How individuals experience and make sense of their problematic mephedrone use: An interpretative phenomenological analysis

By Gurjeet Kaur Bansal

A thesis submitted in partial fulfilment of the requirements for the award for the degree of Professional Doctorate in Counselling Psychology at London Metropolitan University

Student Number: 11028376

December 2016

Acknowledgements

My gratitude and appreciation to the participants who volunteered to contribute towards this research and to the collaborating organisation and individuals, Will Davies and Ajab Aboker, who helped in the recruitment process. It was a pleasure to meet and work with you all.

My sincere thanks to Dr Angela Loulopoulou and Dr Philip Hayton for your supervisory support and reassurance over the years, it is much appreciated.

Much love to my best friend, Sukhi: you have listened to my late-night woes and given me the motivation when I have needed it.

My greatest appreciation to my partner in crime, Steven, for your support over the years and proof-reading skills!

The most special, heartfelt thank-you to my parents for your support, years of hard work that have allowed me to fulfil my dreams, your resilience, your trust in my decisions and believing in me. Without you this would not have been possible. I cannot thank you enough.

~Dedicated to my loving parents~

Table of Contents

List of Figures

List of Tables

List of Appendices

Acronyms

APA-American Psychological Association

BPS-British Psychological Society

BMJ- British Medical Journal

CNWL-Central and North West London NHS Foundation Trust

CoP-Counselling psychology

CSEW-Crime Survey for England and Wales

DA-Discourse analysis

DAST-Drug Abuse Screening Test

DSM-Diagnostic and Statistical Manual

GBL-Gamma-Butyrolactone

GHB-Gamma-hydroxbutrate

GT-Grounded theory

ICD-International Classification of Disease

IPA-Interpretative phenomenological analysis

JCPMH-Joint Commissioning Panel for Mental Health

LDAN-London Drug and Alcohol Network

LGBT-Lesbian, Gay Bisexual and Transgender

NDTMS-National Drug Treatment Monitoring System

NEPTUNE-Novel Psychoactive Treatment United Kingdom Network

NHS-National Health Service

NICE-National Institute for Health and Care Excellence

NIDA-National Institute of Drug Abuse

NPS-Novel Psychoactive Substances

NTA-The National Treatment Agency for Substance Misuse

PSI-Psychosocial intervention

PSM-Problematic substance misuse

SUD-Substance Use Disorder

UK-United Kingdom

U.S.-United States

WHO-World Health Organisation

Abstract

There has been a significant increase in the number of people using club drugs and entering treatment for problematic club drug use in the United Kingdom. It has been suggested, based on socio-demographics, that the treatment needs of such users are different from those of users of traditional drugs, and consequently specialist club drug clinics were introduced.

However, to date no research has explored the subjective experience of problematic club drug use to substantiate an understanding of users' psychological treatment needs or the subjective psychological motivations to use club drugs, or how such users self-identify rather than being categorised in terms of socio-demographics. This research aims to answer these questions, with a focus on mephedrone, one of the most newly identified and popularly used club drugs in the United Kingdom.

Semi-structured interviews with six male users of mephedrone were analysed using interpretative phenomenological analysis. Findings suggested that the subjective experience of mephedrone use is like that of traditional drug use, and consequently that corresponding users' psychological treatment needs are similar. The subjective motivation to use mephedrone was primarily concerned with a want to appease identity distress, a common precursor to substance misuse. Users of mephedrone appeared to make sense of their problematic use by progressing through the stages of change. Moreover, findings implied that stigmatising beliefs operated within the drug-using community, which facilitated the social construction of mephedrone as harmless in comparison to traditional drugs. This perception was found to be further propagated by terminology such as "club drugs" that are used within the professional arena and represent mephedrone as "fun". Not only did the socially constructed image of mephedrone as harmless and fun encourage its use, it appeared to prevent users self-identifying with the stereotypical identity of problematic substance misuse commonly associated with traditional drug use. This potentially acted as a barrier against users of club drugs seeking treatment from generalised services based on the needs of traditional drug use, thus highlighting the necessity for specialised club drug clinics.

Implications of this research include introducing the under-represented area of problematic substance misuse to counselling psychology to promote the applicability of counselling psychologists to work in this field. This research fills the imperative training gap experienced by healthcare professionals based in the United Kingdom in relation to the understanding of problematic club drug use, and does so by providing subjective knowledge of the experience of problematic mephedrone use in order to develop the psychological treatments delivered. Furthermore, this research advocates the introduction of policies that would reduce the harm caused by mephedrone and demystify its socially constructed image. One such policy would be to suggest interventions to distribute information concerning the harms associated with mephedrone. Another would be to reframe the professional language used to describe club drugs. Lastly, this study highlights the need for further investigation into the stigmatising beliefs operating within the drug-using community that potentially act as a barrier preventing users of mephedrone from seeking treatment.

Keywords: mephedrone, club drugs, party drugs, subjective experience, qualitative research

1. Introduction

1.1 Overview

The aim of this research is to explore the experiences, motivations and sense-making of users[1] of mephedrone in the United Kingdom (UK). This section develops a basic understanding of the key concepts and provides an overview of the study, followed by a reflexive account prior to commencing the research.

1.2 Key Concepts

1.2.1 Problematic substance misuse. As opposed to behavioural-related addictions such as gambling, this research focuses on the substance-related addiction of mephedrone use (for an explanation of mephedrone see section 1.2.2.1.1, p.16-17), which is characterised by corresponding symptoms of psychological and physical dependence on withdrawal (Marlatt & Donovan, 2005). Throughout this study the term problematic substance misuse (PSM) will replace the pejorative term addiction (for an understanding of the stigma associated with the term addiction, see section 2.2.3, p.27-28). The term PSM appreciates that "certain individuals use certain substances in certain ways, thought at certain times to be unacceptable by certain other individuals for reasons both certain and uncertain" (Burglass & Shaffer, 1984, p.19). This definition understands that PSM is a unique lived experience that aligns itself with the subjective epistemology of this study (for an understanding of the research paradigm, see section 3.2.1, p.40-41), and with the principle of counselling psychology (CoP) that does "not assume the automatic superiority of any one way of experiencing, feeling, valuing and knowing" (Larsson, Brooks & Loewenthal, 2012, p.55). In line with Mirza and Mirza's (2008; see Table 5, Appendix D, p.110-111) model of stages of drug use, PSM is synonymous with the "late at risk stage" and those beyond, whereas recreational drug use is synonymous with the "experimental" to the "early at risk stage" of use. Substance misuse involves the misuse of drugs beyond their intended use, such as the intended use of ketamine as an anaesthetic which is also sometimes misused as a recreational drug.

1.2.2 Types of drugs.

1.2.2.1 Club drugs. New club drugs are rapidly produced: as of 2009 there were 24 new club drugs, rising to 41 by 2010, 49 by 2011, 57 by 2012 and so forth (Cole, 2011; Hawkes, 2012; European Monitoring Centre for Drugs and Drug Addiction, 2012). Conventionally, the term club drug categorised newly emerging drugs predominantly used in nightclubs, concerts and parties (Gahlinger, 2004; Smith, Larive & Romanelli, 2002). However, use has now expanded to other recreational contexts, e.g. homes, shopping malls and schools (Parks & Kennedy, 2004; Ramo, Gov, Delucchi, Kelly & Parsons, 2010). Some club drugs are sold on the illicit market, while others are sold as "legal highs", "designer drugs" or "novel/new psychoactive

[1] The term "user" is thought to characterise and label people who misuse a chosen substance, and in doing so it linguistically erases individual differences in experience and therefore depersonalises the people to whom the term is applied (Broyles et al., 2014). In this thesis, the term "user" refers "to *a person* using a specific drug problematically". Such use of "people-first language" respects an individual's identity as a person first and foremost (Broyles et al., 2014). This perspective is aligned to the philosophical underpinnings of counselling psychology that appreciates subjectivity and humanistic values.

substances" (NPS; Novel Psychoactive Treatment United Kingdom Network; NEPTUNE, 2015). Such drugs are synthesised substances produced to mimic the desirable effects of favoured controlled substances such as "traditional drugs" (for an understanding of traditional drugs, see section 1.2.2.2, p.17-18), although they have different chemical compositions to evade the provisions of national policies (Advisory Council on the Misuse of Drugs, 2011; Carroll, Lewin, Mascarella, Seltsman & Reddy, 2012).

1.2.2.1.1 Mephedrone (4-methylmethcathinone). In no particular order, the five most commonly used club drugs in the UK consist of: (1) gamma-hydroxybutrate (GHB) and its derivative gamma-Butyrolactone (GBL), (2) ketamine, (3) ecstasy, (4) methamphetamine and (5) mephedrone (NEPTUNE, 2015). Increases in the number of users presenting to treatment were observed for all five club drugs. However, the most significant was an 82% increase in mephedrone presentations from 900 in 2011-12 to 1,641 in 2013-2014 (NEPTUNE, 2015).

Mephedrone is a stimulant manufactured from cathinone, the active ingredient of the African shrub Khat, which is marketed legally as plant food or bath salts (Mackay, Taylor & Bajaj, 2011). It is sold as a white powder that is administered orally, via nasal insufflation or injection. Desirable physiological and psychological effects include increased energy, euphoria, talkativeness, empathy, increased sexual desire and visual and auditory hallucinations (The National Treatment Agency for Substance Misuse; NTA, 2005; Winstock et al., 2011). Such effects have been commonly found to facilitate "chemsex", a term used to describe sexual intercourse between individuals under the influence of drugs which are taken immediately preceding and/or during intercourse (Bourne, Reid, Hickson, Torres Rueda & Weatherburn, 2014). Adverse effects include nose-bleeds, tachycardia, headaches, tremors and skin rashes (Kapitany-Foveny et al., 2013). Deaths by mephedrone have tripled from 6 in 2010 to 18 in 2014 in the UK (Health & Social Care Information Centre, 2014).

Since mephedrone was prohibited as an illegal Class B drug in April 2010, the Crime Survey for England and Wales (CSEW) suggested that mephedrone use reduced. The use of mephedrone among adults (16-to-59-year-olds) was reported as 1.3% (418,600) in 2010-2011; it fell to 1.0% (322,000) in 2011-2012 and to 0.5% (161,000) in 2012-2013, before stabilising in 2013-2014 (0.6%; 193,000; authors' calculations based on 2012 population; Home Office, 2014). However, small-scale surveys of club goers suggested that mephedrone use may have in fact increased from 2010-2011 (Measham, Wood, Dargan & Moore, 2011; Wood, Measham & Dargan, 2012). Either way, the 2011-2012 CSEW reported that mephedrone remained the most used club drug (Home Office, 2014). Mephedrone use among adults (16-to-59-year-olds) was higher (1.0%) than any other club drugs measured in the survey that year (GBL/GHB, spice and Benzylpiperazine were 0.1%). Moreover, during 2014-2015 mephedrone remained the most commonly used drug in combination with other drugs by adults (16-to-59-year-olds) in the UK at 68% (22.4 million people approximately; Home Office, 2015). More recently the UK Psychoactive Substances Act (2016) that aimed to eradicate the market in NPS, including club drugs, claimed that "mephedrone [specifically] has remained popular on the London drug scene" (Hockenhulla, Murphy & Patersona, 2016, p.1720).

Arguably the reliability of the survey data reviewed could be questionable. When completing surveys, the participants could have given exaggerated or false information. However, providing the confidential and flexible method of surveys could have encouraged participants to be more open without the fear of judgement. Arguably, the decrease in mephedrone use, as reported by the CSEW from 2010-2014, could be due to participants being unwilling to disclose their use over time since mephedrone had been made illegal. Nevertheless, the CSEW supported that mephedrone use had remained the most popular club drug of choice, and it could be assumed that such survey data is both internally and externally valid since it is not subject to a particular setting but is undertaken nationally. Whereas, the studies conducted by Measham et al. (2011) and Wood et al. (2012), that suggested that mephedrone use may have increased during 2010-2011, could be deemed internally valid as they provide survey data of the intake of mephedrone by club goers that attended "gay" dance clubs in South London (Measham et al., 2011, p.263), though such findings may not be deemed externally valid as they may not be generalisable to settings outside of the one investigated. However, it could be argued that data that is valid but not generalisable is at least useful for informing practice in the setting in which it is carried out, and that perhaps such studies highlight that such drug use may be problematic or popular in certain settings. Nevertheless, Wood et al. (2012) suggested that although there were overall higher levels of drug use by this particular sample disproportionate to the general population, a salient feature of their survey data is that the ranking of drugs used by participants mirrors that of the CSEW general population survey that suggested mephedrone use was the most preferred drug despite its prohibition.

While research has suggested that mephedrone use is significantly popular and potentially expanding, it is one of the most under-researched club drugs (Van Hout & Brennan, 2011). To increase professional knowledge and inform the development of specialised treatments, NEPTUNE (2015) made an advisory request for "prioritised high-quality research" exploring newly evolving club drugs, including mephedrone (p.44). Therefore, this prompted the focus of this research towards the exploration of problematic mephedrone use.

1.2.2.2 Traditional drugs. The NTA (2012) define the most familiar, eldest and popularly used drugs in the UK as 'traditional drugs', which includes: heroin, crack and powder cocaine. Arguably the criteria of such a definition is unclear and reductionist. For example, the club drug MDMA meets the criteria to be considered a traditional drug. However, since MDMA is considerably used within the context of nightclubs, it is arguably classified accordingly. Nevertheless, cannabis, that has no common context of use and meets the criteria to be considered a traditional drug, is commonly known as a recreational drug. It could be argued that although the definition of traditional drugs appears to be ambiguous, its introduction allows for the ease of identifying particular drugs, a practice this thesis will adopt.

Heroin is an opioid drug synthesised from morphine and sold as a white or brown powder or black sticky substance that is injected, inhaled or smoked. Desirable psychological effects include a sense of euphoria and drowsiness (National Institute of Drug Abuse; NIDA, 2014). Cocaine is a stimulant drug sold as a white powder that is administered via nasal insufflation or injection, while its processed form, known as crack cocaine, forms rock crystals that are smoked. The desirable psychological effects of cocaine are like those of

mephedrone (NIDA, 2013; for undesirable effects of mephedrone, see section 1.2.2.1.1, p.16-17). The adverse effects of these traditional drugs include dysphoria, collapsed veins, abscesses, gastrointestinal, heart, liver or kidney disease and death (NIDA, 2014, 2013). No dominant context of use for traditional drugs has been identified (Flowers, Marriott & Hart, 2010).

1.2.3. Types of drug user. A "club drug user" refers to a person who uses a club drug as their primary drug of choice, whereas a "traditional drug user" refers to a person who uses a traditional drug as their primary drug of choice. In both cases drugs are used either solely or simultaneously (polydrug use) with other drugs (NEPTUNE, 2015). The profile of a club drug user is thought to be broadly similar to the profile of a user of NPS; it was suggested that both are generally young, male, and active participants in the night-time economy (Home Office, 2014; for further exploration of the characteristics of club drug users, see section 2.4.4, p.33-34). By contrast, traditional drug users are thought to be predominately in their forties and male (NTA, 2010, 2012).

1.3 Problematic mephedrone use in the United Kingdom

In the UK, a significant increase in club drug use was identified (Smith & Flatley, 2011; NTA, 2010, 2012). Like traditional drug use, it was suggested that problematic club drug use negatively impacted the user, although to a lesser extent (Joint Commissioning Panel for Mental Health; JCPMH, 2013). Hence the treatment needs of mephedrone users were thought to be different from those of traditional drug users. This was based on socio-demographic characteristics, e.g. functionality, sexual orientation and age (for an exploration of the characteristics of club drug users, see section 2.4.4, p.33-34). As a result, specialised club drug clinics were developed, since treatment services were conventionally based on the treatment needs of traditional drug users.

However, to date no research has expanded on the understanding of the subjective experience of problematic club drug use, specifically mephedrone use (Maxwell, 2003, 2005). Little is known of the subjective psychological motivations to use mephedrone or of the subjective psychological effects of mephedrone, and how such users may self-identify rather than being categorised in terms of socio-demographics. Such understandings could contribute towards appreciating the psychological treatment needs of mephedrone users. This would help develop psychological interventions, enrich the knowledge of healthcare professionals and introduce an under-represented area of work to CoP. Therefore, this study aims to explore mephedrone users' experiences and sense-making of their problematic use (for research aim and questions, see section 2.6, p.37-38).

1.4 The Organisation of the Research Study

The Literature Review (p.22-39) traces the line of enquiry for this research that led to the development of the research questions. The Methodology (p.40-54) summarises the rationale for the methodology, the method chosen and the procedures implemented to gather and analyse data. The Results (p.55-74) outline and discuss the themes revealed through interpretative phenomenological analysis (IPA). The Discussion and

Conclusions (p.75-90) offer detailed theoretical considerations in relation to the insights gained by the research in order to provide a contextualised and meaningful account of the research findings.

1.5 Reflexive Statement: Part One

As it is impossible for the researcher to remain completely objective, reflexive research attempts to understand researcher involvement (Orlans, 2013). Reflexivity is an exercised self-awareness that involves an in-depth understanding of how one's own experiences and cognitions, together with the wider society and culture, may impact on ways of relating or being in the world (Etherington, 2004). Reflexivity is encouraged as an ethical responsibility of the qualitative researcher (British Psychological Society; BPS, 2010), and as a key component of CoP professional practice (Vespia, Sauer & Lyddon, 2006). It makes cognitions, experiences and assumptions explicit and challenges their potential impact on the research process and outcomes (McLeod, 2011). To be consistent with the epistemological ontological position of a constructivist stance, this reflexive statement aims to make explicit my assumptions and experiences in relation to this research topic. It also seeks to understand my involvement in the construction of this research topic and my potential impact on the research process in order to enhance the rigour of this research (McLeod, 2011; Willig, 2001).

On reflection, I understand that my interest in the field of substance misuse originates from professional and personal experiences, which Kasket (2012) explained is a common starting point for identifying a need for research. Through reflexive practice I will attempt to describe these experiences from past to present, identifying what has supported my interest in researching substance misuse.

Beginning with my personal experiences, during my teenage years I was diagnosed with a chronic physical illness which was treated successfully by various medications. Intrigued by the powerful properties of medications on the body, I was prompted to pursue a career in pharmacy. What followed was a bout of mental illness caused by the side-effects of medications taken to treat my physical ailment. This mental illness was successfully treated with medication, although this treatment also required psychological intervention that helped shift my interest towards a concern with the implications of medications on the mind, and a curiosity towards the mind itself as a healing agent. This led to me changing my career pathway and becoming a psychologist, with an interest in the psychopharmacology of drugs and a new belief that the treatment of physical illness could also lie in the treatment of underlying psychological trauma.

During this time a family member began a battle with his use of traditional drugs. Despite the destructive effects of his PSM, he was conflicted over a desire to continue his drug use – something I could not understand. Retrospectively, I appreciate that the personal experiences I have outlined so far influenced my decision to undertake a placement from 2011 until 2013 as a counselling psychologist in training at a charity that provided non-specialist treatment for PSM. On reflection, perhaps pursuing this placement was an unconscious attempt to understand why my family member continued using drugs despite their debilitating effects. Or perhaps it was an attempt to somehow feel that I was helping him through his PSM by helping others.

During this clinical placement, I noticed an increasing incidence of club drug users seeking treatment. At the same time, commissioning bodies introduced club drug clinics, as it was suggested that such specialist

clinics were required because the socio-demographic characteristics of club drug users were different to those of traditional drug users (JCPMH, 2013). Hence, the experience and treatment needs of traditional drug users were thought to be somehow different from those of club drug users. However, at that time no research was available to inform healthcare professionals about the potential subjective differences between club drug and traditional drug users. In line with my "scientist-practitioner" identity as a counselling psychologist to produce research that informs professional practice, I was motivated by this gap in knowledge to study the experience and sense-making of problematic club drug use in the UK, specifically the popularly used and under-researched club drug mephedrone (Kasket, 2012).

As a result of my personal and professional experiences, I am aware that I developed several assumptions. One was that club drug users were different from traditional drug users in terms of their treatment needs, since traditional drug use appeared to be more debilitating than club drug use, which is why different types of services were suggested. Moreover, I assumed that PSM was an addictive disease that appeared to be impossible to overcome. I appreciate that such assumptions or "blinding biases" left unaddressed could affect the research process. The researcher may source or critique literature and analyse data in a manner that aligns their research argument or outcomes to their biases. Also, blinding biases could prevent the researcher from "hearing participants clearly or may influence how [they] make sense of what [they] are hearing" while interviewing (Etherington, 2004, p.128).

To prevent such occurrences, I developed my self-awareness via personal therapy that enabled my potential blinding biases to become "enabling biases", which allowed me to "clear or free up" unresolved thoughts and feelings that may have otherwise hindered the research process as described (Etherington, 2004, p.128; Bernstein, 1983). For instance, I realised that perhaps by exploring users' experiences of problematic mephedrone use, my need to make sense of my family member's motivations to use drugs may have been fulfilled. If left unaddressed, the impact of such a bias could make this research a personal quest to establish some sense of closeness to my estranged relative instead of developing a wider understanding of problematic mephedrone use.

Although my personal experience of drug use in my family could have become a hindrance to the research process if left unmonitored as mentioned above, it provided a source of motivation to pursue this research. I hope that my research will help to develop an under-researched but significant area of CoP by giving voice to drug users who are often stigmatised by society. I also hope it will enable practitioners to better understand such individuals, which could potentially facilitate their treatment. Nevertheless, I am also aware that my hopes for this research may influence the research process. This could be shown in how I construct my research questions, choose my methodology and review and critique literature. This "epistemological reflexivity" has encouraged me to be mindful of such hopes during the research process for the reasons described (Willig, 2013).

To further limit the influence of my hopes, assumptions and biases as described, I will apply the principles of phenomenology to the research process (Smith, Flowers & Larkin, 2009). I will endeavour to "bracket off" my hopes and biases, to try and understand different research perspectives during the literature

review process, and to develop impartial research questions and outcomes (Spinelli, 2005). However, as Milton (2010) explained, it is difficult for a person to be completely objective. Therefore, I aim to maintain my personal and epistemological reflexivity throughout this research in a range of ways. I will monitor and exploring my internal processes through keeping a reflexive journal and I will continue to access personal therapy (Kasket, 2012). I will also undergo supervision to explore and monitor my conscious and unconscious processes and consider how these may affect the research (Evans, 2007). In these ways, the "reflective-practitioner" stance of CoP will be further instilled (Orlans & van Scoyoc, 2008).

2. Literature Review

2.1 Overview

This section presents literature that focusses on problematic club drug use in the UK, specifically mephedrone. The phrase PSM will be explored by critiquing diagnostic definitions, its biopsychosocial underpinnings, societal perceptions and research on the subjective experience. This will be followed by an outline and review of the treatments available for users of traditional drugs and club drugs, while exploring in detail the factors that informed the rationale for the opening of club drug clinics. This will include the in-depth examination of evidence proposing the socio-demographic characteristics of club drug users that correspond to their unique treatment needs. Further analysis will reveal the absence of evidence investigating the subjective experience of problematic club drug use, with a focus on mephedrone, that could inform users' treatment needs. This will lead to the identification of gaps in the existing literature, concluding with the specific research questions that this study seeks to address. Throughout this literature review, attention will be given to the theoretical values underpinning the philosophy of CoP.

