participants who shared by clapping X 2 and showering them with love by moving their hands in the form of a heart)*
- *Kibata! ('Kibata' is a loud clap followed by moving the one hand away from the other when done. One participant takes the lead in appreciating a participant who discovered an aha-moment, shared something profound or made themselves vulnerable. This needs to be an incredibly special moment)*

## 1.4 Check-in

**Materials needed:**

- Open space
- Talking piece (bean bag)

***INSTRUCTIONS***

*Let participants gather in a circle. Using a talking piece let each participant share one thing they will need from the group that day to enable them to participate unreservedly. It may be support, encouragement, being non-judgmental, etc. Give time for voluntary feedback on the participants' 'Bloom with Grace' assignments.*

*Once a participant has shared the group will respond by saying:*

*"Thabo (name of participant), nothing for us, without us!*

## 1.5 Warm-Up Game

### *Your Ideal Day*

Time: 15 Minutes

***INSTRUCTIONS***

*Let all the participants gather in a circle. Give each participant the opportunity to share what their ideal day would look like. Once done the other participants will acknowledge the participant sharing by saying: "Kagiso (name of the participant), rise and shine!"*

## 1.6 Workshop Poem

### *The Habit Poem*


***INSTRUCTIONS***

*Ask participants to open their journals to the page with the "Habit Poem." Let them read the poem a few times and reflect on it by writing in their journals. When done give time for voluntary feedback.*

# The Habit Poem

**I am your constant companion.**

**I am your greatest helper or heaviest burden.**
**I will push you onward or drag you down to failure.**
**I am completely at your command.**

**Half of the things you do you might as well turn over to me and I will do them - quickly and correctly.**

**I am easily managed - you must be firm with me.**
**Show me exactly how you want something done and after a few lessons, I will do it automatically.**

**I am the servant of great people,**
**and alas, of all failures as well.**
**Those who are great, I have made great.**
**Those who are failures, I have made failures.**

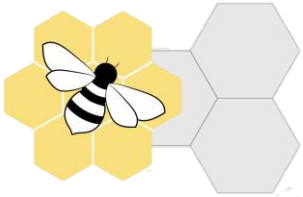
**I am not a machine though**
**I work with the precision of a machine**
**plus the intelligence of a person.**

**You may run me for profit or run me for ruin -**
**it makes no difference to me.**

**Take me, train me, be firm with me, and**
**I will place the world at your feet.**

**Be easy with me and I will destroy you.**

**Who am I? I am Habit.**



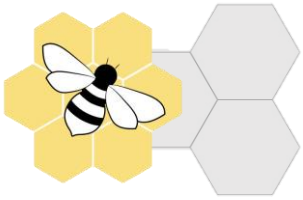
**FACILITATOR**

*Part of creating positive habits during treatment and recovery is creating and implementing a daily routine.*

## 2. GERMINATING AND ROOTING PHASE *(Educational and Skills Development Phase)*

### 2.1 Group Nourishing Session

***A Healthy Daily Routine in Recovery***

**FACILITATOR**

*Use the information provided to explain the importance of a healthy daily routine in recovery.*

Facilitator: Use the information provided to explain the importance of a healthy daily routine in recovery. Maintaining your recovery daily after rehab isn't always going to be easy, especially in early sobriety. There will be times when you feel like giving up, when your cravings are especially strong, or when you convince yourself that you're a failure.

Therefore, it's so important to have a recovery support system in place and a structured routine that will keep your mindset in the right place and improve your physical and mental health. Taking healthy and intentional steps to develop a sober lifestyle will ensure that you always have the support you need, even when things get stressful, boring, or uncertain.

The act of practicing recovery daily typically involves several different aspects of life, so establishing a sober routine for yourself may include:

- Consistently waking up at a certain time every morning.
- Making time for daily exercise.
- Planning and cooking healthy meals.
- Regularly attending a sobriety support group with other sober peers.
- Taking time for self-care.
- Establishing a chore schedule to keep your living space clean and organised.
- Practicing a personal hygiene routine.
- Going to school or work.
- Volunteering.
- Developing a predictable childcare routine (if applicable).
- Keeping a daily journal.
- Learning new things/skills.