2.2 Conceptualising problematic substance misuse

This section provides a basis of understanding of PSM by exploring its diagnostic definitions, biopsychosocial underpinnings, societal perceptions and research on the subjective experience.

2.2.1 Diagnostic definitions of problematic substance misuse. The International Classification of Disease-10 (ICD; World Health Organisation; WHO, 2010) and Diagnostic and Statistical Manual-4 (DSM; American Psychological Association; APA, 1994) define two categories of PSM: (1) 'substance dependence', and (2) 'substance abuse' in DSM-4 that corresponds to 'harmful use' in ICD-10 (Appendix A, p.106; Appendix B, p.107-108). Such diagnostic criteria are predominately used in the USA. Although it is suggested that the substance dependence and abuse definitions are independent diagnoses, there is overlapping conceptual content. For example, within the substance abuse criteria the interpersonal/social problems symptom is defined by continued use despite consequences, and the role impairment symptom defined by recurrent intoxication leading to impaired functioning, which correlates to the compulsive patterns of use typified by substance dependence (Babor, 2007).

Consequently, the DSM-5 created a unifying syndrome known as a 'substance use disorder' (SUD) with varying severities categorised by the heading 'addiction and related disorders' (APA, 2013; Appendix C, p.109). Criticisms have followed concerning this new diagnostic criterion. For example, Martin, Langenbucher, Chung and Sher (2014) suggested that the inclusion of social and legal implications of PSM within the diagnostic criteria of SUD engenders socioeconomic, cultural and contextual biases, and that psychological and physiological processes ought to be prioritised. Moreover, the term 'dependence' was replaced with the debatably pejorative term 'addiction', to avoid confusion with the diagnosis of the 'physical dependence' of medication (Erikson, 2008; O'Brien, 2011). Consequently, individuals with a DSM-4 substance abuse diagnosis

may now be diagnosed with a DSM-5 mild-SUD instead and be considered to have an addictive disorder, a label that has stigmatising implications (for an understanding of the stigmatising implications of the term addiction, see section 2.2.3, p.27-28).

Ultimately, there is no consensual definition of PSM which, in turn, arguably discredits the diagnostic process (First, 2009). Mirza and Mirza (2008) attempted to explain the stages of substance misuse without offering diagnostic criteria (Appendix D, p.110-111). This developmental perspective appreciates the complexity of substance misuse, whilst understanding that not all stages must be experienced and that PSM might not develop. However, the categorisation of stages removes the subjective understanding of substance misuse and prevents deeper explanations of this complex phenomenon from being achieved. Such an approach is adopted by drug services in the UK, where the practitioner and client collaboratively identify the clients diverse drug needs and work towards understanding the clients subjective problematic drug use. Such an approach aligns itself with the values of CoP that attempt to have "respect for the personal, subjective experience of the client over and above notions of diagnoses" (Lane & Corrie, 2006, p.17; Rizq, 2008).

2.2.2 Theoretical perspectives of problematic substance misuse. Approximately one million adults used club drugs during 2011-12, though only 6,846 were treated for problematic club drug use (NTA, 2012). Perhaps, individuals have vulnerabilities that may predispose them to developing problematic club drug use, a suggestion that will be explored by reviewing theories of PSM. Psychological theories will be privileged as these are most relevant to the topic of this research.

2.2.2.1 Biological. The disease model describes PSM as a brain disease resulting from inevitable neuroadaptations in serotonin (Muller & Hombery, 2015) and dopamine pathways (Di Chiara & Bassareo, 2007) following drug use, which causes compulsive behaviour (Allan, 2014). Although genetic theories share a medical perspective, they suggest a greater likelihood that an individual may develop PSM rather than conferring certainty. Advances in genetic studies suggest that PSM is hereditary (Volkow & Muenke, 2012), and that predisposed personality traits (e.g., stress reactivity, impulsivity) increase the risk of PSM (Gorwood et al., 2012). However, Wilbank (1989) suggested that pathologising PSM removes individual responsibility, choice and willpower and instead induces learned helplessness and a reduced self-efficacy that inhibit recovery. Moreover, it is suggested that by "viewing addicts as victims of a disease" (Wilbanks, 1989, p.407) individuals are encouraged to produce an "excuse repertoire" that justifies associated criminality as a potential symptom (Snyder, Higgins & Stucky, 1983).

2.2.2.2 Sociological. Social learning theory (Bandura, 1977) identifies PSM as a learned behaviour acquired through classical conditioning (Pavlov, 1928) and maintained via operant conditioning (Skinner, 1938). Drug use is reinforced by observing others e.g., parents (Barrocas, Paixao & Vieira-Santos, 2016), peers (Baumeister & Leary, 1995) or actors in films (Sulkunen 2007; Waylen, Leary, Ness, Tanski, & Sargent, 2011), gaining pleasure from it or experiencing the pleasure oneself and the punishment of withdrawal

(Sussman & Ames, 2001; Wikler, 1984). Arguably, the learning model is reductionist as it explains human complexities in terms of contingencies and patterns of reward while not considering individual differences.

Theories that explore individual differences via social factors such as socioeconomic status and ethnicity offer a different perspective as to how PSM could develop. Strain theory (Merton, 1968) claims that strain occurs when society popularises aspirations such as wealth that are unattainable for some – defined as "marginalisation". People from ethnic minorities may also experience marginalisation because of "acculturative stress" that could manifest itself if an individual has not yet fully adopted their new culture and concurrently is experiencing a loss of cultural contact with their traditional culture (Berry, Poortinga, Segall & Dasen, 1992; Nouroozifar & Zangeneh, 2006). Although such sociological findings elucidate the etiology of PSM, they also seem to be reductionist and deterministic and to stigmatise members of society.

The moral model concludes that PSM is a choice which corresponds to the rational choice model (Coleman & Fararo, 1992) which proposed PSM as an act of free will made by sinful people with low moral standards (Peele, 1987). This theory may account for religiosity acting as a protective factor for PSM (Yeung, Chan & Lee, 2009), although the moral model has little therapeutic value as it implies that users ought to be punished rather than treated.

2.2.2.3 Psychological. Studies have suggested that identity distress is propelled by those negative life events that inhibit attachment formation and result in low self-esteem, which increases one's vulnerability to substance misuse (Archer, 2008; Berzonsky & Adams, 1999; Campbell, 1990; Cast & Burke, 2002; Pittman, Keiley, Kerpelman & Vaughn, 2011). The psychology of identity, attachment and self-esteem are explored in relation to substance misuse.

There are three distinct definitions of identity: i) that which refers to the culture of a person; ii) that which refers to common identification with a collective or social category such as in social identity theory (Tajfel, 1982); and iii) that which refers to parts of a 'self', composed of the meanings that people attach to the multiple roles they play in differentiated contexts. Identity is dynamic, flexible and develops over time.

Marcia (1966) operationalised Erikson's (1963, 1968) identity theory and created the identity status paradigm. Marcia (1966) proposed that individuals progress through a process of exploration until they are committed to a set of options as an integral part of the self. Marcia proposed four stages of identity development: i) identity diffusion (low exploration, low commitment), where identity options are not explored, nor specific roles, goals and values committed too; ii) moratorium (high exploration, low commitment), characterised by experiencing a crisis without adoption of a fixed set of values and beliefs; iii) foreclosure (low exploration, high commitment), characterised by forming identity commitments prematurely without first exploring many identity options, and iv) commitment (high exploration, high commitment), through internalising a set of values and beliefs.

It is at the stage of moratorium that individuals experience identity distress, "severe subjective distress regarding [the] inability to reconcile aspects of the self into a relatively coherent and acceptable sense of self" (American Psychiatric Association, 1980, p. 65). Wiley and Berman (2012) found that although relationships

between identity formation and substance abuse have been found, these associations may be largely a function of identity distress.

As a consequence of identity distress, individuals may search for a social identity by adopting the beliefs and practices of a drug subculture, corresponding to social identity theory (Tajfel & Turner, 1979). By means of social categorisation, the in-group (the group to which a person belongs e.g. club drug users) discriminates and stereotypes against the out-group (the group to which a person does not belong e.g. traditional drug users) by highlighting differences between them. Research has identified that this may increase individuals' social status and create a sense of belonging, acceptance and support, together with a false sense of empowerment (Dodes, 2002; Anderson & Mott, 1998; Moshier et al., 2012; Neale, 2002; Suh, Mandell, Latkin, & Kim, 1997). What follows is social identification, the adoption of the group identity that one has categorised themselves as belonging to. For example, by adopting the identity of a club drug user, one would begin to act in ways that would represent the identity of that drug subculture. Consequently, PSM behaviours form a central part of the new self-concept, where one's group membership is bound to one's self-esteem, and abandoning these beliefs would exacerbate further identity distress (Koski-Jannes, 2002). Perhaps the adoption of the ingroup identity could be perceived as the 'false self' that acts as a defence against a feeling of internal emptiness and perhaps low self-esteem, that removes oneself from experiencing or exploring their authentic 'true self' (Winnicott, 1960).

The concept of self-esteem in the context of this research refers to the ways in which individuals feel about themselves, based on their sense of worth and competence, formed by ongoing transactions with their environment and is conceptualised as a part of the self-concept or identity (Cast & Burke, 2002). The minority stress theory (Meyer, 1995) suggests that individuals may internalise stigmatising beliefs such as negative beliefs concerning homosexuality which are held by society or family members (DiPlacido, 1998). The internalisation of such beliefs become a stable part of one's self-concept, and can lead to feelings of guilt, self-loathing, shame and low self-esteem, together with a delay in identity formation (Allen & Oleson, 1999; Grossman & Kerner, 1998; Shidlo,1994). Such negative life events that inhibit identity development are thought to increase the likelihood of substance misuse, as drugs are used as a maladaptive coping strategy (Etherington, 2006; Bruce, 1990; Larkin & Griffith, 2002).

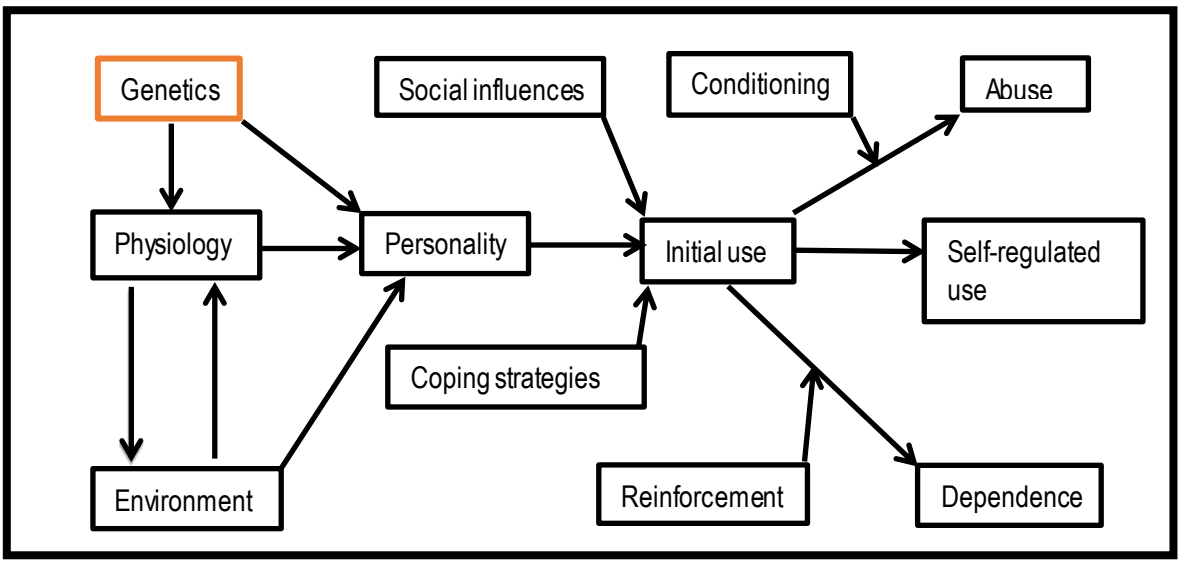
Research has proposed that attachment theory provides a foundation for social and personality development which is key in the formation of identity (Pittman, Keiley, Kerpelman & Vaughn, 2011). Moreover, research has suggested that caregiver-child interaction constitutes the basis for development of one's early sense of self-esteem (Arbona & Power, 2003; Laible, Carlo, & Roesch, 2004), which is a precursor to the development of identity (Berzonsky & Admans, 1999; Campbell, 1990; Cast & Burke, 2002). Attachment can be defined as a deep and enduring emotional bond across time and space, that provides a sense of security and stability, nurtured via the caregiver-child relationship (Ainsworth, 1973; Bowlby, 1969). Four styles of attachment have been identified: secure, avoidant, anxious and disorganised (Ainsworth, 1973). Research suggests an association between insecure attachments (avoidant, anxious and disorganised) and substance misuse, perhaps because insecure attachments are associated with poor emotional regulation, poor social

skills, fears of intimacy and low self-esteem (Borhani, 2013; Kassel, Wardle & Roberts, 2007; Thorberg & Lyvers, 2010). Substances may be misused to manage these negative feelings.

Substance misuse may facilitate self-harming behaviours, including sadistic and masochistic forms of sexual behaviour, to appease psychological distress (Shaw, 2012). In line with the self-medication hypothesis (Khantzian, 2003), substance misuse may function as a coping strategy to appease the symptoms of mental health issues including identity distress, or negative life events such as sexual abuse. Although the self-medication hypothesis has received widespread acceptance, arguably it does not capture the complexity of the process of PSM by just focusing on an individual's use of substances to address discomforting affective states. Moreover, it is difficult to establish whether psychological distress precedes the development of PSM or vice versa.

2.2.2.4 Biopsychosocial model. Ultimately, PSM is a multifaceted phenomenon where a combination of the preceding models, known as the biopsychosocial model, provides a multi-dimensional explanation of its onset. Figure 1 (p.26) proposes how the interplay of factors influences the development of substance misuse and PSM, where the balance of such influences will be unique to each person. This holistic perspective is consistent with the philosophy of CoP that respects individual differences and the complexity of humans that cannot be separated from their biological, psychological or social influences (Ashley, 2010; Strawbridge & Woolfe, 2010; Swanepoel, 2013).

Figure 1: Factors influencing the patterns of substance misuse (DiClemente, 2003).



As highlighted in Figure 1 above, all the factors mentioned influenced the development of the research questions of this study (see section 2.6, p.37-38) apart from the factor of genetics. The factor of genetics is not relevant to the psychological perspective taken in this research, which the other factors inform. For example, the factor of physiology is related to the stress-related physiological response to attachments made in relationships. Where attachment theory is thought to explain the process of and vulnerability towards

substance misuse (Flores, 2004). This could shed light upon the subjective psychological experience and sense-making of drug use.

2.2.3 Perceptions of substance misuse. The normalisation theory (Measham, Newcombe & Parker, 1994) attempted to explain why recreational drug use and types of users increased and became part of everyday 'normal' life, as opposed to PSM that remained stigmatised in the UK. Parker, Aldridge and Measham (1998) tracked the drug attitudes and consumption patterns of a cohort of nearly 800 British adolescents over five years, and considered the following as indications of normalisation: (i) the availability and accessibility of some illicit drugs, (ii) drug "trying" rates, (iii) regular use of some illicit drugs, (iv) levels of drug knowledge, (v) future intentions to use drugs, and (vi) the cultural accommodation of some illicit drug use (e.g. among non-drug users, in popular culture and in policy).

It was suggested that the use of some illicit drugs (cannabis, nitrates and amphetamines, ecstasy) had become 'normalised' by young people and socially and culturally accepted by members of the non-drug using population, as the use of such drugs were likened to leisurely activities e.g., shopping, holidays etc., (Gourley, 2004; Cieslik & Pollock, 2002; Measham, Newcombe, & Parker, 1994; Parker, 1997; Shiner & Newburn, 1997). While research suggested that stigmatising attitudes were common amongst society and non-specialist professionals towards people experiencing PSM, who are often labelled as "addicts" (Lloyd, 2013, p.85). 'Addicts' are perceived to be more blameworthy and dangerous than individuals labelled as 'mentally ill' or recreational drug users, who are in-turn viewed more harshly that individuals labelled physically ill (Link, Phelan, Bresnahan, Stueve & Pescosolido, 1999; Rasinski, Woll, & Cooke, 2005; Room, 2005). It appears that rather than the behaviour of drug taking itself being stigmatised it is the persona associated with PSM that is stigmatised while that of a recreational drug user is normalised (Measham, Newcombe, & Parker, 1994).

Further research indicated that stigma operated within the drug-using population itself e.g., those who inject or use heroin are more stigmatised than cocaine users (Power, Power & Gibson, 1996), whilst regular marijuana users stigmatise alcohol and heroin users more than occasional or past users of marijuana (Plancherel et al., 2005). Despite findings of stigma regarding PSM in society and within the drug-using population, little research has explored how such stigma could be managed to reduce its effects as a barrier preventing users seeking treatment (Adlaf, Hamilton, FeiWu & Noh, 2009).

The most normalised and popular type of drug user is thought to be club drug users, indicative by their drug experience (Parker et al., 1998). Their lifetime rates of "cannabis trying" at nearly 100 percent, and rates for amphetamines, LSD and ecstasy in the 60–90 percent range (Measham, Aldridge & Parker, 2000). Club drugs are also suggested to be normalised by the routinisation of the way in which they are supplied through social networks despite this breaching the Misuse of Drugs Act (Parker, Aldridge & Egginton, 2001). Furthermore, it has been suggested that the use of licit drugs (e.g. alcohol) with the illicit drug (e.g. ecstasy) use, as part of weekend relaxation is commonly referred to in television dramas and serials (e.g. This Life, BBC2, Ali G, Channel 4), that helps to further normalise club drug use (Parker et al., 1998).

However, the normalisation theory has been extensively criticised in that drug use has only become normalised, if at all, for particular users of particular drugs in some countries, and that further consideration ought to be given to the influence of social factors: gender, social class, the legal status of a drug, ethnicity, age, relationships or social context (Pennay & Measham, 2016). For example, it has been suggested that there is an overall normalisation of club drug use and users. However, with consideration to the social factors highlighted it could be argued that club drug use has become particularly normalised for young adults (18-24-year-olds) who have suggested to be predominant users within the socially acceptable context of nightclubs (NTA, 2010, 2012). Whereas, older adults who may be unemployed, could be stigmatised for using such drugs. More specifically the significant increase in mephedrone use, could indicate the normalisation of the drug due to its then legal status; its reduction in use and hence denormalisation indicative of its now illegal status. However, despite mephedrone's illegal status, it could be argued that it has remained popular and hence normalised for the LGBT proportion of society due to its pertinent chemsex properties (Measham et al., 2011; Wood et al., 2012). Furthermore, mephedrone appears to be normalised for those users that snort it than those that inject it, due to the latter being associated with PSM (Van Hout & Brennan, 2011).

These examples highlight that the concept of drug normalisation evolves meaningfully with shifting drug trends and attitudes, and so it requires in-depth exploration to understand the consequences and particulars of normalisation and to form adequate responses to it. Although the normalisation theory offers a broad explanation of the normalisation of a drug on a social level, this study attempts to explore the potential subjective process of mephedrone use for the individual.

2.2.4 Subjective experience of problematic substance misuse. Quantitative research has dominated the understanding of PSM. However, there is now a growing interest in the use of qualitative methods that describe the lived experience of drug use from the participant's perspective (Rhodes & Moore 2001; Neale, Allen & Coombes, 2005; Nichter, Quintero & Nichter, 2004). Due to the lack of research commenting on the subjective experience of problematic club drug use, three relevant studies were located that describe the experiences of problematic illicit drug use, including the use of stimulants, and of alcohol misuse. Also, it has been suggested that stimulants and alcohol use parallel the pattern of problematic club drug use (NEPTUNE, 2015).

Through narrative inquiry, Hsieh et al. (2015) explored the subjective experience of problematic illicit drug use. Ten participants were recruited from therapeutic communities in Taiwan. Results proposed three themes that described the participants' experiences of PSM: (1) An "uncontrollable adherence" to the substance, where the positive experience of the substance reinforced its continuous use and subsequently the substance became the participants' highest priority. (2) A "trapped life", where participants explained that they felt the drug controlled their lives as they were trapped within a cycle of love while using the drug and experienced feelings of hate upon withdrawal. Participants reported missing critical life events such as funerals in preference for drugs. (3) Participants described their "tragic descent" as they experienced conflict between their desire to use and to quit the drug. Although it was an insightful description of the experience of PSM was

given, the study did not identify what specific drugs participants used. Moreover, the study took place in Taiwan, and arguably the results may not be generalisable to the UK, due to differences in culture (Firestone, 1993).

Shinebourne and Smith (2009) researched the experience of alcohol addiction of a female participant from the UK, using data from semi-structured interviews that were analysed using IPA. Three superordinate themes were identified: (1) *The experience of the self.* The experience of PSM is likened to a state of flux and instability. Initially the use of alcohol is described as an enabler, providing a route from feeling depressed to enjoyment, contentment and sociability. A loss of control is experienced as well as the negative side-effects upon withdrawal. (2) *I created such a character for myself*: The participant described the initiation of an alternative character via drinking that allowed her to feel free. However, this personality conflicted with her true self. (3) *Perception of the self*: The participant perceived herself to be a mixture of conflicting selves, from one self that acknowledged that her PSM was destructive and wanted to stop, to the other that enjoyed engaging in the positive qualities associated with her drinking.

Shinebourne and Smith (2010) also researched how participants used metaphors to communicate experiences of alcohol misuse using IPA. Six participants were recruited and their experience of PSM was described as an "affliction" via several classes of metaphors that explained a range of phenomena: the futile struggle to get rid of psychic "pain"; "the void" as an emotional emptiness which could not be filled; the "detachment" from emotional engagement; and PSM as a "battlefield" between surrendering to the drug or fighting against one's own personal demons.

2.3 Treatment of Problematic Substance Misuse

A considerable number of individuals with PSM recover without engaging in treatment or self-help groups, this is known as 'natural recovery' (Slutske, 2006). It has been suggested there can be a "maturing out" phenomenon (Best, Ghurfran, Day, Ray & Loaring, 2008) or an experience of a "eureka" moment (Mariezcurrana, 1994), where individuals become less interested in their drug use over time. There are many different factors that could contribute towards individuals' natural recovery, these include social factors: marriage, a change of job, legal problems, pregnancy, financial crisis; or biological factors: changes in physical health; or psychological factors: self-control, willpower, motivation or the creation of a new identity (Mariezcurrana, 1994). The simultaneous consideration of the factors outlined forms a biopsychosocial theoretical perspective, that provides a meaningful account of how subjective natural recovery can occur.

Nevertheless, this section highlights the stages of change a user enters that could result in them seeking treatment, and with relevance to this research explores the recommended evidenced-based psychosocial interventions (PSIs) that form the basis of treatment for substance misuse services in the UK. This includes an evaluation of present guidelines available for the treatment of problematic club drug use in the UK.

2.3.1 The transtheoretical model. The transtheoretical model (Prochaska & DiClemente, 1983; Prochaska, DiClemente, & Norcross, 1992) highlights the process of intentional behaviour change motivating a user to access treatment. The transtheoretical model includes the stages of change which individuals move

through, often in a non-linear fashion, when modifying their PSM. An outline of each state of change is given in Appendix E (p.112). It is the stage of "action" in which individuals begin to engage with treatments, including PSIs.

2.3.2 Psychosocial interventions. In line with the psychological interest of this study, a focus is placed on PSIs rather than pharmacological interventions. PSIs address the psychological, social, personal, relational and vocational problems associated with PSM. PSIs aim to assist individuals in making and sustaining changes in their substance misuse behaviours, and in addressing underlying or additional mental health problems (NTA, 2005). Some interventions are termed psychological therapies but come under the PSI umbrella. PSIs are the principal treatment for PSM for most substances, as few types of PSM have recognised pharmacological interventions (Amato, Minozzi, Davoli & Vecchi, 2011).

2.3.3 Psychosocial interventions for problematic substance misuse. In the UK, the evidence-based guidelines provided by National Institute for Health and Care Excellence (NICE) and NTA suggest specific PSIs for the treatment of PSM, based on widespread research into the effectiveness of PSIs for alcohol, opiates, stimulants and cannabis (NTA, 2005; Appendix F, p.113-114). However, the NTA and NICE do not provide specific guidance on how to treat problematic club drug use. There is evidently a disparity between the availability of NICE guidelines and suggested PSIs by the NTA for the treatment of problematic club drug use in comparison to other types of PSM, and this may reflect that problematic club drug use is relatively new and an extensive literature base is yet to develop.

Nevertheless, Mollon (2009) proposed that NICE guidelines, aligned with the medical model, implicitly reduce psychological therapy to a standardised "verbal drug" to treat clients (p.15). In doing so, the complexity and individuality of clients are eliminated, and clinicians are devoid of "clinical judgement, innovation and adaptation to the individual client" (Mollon, 2009, p.15). Mollon (2009) suggested the introduction of "truth therapy" (Langs, 1982), i.e. the use of many theories that evolve and change when applied to treat the client's unique needs. This approach aligns itself to the philosophy of CoP that "challenges the views of people who pathologise" and instead strives to be "attentive to life experience, modes of inquiry and areas of knowledge" to aid the unique, pluralistic treatment of clients' subjective needs (BPS, 2005, p.7).

2.3.4 Psychosocial interventions for problematic club drug use. The JCPMH (2013) produced a commissioning report requesting more efficient substance misuse services due to a shortfall in relevant services in the UK. Bowden-Jones (a consultant psychiatrist in substance misuse and past Chair of the Faculty of Addictions at the Royal College of Psychiatrists) presented as an "expert reference" for developments in problematic club drug use (JCPMH, 2013, p.21). Bowden-Jones opened the first official club drug clinic in 2010 in Central and North West London (CNWL; Wise, 2011). The opening of other club drug clinics soon followed, including: The Party Drug Clinic (South London & Maudsley, 2010), MMagik (Bristol, 2013), The Haringey Club Drug Clinic (Haringey, Enfield & Barnet, 2013) and Grip (Camden & Islington, 2014).

Bowden-Jones recommended that tailored and "new models of treatments" ought to be introduced to these specialist services in order to meet the suggested unique treatment needs of club drug users (Hawkes, 2012, p.1; NTA, 2012). Bowden-Jones subsequently founded NEPTUNE in 2013, which released clinical guidelines in relation to the treatment of club drug and NPS use (NEPTUNE, 2015). Due to a "lack of robust evidence" in club drugs, treatment recommendations were based on available research for the treatment of stimulant misuse, as "most NPS are stimulant in nature", and for alcohol misuse, as "NPS use shows a close parallel" to the pattern of alcohol use (NEPTUNE, 2015, p.45; for guidelines that were also recommended for the treatment of problematic club drug use, see Appendix F, p.113-114). Arguably, unifying treatments for different types of PSM suggests that users of different types of drugs have the same treatment needs irrespective of the context in which the drug is used, or of the effects of specific drugs and characteristics of different types of drug user. Such an approach seems reductionist and departs from a CoP perspective that attempts to understand individual differences and the complexities of different types of drug user. It also brings into question the necessity for specialist club drug clinics that attend to the suggested unique treatment needs of problematic club drug users.

As "the bulk of the research available provides what is referred to as emerging research evidence" such as case reports and the analysis of patient records (NEPTUNE, 2015, p.21), perhaps further empirical research in problematic club drug use is necessary in order to inform what such users' unique treatments are and how they could subsequently advise treatment suggestions.

2.4 Rationale for Specialist Club Drug Clinics in the United Kingdom

With an understanding of the treatments available for PSM, specifically club drug use, now in mind, this section explores and critiques the factors that informed the rationale for the opening of club drug clinics.

2.4.1 Diversification of drug use in the United Kingdom. Bowden-Jones proposed the opening of club drug clinics based on the "changing pattern of drug use" in the UK (Wise, 2011, p.1). It was suggested that club drugs were replacing traditional drugs as the leading drugs of choice, since club drug use was increasing and traditional drug use was decreasing (Wise, 2011). Bowden-Jones' assertions were gleaned from statistical evidence from 2005-2011 from the CSEW and National Drug Treatment Monitoring System (NDTMS).

The CSEW estimates the prevalence of illicit substance misuse among a nationally representative sample of residents (16-to-59-year-olds) in households in England and Wales. From 2005-2006 to 2010-2011 problematic cocaine users decreased from 764,000 to 684,000; problematic crack cocaine users decreased from 53,000 to 47,000, and problematic heroin users decreased from 39,000 to 34,000 (Lader, 2015). From 2005-2011 mephedrone use was not monitored due to its prohibition in 2010. However, ketamine was controlled as a Class C drug in 2006. From 2006-2007 to 2010-2011 problematic ketamine users increased from 93,000 to 197,000 (Lader, 2015).

Although these findings validated Bowden-Jones' observations, the CSEW findings do not include minority groups that potentially have relatively higher rates of drug use such as homeless people or prisoners

(Smith & Flatley, 2011). Also, the CSEW does not "reach those problematic drug users whose lives are so busy or chaotic…that are unable to take part in an interview" and consequently the use of "cocaine" might be underestimated (Smith & Flatley, 2011, p.43). Moreover, the CSEW only monitors the use of controlled drugs, and consequently the use of legal club drugs is unknown. There may also be issues concerning the participants' willingness to report illicit substance misuse during an interview. Hence, estimates of the prevalence of illicit substance misuse may be considered lower estimates of the true level within the general population.

The NDTMS is a part of Public Health England and collects data from all substance misuse treatment services, which is analysed by the National Drug Evidence Centre and reported on by the NTA. From 2008-2009 to 2009-2010 the number of people in treatment for problematic cocaine use decreased from 8,522 to 7,304; problematic crack cocaine use decreased from 5,045 to 3,686; and problematic heroin use decreased from 3,005 to 2,312 (NTA, 2010). However, from 2005-2006 to 2011-2012 the number of people in treatment for problematic club drug use increased from 4,656 to 6,486 (NTA, 2012). These statistics suggested that the number of problematic traditional drug users in treatment was decreasing whilst the number of problematic club drug users in treatment was increasing, which is thought to parallel the changing pattern of PSM in the general population, as suggested by Bowden-Jones.

However, rather than the decreasing number of users of traditional drugs in treatment reflecting a decrease in the use of such drugs in the general population, the results could reflect an improvement in the effectiveness of treatments available provided by non-specialist substance misuse services. A government initiative was introduced in 2001 to improve non-specialist treatment services in the UK, and consequently 64% of cocaine users who finished treatment in 2005-2006 did not return to treatment within four years of leaving, which suggests they sustained recovery (NTA, 2013; NTA, 2010). Moreover, the increasing prevalence of problematic club drug use could be accounted for by the legal status and ease of availability of club drugs on the internet (Winstock et al., 2011). Drug users may have also preferred to buy cheaper alternatives to cocaine such as mephedrone, as it was proposed that its purity had decreased while its cost had increased over the years (NTA, 2010).

However, Bowden-Jones (2012) suggested that there are more problematic club drug users than documented by the NDTMS, as many do not seek treatment because non-specialist services lack the expertise to meet their unique treatment needs. This is based on anecdotal evidence, as no documented subjective accounts by problematic club drug users exist, nor does a summary of how such users' treatment needs might differentiate from problematic traditional drug users. Although Bowden-Jones' assertions are insufficiently substantiated as they are not grounded in systematic research, arguably gaps in service provision may be identified through clinical experience at the level of service delivery that spurs further research (Kasket, 2012).

In summary, there may be a "changing pattern of drug use" as Bowden-Jones suggested, although it is unclear whether club drugs are becoming the leading drugs of choice (Wise, 2011, p.1).

2.4.2 Health and wellbeing. To further emphasise the need for club drug clinics, Bowden-Jones used anecdotal evidence to describe the adverse effects of club drug use in two articles for the British Medical Journal

(BMJ; Hawkes, 2012; Wise, 2011). These effects are the same as those described in the JCPMH (2013) and associated with general PSM, which include an increase in crime, family breakdown and poverty. Physiological harms include death, intoxication, consequences of injecting such as vein damage, sexually transmitted diseases, hypertension, stroke and coronary heart disease. Psychological harms include depression, anxiety and the exacerbation of mental illnesses e.g., psychosis (JCPMH, 2013).

Since the harms caused by club drug use are like those caused by PSM in general, it is difficult to substantiate how the treatment needs of club drug users are unique, and, in turn, if they warranted the commissioning of specialist clinics. The subjective experience of users could be explored in order to better develop an understanding of the psychological harms of problematic club drug use. Such an approach would depart from the medical genre of the BMJ and adopt a CoP perspective with a phenomenological epistemology (Woolfe, Strawbridge, Douglas & Dryden, 2010). Such an understanding could inform the understanding of the psychological treatment needs of club drug users and elucidate how such treatment needs may differ from those of traditional drug users.

2.4.3 Training gap. Using anecdotal evidence, Bowden-Jones proposed a "training gap" among UK based healthcare professionals, e.g. psychiatrists, psychologists, nurses etc., in the field of club drug use, particularly with respect to associated risks and their knowledge of treating users (Wise, 2011, p.1; Hawkes, 2012). To overcome such a "training gap", Bowden-Jones recommended that club drug clinics should introduce tailored "new models of treatments" to meet the suggested unique treatment needs of club drug users, which would hopefully inform professionals' understanding when treating such users (Hawkes, 2012, p.1; NTA, 2012). However, Bowden-Jones did not elaborate on how the risks associated with club drug use and the knowledge required to treat such users were unique in comparison to that of traditional drugs and users alike.

In line with his medical profession, Bowden-Jones provided a medical stance when considering the treatment of club drug users in terms of risk and physical harms, but he did not emphasise the importance of also understanding the psychological harms associated with club drug use. This could be achieved by exploring the subjective experience of problematic club drug use. Such a holistic understanding adopts a CoP perspective that could contribute towards the closure of the "training gap" for professionals by providing knowledge of experiences of psychological effects of club drug use.

2.4.4 The specific characteristics of club drug users and their treatment needs. Club drug clinics were advocated as it was suggested that users represented a distinct drug group in terms of their sociodemographic characteristics which related to their unique treatment needs (NTA, 2012). The proposed sociodemographic characteristics, which were purported as being exclusive to club drug users, are described below.

2.4.4.1 Functionality. Based on clinical observations, Winstock (Researcher and Psychiatrist) and Davies (Manager at Drug Advisory Service in Haringey, London) suggested that club drug

users are "high-functioning addicts" in terms of their ability to maintain a job, family or social network, in contrast to traditional drug users (London Drug and Alcohol Network; LDAN, 2012; NTA, 2012). Simpson (a policymaker for LDAN; 2012) argued, based on his opinion, that since club drug users are thought to have more "recovery capital", e.g. employment, social network, stable accommodation etc., than traditional drug users, they ought to do better in the non-specialist drug services already available. He suggested that the socio-demographic profile of club drug users reduces their need for psychological support in terms of promoting activity, creating supportive relationships or generating motivation for change, and therefore implies that their treatment needs are less than and not unique to those of traditional drug users. Further research is needed to establish the generalisability of Winstock's and Davies' clinical observations and Simpson's argument.

2.4.4.2 Sexual orientation. Based on anecdotal evidence, Bowden-Jones suggested that "lesbian, gay and bisexual people form a large proportion" of club drug users, although the "NDTMS does not record enough data to confirm this" (NTA, 2012, p.6). Nevertheless, Antidote argued (from their experience as the UK's only Lesbian, Gay, Bisexual and Transgender (LGBT) specialist service for substance misuse) that club drugs "account for almost all of our work" that is "almost exclusively linked to sexual use by gay and bisexual men" (NTA, 2012, p.6). As a result, psychological interventions have been adapted to meet the treatment needs of club drug users from the LGBT community, such as "motivational interviewing talks about how to achieve sexual intimacy without drugs" (LDAN, 2012, p.6).

However, Lea et al. (2013) argued that some gay and bi-sexual men inject heroin to enhance sexual behaviours, as well as using club drugs. Therefore, it becomes questionable as to whether the adaptations made by Antidote to particular PSIs are exclusive to the needs of club drug users. Perhaps the treatment needs of traditional drug and club drug users from the LGBT community do not differ. However, providing club drug clinics for users from the LGBT community allows them to feel "comfortable discussing LGBT issues related to club drug use" (CNWL, 2010, web page). To validate such propositions, further research would be required to explore how club drug users from the LGBT community experience and to make sense of their use.

2.4.4.3 Age. Based on statistical evidence, the NTA (2010, 2012) suggested that club drug users in treatment are predominantly young adults (18-to-24-year-olds), while traditional drug users are predominately older adults (40-year-olds and above). However, based on anecdotal evidence Davies suggested that many club drug users are "in their thirties" (LDAN, 2012, p.1). Further research or statistical evidence would be required to understand whether a specific age group is exclusively associated with problematic club drug use, which could have implications for treatment.

2.4.5 Summary. As explained, to examine the role and necessity of club drug clinics, further research is required to explore whether the specific socio-demographic characteristics mentioned are exclusive to club drug users and how they may relate to their proposed unique treatment needs. Perhaps by exploring the subjective experience of club drug users and how they make sense of their problematic use, this may harness

an understanding of how club drug users themselves may self-identify, how users may experience the psychological effects of club drugs, and their psychological motivations for use. Such information could help clarify club drug user's psychological treatment needs, facilitate the development of psychological interventions and contribute towards closing the "training gap" for professionals who provide treatment (Wise, 2011, p.1; Dew, Elifson & Sterk, 2006; Hawkes, 2012). Such an approach would facilitate a significant shift in perspective. At present, the arguably dominant perspective is one that categorises club drug users' treatment requirements in terms of socio-demographics. This could shift towards a more humanistic person-centred stance that engages with the complexity of club drug users based on individual differences and subjective experience, aligned to the principles of CoP (Cooper & McLeod, 2011).

2.5 Focused Critique of Research Closely Related to the Present Study

Keeping in mind the potential for qualitative research exploring the subjective experience of problematic club drug, studies in club drug use were explored and critiqued in-depth while identifying gaps in research to support the aims of the present study. Due to limited relevant research in club drug use (to highlight the limited research in club drug use, see section 2.2.4, p.28-29) a range of studies are mentioned. Two studies are discussed in greater detail as they highlight areas relevant to this research: users' motivations to use club drugs (Parks & Kennedy, 2004); and the experience of club drug use (Van Hout & Brennan, 2011).

2.5.1 Focused critique of relevant research in club drugs. Parks and Kennedy (2004) suggested that the reasons why club drugs (ecstasy, GHB, ketamine, rohypnol, methamphetamine, LSD) are used may be linked to the context in which they are used. This includes how the drug is used; the experience of psychological and physiological effects of the drug, including associated risks; and how a person's drug use began. Fifty young adults (18-to-30-year-olds) were recruited from university campuses in New York, United States (U.S.). Each participant took part in a 60-minute face-to-face interview that involved closed questions, selecting an answer from several options and completing questionnaires that assessed several areas. These comprised: (1) personal history of substance use, (2) patterns of current club drug use, (2) context and location of club drug use, (3) reasons for using club drugs, (4) consequences of club drug use, and lastly (5) the presence of substance abuse and substance disorder, screened by the Drug Abuse Screening Test (DAST; Skinner 1982).

Results were analysed using Analysis of Variance and chi-square tests, and questions regarding the context and positive consequences of club drug use were analysed in terms of the most common answers given that created a "theme" (Parks & Kennedy, 2004, p.299). The participants indicated that they predominately used club drugs to experiment, to feel good or high, and to socialise (Parks & Kennedy, 2004).

Arguably there are few cultural differences between the UK and U.S., and therefore results could be generalised to the UK (Firestone, 1993). Although the use of questionnaires provided "descriptive" data as intended (Parks & Kennedy, 2004, p.295), it did not engage with the participants' lived experience, which arguably is required to establish an in-depth understanding of the phenomenon. Although, Parks and Kennedy

(2004) estimated the participants "problematic" club drug use by using the DAST, none of the participants self-rated their club drug use as problematic or offered their subjective understanding, and none of the participants were receiving or had previously engaged in treatment.

To date, no research has explored the reasons why "problematic" users use club drugs, research that is imperative as it is these users who are most likely to access treatment. As suggested, a qualitative methodology could be used to access users' subjective experiences. This could elucidate our understanding of users' psychological motivations to use club drugs, how users make sense of their problematic use, and how club drug use is experienced, including psychological effects. Such rich and detailed qualitative information could be useful in suggesting what types of psychological interventions may be helpful to facilitate club drug users' recovery, as well as enrich healthcare professionals' understanding of the difficulties experienced by users. Due to the paucity of literature in the field of club drug use as explained, three studies exploring the subjective experience of PSM based on illicit drug use and alcohol misuse were discussed in section 2.2.4 (p.28-29), and the potential biopsychosocial motives to use drugs are discussed in section 2.2.2 (p.23-27).

In terms of how club drug users self-identify, based on anecdotal evidence Bowden-Jones suggested that club drug users identify their use to be less problematic than alcohol, heroin and crack cocaine users (Royal College of Psychiatrists, 2014). It is suggested that this may be because club drug users, specifically mephedrone users, perceive mephedrone not to have undesirable effects in comparison to other drugs (Van Hout & Brennan, 2011). Furthermore, quantitative research suggested that ecstasy users perceive a lack of service provision in terms of treatment specifically for club drug users (Dew, Elifson & Sterk, 2006). This implies that club drug users perceive themselves to be different to traditional drug users in terms of their severity of use and treatment needs.

Further research is required to elucidate how club drug users make sense of their problematic use and self-identify, which could have implications for treatment. Monk and Heim (2011) proposed that a self-image bias operates among those who use drugs (Hill, Smith & Hoffman, 1988). This is based on social projection theory that suggests that people perceive certain others as similar in terms of beliefs, feelings and behaviours and that they project these onto others (Krueger, 1998, 2000). For example, users are likely to attribute the label "addiction" towards "heavy" users rather than those perceived as "light" users (Monk & Heim, 2011).

2.5.2. Focused critique of relevant research in mephedrone use. The rationale for choosing mephedrone for further exploration was explained (see section 1.2.2.1.1, p.16-17). Moreover, Parks and Kennedy (2004) suggested the study of a club drug such as mephedrone, rather than club drugs as a collective, as the "consequences [of use] differed by type of club drug used… [and therefore] future research should explore the reasons for club drug use by individual drug" (p.301).

Some quantitative studies have explored the psychological and physiological effects of mephedrone (Carhart-Harris, King & Nutt, 2011; Dargan, Albert & Wood, 2010; Freeman et al., 2012; Kapitány-Fövény et al., 2013; Winstock et al., 2011). Many of these studies were conducted in the UK, and suggested that mephedrone has empathogenic qualities similar to ecstasy. However, none of these studies used a qualitative methodology

to explore participants' lived experience of mephedrone use, which would provide a more detailed, subjective and idiographic account.

The only study to have used a qualitative methodology to explore experiences of mephedrone use was conducted in Ireland by Van Hout and Brennan (2011). They used thematic analysis to explore the experiences of mephedrone use for 22 adults (18-to-35-years-old) pre-legislation. Semi-structured interviews were conducted with participants who had used mephedrone within the past 6 months. Results included the following themes:

(1) *Mephedrone choices, experiences and outcomes* highlighted participants' initiation to mephedrone based on decision-making factors that included exposure, availability, curiosity, peer use, competitive pricing and lack of negative comedown in comparison to ecstasy and cocaine. Insufflation was described as the main route of administration.

(2) *Social situatedness of mephedrone use* suggested that mephedrone was central to certain sub-group atmospheres and music types such as techno/dance. User patterns were explained as sporadic to weekly, and there seemed to be a perceived "degree of self-control" associated with mephedrone that made it attractive (Van Hout & Brennan, 2011, p.376).

(3) *Perceptions of risk and legality* proposed that mephedrone was a safer alternative than illicit drugs, as participants observed the drug outcome to be reliable in terms of potency, quality and perceived purity. Since mephedrone was available in "headshops" (shops licenced to sell legal highs), it cost less and was easily available on the internet.

Nevertheless, Reid, Flowers & Larkin (2005) argued that thematic analysis provides a superficial and simply descriptive analysis which does not adequately represent the participants' lived experience. Moreover, although beyond the scope of this research, the study failed to explore the subjective reasons or motivations for participants' mephedrone use, an understanding of which could help suggest what psychological interventions may facilitate the treatment of users. Lastly, this study failed to explore the experience of "problematic" mephedrone use, which is imperative as it is these users who would most probably access treatment services.

To date, no research has explored the subjective experience of problematic club drug use, specifically mephedrone use. As explained earlier, such research in problematic mephedrone use would be imperative for elucidating the psychological motivations of users, the psychological experiences, how users make sense of their problematic use and how they may self-identify. Such information could be useful in facilitating their treatment.

2.6 Research Aim and Questions

Hence, considering this research gap this study aims to explore mephedrone users' experiences and sense-making of their problematic use by asking the following research questions:

1) How do participants describe their experiences of mephedrone use?
2) How do participants understand their motivations for their mephedrone use?

3) How do participants make sense of their problematic mephedrone use?

2.7 Counselling Psychology Relevance

This research focuses on exploring mephedrone users' subjective experiences and sense-making of their problematic use, beyond what is can be inferred from a diagnosis of PSM. This resonates with the principles of CoP that is concerned with respecting and valuing subjective experiences and appreciating individual differences "over and above notions of diagnoses" (BPS, 2005; Lane & Corrie, 2006, p.17; Strawbridge & Woolfe, 2010). This approach suggests that the meanings and sense-making of drug use as understood by the individuals whom we, as psychological practitioners, attempt to treat are more meaningful, helpful and informative than those meanings attributed by a medical construct (Orlans, 2013; Swanepoel, 2013). It is hoped that by adopting such a humanistic, exploratory approach that emphasises the idiosyncrasies and exclusivity of human experience, a more holistic understanding of club drug use could develop. Such an understanding could contribute towards the progression of psychological treatments and inform counselling psychologists on how best to treat club drug users.