Setting each of these things in motion isn't always easy and it will take a lot of effort, planning, and organization on your part, but getting started is the hardest part.

Eventually, these things will become daily habits and the structure of your day will become an essential part of your sobriety. Prioritizing each of these things will support a lifestyle of recovery daily while you gradually assimilate back into society as a high-functioning sober individual.

## Benefits of a Routine in Recovery

There are many benefits to having a daily routine in recovery, some of which you may have already discovered in rehab. If you're wondering why you need to continue with a defined daily routine now that you're done with rehab, here are some of the top benefits.

**1. You maintain a sense of purpose in your everyday activities.**

Creating a daily routine for yourself gives you a purpose, keeps you busy, and reduces the temptation to use drugs and alcohol again.

**2. You are better equipped to deal with stress.**

Stress is what causes many people to relapse. By maintaining a daily routine, you reduce the anxiety you feel due to unexpected events. This is because you take the time to develop structure in your life that prepares you for the unexpected.

**3. You improve your self-esteem and self-efficacy.**

As you learn to prioritize your health and emotional well-being in recovery, you'll also learn to value yourself and love yourself for who you are.

**4. You improve your brain function.**

According to the Harvard Medical School, a routine that involves daily exercise can help reduce cognitive impairment, anxiety, and stress while improving memory, mood, and sleep.

**5. You reduce your overall chances of relapse.**

By building and implementing a daily routine for yourself, you are safeguarding your recovery and preventing relapse with positive, life-changing behaviours and thoughts that will consistently fight cravings and help you find meaning in a substance-free life.

## How to Develop a Routine for Yourself

There are several things you can start doing today to get into a healthy routine. While these are all valuable tips, it's important to build a routine that works for you, as this will look different for every person in recovery. Here are a few simple ways you can get started.

**Nutrition**

First and foremost, you need to prioritize a healthy diet in recovery. While you probably focused on this during your inpatient rehab treatment, there was probably an on-site chef doing all the cooking. Now it's up to you to cook your own meals and do the grocery shopping.

According to a study published in the Indian Journal of Psychiatry, nutritional deficiencies (especially that of some amino acids) can play a role in the onset, severity, and duration of depression.

Other studies have shown that when supplements containing amino acids and other essential nutrients, symptoms of depression and mental illness decreased. As this research shows, creating a weekly meal plan for yourself and sticking to it can help you maintain a healthy weight while also combating mental illness and depression.

### Exercise

Regular exercise such as running, strength training or yoga can increase endorphins and improve overall well-being by reducing cravings, relieving stress, improving confidence and body image, and increasing energy. All these benefits work together to fight relapse and help you stay motivated to remain sober. If you haven't had a regular exercise routine in the past, it can be helpful to find a workout buddy who is willing to go to the gym with you or complete workouts at home with you. This may help keep you motivated to stick to your fitness goals.

### Sleep

Sleep deficiency can contribute to several chronic health problems, including high blood pressure, kidney disease, depression, stroke and diabetes (among others). Getting enough sleep is essential to maintaining a high quality of life, as well as your physical, mental and emotional health. A study published by Penn State also found that when people in recovery from opiate addiction got adequate amounts of sleep, they experienced fewer cravings for opioids. One way to make sure you're getting enough sleep is to set a regular bedtime and stick to it. If you have trouble getting into bed on time, try setting an alarm on your phone. If you typically shower before bed, make sure the alarm leaves you with plenty of time for you to shower, brush your teeth and get into bed by your desired bedtime.

### To-Do Lists

To-do lists are a great tool to manage daily tasks and reduce overall stress. Every night before bed, try making a list of the things you need to do the next day. This can be done in an hourly schedule format or it can just be a simple bulleted list of things you want to achieve.

### Sober Fun

Try out a new hobby or learn a new skill. It's important to have fun while in early recovery to reduce boredom and build your social circle. Many individuals feel a sense of loss or loneliness in early recovery because they are struggling to fill a void that they previously filled with alcohol or drugs. It will take some time to feel normal again, but it can be done, and a supportive group of peers can help.