Moreover, the BPS (2014) outlines the standards of competences for counselling psychologists which includes "developing knowledge and an understanding of equality of opportunity and diversities and how to work affirmatively to promote social inclusion in their clinical practice" (p.14). In line with this, this research hopes to achieve an understanding of club drug users who are a commonly stigmatised and marginalised proportion of society by members of the public and professional domain (Gourley*, 2004).* Furthermore, work towards "cultivating a deep respect for all users of therapy" despite their presenting issues, to facilitate and optimise their treatment (Cooper & McLeod, 2011, p.141).

This research also hopes to support counselling psychologists to work in the field of PSM. The BPS (2014) recommended that clinical as well as counselling psychologists in training should experience clients with specialist needs, such as those with SUDs, in order to develop imperative generalisable and transferrable skills and competencies. However, the Health and Care Professions Council (2012) advised that it was essential for only clinical psychologists to develop a standard working proficiency in the field of PSM. Perhaps this was because traditionally counselling psychologists were thought to work with mild mental health issues while clinical psychologist were thought to work with more serious mental health issues such as SUDs. Consequently, this research hopes to contribute towards the development of a standard working proficiency in the field of PSM that is essential for counselling as well as clinical psychologists.

Further studies suggested that most clinical as well as counselling psychologists have no formal training or placement experience enabling them to understand, assess, and treat individuals with SUDs (Aanavi, Taube, Ja & Duran, 1999; Chiert, Gold & Taylor, 1994; Cellucci & Vik, 2001; Corbin, Gottdiener, Sirikantrapom & Armstrong, 2013). Anecdotal evidence from Bowden-Jones also suggested a "training gap" among UK healthcare professionals with respect to their knowledge of the risks associated with problematic club drug use and how to treat such users (Wise, 2011, p.1; Hawkes, 2012). Hence, it appears that there is an imperative need for further training of UK based healthcare professionals, including counselling psychologists, in the

treatment of PSM, particularly problematic club drug use. To further the knowledge of psychologists treating PSM, Miller and Brown (1997) suggested that psychologists actively contribute towards the progression of treatment systems, policy and related research. Therefore, this research hopes to adopt a scientist practitioner stance that contributes towards remedying the lack of evidence-based knowledge when treating club drug users. This would better inform counselling psychologists to work with such users and so enhance therapeutic efficacy.

Lastly, since the CoP doctorate programs uniformly have the goal of training psychologists to engage ethically in clinical practice, those responsible for developing and maintaining such programs bear an ethical responsibility for ensuring students receive PSM treatment training at least at a foundation level (Harwood, Kowalski & Ameen, 2004). Aanavi, Taube, Ja and Duran (1999) suggested that graduate programmes in clinical as well as CoP integrate PSM treatment training into their core curricula. Moreover, CoP "values a search for understanding" (Rafalin, 2010, p.41), and aims to "understand ways to contribute to the development and leadership of the counselling psychology profession" (BPS, 2014, p.14). In line with these principles, this research hopes to contribute towards the growing importance and promotion of counselling psychologists' learning in the field of PSM, and so promote an "ethical way of working" with such a prevalent group of clients (BPS, 2014, p.10).

3. Methodology

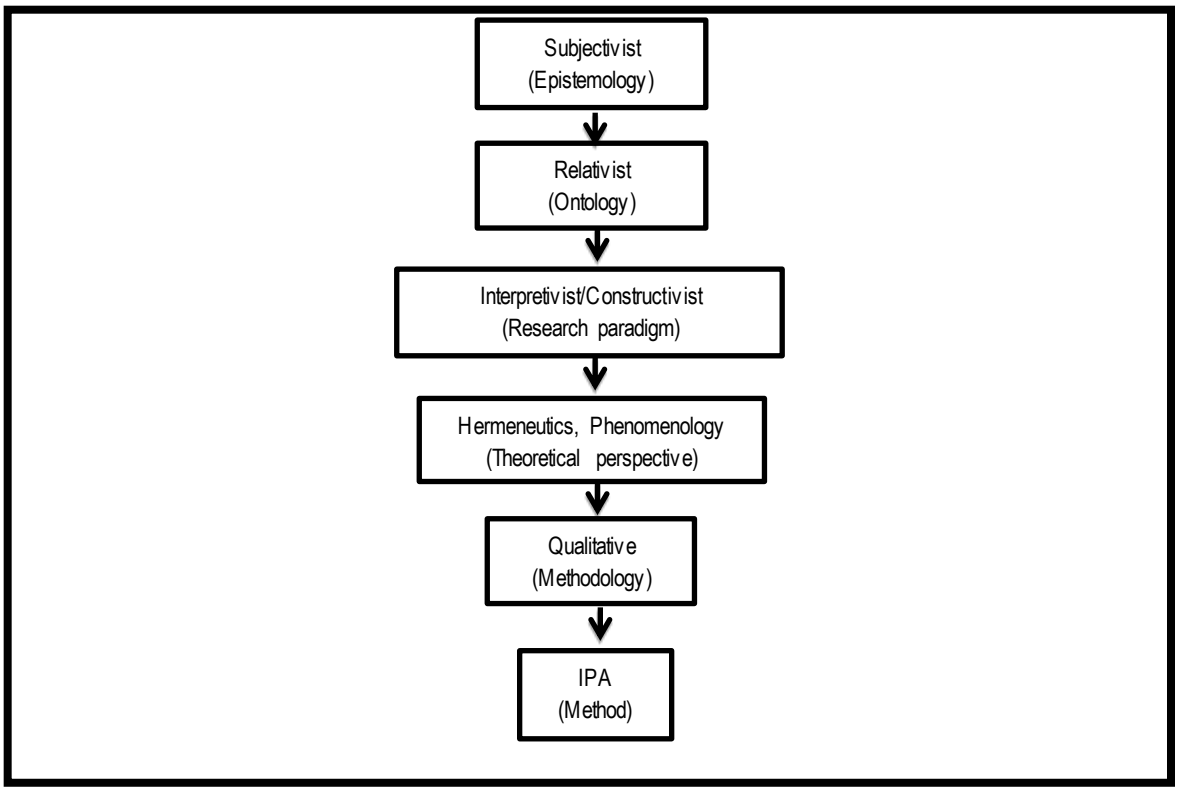
3.1 Overview

This section locates this study within the wider epistemological and methodological context. It outlines the procedures implemented to gather and analyse data, considers ethical issues and concludes with a methodological reflexive account.

3.2 Research Design and Rationale

The Figure below illustrates the philosophical underpinnings of the chosen methodology and method, the rationale of which will be discussed throughout.

Figure 2: An overview of the philosophical foundations underpinning this research study.



3.2.1 Research paradigm. Paradigms are characterised by their ontology (beliefs about how reality is constructed) and epistemology (a theory of knowledge; Guba, 1990). The research paradigm of this study is a constructivist approach, which stems from the philosophies of phenomenology and hermeneutics (Mertens, 2005). Husserl (1970, 1982) described phenomenology as the examination and understanding of an observable event in a particular context, whereas Heidegger (1927, 1962) explained hermeneutics as the theory of interpretation to uncover aspects of the experience in order to facilitate the understanding of the phenomenon under investigation.

The intention of constructivists is to understand the world by making sense of an individual's unique lived experience. Constructivists view the individual as an inclusive part of reality, a reality that is nuanced and

is socially and discursively constructed within a particular context. This thinking is aligned with a subjectivist epistemology, while an objectivist epistemology would suggest the existence of a universal reality that is stable and independent of the observer. Moreover, constructivists recognise that the observation of an individual's experience does not exist independently from the researcher's active interpretation, which is mediated by the researcher's preconceptions. This is unlike positivists, who believe that reality can be observed in a controlled manner without any mediation. However, in line with constructivists an attempt to suspend the researcher's preconceptions. They do so in order to sensitively get as close as possible to the participant's lived experience, although they acknowledge that a genuine first-person account is unachievable (Larkin, Watts & Clifton, 2006). Hence, constructivists acknowledge that all individuals create their own interpretations of reality, originating from a relativist ontology that argues that there are as many realities as there are participants, *and* including the researcher's. (Hansen, 2004; Morrow, 2007). Lastly, within the constructivist paradigm, research is inductive and patterns of meaning are established throughout the research process. By contrast, positivists begin with a theory in order to deduce generalised statements about a phenomenon (Creswell, 2003).

3.2.2 Research aim and questions. This study aims to explore mephedrone users' experiences and sense-making of their problematic use by asking the following research questions:

1) How do participants describe their experiences of mephedrone use?
2) How do participants understand their motivations for their mephedrone use?
3) How do participants make sense of their problematic mephedrone use?

With consideration to the constructivist paradigm, the first question is descriptive, in line with a phenomenological approach that frames the accounts of the participants' lifeworld. The second and third questions develop the hermeneutic avenue as participants reflect on their own accounts in their attempts to make sense of their experiences of mephedrone use (Smith, 2008).

3.2.3 Rationale for a qualitative methodology. Quantitative research aims to develop an objective, quantifiable and macro-level understanding of reality uncontaminated by subjective mental processes (Willig, 2001). However, when research is concerned with the micro-level understanding of subjective phenomenon, such as exploring mephedrone users' experiences and sense-making of their problematic use, a qualitative approach is well suited. Qualitative methods are particularly appropriate for the exploration of phenomena that are complex, subtle or difficult to explore through quantitative methods (Burman, 1994). The focus of this qualitative research tends to be on the "quality and texture of experience" rather than "cause-effect relationships" and enquiry typically involves the study of people in their natural environment (Willig, 2001; p.9).

Moreover, qualitative research aligns itself with the constructivist research paradigm. It does so by aiming to understand unique versions of reality held by individuals, how these versions of reality are shaped by their cognitions and experiences, and the limitations and opportunities of the physical, socio historical and linguistic background and context (Yardley, 2000). While this approach applies to the beliefs and perceptions of the participants in the study, it also considers the views of reality held by the researcher. Hence, unlike

quantitative researchers who adopt impartiality and objectivity when observing a phenomenon, researchers recognise that they themselves are inseparable from the world that is being researched and therefore are impacting on the analytic process (Finlay, 2006).

Overall, qualitative research's emphasis on language and thought processes makes it an intrinsically psychological approach to scientific inquiry (Smith, 2008). Hence, Smith's (2008) description of an "explosion of interest in qualitative psychology" (p.1) depicts the welcoming of qualitative research by social sciences and mainstream psychology, particularly when researching substance misuse (Rhodes & Moore 2001; Nichter, Quintero & Nichter, 2004). Neale, Allen and Coombes (2005) suggested that qualitative methods "proved very valuable in demystifying drug and alcohol use and replacing stereotypes and myths about addiction with more accurate information that reflects the daily reality of substance users' lives" (p.1586–87). This further supports the appropriateness of this methodology for this study.

Qualitative research has also received greater popularity and acceptability from CoP, which shares a common value base (McLeod, 2003). Qualitative research seeks to elucidate subjective attitudes, perceptions and experiences through textual analysis characterised by the exploration of rich and detailed accounts (Geertz, 1973). This accords with the description of a CoP value set as one that "favours the person and the subjective alongside scientific values" (p.14) and "privileges respect for the personal, subjective experience of the client" (Lane & Corrie, 2006, p.17).

In respect of the factors outlined, a qualitative approach was deemed particularly appropriate to explore this study's research questions. According to Smith, Flowers and Osborn (1997), this advantageously maintains flexibility and open-endedness. It also prioritises the individuality and uniqueness of the participant experience in order to determine the extent to which a portion of the population experiences particular issues and to compare these findings against established norms. This hypothesis-generating approach has the potential to provide crucial evidence that could inform the understanding of problematic mephedrone use.

3.2.4 Rationale for interpretative phenomenological analysis. IPA is informed by phenomenology, hermeneutics and ideography (Smith, Flowers & Larkin, 2009). These areas of philosophical knowledge will be explained below, while evaluating the suitability of IPA in comparison to other qualitative methods in ascertaining this study's aim.

3.2.4.1 Interpretative phenomenological analysis.

3.2.4.1.1 Phenomenology. Although phenomenology suggests that an individual perceives and experiences reality differently depending on their orientation (a relativist ontology), it strives to understand the universal "essence" of a subjective phenomenon (a core understanding of an experience that is thought to be experienced the same by everyone) and the "intentionality" of human experience (the unconscious connection of an individual to their world; Husserl, 1970, 1982).

IPA adopts the principles of "phenomenological inquiry" by aiming to understand the lifeworld of individuals within a specific context by exploring their self-reflections (Smith, Flowers & Osborn, 1997). This is

thought to be achieved via the process of "bracketing" (the suspension of one's own beliefs about the world in order to be open to the beliefs of others; Husserl, 1970; van Manen, 1990). Bracketing develops a descriptive account, unobstructed by the researcher's preconceptions, that produces an "insider's perspective" of the participant's lived experience (Smith, 1996, p.264).

3.2.4.1.2 Hermeneutics. Phenomenology evolved into hermeneutics, which aims to offer an interpretation of the participant's descriptive account. Heidegger's concept of Dasein or "being-in-the-world" emphasises humans' immersion in their surrounding world, and also that our interpretations of phenomena are shaped, limited and enabled by language and culture (Finlay, 2011; Heidegger, 1927, 1962). Additionally, individuals' sense-making occurs in and as a result of varied relationships and social interactions with others (symbolic interactionism). This thinking aligns itself with a subjectivist epistemology (knowledge cannot exist without individuals to construct it in their unique way) and a relativist ontology (there are many versions of reality).

IPA adopts a "double hermeneutic", where the researcher makes sense of the participant making sense of their own experience (Smith, Flowers & Larkin, 2009). "Hermeneutic thinking" suggests that the history of the researcher is as much a part of the interpretation as is the history of the creator of the text. As a result, the researcher cannot completely bracket off their presuppositions to reveal the "essence" of an experience, as phenomenology suggests (Heidegger, 1927, 1962; van Manen, 1990). However, the researcher prioritises the interpretation of the lived experience from the participant's perspective via reflexive practices (see section 1.5, p.19-21; section 3.5, p.53-54; section 5.8, p.90-91), which attempts to bracket off the researcher's biases as much as possible in order to get as "close to the participant's view as is possible" (Larkin, Watts & Clifton, 2006, p.104).

3.2.4.1.3 Idiography. Idiography (the study of the particular) is concerned with the study of an individual's account of a specific phenomenon within specific contexts as unique and nuanced, with the aim of accessing the participant's lifeworld and meaning-making (Smith, 2008). This corresponds to the philosophical perspective of CoP, which states that counselling psychologists have a commitment to engage with subjectivity and to strive "to respect first person accounts as valid in their own terms" (BPS, 2005, p.1). IPA's analytic process appreciates there are many unique versions of reality (a relativist ontology) by maintaining a level of focus on what is distinct in individual cases, while also attempting to understand shared commonalities across a group of participants in order to produce a detailed account of patterns of meaning for participants reflecting on a shared experience (Reid, Flowers & Larkin, 2005). The findings of such studies can shed light on the extant of existing nomothetic psychological research.

3.2.4.2 The relevance of interpretative phenomenological analysis to this current study.

IPA was considered, since the ontological and epistemological foundations of this research make it appropriate that the theoretical perspectives underpinning the methodology should emanate from hermeneutics and

phenomenology (Krauss, 2005; for a diagrammatical understanding of the research paradigm, see Figure 2, p.40). Such theoretical underpinnings agree with the philosophy of CoP and the constructionist paradigm, as they aim to describe and explain participants' unique subjective experiences of a particular phenomenon. Secondly, IPA bears intrinsic relevance to psychology at large and is deemed a "specifically psychological approach" (Willig, 2001; p.69). Smith and Osborn (2008) highlighted how the theoretical commitment of IPA to meaning-making implies a concern with cognitions and mental processes as a central feature of the analytic process, and hence mark a point of convergence with cognitive psychology. Thirdly, the idiographic and context-specific focus of IPA was regarded as a useful framework in which the current topic could meaningfully be explored. According to Smith and Osborn (2008), the use of IPA is "particularly suitable where the topic under investigation is novel or under-researched, where the issues are complex or ambiguous and where one is concerned to understand something about process and change" (p.211). This corresponds with the current research focus on a previously unexplored dimension of problematic mephedrone use. Lastly, Shinebourne and Smith (2009) suggested that IPA provides a qualitative understanding and a subjective knowledge that are infrequently accessed in psychological accounts of addictive behaviour. Hence, IPA is the most suitable method for this study's aim.

3.2.4.3 Interpretative phenomenological analysis versus discourse analysis. Smith, Jarman and Osborn (1999) make the comparison between IPA and discourse analysis (DA; Potter & Wetherell, 1987). They state that both methods share a commitment to the prioritisation of language, but that DA is more focused on the performative tasks of language, and that it recognises pre-existing discourses that are drawn on by speakers. DA regards language as behaviours in their own right warranting functional analysis, while IPA does not view language as the sole constructor of reality. Rather than exploring the role of language in specific contexts as in DA, IPA engages with the individual's beliefs, thoughts and lived experiences. Hence, IPA is more aligned with exploring this study's research aim to understand mephedrone users' experiences and sense-making of their problematic use.

3.2.4.4 Interpretative phenomenological analysis versus grounded theory. Grounded theory (GT) and IPA share an inductivist approach; GT often requires large scale sampling that works towards a conceptual explanatory level analysis of individual accounts. The result is a theoretical-level account of a phenomenon associated with social processes, which would not fulfil this study's aim of exploring mephedrone users' experiences and sense-making of their problematic use. IPA is more likely to offer a more detailed analysis of the lived experience of a small number of participants with a focus on the convergence and divergence between participants, thus providing subjective knowledge more relevant to this study's aim (Smith, Flowers & Larkin, 2009).

3.3 Procedures

This section explores the procedures implemented to gather and analyse data.

3.3.1 Materials. The materials used in the research were as follows:

- Participant Information Sheet (Appendix J, p.119-122)
- Informed Consent Form (Appendix K, p.123-124)
- Demographic Questionnaire (Appendix L, p.125)
- Interview Schedule (Appendix M, p.126-128)
- Debriefing Form (Appendix N, p.129-130)
- Plan of Action (Appendix O, p.131)
- Ethical-decision Making Tool (Appendix P, p.132)
- Distress Protocol (Appendix Q, p.133-134)
- Digital recorder

3.3.2 Sample selection.

3.3.2.1 Participants. Purposive sampling was used that aligns itself with the aim of an IPA study to recruit a homogenous sample for which the research question is significant, and therefore gives insight into idiosyncratic experiences (Smith & Eatough, 2006). Six participants were recruited, as Smith and Osborn (2008) recommended this as a reasonable sample size for doctoral IPA research (for the demographics of participants, see Table 1, p.48). It allows sufficient in-depth engagement with each individual case, as well as detailed examination of the similarities and differences of the shared experience among participants. Demographic information was collected prior to interviewing each participant in order to situate the sample and enable assessment of the relevance of results (Elliott, Fischer & Rennie, 1999).

3.3.2.2 Inclusion and exclusion criteria. Although IPA's epistemological stance proposes that results cannot be generalised to the wider population, maximal homogeneity ensures the findings' utility in providing useful insights for similar groups and contexts to the one under investigation (Johnson, 1997; Yardley, 2008). Therefore, the homogeneity of the sample was emphasised, while not restricting inclusion and exclusion criteria in order to maximise recruitment.

A summary of the main inclusion and exclusion criteria are given, together with a detailed, extensive list in Appendix G (p.115). Participants were excluded if they did not self-rate their mephedrone use as problematic, since the aim of this study was to explore subjective problematic mephedrone use. Participants were recruited who used mephedrone, as this is the club drug under investigation. Participants who had a serious co-morbid mental health condition were not recruited (Appendix G, p. 115), in order to minimise potential interference with their recovery and because participants may not have been competent enough to give informed valid consent.

With respect to age, gender and sexual orientation, there were no restrictions, since these factors were not under investigation. Moreover, since this study did not focus on participants' experiences of mephedrone use within a specific time-frame, there were no restrictions concerning the length of time between when the participants last used mephedrone and when they spoke about their experience. Kahneman (2010) explained

that a participant's experience of a particular phenomenon does not become less valid according to the longer ago it happened. Kahneman (2010) distinguished between, on one hand, the "experiencing-self" as fast, intuitive and an unconscious mode of thinking that operates in the present moment; and, on the other, the "remembering-self" as slow, rational and a conscious mode of thinking that tells the story of our experience. While it is suggested that each moment of the experiencing-self lasts approximately three seconds, what gets remembered by the remembering-self are significant moments in the story (Kahneman, 2010). If a participant recalls an experience from a month ago or six years ago, their self-reflections may alter through time, because individuals' attitudes and perceptions are fluid. However, their accounts remain as valid as each other since there is no right or wrong experience.

3.3.3 Interview schedule. A semi-structured interview schedule was developed as a result of the gaps identified by the literature review. This was done by receiving feedback of four drafts from the academic supervisor and from an IPA regional research group meeting; and by piloting the interview with friends from a background related to neither psychology nor research.

Three main research questions informed nine main interview questions which aimed to explore the experience of mephedrone, the motivations for using mephedrone, and how the participants made sense of their problematic use (see Table 2, p.49). Open-ended main questions allowed the participant to set their own parameters for discussion, and gave a descriptive response that allowed the participant to feel comfortable when talking (Smith, Flowers & Larkin, 2009). Prompts allowed the researcher to probe for expansion into areas in a flexible manner and in an order most suited to the interviewee (Legard, Keegan & Ward, 2003). Using the "funnelling technique", questions *began more general and became progressively specific*; moved progressively from the general to the specific; hence the word "problematic" does not appear until late in the interview schedule. This facilitated rapport and eased the participants into the interview (Smith, Flowers & Larkin, 2009). The tenth question is not considered a main question but acknowledges the closing of the interview, while giving participants the opportunity to share their final thoughts.

3.3.4 Data collection.

3.3.4.1 Recruitment process. Participants were recruited from a primary care service for substance misuse from the National Health Service (NHS) located in North London, and recruitment took place from 26th October 2015 to 25th May 2016.

The Service Manager reviewed the service database to locate participants who met the inclusion and exclusion criteria. The Manager made initial contact with the potential participant via telephone or face-to-face conversation in order to deduce their interest in participating, and also provided the participant with an information sheet via email or in person. If the participant conveyed interest in participating in the study, their contact details were shared with the researcher, with the participant's consent. The researcher then telephoned the participant, and the following areas were discussed: their interest in participating; the purpose of the study;

a further review of the exclusion and inclusion criteria, including screening for serious mental health issues; and any questions the participants had were answered. Subsequently, a consent form was emailed to the participant.