## Don't Give Up: Stay Motivated Through Drug Rehab and Sober Living

Devoting yourself to recovery daily may not always be a walk in the park, but there are several different ways you can stay motivated through drug rehab and sober living.

1. If you keep a daily journal, write yourself encouraging letters that you can look back on when you have a rough day.
2. Communicate with your sponsor and sober peers regularly and let them inspire you with their own progress.
3. Use an app to track your days of sobriety.
4. Celebrate your sobriety birthday.
5. Invite your friends and family to be a part of your recovery journey by sharing milestones, goals, and achievements.
6. Find fun sober activities to do.
7. Continue your addiction treatment as long as needed by enrolling for Aftercare.
8. Listen to or read other peoples' recovery stories to remind yourself of why you're working so hard to sustain your own sobriety.

### Accountability Matters

Living in a men's or women's sober home can keep you accountable to your recovery and your new routine. Not only is it much more difficult to break a routine when you are living with your peers, but it's also very helpful to have their support.

For example, if you'd like to focus on your fitness goals but can't seem to find the motivation to get it done on your own, ask a sober roommate to join a gym with you and work out together. You may also want to cook healthy weeknight meals together or pick up ingredients from the store together every Sunday.

Building a routine in your newfound sobriety can be much easier when you have the support and accountability of your peers in recovery. If you have recently graduated from an inpatient rehab program and are finding it difficult to manage the stresses of life in early recovery, enrolling in a women's sober living or men's sober living program is a great way to get back on track.

## 2.2 Personal Nourishing Activity

### *Reflect on the day's achievements*


***INSTRUCTIONS***

*It can be easy to lose sight of victories after a long day. Taking just a few moments at the end of the day to reflect on and celebrate your wins puts things into the proper perspective and gives you encouragement for the coming day. It helps you overcome the discouragement that often comes with setbacks, more so during recovery.*

*In addition to asking at the start of each day "What good shall I do this day?", Benjamin Franklin asked every evening "What good have I done today?".*

| | | |
|---|---|---|
| The morning question, What good shall I do this day? | 5 | Rise, wash, and address *Powerful Goodness;* contrive day's business and take the resolution of the day; prosecute the present study; and breakfast. |
| | 6 | |
| | 7 | |
| | 8 | |
| | 9 | Work. |
| | 10 | |
| | 11 | |
| | 12 | Read or overlook my accounts, and dine. |
| | 1 | |
| | 2 | Work. |
| | 3 | |
| | 4 | |
| | 5 | |
| | 6 | Put things in their places, supper, music, or diversion, or conversation; examination of the day. |
| | 7 | |
| | 8 | |
| | 9 | |
| Evening question, What good have I done today? | 10 | Sleep. |
| | 11 | |
| | 12 | |
| | 1 | |
| | 2 | |
| | 3 | |
| | 4 | |

*Benjamin Franklin's daily routine*

Zen Habits author Leo Babauta puts it this way:

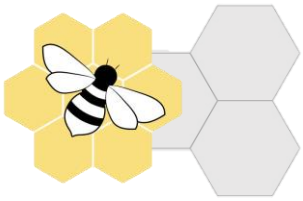
**If you reflect on the things you did right, on your successes, that allows you to celebrate every little success. It allows you to realize how much you've done right, the good things you've done in your life.**

Take your time and use the template provided to create a daily routine for yourself to use during your recovery.

### My Daily Routine

| Suggestions | Time | My Routine |
|---|---|---|
| Sleep | 5 | |
| Rise and Shine! What good shall I do today? OR What can I be grateful for? | 6 | |
| | 7 | |
| | 8 | |
| | 9 | |
| | 10 | |
| | 11 | |
| Lunch | 12 | |
| Lunch | 13 | |
| | 14 | |
| | 15 | |
| | 16 | |
| Exercise | 17 | |
| Exercise | 18 | |
| Family Time – connecting with other family members or partner | 19 | |
| What good have I done today? OR What can I be grateful for? | 20 | |

| | | |
|---|---|---|
| Sleep | 22 | |
| Sleep | 23 | |
| Sleep | 24 | |
| Sleep | 1 | |
| Sleep | 2 | |
| Sleep | 3 | |
| Sleep | 4 | |