Table 1:

Demographics of participants

Pseudonym	Age	Sexual orientation	Level of education	Employment status	Housing situation	When mephedrone use began	Other drugs used in combination with mephedrone	When mephedrone was last used prior to the date of interview
Robert	40	Heterosexual	Level HND	Volunteering	Renting	2015	None	3-4 months
Daniel	30	Bisexual	GCSE	Part-time	Lives with parents	2011	Cocaine, GHB	2 weeks
Greg	35	Homosexual	University degree	Full-time	Renting	2013	GHB, Marijuana, MDMA, Cocaine, Ecstasy	2 months
Josh	24	Homosexual	University degree	Part-time	Lives with parents	2013	Crystal meth, GHB, MDMA, Ketamine, Cocaine, Alcohol	One month
Alexander	27	Bisexual	University degree	Full-time	Renting	2015	GHB, Crystal meth, Marijuana	One month
John	52	Homosexual	A Level	Self-employed	Renting	2010	Crystal meth, GHB, Cocaine, Marijuana, MDMA	2 months

The researcher then telephoned the participant after two days to receive their final decision to participate.

If the participant chose to participate, a face-to-face research discussion was scheduled with the researcher. Prior to commencing the research interview, the researcher reviewed the information sheet, the consent form and the plan of action with the participant, and again answered any questions the participant may have had. Two signed copies of informed consent per participant were acquired in person: one copy for the participant and the other for the researcher's records.

Table 2:

Interview questions in relation to research questions

Research Question	**Interview Question (number indicative of the position in the interview schedule)**
How do participants describe their *experiences* of mephedrone use?	(2) Can you tell me about your initial experiences of using mephedrone? (4) Can you describe how you felt about yourself at this time in the wider society? (6) Can you describe your experiences of problematic mephedrone use? (8) Can you describe how you felt about yourself when your drug use was problematic?
How do participants *make sense* of their problematic mephedrone use?	(5) Can you tell me how you noticed your mephedrone use had become problematic? (6) Can you describe your experiences of problematic mephedrone use? (9) Can you tell me how you decided you wanted to seek help for your problematic drug use?
How do participants understand their *motivations or reasons* for their problematic mephedrone use?	(1) Can you tell me about how your mephedrone use began? (3) Can you tell me what role mephedrone had in your life during your initial stages of use? (7) Can you tell me what role mephedrone had in your life when your use was problematic?

3.3.4.2 Interview process. Interviews lasted between 40 minutes and 1 hour 35 minutes, averaging 57 minutes, and were audio recorded using a digital recorder. Prior to interviewing, the participant was socialised to the interview process by collaboratively reviewing the information sheet. That included making them aware of the time it may take, that it would be more like a "conversation with a purpose" than an interview, and that the researcher was interested in their experiences rather than there being any right or wrong responses (Smith, Flowers & Larkin, 2009, p.57).

The aim of the interview was to access the participant's lifeworld. In accordance with the principles of IPA, the schedule was used flexibly. That enabled a "dual focus" where the interview was participant-led, since the participant is perceived as the experiential expert, while being guided by the researcher. The researcher listened and asked follow-up questions such as: "Can you tell me more about this?" The researcher asked further open-ended questions if relevant topics arose that were not on the interview schedule in order to better understand the participant's feelings, opinions and beliefs (Legard, Keegan & Ward, 2003).

On the completion of the interview, the participant was verbally debriefed and given a debriefing form. The researcher kept a reflective diary of the interview process and noted non-verbal information that informed the analytic process (Smith, Flowers & Larkin, 2009).

3.3.5 Analysis.

3.3.5.1 Transcription. The interviews were transcribed verbatim with the semantic record of every word uttered. O'Connell and Kowal (1995) suggested that it is unnecessary to transcribe prosodic information – pauses and non-verbal utterances – which will not be analysed, as it is the *content* of the participant's account that is favoured in IPA. Therefore, only relevant non-verbal utterances were recorded via bracketed text, e.g. (laughter) (Smith, Flowers & Larkin, 2009). Each turn of phrase was numbered for ease of reference, and the margins were widened for ease of coding (see Appendix R, p.135-136).

3.3.5.2 Analytic process. Smith, Flower and Larkin's (2009) recommendations for analysing data was adopted. To immerse oneself in the participant's lifeworld, the transcript was read and the interview recording listened to several times. A core phenomenological approach was taken, with the left-hand margin used for free textual analysis. This involved descriptive comments on the content of what the participant said, linguistic comments on the participant's use of specific language, and conceptual comments that formed a more interrogative and theoretical approach to the data (see Appendix R, p.135-136). A hermeneutic approach followed, with the right-hand margin used to mark emerging themes. This involved forming connections between the initial notes in order to produce statements that were grounded in the participants' account.

The emergent themes were then written on pieces of paper, and possible connections between them inferred which resulted in a more theoretical ordering. Themes were clustered using mainly the strategies of abstraction (grouping themes with a similar meaning), subsumption (the emergent theme itself becoming a master theme), polarisation (examining oppositional relationships), and numeration (looking at the frequency at which a theme emergences; Smith, Flowers & Larkin, 2009). Some emergent themes were omitted if they did not "fit well in the emerging structure nor are rich in evidence within the transcript" (Smith & Osborn, 2008, p.72). A table of superordinate themes was constructed for each participant. Subsequent participants were systematically analysed in the same manner, while bracketing out findings of previous participants as much as possible.

Each superordinate theme table was then analysed together in order to identify patterns across participants. Higher order superordinate themes were reconfigured and relabelled in order to produce a final Master table of themes (see Table 3, p.55; Appendix S, p.137-144).

3.4 Ethical Consideration and Validity

This section describes the ethical issues and the validity of the study.

3.4.1 Ethical consideration. Ethical approval was achieved from Research Ethics Committees at London Metropolitan University (see Appendix H, p.116) and Derby NHS (see Appendix I, p.117-118).

A mobile telephone number and e-address solely for this research were displayed on materials in order to maintain the professional boundaries between participant and researcher. In accordance with the principle of respect for the autonomy and dignity of persons as described in the Code of Ethics and Conduct (BPS, 2009), the information sheet included sufficient details regarding the exclusion and inclusion criteria which enabled participants to make an informed decision as to whether it was appropriate for them to participate.

Prior to interview, participants were provided with a range of information, starting with an explanation of the purpose of the study. They were informed that they were under no obligation to participate and that not participating would not affect their treatment; that breaks could be taken whenever necessary during the interview; that they could refuse to answer any questions; and that they could withdraw from the study up to 6 weeks after interview or until data analysis had begun (whichever length of time was the greater), at which point their data would be destroyed. Participants were also informed that they would be unable to participate while under the influence of any intoxicants, on the grounds that this may have affected the validity of the consent given and the reliability of the results, as participants would be deemed incompetent and might not be able to give coherent responses (Walker, 2008). Participants were not able to participate if they were diagnosed with a serious mental health problem, as this could potentially interfere with their recovery. As well as the Manager of the service screening for serious mental health problems, further screening was conducted by the researcher during initial telephone contact, when questions were asked such as: “Have you ever been diagnosed with a serious mental health disorder or otherwise? If yes, what was this?” and “Are you currently experiencing symptoms associated with this mental health condition? What are these?”

Permission was requested for the interview to be audio-recorded, and for selected anonymised verbatim comments to be used for illustrative purposes. Participants were assured that all data would remain anonymous, as personal identifying information would be removed from transcripts, recordings and throughout the study write-up. Under NHS ethical guidelines, audio recordings of the interview were stored in a safety deposit box located in a locked filing cabinet within the service, and audio recordings located on the researcher's laptop that were password protected. Participants were informed that data would be kept for a maximum of five years, in case of publication, after which it would be erased. Participants were informed that the confidentiality of participants would be breached if information was disclosed that indicated an imminent risk of harm to

someone else or themselves (BPS, 2010; Daley, 2009). Also, participants were shown and explained the plan of action (see Appendix O, p.131), namely a flow diagram corresponding to the course of action taken to inform the appropriate authorities if any information causing a breach of confidentiality was disclosed (Walker, 2008). This included: the possession of illegal drugs; the supply of illegal drugs; and information about activities such as theft or prostitution that may be used to fund their SM (Walker, 2008). Prior to contacting the authorities, each case would be evaluated on its own merits, with the first supervisor using an adapted version of Robert and Dyer's (2004) ethical decision-making tool (see Appendix P, p.132). In general, confidentiality was not broken when discussing the illicit use of drugs, as participants were recruited to discuss this topic and were seeking treatment for their PSM where the disclosure of their illicit drug use ought to be respected (Roberts, 2008).

For the participants' wellbeing, their Keyworker was informed of their participation in the study, although no data was shared with their Keyworker, who in any case was not present at the interview. A distress protocol (Cocking, 2008; see Appendix Q, p.133-134) was also implemented in case a participant became distressed during the interview. Interviews were conducted at the treatment service, which is a safe, clinical environment for this vulnerable client group. At the end of the interview, participants were given a written debriefing form (Appendix N, p.129-130), which included contact details of helplines should the participant require further support, together with information about how to make a complaint if the participant felt the interview was conducted inappropriately.

3.4.2 Validity. In line with a pluralistic and rigorous stance, Smith, Flowers and Larkin (2009) suggested Yardley's (2000) four principles for assessing the quality of qualitative research, which are discussed with relevance to this study.

3.4.2.1 Sensitivity to context. To maintain sensitivity to this study's theoretical context, research questions originated from identifying gaps in the literature review (Yardley, 2000; for focused critique of literature, see section 2.5, p.35-37). IPA was chosen since it drew upon subjective knowledge, which is infrequently accessed when researching the field of addictions (Shinebourne & Smith, 2009). Interviews were conducted sensitively, respecting each participant and trying to facilitate rapport so that participants felt comfortable. This reflects the subjectivity and intersubjectivity values of CoP (BPS, 2005). Similarly, sensitivity was given during the write-up of the research by carefully using relevant verbatim extracts and through offering "interpretations as possible readings grounded in the data" (Shinebourne, 2011, p.27)

3.4.2.2 Commitment and rigour. Commitment was demonstrated by the researcher's continuous engagement with the study through the difficult process of recruiting participants, attention to the participants during the interview process and personal dedication to the topic. In terms of rigour, participants were carefully selected to be a homogenous sample that would adequately address the research questions. Also, great effort was taken to sustain the quality of the interview, as numerous drafts of the interview schedule

were produced. Analysis of each case involved "prolonged contemplative and empathic exploration" that addressed the complexity and variation within each account (Yardley, 2000, p.222). Moreover, a theoretical audit ensured that themes were well matched and grounded in verbatim extracts, giving participants a voice (for superordinate theme with participant quotes, see Table 8, Appendix S, p.137-144).

3.4.2.3 Transparency and coherence. An "audit trail" offering documentation pertaining to all analytic stages of research was retained in order to allow the reader to verify and scrutinise the researcher's decision-making and theme-generating process (Lincoln & Guba, 1985). The consistency between the research paradigm and chosen method is explored (for discussion of the research design, see section 3.2, p.40-44). Personal reflexivity has been engaged in and commented upon throughout the research process (see section 1.5, p.19-21; section 3.5, p.53-54, section, p.5.8, p.90-91), highlighting how the researcher's assumptions, engagement with the participant, experiences of the research process and so forth could potentially impact upon the research.

3.4.2.4. Impact and importance. The importance of this research is commented on during the conclusion of the review of relevant literature (see section 2, p.22-39) and CoP relevance section (see section 2.7, p.38-39), and its impact is deduced in the discussion and implications of findings (see section 5, p.75-90) further illustrating the validity of this study.

3.5 Methodological Reflexivity

This section gives a reflexive account concerning the implementation of the chosen method.

3.5.1 Reflexive statement: Part two. I will attempt to outline the potential impact I had as a researcher on the development of the interview schedule and analysis, further facilitating the study's rigour (Willig, 2001). One of my initial assumptions was that the experience of problematic mephedrone use differed from problematic traditional drug use, in that traditional drug use is more debilitating.

Through reflexivity I realised that I was imposing this presupposition on the initial drafts of the interview schedule. My initial interview questions were structured and leading, perhaps aiming to ensure that participants would express a difference in their experiences of problematic use. Re-drafting the interview schedule became an iterative process, as questions were reformulated following feedback received from supervision and the IPA regional research group in order to avoid "blocking the participants voice" (Finlay, 2002, p.41). When constructing the interview schedule, I also sensitively considered my use of language. I avoided using stigmatising language such as "addiction" (for an understanding of the stigmatising implications of the term addiction, see section 2.2.3, p.27-28) and, in turn, used the term "problematic use". I hoped that this would allow participants to freely discuss their subjective experience without the influence of associated stereotypes. Therefore, the interview schedule was constructed to prioritise participants' experiences.

I read my reflexive journal prior to interviewing in order to enhance my ability to bracket my assumptions. I attempted to interview as a naïve researcher respecting each participant's unique experiences, thus upholding my profession's values (Orlans & van Scoyoc, 2008). While conducting interviews, I understood well the principle of the interview schedule being a guide rather than each question needing to be followed in sequence. I learned to become flexible with my questioning and, in turn, left the "research world and came around the hermeneutic circle to the participant's world" (Smith, Flowers & Larkin, 2009 p.64).

I found analysis a time-consuming though interesting experience while I explored participants' life stories. I was aware that due to my personal experience of substance misuse, a third layer of interpretation would be added to the two-stage hermeneutic process that takes place in IPA (Smith, 2008). In this way, not only would the participants be making sense of their experiences, but I would be interpreting their experiences from my standpoint as both counselling psychologist and researcher and as someone with a personal experience of substance misuse. I monitored this by employing reflective practice (see section 1.5, p.19-21) to ensure I remained as close as possible to the participants' lifeworld.

Following several attempts at analysis, my themes moved from being descriptive in nature to more interpretative. I struggled to form adequate master theme titles that I felt encapsulated the experience of the participant and "knowing what does make a piece of work good enough" (Smith, Flowers & Larkin, p.184). I managed my anxieties by consulting my supervisor, and believe that because of such struggles, I developed as a reflexive researcher.

4. Results

4.1 Overview

Table three conveys the final three superordinate and nine subordinate themes, which are translated into a narrative account and dispersed with verbatim extracts. The themes are presented in a sequence which is intended to convey the progression from reasons for using mephedrone to the experiences of using mephedrone and finally to the sense-making and realisation of problematic mephedrone use. All six participants' accounts both converge and diverge so as to contribute to all subordinate themes, which are evidenced with at least three participants to promote "sufficient sampling" (Smith, 2010, p.17). Table 8 (see Appendix S, p.137-144) includes quotations partially referenced, or not referenced, in the results section due to limited word-count.

Table 3:

Final superordinate and subordinate themes

Superordinate Theme	Subordinate Theme
1) **Mephedrone as a credulous fix for ongoing identity vulnerability and distress, initiating a vicious cycle of deliberate use**	1a) A way of connecting that creates a false sense of belonging 1b) The externalisation of "deep psychological damage" allows for short-lived appeasement 1c) An attempt to create an empowered, idealised false-self through calculated mephedrone use
2) **The paradoxical experiences of progressive mephedrone use**	2a) "Love at first sight" versus a devilish mistake 2b) Naive control versus a sense of being out of control 2c) A desirable need versus a "pointless" activity
3) **Making sense of one's problematic mephedrone use via self-reflective processes**	3a) Stigmatising beliefs assist in the self-identification of problematic mephedrone use 3b) A critical incident that triggers the self-evaluation of one's mephedrone use as subjectively problematic 3c) An internal debate between desires versus values and beliefs that motivates change

4.2 Exploration of Themes

4.2.1 Superordinate theme 1: Mephedrone as a credulous fix for ongoing identity vulnerability and distress, initiating a vicious cycle of deliberate use. This superordinate theme includes three subordinate themes that explore the motivations of participants to use mephedrone, which perpetuated a vicious cycle of use.

4.2.1.1 Subordinate theme 1a: A way of connecting that creates a false sense of belonging. Daniel explained that his parents divorced when he was an adolescent and that during his twenties he divorced his wife after the birth of their son. He felt an unreciprocated care towards his friends, and three months prior to using mephedrone he *"got left redundant…and erm, ended up partying a lot more"* (p.5, L48). Due to these experiences, Daniel may have felt excluded or rejected from mainstream society and this resulted in feelings of loneliness, low-self-esteem, and identity confusion. This may have caused his vulnerability towards using mephedrone as a way of fulfilling unmet attachment needs and of renegotiating his identity by connecting to a new drug subculture. Daniel explained:

"I felt like a kid again, I felt like being back in school. I was around a lot of people, we was all around the same age, a bit younger. We were like a big crew, was like a big family and erm (…) nobody could tell us nothing, and we were just having the best, we were having the best amount of times. Erm people was like taking pictures, it was just like, people, everyone, like, became, everyone was defending each other. Like people would buy each other drinks, and just like, as much as it sounds trivial now it's really really really (..) a life that would love as a kid. Like whoever's in school now, if you got friends like the friends that I had back then, that was so supportive of you, made you feel like you's a part of something, and you was erm, you was, you was wanted, and that's how they made you feel and that is that, that's exactly the thing I holded onto." (p.11, L76)

Daniel described himself as a *"kid"* among his peers who formed a *"big crew"*, which suggested feelings of invisibility, support and trust, e.g. *"defending each other"*, fun, e.g. *"having the best amount of times"*, belonging, e.g. being *"part of something"*, and acceptance, e.g. feeling *"wanted"* by others. A sense of naivety was also created as Daniel described himself as a *"kid"* who believed that via the connection with mephedrone and subsequently others that used it, he would have a long-term resolution to his feelings of social exclusion from mainstream society. Daniel proposed that in the mephedrone-using community he got his *"feelings and…your worries answered, so [laughs] you are gonna gravitate towards people like that, that are actually listening to you"* (p.12, L78), which mirrored the qualities of a quasi-support group or surrogate *"family"* (p.11, L76). Feelings of importance, care, acceptance and belonging are suggested, which appeared to have harnessed a positive sense of self, and replaced the painful *"void"* (p.12, L78) of loneliness with a sense of inclusion and secure attachments. To *"hold onto"* (p.11, L76) the gravitational allure of such positive feelings and therefore his membership of the mephedrone-using community that contained his fragile sense of self, Daniel continued using mephedrone, and this subsequently formed part of his new, adopted identity.

Josh's family rejected him when he disclosed his sexual identity as being *"gay"* (p.8, L64). Consequently, Josh used mephedrone to facilitate chemsex, which promoted feelings of belonging and the acceptance of his sexual identity. Josh explained:

"…I remember the fire burning rush that comes up the body, through the heart it spreaded out instantly. It made me addictive to want him, erm want everything. I became, it it's everything people said that was gonna happen.

My inhibitions my went down, my I mean my inhibitions were already low (laughs), as so at that age, but erm (..) yeh I yeh as soon as I took mine he took his (..) it was, we just went off on one, we couldn't stop. I didn't want to stop. I felt loved really and I think that was, I knew that back then and I knew that now, and that was my problem, erm…" (p.2, L18)

Josh described how mephedrone *"spreaded out"* around his body, which created an image of warmth and embrace. This highlighted Josh's connection with the drug itself, which appeared to create a sense of containment of Josh's fragile sense of self (for the changing connection or relationship participants shared with mephedrone, see section 4.2.2.2 p.64-65). This theme of intimacy and containment was continued by the heightened sexual arousal between Josh and *"him"*, *"him"* being a stranger at a sex party, which proved uncontrollable as Josh was *"addictive to want him",* thus illustrating the potent effects of mephedrone. Josh's *"inhibitions"* were lowered and he was enabled to express his true sexual identity. Consequently, Josh felt *"acceptance love"* (p.10, L72), which harnessed a positive sense of self as his sexual identity was accepted by others and which in turn produced feelings of belonging that replaced his feelings of loneliness and rejection. Josh explained:

"…It made me feel like I had a circle of friendship. Even though I had friends before the drugs, I felt accepted, I think that's, that's what I had to admit to myself. I didn't really accept myself as being gay, and it didn't help my family, they didn't support me…" (p.8, L64)

However, Josh later recognised that this feeling of love was not authentic but *"false love"* (p.10, L72), a term that depicted the false nature of his intimate relationships during chemsex as they were manufactured by the effects of mephedrone. Nevertheless, Josh continued to use mephedrone as it temporarily and superficially masked his painful reality of loneliness and rejection with a false sense of belonging that allowed him to freely unveil and explore his true sexual identity.

This false sense of belonging, acceptance and mutual support initially created by participating in the mephedrone-using community was short-lived for both Daniel and Josh. It was replaced by a lack of care and distrust as their connection or relationship with mephedrone became problematic and was prioritised over their relationships with other mephedrone users. Daniel explained that *"all drug users…they're not really friends"* (p.21, L118), and Josh reiterated that *"…people don't really care of other people's feelings. They only want what they want…"* (p.28, L162). These realisations were triggered by witnessing others participating in deceitful actions to selfishly obtain mephedrone, or by taking such actions themselves. Daniel described how he would when *"nobody's looking…scrape some off the top and put it in some tissue"* (p.12, L80). Moreover, authentic relationships with family members and long-term friends outside the mephedrone-using community broke down, as the *"drug life"* (Daniel, p.12, L78) of participants was prioritised and kept *"secret"* (Daniel, p.14, L86).

Greg explained that he missed family *"birthdays"*, his *"grandad's funeral (laughs) just for drugs…"* (p.10, L72) and lost his *"real friends"* (p.8, L86). So he, too, had initial feelings of being "*alone*" (Greg, p.16, L137), rejected and excluded from mainstream society which created identity distress and vulnerability. For all three participants, this was exacerbated as they were now rejected from their inner circle and newly adopted drug subculture (for participants' heightened sense of identity issues following mephedrone use, see section 4.2.3.3, p.72-73).

Ultimately, using mephedrone was naively thought to solve the participants' enduring identity issues. In fact, it deceptively lured participants into a false sense of belonging that was short-lived, to the point where the only connection or relationship that was left was to the drug itself (for further discussion of the implications of the prioritisation of mephedrone, see sections 4.2.2.2 p.64-65 and 4.2.2.3 p.65-67). This made participants more dependent on the use of mephedrone to subdue their heightened psychic pain, thus creating a vicious cycle of use.

4.2.1.2 Subordinate theme 1b: The externalisation of "deep psychological damage" allows for short-lived appeasement.

John has had *"internalised homophobia"* (p.15, L69) since childhood that has resulted in a continuous struggle to accept his sexual identity. John perceived his sexual identity as an "unacceptable" or a *"subconscious"* (p.6, L33) facet of his identity that led to him *"self-loathing"* (p.6, L33). Perhaps John's rejection of his unacceptable sexual identity resulted from him being teased during his childhood for being *"gay"* (p.15, L69), which made John feel different or excluded from mainstream society. John explained that *"just being born gay in a world where everybody's straight…that's enough to do the damage"* (p.15, L69); *"damage"* in this sense resembling *"deep psychological damage"* (p.15, L69) associated with feeling somewhat inadequate. John likened this psychic pain to the researcher's assumed social exclusion from mainstream society based on her ethnicity:

"Same as your race, everybody else is white, would be enough for you to have damage, some sense that you're not the same, and maybe not as good as everybody else." (p.15, L69)

Perhaps this highlighted John's attempt to relate to the researcher, the implications of which are explained in section 5.8, p.90-91.

To manage John's identity distress, related to his sexuality, he participated in a masochistic form of chemsex:

"…it's based on get it high use it like a piece of meat infect it, destroy it…use it like a piece of meat, lock you in a dungeon, just fuck it, fuck it, fuck it till it's dead." (p.14, L67)

John allowed himself to be used *"like a piece of meat"*, *"destroyed"* and *"infected"* by others who were HIV positive until he was mentally *"dead"*. John was also HIV positive, which represented another unacceptable

facet of his identity. The repeated use of expletives suggests the destructive action of this version of chemsex, in which John appeared powerless, defenceless, senseless and insignificant. Furthermore, this form of chemsex seemed to have had an element of secrecy, as John was metaphorically locked *"in a dungeon"*, and perhaps this symbolised John's figurative compartmentalisation of his psychic pain.

This masochistic form of chemsex resembled a form of self-harm, facilitated by mephedrone use and the actions of others. The use of mephedrone allowed John to *"act out this damaged"* (p.6, L33) or to actively reject the unacceptable parts of himself that he loathed and perceived as inadequate. This in turn encouraged his unacceptable self to be deservedly *"used"* (p.4, L25) and punished by others during sex and so provide him with temporary relief from his psychic pain.

However, it appeared that John's mephedrone use ironically heightened his identity distress. John described:

"…I've got this beautiful life, the drug use is incongruence within my life and I know it's damaged, it's sexual damage from my childhood if you like, that I'm acting on, that it doesn't fit with who I am. I'm a kind caring person, and yet I take a bit of this drug and I suddenly want to be used like a piece of meat. It's like Jekyll and Hyde." (p.4, L25)

John recognised that his mephedrone use was an externalisation of his psychic pain, stemming from his sexual identity distress, which allowed him to objectify his unacceptable self that *"doesn't fit with who I am"* (p.4, L25). However, John acknowledged that his mephedrone use ironically exacerbated his identity distress and dislike for himself, as his drug use constituted another unacceptable facet of his identity (for further discussion of participants' heightened identity distress because of mephedrone use, see section 4.2.3.3, p.72-73).

The exacerbation of John's psychological distress by mephedrone was further illustrated by his analogy of mephedrone as an *"evil temptress"* (p.20, L89) that harmed him, himself being *"Alice"*, who was innocent, friendly and naive. John explained:

"…you go to wonderland, you come home in the morning with your dress shredded and your knickers in tatters." (p.20, L89)

Although mephedrone was initially used to rid John of his unacceptable self that he loathed, both the "acceptable" self, signified by the *"dress"* that could be seen, and the unacceptable self, signified by the *"knickers"* that were hidden, are destroyed in the end. This depicted the destructive nature of mephedrone and the further psychological damage that resulted from its use, representing a *"huge price tag"* (p.20, L91) to pay in exchange for part-time relief by visiting *"wonderland"*. "Wonderland" symbolised the alluring, short-term positive qualities produced by mephedrone. To defend against John's heightened psychic pain, further mephedrone was used with naïve optimism in order to provide a quick-fix in the hope of appeasing John's enduring identity distress, although not to resolve it.

Robert explained that he arrived in the UK from Brazil and at the time ~~he~~ was unemployed while being faced with the responsibility of providing for his family. Due to *"little prospect"* (p.8, L80), Robert became depressed and felt *"out of control"* (p.3, L26) or unsettled, feelings that may have manifested themselves because of the identity distress experienced while he transitioned between two different cultures.

To manage his feelings of depression, instability, hopelessness and identity distress, Robert used mephedrone as a naïve quick-fix to the enduring process of acculturative stress. Robert described how mephedrone would *"numb the problem[s]"* (p.24, L210) he faced. An image was created of Robert being in *"another world"* (p.5, L54) where he felt *"mellow"* (p.14, L132) and his psychic pain was temporarily appeased. This image was reinforced as Robert explained that mephedrone would *"block you out the reality, so you don't have to face your problems no more"* (p.7, L76). Mephedrone appeared to function as an avoidance strategy, as it acted as a metaphorical *"mask"* (p.15, L140) so that Robert no longer *"face[d]"* his problems, and as a *"shield"* (p.7, L76) that metaphorically defended or protected Robert against his negative feelings.

However, Robert explained:

"…thing is you keep using that because of the depression, when…you wake up and then you feel that depression like the emptiness, then you go after it again." (p.11, L118)

Robert acknowledged that the appeasement of his depression was short-lived, and was exacerbated as he suffered from the negative side-effects of mephedrone use. This perpetuated further mephedrone use as an external method to instantly self-medicate against his negative feelings rather than to explore a reflexive process that would result in long-term resolution. This culminated in a vicious cycle of mephedrone use.

4.2.1.3 Subordinate theme 1c: An attempt to create an empowered, idealised false-self through calculated mephedrone use. Greg was the second youngest child of seven siblings and had one eldest brother and five sisters. His father passed away during his pre-teens and his mother remarried. During Greg's adulthood, he moved from Brazil to Spain and currently lives in the UK. Greg explained that his drug use began in Brazil and that he moved countries with the purpose of achieving abstinence. Greg described how he felt unhappy, like he was *"achieving nothing"* (p.4, L40) and was not *"happy about myself"* (p.4, L40). Greg also described how *"as a personality I'm paranoid"* (p.13-14, L116), which may have contributed towards his lack of *"confidence to talk to other people"* (p.2, L20).

Alexander moved to the UK from Syria during which time he experienced acculturative stress, which included missing his family and friends, as well as difficulties in finding employment and establishing a new supportive network in the UK. Alexander described himself as *"shy"* (p.5, L40) and unable to express himself sexually and verbally as he desired. As a result of Greg's and Alexander's experiences, they may have both experienced identity distress and a reduced sense of self-efficacy and self-esteem.

To contain their fragile sense of selves, they both used mephedrone as a way of creating an empowered, idealised self that had the qualities they wished they organically possessed. Greg explained:

"…at work if you use mephedrone and you're dealing with customers, it just blank yourself, you don't care about other things, it just like…it doesn't matter. I don't care. You keep going and you feel strong, and then you, no don't paranoia about washing, they think clean or what. Sometimes you have an awkward moment with the customer, you know I should have said that or I shouldn't have, but then there I times when I think, good, I said, I said whatever, I don't mind, why you think like that, it's okay, it's up to you (laughs)." (p.13-14, L116)

Alexander explained:

"Feels like you need to use that drugs to have confidence. And when you use that drugs somehow you are smart, you know how to talk. I don't know where the thoughts come from, but it helps with conversation and stuff…" (p.19, L124)

"Cos er with mephedrone you do things that you would never do in terms of sex and stuff…" (p.22, L146)

Mephedrone use may have provided a quick-fix that allowed participants to temporarily escape their insecure true-selves by offering an idealised false-self with a superficially increased self-esteem and self-efficacy. But prolonged mephedrone use resulted in the heightened fragility of their true-selves. As Greg's mephedrone use progressed, he explained that he *"felt like I was going to kill myself cos I really feel like paranoid"* (p.17, L52); he experienced increasing depression and felt *"…complete stuck, at work I feel stuck, with the drugs I feel stuck…"* (p.7, L74). The image of metaphorically being "stuck in the mire" comes to mind, suggesting that Greg was unable to achieve what he wanted in his life. Alexander explained that *"…now I'm paranoid"* (p.18, L118), and due to the worsening *"comedowns"* (p.10, L92), he missed days of work. As a consequence of such negative side-effects, participants' initial feelings of discontent concerning their true-selves were exacerbated, and this motivated the continuous use of mephedrone, resulting in a vicious cycle.

4.2.1.4 Summary. The data identified that negative life experiences resulted in identity issues that influenced the development of the vulnerability to use mephedrone. Generally, participants had difficulties forming a sense of self or identity for a number of reasons: loss of relationships; familial rejection that resulted in unmet attachment needs; social exclusion from mainstream society; identity issues resulting from acculturative stress; difficulties accepting one's sexuality; and a discomfort with their true-self associated with low self-esteem and self-efficacy.

Mephedrone use had a range of functions and motivations. One was to create a sense of belonging and acceptance via the participation, support and adoption of a new identity as part of the mephedrone-using community. A second was to provide a strategy to avoid psychic pain and to allow the appeasement or compartmentalisation of psychic pain via self-medication and self-harming behaviours. A third was to allow the creation of an empowered, idealised false-self that enabled users to escape their fragile and loathed true-selves.

The use of mephedrone acted as an externalised method of coping that provided a credulous quick-fix for participants' psychological issues that was short-lived and superficial. It did not allow participants to confront and resolve their psychological issues via a method based on an internal, deep reflexive exploration of their fragile true-self or psychic pain. Participants' misplaced and naïve optimism in the use of mephedrone to resolve their psychological distress in fact deceptively resulted in its exacerbation. Participants became increasingly lonely as they were rejected by their inner circle and the mephedrone-using community. Their identity distress, coupled with the fragility of their true-selves, was exacerbated by further self-loathing of their newly adopted stigmatised drug-using identity and by the negative side-effects of problematic mephedrone use. As a consequence, further mephedrone was naively used with the secondary motivation to *"blank"* (Greg, p.13-14, L116) out their perpetuated psychological issues, which instigated a vicious cycle of use.

4.2.2 Superordinate theme 2: The paradoxical experiences of progressive mephedrone use. This superordinate theme includes three subordinate themes that explore the changing experiences, perceptions of and relationship with mephedrone, as its use progresses from recreational to problematic.

4.2.2.1 Subordinate theme 2a: "Love at first sight" versus a devilish mistake. The experience of using mephedrone before it became problematic resembled the pinnacle of happiness. Josh described recreational use as the *"…most amazing time of my life…"* (p.6, L50), *"…the peak of my happiness…"* (p.31, L179), while Daniel explained it as the *"…best time of my life…"* (p.7, L51). Participants' perceptions of mephedrone before problematic use appear to be positive and safe, as mephedrone depicted *"everything good"* (Daniel, p.7, L58) and reflected a source of *"happiness"* (Greg, p.21, L22). Furthermore, mephedrone was perceived as uniquely *"powerful"* (Alexander, p.3, L20) as it was described *"like nothing, no other drugs"* (Robert, p.5, L54) when compared to cocaine, MDMA or crystal meth. It was thought that mephedrone could maintain the potent qualities of traditional drugs without its associated negative implications.

The relationship between mephedrone and user was described as an ultimate attraction since it *"was love at first, first sight, I loved it"* (Daniel, p.11, L74). Daniel explained that mephedrone *"gnaws your brain, like I'm gonna look after you"* (p.21, 118). An image was created of a powerful animal that overtook the brain, an organ that controlled the mind and body, which made the recipient feel safe and secure. This related to subordinate theme 1a (section 4.2.1.1, p.56-58), which described the feelings of belonging and acceptance created by even the connection with mephedrone alone.

In summary, it seemed that during the initial stages of mephedrone use, the first phase of use, participants experienced a sense of awe, euphoria and peace. Participants appeared to perceive mephedrone as safe and fun, which depicted their trusting and secure relationship with the drug. These preliminary positive experiences highlighted participants' primary motivations to use mephedrone in order to appease their psychological distress, as discussed in superordinate theme 1 (section 4.2.1, p.56-62).

As mephedrone use proceeded, the problematic nature of mephedrone became a reality, the second phase of mephedrone use. During problematic mephedrone use, participants' experiences of mephedrone changed for the *"worse"* (Robert, p.15, L140). Mephedrone was interpreted as the *"biggest mistake"* (John, p.3, L32), the *"biggest regret"* (Josh, p.31, L174), life was described as a *"struggle"* (Josh, p.10, L74), *"bad"* (Robert, p.14, L138), and as *"life is going down"* (Robert, p.19, L178). Participants' perceptions of mephedrone appeared negative, as a *"hate"* (Robert, p.20, L186) developed towards mephedrone, where mephedrone resembled an *"enemy"* (Robert, p.20, L186). Josh described mephedrone as a powerful *"tool"* (p.23, L136) formed by the *"devil"* (p.23, L136) to facilitate evil doings that were inflicted upon Josh, rather than mephedrone being willingly used for its potent effects. Hence, mephedrone was still perceived as powerful, although its powerful nature was now experienced negatively as it was associated with the negative implications naively thought not to exist during initial use (examples of a loss of relationships, see section 4.2.1.1, p.56-58, and implications at work, university and financial strain, see section 4.2.3.3, p.72-73). Such negative implications appeared to lower participants' self-esteem, making them feel powerlessly dependent upon mephedrone.

Josh described his relationship with mephedrone:

"I felt like it was a baby you can't get rid of." (p.23, L136)

"Erm, I mean, I say it in that analogy because if, to put it simply if you're pregnant and you had the option of abortion and you were okay with it you would abort it. If I knew I was addicted to drugs before I took drugs I would abort that mind. I would aborted the, get rid of that mind-set, and I would have moved on quickly." (p.23, L138)

Josh likened the mind-set of being dependent on mephedrone to a *"baby"*, which in this sense was perceived as a burden that he would have preferred to *"abort"* if he had known, prior to taking mephedrone, the reality of suffering its negative implications.

In summary, as problematic mephedrone use developed, the second phase of mephedrone use, participants experienced a sense of survival and feelings of remorse and helplessness. Such feelings were associated with the exacerbated fragility of their true-self because of problematic mephedrone use (discussed in superordinate theme 1, see section 4.2.1, p.55-62). The benign identity of mephedrone, initially perceived and created through participants' narrative of mephedrone as safe and fun, was tarnished with the reality that mephedrone was powerfully problematic, like traditional drugs. Participants began to perceive mephedrone as evil and intrusive, and feelings of hate and rejection towards mephedrone developed. As mentioned by participants, if they had been aware of the problematic nature of mephedrone prior to its use (for reasons why participants do not know about the problematic nature of mephedrone, see section 4.2.2.2, p.64-65), it would have deterred them from using mephedrone in the first instance. What followed were feelings of deep regret, as the use of mephedrone transformed from an innocent, harmless recreational activity to a destructive, unsuspecting mistake.

4.2.2.2 Subordinate theme 2b: Naive control versus a sense of being out of control.

During the initial use of mephedrone, the first phase of mephedrone use, participants socially constructed an image of mephedrone as safe (for the participants' positive perception of mephedrone, see section 4.2.2.1, p.62-63), which allowed them to *"…think you can control"* mephedrone (Alexander, p.16, L104). This socially constructed image of mephedrone was maintained through various processes, discussed in the following paragraphs, that maintained participants' naivety towards the problematic nature of mephedrone use.

Firstly, participants did not know what mephedrone was. Alexander explained he would *"see them having a small bag with white powder, I never know what is inside"* (p.1, L4) and he *"thought all the powders are one kind of powder, I didn't know mephedrone was a specific kind of one. Before I know nothing…"* (p.3, L22). Secondly, participants lacked knowledge concerning the problematic nature of mephedrone. Robert explained:

"…they don't know there is a problem, that's the battle with this drug, they don't know there is a problem…But you don't feel that you are addicted to that…" (p.6, L68)

Thirdly, the socially constructed image of mephedrone as benign, safe and fun was not refuted by participants as they tended not to discuss the destructive effects associated with problematic mephedrone use due to the stigma of appearing *"weak"* (Daniel, p.35, L204). Daniel explained:

"It's not something that you'd discuss really…Some of them see it as a weak link, like 'oh my god I didn't know it was that bad'…" (p.35, L204)

Not discussing the problematic nature of mephedrone perpetuated the *"battle with this drug"* (Robert, p.6, L68). This was a battle or conflict between, on one side, the socially constructed image of mephedrone as safe, which was misleading and encouraged its use by unsuspecting hopefuls; on the other, the contradicting actuality of the problematic nature of mephedrone that resulted in destruction and feelings of deep regret (see section 4.2.2.1, p.62-63). Lastly, it appeared that the perception of mephedrone as safe was maintained by users of mephedrone, as it was described as *"not addictive"* (p.14, L94), and by professionals or the NHS, who were assumedly complicit (see section 4.2.3.1, p.68-70). Alexander further explained:

"Even mephedrone, people will say just use it, it's not addictive. When you google that, NHS or anything like that, it's not addictive, it's not addictive so you keep using." (p.14, L94)

As mephedrone use progressed, there was a transitional period where individuals noticed their loss of control. Robert explained:

"Yeh, the first time I really like it and I can control it then. It becomes like once in a week then, once in a 15, 15 days, once in a week. Then I notice, it was like I was deeply in that, getting deeper and deeper in that…" (p.5, L52)

"…the small amounts will get more intense to the point you cannot control it any more…" (p.15, L144)

A sense of drowning was created in what seemed to be the progressive or *"deeper"* use of mephedrone, which became more *"intense"* and overwhelmingly uncontrollable. It seemed that the *"balance"* (Greg, p.11, L96) or the *"juggle"* (Josh, p.10, L72) between their non-drug-using life and *"drug life"* (Daniel, p.21, 118), which participants thought was initially achievable, was in fact unattainable as mephedrone use eventually became physically addictive.

Daniel likened his feeling of a lack of control to that of reciprocated abuse from mephedrone:

"…cos I abused that, so now it should start to abuse me." (p.21, L118)

This analogy mirrored Daniel's early life experiences, in which he witnessed his mother and experienced himself being physically and mentally abused by his father. Perhaps in this instance mephedrone metaphorically became the "other", the abuser, and therefore his dysfunctional relationship style was emulated. Greg further explained how he experienced feeling out of control, as if mephedrone was *"controlling"* him (p.16, L104). This emphasised an image of mephedrone as dominating, powerful or abusive and the user as submissive, controlled or the abused.

This relationship dynamic was further highlighted as mephedrone was described as a *"trap"* (Robert, p.20, L186), *"the drug that caught me!"* (Robert, p.16, L156) or *"hooked me"* (Robert, p.6, L68), a drug that *"haunts"* me (Alexander, p.19, L124), and that *"doesn't let you eat"* (Robert, p.15, L148). Life was now described as a *"struggle"* (Josh, p.10, L74) and a *"fight"* (Greg, p.4, L40). A sense of feeling at war with mephedrone manifested itself, which perhaps resembled a battle to regain some sense of control or autonomy over their lives, but which was lost along with their sense of self and self-esteem as they became helpless victims. What appeared to be safe and fun, taken originally with the idea to appease their identity issues by creating an empowered idealised self (see section 4.2.1.3, p.60-61), was in fact destructive and heightened the fragility of their sense of self (reiterated in sections 4.2.1, p.55-62, and 4.2.2.1, p.62-63), which perpetuated further mephedrone use.

4.2.2.3 Subordinate theme 2c: A desirable need versus a "pointless" activity. During participants' progressive use of mephedrone, it was initially described as a basic need. Alexander likened mephedrone to food:

"I have a bit like at 10 o'clock in the morning, and maybe I take a few lines, then at one o'clock lunch. It's like food." (p.8, L62)

"…If you go in my room, at that time on my table, like an oyster card one, two, three, four lines ready. So when I go inside the house, because I work like five minutes from my house. So when I have a break I go home to eat and come back. So if I do one line when I am at home, I go to work." (p.15, L98)

"It is like chocolate." (p.7, L52)

Mephedrone became part of Alexander's everyday life, which he consumed in a casual, recreational manner throughout the day during his breaks at work like *"food"*, particularly *"chocolate"*. The euphemisms used to describe mephedrone coincided with the socially constructed image of mephedrone as safe and fun (for further exploration of the socially constructed image of mephedrone, see sections 4.2.2.1, p.62-63; 4.2.2.2, p.64-65; 4.2.3.3 p.72-73). Moreover, mephedrone appeared to take on the role of emotional sustenance required for users to survive.

As mephedrone use progressed, the desire for it heightened in line with a growing tolerance towards it. Daniel described his desire for mephedrone as a *"need"* (p.19, L178) and *"want"* (p.19, L178) as his tolerance increased. The increased desire for mephedrone became apparent as it was acquired in a *"hustling, survival type way"* (Daniel, p.8, L66). Daniel further created the image of competitive survival as he explained that he sought out mephedrone *"like a hawk in the sky"* (p.6, L52). An image was created of Daniel as a bird that was agile and strong and could scope out its prey, namely mephedrone, and that could attack it and obtain it to survive (this relates to the uncontrollable use of mephedrone, see section 4.2.2.2, p.64-65).

As a tolerance or *"resistance"* (Robert, p.6, L64) towards lower doses of mephedrone built, Robert described his body as being *"chemically…hooked"* (Robert, p.19, L182). It seemed that mephedrone became an increasing priority in Robert's life as *"…you keep searching for more and more and more"* (Robert, p.22-23, L198) beyond the scope of his personal safety and wellbeing. This related to the ironic twist (described in subordinate theme 1a, section 4.2.1.1, p.56-58) from the sense of belongingness created by mephedrone to the ensuing lack of distrust among mephedrone users as mephedrone becomes the priority.

However, as problematic mephedrone use further ensued, participants explained that mephedrone use felt like a pointless activity. Josh highlighted that he felt like he was *"wasting my life…"* (p.19, L104) and that he now perceived mephedrone as *"a pointless drug"* (p.27, L160). Josh explained:

"…we didn't even had sex and we just took it, watched family guy. I guess that even made it even worse, taking drugs and doing nothing with it (laughs), it's not fun." (p.17, L92)

Josh appeared to have had an epiphany, as he noticed that he was now taking mephedrone outside of his usual context of chemsex. He questioned the purpose of his mephedrone use, and realised he may have become dependent. This process was reiterated by Greg as he described:

"So you start to realise all these things, after all those uses, all these nightlife, all these enjoyable ones that I'm not getting nothing out of it, I'm just destroying myself, I'm not getting nothing, and it's really really painful like…it's really painful." (p.7, L64)

Furthermore, Alexander explained:

"Probably when you come down off these drugs you feel bad because you waste how many days, you don't go to work. You're gonna upset your manager and you have too many appointments you miss them, too many parents call you never answer." (p.17, L110)

Greg and Alexander shared Josh's epiphany that mephedrone use had become fruitless. It appears that the perception of mephedrone changed to something that was unwanted and worthless instead of contributing towards their life positively. This corresponded to the subordinate theme 2a (section 4.2.2.1, p.62-63) and 2b (section 4.2.2.2, p.64-65), where their perception of mephedrone changed to something negative, an experience that is rarely discussed among users.

4.2.2.4 Summary. Initially mephedrone, during the first phase of use, was perceived and experienced by users as positive, safe, fun and non-problematic, which promoted its innocent use in an accepted and recreational manner. This positive socially constructed image of mephedrone appeared to be maintained by several factors: (1) participants did not know what mephedrone was; (2) participants had no knowledge of the problematic nature of mephedrone; (3) professionals were perceived to be complicit with the promotion of mephedrone as safe; and (4) lastly, users of mephedrone did not openly discuss their negative experience of problematic mephedrone use.