**FACILITATOR**
*Give time for voluntary feedback.*

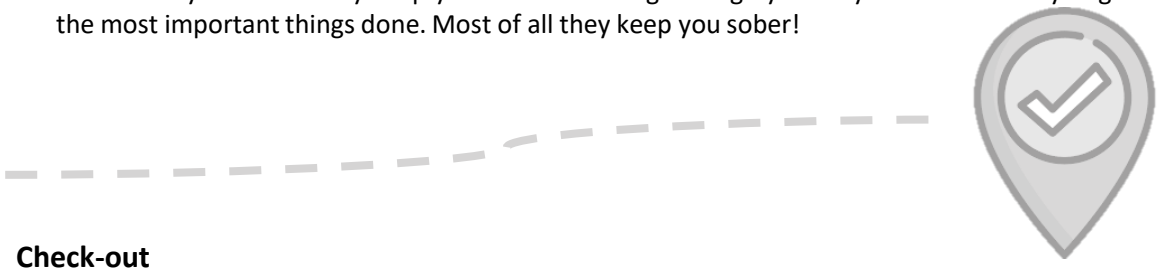
## 3. GROWING PHASE *(Summary and Termination Phase)*

### 3.1 Wrap-Up Times Three

Allow three volunteers (as identified in the beginning of the workshop) to identify an activity during the workshop where they practiced each of the three basic psychological needs: autonomy (people are empowered when they feel a sense of choice and endorsement in a task), competence (individuals seek control to allow them to experience mastery over a task) and relatedness (individuals have a need to interact with others).

### 3.2 Conclusion

Daily routines prime you for success. They help you achieve more, think clearly, and do work that actually matters. They keep you from stumbling through your day and make sure you get the most important things done. Most of all they keep you sober!



### 3.3 Check-out

***Watching the Sunflowers grow!***

***INSTRUCTIONS***

*Let participants gather in a circle. End the Sunflower PPI by allowing each participant to complete the following sentence: "In our garden of recovery we have…*
*End the session with everyone reciting the Sunflower Chant:*

Before speaking to anyone about today's workshop please use the space provided to journal about it. You may want to investigate your thoughts and feelings after the workshop. Perhaps you can also think about the choices you have been given during the workshop and your interaction with your fellow participants. Maybe you also want to journal about new skills you may have learned or want to develop after the workshop. Finally, you can also write about something that you appreciate about yourself after the workshop. Once done you may want to read what you have written and reflect on it, sum up your takeaway in one or two sentences, starting with statements like: "As I read this, I notice…; "I am aware of…", or "I feel…"

## Journaling

- **Flower 1: I am poem! (Practising Competence)**
  Use the structure provided to write your own "I am" poem. If you do not want to use the structure below you may also write your own poem to celebrate what you have learned during the Sunflower prorgam. Keep this poem to remind you of what you have achieved during your treatment.

## I AM…

**First Stanza**

- I am (2 of your favourite character strengths)
- I wonder (something you are still curious about)
- I hear (your favourite song)
- I see (your favourite thing to look at)
- I need (an actual desire)
- I have recovered from (drug of choice)
- I am (your other 3 character strengths)

**Second Stanza**

- I pretend (something you actually pretend to do)
- I feel (how you are feeling when writing this poem)
- I worry (something you are still worried about)
- I touch (something you would like to touch)
- I cry (something that makes you sad)
- I am (the first line of the poem repeated)

**Third Stanza**

- I understand (something your learned during the Sunflower program)
- I say (something you believe in)
- I dream (something you dream about)
- I appreciate (something you are grateful for)
- I try (something you really make an effort about)
- I hope (something you actually hope for)
- I am (all 5 your character strengths)

## I AM...

**First Stanza**

- I am
- I wonder
- I hear
- I see
- I need
- I have recovered from
- I am

**Second Stanza**

- I pretend
- I feel
- I worry
- I touch
- I cry
- I am

**Third Stanza**

- I understand
- I say
- I dream
- I appreciate
- I try
- I hope
- I am

**Always remember... you are braver than you believe smarter than you think and twice as beautiful as you ever imagined!**