Mephedrone was initially used to appease or escape psychological distress, thus representing emotional sustenance likened to food that offered security, containment and happiness. However, participants experienced the harsh, unsuspecting and contrasting reality of problematic mephedrone use. This second stage of mephedrone use was associated with negative, destructive experiences, and participants' relationship with and perception of mephedrone changed to one of evil, hate and insecurity. The participants' paradoxical shift in their experience of mephedrone was accompanied by exacerbated feelings of a loss of autonomy, sense of self and self-esteem, as users resembled helpless victims of abuse by mephedrone (the abuser).

The paradoxical experiences described as mephedrone use progressed from recreational to problematic use highlighted the deceptive nature of mephedrone. For instance, mephedrone hid behind its socially constructed façade as a recreational, safe drug that was as potent as traditional drugs, but could be

used in a controllable manner as it was naively perceived as unproblematic and harmless. Mephedrone was in fact as problematic and destructive as traditional drugs but by the time this was realised, participants were chemically dependent. It seemed that mephedrone underwent its own identity distress, a conflict between the safe, benign identity of mephedrone and its realistic destructive identity.

Eventually, participants realised that their mephedrone use had become a wasteful, pointless activity, which could be likened to the contemplative stage of the process of change, and this was a stark contrast to their initial desire that drove their dependent use of mephedrone.

4.2.3 Superordinate theme 3: Making sense of one's problematic mephedrone use via self-reflective processes. This superordinate theme includes three subordinate themes that explore the self-reflective processes undertaken by participants as they made sense of their problematic mephedrone use and consequently decided to change it.

4.2.3.1 Subordinate theme 3a: Stigmatising beliefs assist in the self-identification of problematic mephedrone use. Participants made sense of their mephedrone use by self-identifying, i.e. attributing certain characteristics or qualities of other types of drug user to themselves. This reflective process was affected by the participants' awareness of the stigmatising beliefs held by society and the drug-using community.

Alexander explained:

"…when I see someone smoke weed I say this is a bad person, but now me I am taking the drugs that are powder, powder is something that is very, very bad." (p.4, L36)

Alexander associated substance misuse with being a *"bad person"*, whereas not using drugs was associated with being a good person. Perhaps Alexander's perspective manifested itself because of his religious beliefs as a Muslim that prohibited substance misuse (for further discussion of the impact of religious beliefs on mephedrone use, see section 4.2.3.3 p.72-73). Or perhaps it did so ~~or~~ because of participants' perspective *"that society doesn't really deem erm [substance misuse] sensible (laughs)"* (Josh, p.4, L30), and therefore substance misuse is deemed socially stigmatised. Furthermore, Alexander rationalised his mephedrone use as being worse than smoking *"weed"* that is organically produced from a plant, whereas mephedrone is a chemically manufactured "*powder"*. Therefore, not only was Alexander considered a *"bad person"* as defined by society and his religion, but he perceived his mephedrone use as *"very bad"* due to its manufactured origin.

Although participants realised their substance misuse was *"bad"*, users within the drug-using community identified their mephedrone use as less problematic when compared to traditional drug use. Daniel explained:

"Yeh, because their lifestyle's completely different. You've gotta have, from what I've learnt, you've got to have, erm, a lot of money to supply that that addiction, and that means you man rob people's houses and their rob cars and st-, and their phones and stuff. You're even robbing at erm at the cash point. You're not gonna get someone on mephedrone tryna rob you at the cash point, or trying to erm, they haven't got to, they haven't got a £300 a day drug addict. It's £20 for a gram, [laughs] it's a bit of difference in the, in the value. And by the way they take it as well, and the way that erm heroin is easier easier easier to pass away on that drug…" (p.27, L154)

Daniel related traditional drug use to negatives such as crime such as robbing, the stigmatised term *"addiction"*, a financial burden, a greater risk to health and generally a completely different lifestyle. Users of traditional drugs were also referred to by the derogatory terms *"druggies"* (Daniel, p.21, L118) and *"…addicts [that are] are very like… loud"* (Daniel, p.31, L180). In contrast, mephedrone was frequently referred to as a *"party drug"* (John, p.3, L15), used commonly within the contexts of *"chill-outs or sex parties"* (Alexander, p.14, L92), and on the *"weekend"* (Josh, p.5, L50), and was associated with *"more fun"* (Alexander, p.5, L38) than the use of traditional drugs.

As a consequence of the terminology used to describe mephedrone, it was socially constructed as safe and fun in comparison to traditional drugs. The professional arena appeared to be complicit in maintaining this, as the terms *"club drug"* or *"party drug"* are used to define such drugs. Nevertheless, club drugs were associated with normative recreational contexts of parties or clubs. This provided a further mechanism that dissociated club drugs from their true destructive and problematic nature, hence maintaining its benign identity (for other processes by which the benign identity of mephedrone was maintained, see section 4.2.2.2, p.64-65). As a consequence, mephedrone users self-identified with a lifestyle that was socially constructed as much less problematic (for the social construction of mephedrone as less problematic, see section 4.2.2, p.62-68), controllable, recreational and fun, in contrast to the lifestyle of traditional drug use that was constructed and perceived as uncontrollable, problematic and stigmatised. However, mephedrone use could result in the loss of relationships, harm to one's wellbeing and financial strain (for the negative consequences of mephedrone use, see sections 4.2.1.1, p.56-58 and 4.2.3.2, p.70-71) in the same way as traditional drug use, although the destruction caused by mephedrone use was not commonly discussed. This further helped to uphold the socially constructed image of mephedrone as safe or as safer than traditional drugs (for the processes that socially constructed mephedrone as safe, see section 4.2.2.2, p.64-65).

Moreover, there appeared to be a hierarchal system that operated within the drug-using community, where the increasing price of a drug related to its increasing potency and therefore problematic nature. Daniel explained that because mephedrone was *"cheaper"* (p.25, L140) than cocaine, it was thought to be less problematic than cocaine. Beyond cocaine Daniel explained:

"Yeh, then you get called a crackhead, then then the heroin, then you're a heroin user [conveys hierarchal levels using hand gestures]." (p.27, L160)

Daniel explained that crack cocaine was more expensive/problematic than cocaine, while heroin was the most expensive and therefore problematic drug. Daniel's reference to users of crack cocaine as *"crackheads"* further depicted the stigmatising perspective of traditional drugs within the drug-using community.

Lastly, although mephedrone use was deemed the least stigmatised and problematic by the drug-using community in contrast to traditional drugs, it seemed that there were social divides that operated within the mephedrone-using community. These were based on the route of administration of mephedrone that correlated with its problematic nature. Josh explained:

"So maybe that's it actually we just figured it out (laughs) erm you always, you associate it with something in your mind with something's that's bad, and it's ridiculous to be honest, and especially in this country a lot of people do judge life on television, I don't know about the rest of the world, I haven't been, but they do judge life on television and East Enders, things like that (laughs)." (p.30, L172)

Josh explained how the commonality of seeing drugs *"snorted"* on television socialised it as the *"norm"* in relation to administrating drugs, and therefore *"snorting"* was associated with less PSM by society. By contrast, injecting drugs was rarely televised and maintained a common association with heroin use that appeared to be the most stigmatised by society and those within the drug-using community. Injecting or *"slamming"* (Josh, p.2, L10) mephedrone was associated with the stigmatising connotations associated with heroin use, and was therefore identified as problematic mephedrone use. Furthermore, Josh described injecting mephedrone as the *"final hurdle"* (p.29, L168) into the realms of PSM since the potency of the drug became *"100%"* (p.29, L168), and there were greater risks of *"catching hepatitis C and HIV"* (Alexander, p.21, L140). Such harms were also associated with traditional drug use which was perceived as more problematic. Therefore, users within the mephedrone-using community self-identified their mephedrone use as problematic if they injected, because injecting was stigmatised, associated as it was with the increased likelihood of risk, greater potency and heroin use.

4.2.3.2 Subordinate theme 3b: A critical incident that triggers the self-evaluation of one's mephedrone use as subjectively problematic. All participants experienced a critical incident that triggered them to reflect on their mephedrone use, and to recognise how it was personally problematic for them beyond physical and psychological dependency.

Alexander explained:

*"And er I work at *** cutting car parts, and once I cut my finger holding a glass, I cut my finger and blood started to go, so when I washed my hand then the blood didn't stop, when I pressed on it, you know I think some blood was there, I got the taste of mephedrone, it tasted like mephedrone and smelled like mephedrone in my blood. That's when I knew, I'm using too much. Erm my job is like dangerous because I need to carry glass the okay*

and er you need to concentrate. If you are falling asleep because you were awake last night or something, it's dangerous." (p.8, L68)

Alexander detected mephedrone in his blood, which indicated to him that he was *"using too much"* since it became physically a part of his body. What followed was the further realisation that his accident at work was caused by him *"using too much"* mephedrone, which reduced his concentration and alertness. Alexander realised that such incompetence was detrimental or *"dangerous"* for his work, which could lead to him losing his job and his financial stability. This signified his subjective understanding of how his mephedrone use had become problematic for him.

John explained:

"Financially, I've used savings with all this using, its costs me 26 grand in two years, I've only got 10 grand left. It's got to be reversed now. I mean not all of it is drug use, I mean I've been on quite a few nice holidays but I can't afford this to carry on, because if all my savings are gone. I'll be depressed. So it's a bit critical." (p.12, L53)

John's increasing mephedrone use caused him to use his savings, which he had planned to keep as his pension. Without his savings, he was aware that he could become depressed, due to financial pressure. Again, it was the potential financial instability that signified his subjective understanding of mephedrone as problematic.

Greg explained:

"July, no, no July. Was the last time when I did, which was that weekend. I spent all weekend doing sex and then did have a small fracture. I had to go to hospital and at that point I said 'no'. I really have to stop now because going to needles now, is going beyond my, it's going too far. I'm thinking going too far with the drug usage. I have to stop." (p.16, L134)

Due to Greg's increased sexual activity at "gay pride festival", spurred by mephedrone use, he fractured his penis. This conveyed the potent nature of mephedrone and its potential damaging effects on users' wellbeing, since *"when you're doing drugs you don't think about anything, you don't think about condoms you don't thinking about protecting yourself, you just don't, you just think about the, the sex"* (p.7, L68). This, coupled with Greg's progression of mephedrone use from insufflation to injecting, made him feel that his mephedrone use was going beyond his acceptable limit. Perhaps this was because Greg had subconsciously adopted the stereotypical perception that injecting drugs was associated with heroin use, and therefore deemed more problematic in comparison to snorting (for further exploration of stigmatising beliefs, see section 4.2.3.1, p.68-70). So, it was the consequential negative effects of mephedrone on Greg's wellbeing and his progression to *"slamming"* (Josh, p.2, L10) that signified to him that his mephedrone use had become problematic.

4.2.3.3 Subordinate theme 3c: An internal debate between desires versus values and beliefs that motivates change. As participants realised their mephedrone use was problematic they continued to make sense of their problematic mephedrone use. By undertaking an internal debate between their desires to continue their problematic mephedrone use and their conflicting values and beliefs, participants realised that their mephedrone use took them further away from their true-selves, hence exacerbating their identity distress and propelling their motivation to change (this refers to the contemplative stage of change that is highlighted section 4.2.2.3, p.65-67).

Josh explained:

"You know when they tell you, you have the good voice and the bad voice on your shoulder, I can identify which one it is. I can identify when the bad is telling me, and the strong of reason is telling you not to. Sometimes if I can't, I'll take a moment to think hold on let's think about this, and stop those voices and think it myself on my own self would you want to do that? What is going to happen? Erm so it was those, it was it was I guess my subconscious of my mind telling me again, alright now it's time to come out." (p.18, L96)

Josh described the internal debate he underwent between his *"good voice"* encouraging him not to use mephedrone, and his *"bad voice"* encouraging him to fulfil his desire to use mephedrone. Josh explained how he tried to regain objectivity from his internal voices that almost resembled "others" and tried to decipher what his true-self valued. He realised that although he may have consciously desired mephedrone and wanted to use it, subconsciously he appreciated that he should no longer use mephedrone as it had become problematic for him. Moreover, Josh explained:

"I almost let down my mum, the head lecturer and myself, they put, the head lecturer put his neck out for me, my mum I can't let her go through that again." (p.15, L86)

Josh contemplated who he would *"let down"* if he surrendered to his *"bad voice"*: his mother who had provided emotional support, and his university lecturer who supported his decision to repeat his last year of university that he had failed because of missing lectures due to using mephedrone. Coupled with his own realisation that his mephedrone use had become problematic, it seemed that it was the prospect of letting others down that created feelings of guilt for Josh, and this motivated him to change his problematic mephedrone-using behaviour.

Alexander explained:

"I say okay this is the last time I'm going to use it, and er you know I think it comes back to a religion thing. Because even there are Muslims dealing, they are doing partying, gay and still practice, still Muslim. So always you know it's bad and you're doing it. You know you shouldn't be doing it and it makes you feel guilty." (p.17, L114)

Alexander's religious beliefs appeared to be ever-present in his thoughts while he was participating in the prohibited acts of mephedrone use and *"doing partying, gay"*, which triggered an internal conflict between his desires to use drugs and his religious values as a Muslim. It was this identity distress that made Alexander feel guilty, and subsequently motivated him to want to change his problematic mephedrone-using behaviour.

John explained:

"…I'm spiritual and more interested in having a cup of coffee and a conversation then going out and getting slaughtered. So I complete, the drug side of me and my sexually identity don't fit with me at all, its two different people." (p.6, L31)

John understood that his *"spiritual"* self, who seemed calm and civilised, was incongruent with the *"drug side of me"*, who wanted to get "slaughtered". Although the colloquial definition of the word *"slaughtered"* translated to the intoxication by the misuse of substances, an uncivilised image comes to mind, of animals being unwillingly killed, that conjures feelings of being trapped and helpless. Ultimately, John realised that using drugs has not brought himself closer to his true-self or resolved his sexual identity distress, but that his *"drug side of me"* has drawn him further away from his *"spiritual"* self. It was this realisation that motivated him to want to retreat from the *"drug side of me"*.

4.2.3.4 Summary. Participants made sense of their mephedrone use via various self-reflective processes, including self-identifying, self-evaluation and internal debate. The process of self-identifying reflected how participants often referred to specific drug types or characteristics as a way of defining who they were. This process seemed to be affected by participants' awareness of the stigmatising beliefs held by both society and the drug-using community.

While mephedrone users seemed to share the societal perception that substance misuse was bad, they felt club drug use offered a sense of belonging as a reaction to feeling excluded from mainstream society. Moreover, a socially constructed image of mephedrone as safe and fun (initially recreational and part of a relatively superficial and escapist "party" environment) was formed by participants, which was in direct contradiction to the problematic and stigmatised perception of traditional drug use, a lifestyle mephedrone users did not self-identify with. Social divisions were also created within the mephedrone-using community itself, where injecting was associated with problematic use due to its association with heroin use.

Participants subjectively made sense of their problematic mephedrone use via the prompting of a critical incident, which motivated them to self-evaluate their mephedrone use. They did this in respect of their personal beliefs and ideas concerning what was important in their lives, stereotypes they had, and their contextual circumstances. Further contemplation occurred as participants entered an internal debate between their desire to continue their problematic mephedrone use ("*the drug side of me*"; John, p.6, L31) and their conflicting spiritual or religious beliefs. It was through the process of this heightened identity distress that

participants re-evaluated their values and beliefs. This motivated participants to decide what self they most want to accept, nurture and like, and led to them challenging their problematic mephedrone use in the hope of abstaining.

5. Discussion and Conclusions

5.1 Overview

This study aimed to explore mephedrone users' experiences and sense-making of their problematic use by asking the following research questions:

1) How do participants understand their *motivations* for their mephedrone use?
2) How do participants describe their *experiences* of mephedrone use?
3) How do participants *make sense* of their problematic mephedrone use?

The use of semi-structured interview questions, with a specific focus on the research questions, enabled participants to share their lived experiences of problematic mephedrone use. IPA was used to analyse data that highlighted participants' psychological motivations to use mephedrone. Their vulnerability towards problematic mephedrone use was based on negative life events that resulted in difficulties forming a sense of self. To resolve such a psychological deficit, participants strived to form connections with others in a recreational context in order to create a superficial sense of belonging, acceptance and support. The participants tried to temporarily compartmentalise, avoid and defend themselves against their psychological distress by using self-medicating and self-harming behaviours. Lastly, participants attempted to create an empowered, idealised false-self to escape from their fragile true-self. Participants' misplaced optimism in this externalised method of coping via substance misuse provided a credulous quick-fix for their psychological issues. This prevented them from confronting and resolving their issues via a method based on internal, deep reflexive exploration of their fragile true-self or psychic pain. It seemed that participants' initial innocent and recreational mephedrone use resulted in the ironic exacerbation of their psychological distress, which promoted a vicious cycle of problematic mephedrone use. These findings are explored under the research question: "How do participants understand their *motivations* for their problematic mephedrone use?" (p.76-80).

The findings also suggested how participants experienced, related to and perceived mephedrone itself. Prior to and during the initial stages of mephedrone use, participants perceived mephedrone as positive, safe, fun and non-problematic, which promoted its innocent use in an acceptable recreational manner. Initially, mephedrone was experienced positively, was *"loved"* (Daniel, p.11, L74) and perceived as emotional sustenance, similar to food, that fulfilled the participants' primary motivations to use it in order to escape their psychological distress (as explained in the paragraph above). However, as participants entered the problematic stage or second phase of mephedrone use, they described mephedrone as their enemy, and that it was destructive, uncontrollable and negative. Despite this, participants were motivated to continue their mephedrone use in order to appease their negative withdrawal symptoms, the result of becoming physically dependent. Consequently, participants experienced an exacerbated lack of autonomy, identity distress and low self-esteem, as they now resembled helpless victims of the eventual abuser, mephedrone. Since participants did not publicly speak of such negative experiences, mephedrone's socially constructed image as safe, fun and non-

problematic was maintained. Moreover, participants' lack of knowledge concerning mephedrone and professionals' use of terminology to describe it, e.g. club drug or party drug, helped to maintain and promote mephedrone's positive image. Thus, it appeared that mephedrone itself underwent its own identity distress between mephedrone's perceived safe identity and its actual problematic identity, which included negative and destructive experiences similar to those of traditional drugs. These significant findings are discussed under the research question: "How do participants describe their *experiences* of mephedrone use?" (p.80-82).

Lastly, the findings suggested how participants made sense of their mephedrone use via various self-reflective processes, including self-identifying, self-evaluation and internal debate. Self-identifying reflects how participants referred to specific characteristics of users of different types of drugs. This offered a way of defining who they were as a user of drugs, rather than being categorised in terms of socio-demographics. This process seemed to be affected by participants' awareness of the stigmatising beliefs held by society and the drug-using community. Furthermore, participants appeared to subjectively make sense of their problematic mephedrone use via a critical incident such as an accident at work which motivated them to self-evaluate their mephedrone use. This involved contemplating the conflict between their desire to continue their problematic mephedrone use ("*the drug side of me*"; John, p.6, L31) and their spiritual or religious beliefs. Eventually, users realised that their mephedrone use had become a wasteful, pointless activity, in stark contrast to the initial desire that drove their mephedrone use. These significant findings are addressed under the research question: "How do participants *make sense* of their problematic mephedrone use?" (p.82-85).

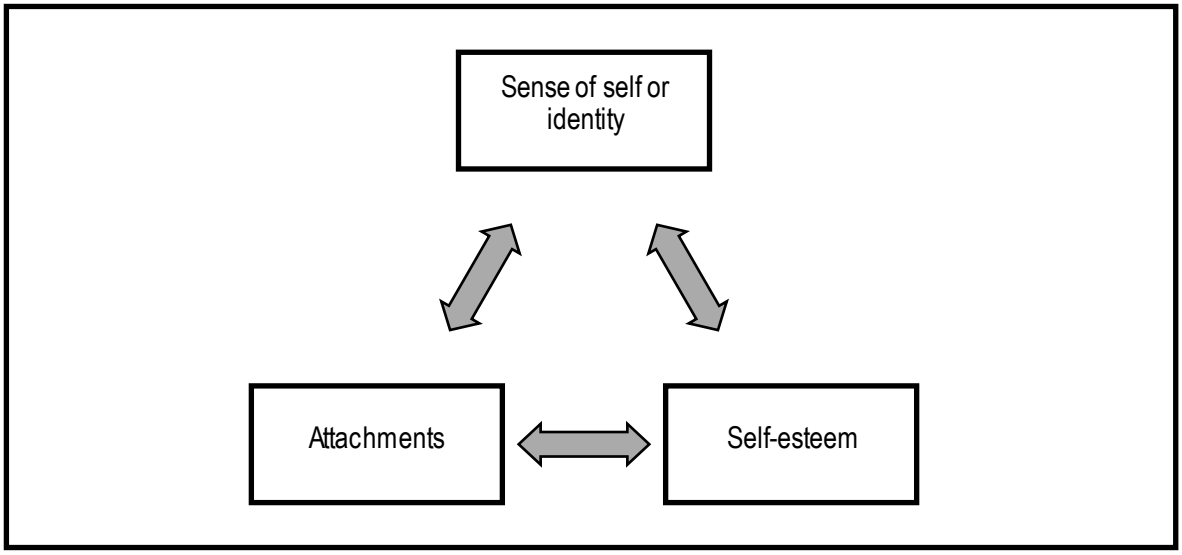
5.2 Findings

In this section, the findings of this research are discussed in relation to existing literature.

5.2.1 How do participants understand their *motivations* for their mephedrone use?

5.2.1.1 The relationship between the development of identity, self-esteem and attachments. An unstable sense of self or identity may originate from negative life events, which could increase the likelihood of substance misuse (Etherington, 2006; Bruce, 1990; Larkin & Griffith, 2002). These negative life events e.g., abuse, could result in maladaptive attachments e.g., child-parent, which could hinder the development of one's identity and self-esteem. Research has proposed that attachment theory provides a foundation for social and personality development which is key in the formation of identity (Pittman, Keiley, Kerpelman & Vaughn, 2011). Moreover, research has suggested that child-parent interaction constitutes the basis for development of one's early sense of self-esteem (Arbona & Power, 2003; Laible, Carlo & Roesch, 2004), which is a precursor to the development of identity (Berzonsky & Admans, 1999; Campbell, 1990; Cast & Burke, 2002). Hence, there is a bidirectional relationship between the development of attachments, self-esteem and identity, that if impaired by negative life experiences could precipitate substance misuse.

Figure 3: The relationship between the attachments, identity and self-esteem



Since all the participants said they experienced negative life events that resulted in unmet attachment needs and lowered self-esteem, it could be proposed that this impaired participants' development of their identity, which increased their vulnerability towards problematic mephedrone use. For example, Daniel, Josh and Greg experienced difficulties in their familial relationships. Daniel's parents divorced when he was younger and his father was physically abusive towards him. Josh's parents divorced when he was younger and his father was also physically abusive. Josh felt rejected by his family after he explained to them that he was "gay" (Josh, p.8, L64), and Greg's father died when he was young.

Research has proposed that negative familial relationships could lead to the formation of low self-esteem and consequently an unstable sense of self (Archer, 2008; Berzonsky & Adams, 1999). Conversely, healthy identity development is suggested to be strongly influenced by parental acceptance and encouragement (Arnett, 2001), and that nurturing family factors e.g., affective responsiveness and involvement, communication and problem solving, are positively correlated to self-esteem and identity development in emerging adulthood (Schumacher & Camp, 2010). Such research could help to explain how participants' negative life experiences concerning their family, may have resulted in low self-esteem and difficulties in forming a stable identity, which could have increased their vulnerability towards substance misuse.

In different ways, participants also experienced the negative life event of being excluded from mainstream society. For example, Daniel was made redundant. Strain theory (Merton, 1968) proposed that when mainstream society popularises aspirations e.g., wealth, which are unattainable by some i.e., marginalisation, occurs. Due to such marginalisation, identity distress can be experienced by individuals who do not feel accepted by mainstream society (Anderson & Mott, 1998; Sam & Berry, 1995). Greg, Robert and Alexander also experienced marginalisation, as they felt like an ethnic minority in the UK. Such marginalisation could have resulted in a form of identity distress known as acculturative stress (Nouroozifar & Zangeneh, 2006), as they had not yet adopted to the new culture of the UK whilst simultaneously experiencing a loss of cultural contact with their traditional culture (Berry et al., 1992). Lastly, John was stigmatised by society for being "gay" (p.8, L64). Minority stress theory (Meyer, 1995) proposed that individuals who experience stigmatising beliefs

held by society or family members concerning their sexual orientation, may internalise such opinions that could manifest in "internalised homophobia" (John, p.15, L69; DiPlacido, 1998). This could result in feelings of guilt, self-loathing, shame, low self-esteem and a delay in identity formation (Allen & Oleson, 1999; Grossman & Kerner, 1998; Shidlo, 1994). Thus, these examples of exclusion from mainstream society, illustrate how they could have negatively impacted on an individual's self-esteem and sense of self or identity, which could have increased one's vulnerability towards substance misuse.

5.2.1.2 The function of mephedrone use. This section explores participants' motives to use mephedrone as a potential fix for a sense of identity distress.

5.2.1.2.1. A primary function of mephedrone use: the superficial sense of belonging, acceptance, support and empowerment. Social identity theory (Tajfel & Turner, 1979) suggested that because of social exclusion, from mainstream society or family as explained, individuals may search for a new identity by adopting the beliefs and practices of a drug subculture known as social identification. This can result in a perceived sense of belonging, acceptance and a sense of empowerment (Dodes, 2002; Anderson & Mott, 1998; Moshier et al., 2012). Within Marcia's (1966) identity status paradigm this is also known as the stage of moratorium, where an individual is experiencing identity distress and explores different identities to reduce their stress and create a sense of belonging. This corresponds to the findings of subordinate themes 1a (section 4.2.1.1, p.56-58) and 1c (section 4.2.1.3, p.60-61), where Daniel recalled that belonging to the mephedrone-using community felt like being part of a "big family" (p.11, L76), Josh "felt accepted" (p.8, L64), and Alexander experienced an increased sense of "confidence" (p.19, L124). Qualitative research has also suggested that drug-using peers offer emotional support like that of self-help groups (Neale, 2002; Suh, Mandell, Latkin & Kim, 1997). For example, Daniel described that he felt he got his "feelings and…your worries answered, so [laughs] you are gonna gravitate towards people like that, that are actually listening to you" (p.12, L78). This new identity also reflected an empowered and idealised false-self, that contained their fragile sense of selves and reduced their sense of identity distress, following their rejection from family or mainstream society (see section 4.2.1.3, p.60-61; Winnicott, 1960).

A significant finding of this research was that not only did the connections participants make with fellow mephedrone users help them manage their psychological distress, but that this was also facilitated by the initial positive connections participants made with mephedrone itself (explained in sections 4.2.1.1, p.56-58 and 4.2.2.1, p.62-63). For example, Josh described how mephedrone "spreaded out" (p.2, L18) around his body, which created an image of embrace and warmth. Moreover, Daniel described his connection with mephedrone as if it "was love at first, first sight, I loved it" (p.11, L74). It seems mephedrone underwent a process of anthropomorphism, the attribution of human qualities to a non-human entity, that helped signify the intense, intimate relationships participants formed with mephedrone that allowed participants to feel a sense of belonging and containment.

5.2.1.2.2 A primary function of mephedrone use: the avoidance and appeasement of psychic pain. Mephedrone use appeared to facilitate self-harming and self-medicating behaviours, which allowed participants to appease or avoid their psychological distress associated with their identity issues (see section 4.2.1.2, p.58-60). For example, John participated in a self-harming form of chemsex that involved him being used "like a piece of meat", "destroyed" and "infected" (John, p.14, L67) by others that were HIV positive, until he was mentally "dead" (John, p.14, L67). This form of chemsex allowed for John's perception of the unacceptable aspects of himself e.g., being gay, that he loathed and perceived as inadequate, to be "used" (John, p.4, L25) by others, which provided him with temporary relief from his internalised homophobia. Shaw (2012) explained how sadistic and masochistic forms of sexual behaviour, could be used to externalise psychological distress e.g., sexual identity distress, by inflicting pain upon oneself where the pain could eventually become cathartic.

Alternatively, Robert experienced depression because of the acculturative stress he experienced, which propelled him to use mephedrone to metaphorically "mask" (Robert, p.15, L140) his problems, and "shield" (Robert, p.7, L76) him from his negative feelings. Hence, mephedrone facilitated Robert's temporary avoidance of his depression, which he experienced because of his identity distress as he transitioned between cultures. This coincides with the self-medicating hypothesis (Khantzian, 2003) that suggested substance misuse provided individuals with a coping strategy to appease the symptoms of mental health issues and negative life events.

5.2.1.2.3 The secondary function of mephedrone use: the appeasement of the negative consequences of problematic mephedrone use. Although, participants used mephedrone to cope with their feelings of loneliness, rejection and exclusion from mainstream society and family, such feelings were ironically exacerbated. Participants described how their loneliness and sense of exclusion increased as their authentic relationships disintegrated, as their mephedrone use became the highest priority in their lives, which paralleled Hsieh et al.'s (2015) findings. For example, Greg explained that he missed family "birthdays", his "grandad's funeral (laughs) just for drugs…" (p.10, L72) and lost his "real friends" (p.8, L86) as drugs were prioritised. Participants may have also felt, at times, rejected by their newly adopted drug subculture. For example, Josh explained that "…people don't really care of other people's feelings. They only want what they want…" (p.28, L162). Hence, the newly adopted identity of participants as a mephedrone user, was also challenged as drugs were prioritised; consequently, their superficial sense of belongingness and acceptance within the mephedrone-using community was challenged, that may have contributed towards the exacerbation of their identity distress.

Participants also experienced the negative side-effects of mephedrone on withdrawal, which exacerbated participants psychic pain. For example, Robert explained that the "…thing is you keep using that [mephedrone] because of the depression, when…you wake up and then you feel that depression like the emptiness, then you go after it again" (p.11, L118). Further negative side-effects are discussed in research question 2 (see section 5.2.2, p.80-82), and the experience of participants heightened identity distress is

discussed in research question 3 (see section 5.2.3, p.82-86). Although, mephedrone was primarily used to naively appease participants psychic pain associated with their identity distress (see sections 5.2.1.2.1, p.78 and 5.2.1.2.2, p.79), it seems to have ironically exacerbated participants' identity distress as outlined above and further distanced participants from their true selves (Winnicott, 1960). This perpetuated further mephedrone use (secondary mephedrone use) by participants as a way of appeasing their heightened psychological distress, which concluded a vicious cycle of use. Shinebourne and Smith (2009) proposed that the initial use of alcohol was perceived as enabling, as it appeared to provide a route from experiencing psychic pain, though long-term use resulted in negative side-effects on withdrawal which ironically exacerbated psychic pain though perpetuated further use.

What is unique to this piece of research, is that participants seemed to naively believe that mephedrone could rapidly provide a harmless cure for their ongoing psychological distress. Such a belief may have been influenced by the socially constructed image of mephedrone as safe, fun and innocent, which is further explored in the next section.

5.2.2. How do participants describe their *experiences* of mephedrone use?

5.2.2.1 The socially constructed image of mephedrone as positive. A unique and significant finding of this research, was that mephedrone was found to be socially constructed by participants as safe, fun and non-problematic. This socially constructed image of mephedrone was achieved and maintained by several processes: (1) due to a lack of available knowledge, participants suggested that they did not know of any negative effects of mephedrone prior to themselves using it, and therefore naively thought mephedrone could be used in a controlled manner (see section 4.2.2.2, p.64-65). Alexander explained that "…even mephedrone, people will say just use it, it's not addictive. When you google that, NHS or anything like that, it's not addictive, it's not addictive so you keep using" (p.14, L94). A study conducted by Van Hout and Brennan (2011) suggested that mephedrone users think there are no undesirable effects of mephedrone, and therefore participants maintain an internal ideology of a perceived control; (2) participants explained that they did not know what mephedrone was e.g., "see them having a small bag with white powder, I never know what is inside" (Alexander, p.1, L4); (3) participants did not speak of their negative experiences of mephedrone use to others e.g., family, friends or fellow users; (4) the operationalisation of stigmatising beliefs within the drug-using community, naively presented mephedrone as the least problematic drug in comparison to traditional drugs (for further discussion of this see research questions 3, section 5.2.3, p.82-85), and lastly, (5) professionals appeared to be unintentionally complicit with the construction of mephedrone as positive by the use of their language to describe such drugs e.g., club drugs, party drugs.

Drug policy has introduced the terms "club drugs" and "party drugs" to describe non-traditional drugs, with the aim of reducing the potential stigma felt by individuals using such drugs and enable them to access treatment. Although there may not be any direct drug harms associated with the introduction of such terminology, there is an unintended collusion with the socially constructed image of mephedrone as safe as suggested by the participants of this study. It could be argued that the use of such terminology presents

mephedrone as a recreational drug used within an acceptable recreational context, and research has suggested that representing drugs as recreational appears to normalise their use, which makes them seem less problematic and more appealing (Cieslik & Pollock, 2002; Parker, 1997; Shiner & Newburn, 1997). Hence, it could be argued that the use of such terminology could unintentionally discourage non-traditional users from accessing treatment.

It could also be argued that participants could have known of the harms associated with mephedrone via the prohibition of it 2010 and numerous negative media representations, and that perhaps the participants attempt to socially construct the image of mephedrone as safe, fun and non-problematic may have been their attempt to justify their use. However, IPA aims to focus on the subjective experience of the participant that is not generalisable to all mephedrone users. Using the data collected it would not be possible to justify such a claim, however perhaps this introduces scope for further research into the purpose of the narratives participants construct in relation to their drug use using discourse analysis.

In summary, socially constructed image of mephedrone as safe, fun and non-problematic appears to have encouraged mephedrone's use, though in reality once mephedrone had been used its true destructive, uncontrollable and problematic nature was revealed. Such paradoxical experiences highlighted the deceptive nature of mephedrone as it seemed to undergo its own identity confusion between its benign safe identity, a façade that encouraged its use, versus its realistic destructive identity that "hooked" (Robert, p.6, L68) the user. To resolve this identity distress perhaps the true destructive nature of mephedrone could be highlighted, which may discourage its use or encourage at least the informed use of such a drug (see section 5.6, p.87-88).

5.2.2.2 The paradoxical experience of mephedrone use. During the initial phase of mephedrone use, participants described their experiences as commonly positive (see section 4.2.2.1, p.62-63). For example, the "*…most amazing time of my life…*" (Josh, p.6, L50), "*…the peak of my happiness…*" (Josh, p.31, L179), and the "*…best time of my life…*" (Daniel, p.7, L51). However, during the second phase of mephedrone use or as it became progressively problematic, participants described their experiences as paradoxically negative. For example, as a metaphorical burden e.g., "*…a baby you can't get rid of*" (Josh, p.23, L136), an "*intrusion*" in one's life (John, p.8, L37) and a "*struggle*" (Josh, p.10, L74; see section 4.2.2.1, p.62-63). Rather than feelings of "*love*" (Daniel, p.11, L74) towards mephedrone during its initial use, "*hate*" (Robert, p.20, L186) eventually developed as mephedrone became problematic and was perceived as the "*enemy*" (Robert, p.20, L186).

These paradoxical experiences resembled that of Hsieh et al.'s (2015) findings, who proposed that as drug use dominated participant's lives, they were trapped in a cycle of love, a desire to use drugs for their positive effects, and hate, upon the negative withdrawal of the drug, that motivated further use. Furthermore, these paradoxical experiences could be explained in line with social learning theory (Bandura, 1977). Wikler (1984) argued that the euphoric effects of a drug can reinforce its initial use via the method of operant conditioning (Skinner, 1938). However, as drug use becomes problematic or chemically addictive, as suggested

by the disease model (Muller & Hombery, 2015), the emergence of negative withdrawal symptoms can also encourage its further use in order to appease such effects (Sussman & Ames, 2001; Wikler, 1984).

The paradoxical experiences of mephedrone use were expressed further, as participants described their changing relationship with mephedrone as their drug use progressed. During the initial use of mephedrone, participants perceived mephedrone to be a natural source of nourishment, a source of emotional sustenance that created positive feelings ("*It is like chocolate*"; Alexander, p.7, L52). The euphemisms used to describe mephedrone coincided with the socially constructed image of mephedrone as positive (for how the positive perception of mephedrone was socially constructed, see section 4.2.2.2, p.64-65). However, as mephedrone use progressed, participants became "*chemically…hooked*" (Robert, p.19, L182), and the "*need*" or "*want*" (Daniel, p.19, L178) for mephedrone became uncontrollable and increased to the point it was described as "*survival*" (Daniel, p.8, L66). This uncontrollable use of mephedrone that participants described could be corroborated by Hsieh et al.'s (2015) suggestion that users of illicit drugs generally feel a lack of control concerning their problematic drug use (see section 4.2.2.2, p.64-65) This is perhaps due to underlying neuroadaptations that may have occurred because of prolonged drug use and that may inhibit one's self-control (Gorwood et al., 2012).

Eventually, the participants in this study no longer perceived their mephedrone use as safe, but instead described their problematic mephedrone use as the "*biggest mistake*" (John, p.3, L32), the "*biggest regret*" (Josh, p.31, L174), and as a "*tool*" (Josh, p.23, L136) formed by the "*devil*" (Josh, p.23, L136) to facilitate evil doings that were inflicted upon the participant, rather than mephedrone being willingly used for its potent effects. These findings are similar to those of Shinebourne and Smith (2010), who also identified the experience of alcohol "addiction as an affliction". Furthermore, mephedrone was metaphorically described as an abuser (see section 4.2.2.2, p.64-65) that ironically "*doesn't let you eat*" (Robert, p.15, L148). It appeared that everything rapidly became food for the drug, and the participants' sense of self, autonomy and livelihood (even their sexuality) was metaphorically eaten away by the drug itself. What began as being fed (the user) quickly becomes the one being devoured, as the initial rescuer (mephedrone) progressively becomes the persecuting enemy in a tragic drama perpetrated upon oneself to avoid inner pain. Mephedrone, the source of hoped-for mastery and control, becomes the destructive master out of one's control. In terms of Maslow's (1943, 1954) hierarchy of needs, mephedrone could initially be likened to the provider of one's "basic needs" such as food that facilitates personal growth. Instead it deceptively becomes the destroyer, preventing not only the development of one's "psychological needs" such as a sense of belonging or self-esteem, but even the maintenance of one's basic needs such as physical wellbeing.

5.2.3 How do participants *make sense* of their problematic mephedrone use?

5.2.3.1 Self-identification via stigmatising beliefs within the drug-using community. A unique finding of this study was how participants made sense of their mephedrone use by self-identifying, attributing certain characteristics or qualities of other types of drug user to themselves (see section 4.2.3.1,

p.68-70). This reflective process was affected by the participants' awareness of the stigmatising beliefs held within the drug-using community.

Although participants realised their substance misuse was "*bad*" (Robert, p.14, L138), participants within the drug-using community identified mephedrone use as less problematic or as recreational in comparison to traditional drug use. Participants associated traditional drug use with crime such as robbery, the stigmatised term "*addiction*", a financial burden and a greater risk to one's health, and generally with the view that their "*lifestyle's [are] completely different*" (Daniel, p.27, L154). Participants referred to users of traditional drugs by stigmatising terms such as "*druggies*" (Daniel, p.21, L118) or "*crackheads*" (Daniel, p.27, L160), and stereotypes, e.g. "*…addicts [that are] are very like… loud*" (Daniel, p.31, L180). In contrast, mephedrone was commonly referred to as a "*party drug*" (John, p.3, L15), used within the contexts of "*chill-outs or sex parties*" (Alexander, p.14, L92) or on the "*weekend*" (Josh, p.5, L50), and was associated with "*more fun*" (Alexander, p.5, L38) than traditional drug use.

It was evident that the terminology used by participants helped reinforce the stigmatising beliefs present with the drug-using community, namely that traditional drug use was problematic and that mephedrone use was recreational and non-problematic. Research suggests that society, as well as professionals, perceive recreational drug use as more acceptable and as a normalised behaviour (Cieslik & Pollock, 2002; Gourley, 2004; Lloyd, 2013; Parker, 1997; Shiner & Newburn, 1997). It appears that the language used by participants and mephedrone users alike facilitated the social construction of mephedrone as safe, fun and non-problematic. The professional arena was complicit too, as the terms "club drug" or "party drug" are used to classify such drugs. This coincides with the constructivist research paradigm of this study, which suggests reality is socially and discursively constructed within a particular context.

Further exploration demonstrated that a hierarchal system operated within the drug-using community regarding the price of drugs, which related to their problematic nature. Daniel explained that because mephedrone was "*cheaper*" (p.25, L140) than cocaine, it was thought to be less problematic than cocaine, followed by crack cocaine, and lastly by heroin, which was the most expensive and therefore perceived as the most problematic drug of all. Such findings were similar to that of Power, Power and Gibson (1996) who proposed that heroin users are perceived as more negative than those who use cocaine within the drug-using community.

Although mephedrone use was deemed the most acceptable and least problematic drug by the drug-using community in contrast to traditional drug use, it seemed there were social divides within the mephedrone-using community itself. These were based on the route of administration that identified whether an individual's mephedrone use was problematic or not. Participants explained that those who injected mephedrone were perceived as problematic users in comparison to those who snorted it. This was because participants associated injecting with a greater risk to one's wellbeing and with greater potency, whereas the socialisation of snorting was portrayed by media images as the norm. Perhaps this coincided with the social learning theory (Bandura, 1977) that contended that beliefs concerning PSM could be learned via television or actors in films (Sulkunen 2007; Waylen, Leary, Ness, Tanski, & Sargent, 2011). Furthermore, participants appeared to associate injecting

as a common route of administration for the most problematic and stigmatised drug, namely heroin; therefore, injecting symbolised problematic drug use. It could be that a self-image bias operated within the mephedrone-using community, since heroin users were perceived as the most problematic drug user. As a result, any behaviour that was attributable to a heroin user implied that one's own drug use was problematic (Hill, Smith & Hoffman, 1988).

5.2.3.2 The contemplative stage of change. In line with subordinate theme 3 (see section 4.2.3, p.68-74), it appeared that participants began to realise that their drug use was "*pointless*" (Josh, p.27, L160), since it no longer resembled a source of happiness. Feelings of unproductivity were exacerbated by, for example, missing work due to negative withdrawal symptoms. In line with the transtheoretical model (Prochaska & Diclemente, 1983), although participants may not have been ready for treatment, their change in perception of mephedrone use from safe to problematic could have reflected their initial acknowledgement of the disadvantages of using mephedrone as they entered the contemplation stage of change.

Participants continued to progress through the contemplative stage, evidenced as they spoke of a critical incident that prompted the initial self-evaluation of their mephedrone use (see section 4.2.3.1, p.68-70). Participants identified how their mephedrone use had become subjectively problematic in their lives. Participants recalled the negative impact of mephedrone on their wellbeing and employment, together with a loss of social network and depreciating financial status. This was inconsistent with the image of high-functioning addicts that mephedrone users were suggested to be (LDAN, 2012; NTA, 2012), and that perhaps in turn upheld the socially constructed image of mephedrone as safe. Nevertheless, it appeared that the negative impacts of mephedrone use were the same as those of traditional drug use (JCPMH, 2013). Therefore, Bowden-Jones' suggestion that club drug users' psychological treatment needs were unique (Wise, 2011) appears to be incorrect in this instance, as does Simpson's claim that their psychological treatment needs would be less than those of traditional drug users (LDAN, 2012). This suggests that the psychological support required to treat mephedrone users, e.g. in terms of promoting activity, creating supportive relationships or generating motivation for change, is the same as that of traditional drug users.

Participants contemplated further as they underwent an internal debate between their desires to use mephedrone and their values and beliefs that argued against their mephedrone use. Josh described the internal debate between his "*good voice*" (Josh, p.18, L96) encouraging him not to use mephedrone, and his "*bad voice*" (Josh, p.18, L96) encouraging him to fulfil his desire to use mephedrone. This mirrored Hsieh et al.'s (2015) findings that participants who used illicit drugs experienced a tug of war between oscillating thoughts involving the desire to use the drug and the desire to quit it. Participants of this present study also experienced an internal conflict between their many selves that maintained different values and beliefs. For example, Alexander experienced a conflict between religious identity as a Muslim and with his mephedrone-using identity, and John understood that his "*spiritual*" self (p.6, L31), who seemed calm and civilised, was incongruent with the "*drug side of me*" (p.6, L31), who enjoyed "*getting slaughtered*" (p.6, L31). Perhaps this signified the moral model that accounted for religiosity as a protective factor against the use of drugs (Yeung, Chan & Lee, 2009). Furthermore,

such findings corroborated Shinebourne and Smith's (2009) findings that explored participants' "perception of the self", and identified that participants experience a mixture of conflicting selves: one self acknowledges that the problematic use is destructive and wants to stop, while the other self enjoys engaging in the positive qualities associated with their PSM. However, it is the participants' realisation that using drugs has not brought them closer to their true-self, a further disadvantage, which further motivates them to want to abandon the "*drug side of me*" (John, p.6, L31).

5.3 The Use of Metaphors

Lakoff and Johnson (1980) believed that "metaphor is one of our most important tools for trying to comprehend partially what cannot be comprehended totally: our feelings, aesthetic experiences, moral practices, and spiritual awareness" (p.193). The present study captured metaphorical expressions embedded in participants' accounts, which enabled a richer understanding of the participants' experience (example of a metaphor, p.85). Schon (1993) referred to metaphors as a "process by which new perspectives on the world come into existence" (p.137). The use of metaphors by participants, in this study, during interviews may have highlighted significant episodes where a participant was engaging in expressing or making sense of a previously unexpressed or unexplored aspect of their experience (Shinebourne & Smith, 2010). IPA is well suited to exploring both the experiential dimension of metaphors through phenomenological analysis, and hermeneutic possibilities emerging through the capacity of metaphors to make connections between different ideas and concepts (Shinebourne & Smith, 2010).

An example of the use of metaphor in this study includes Daniel describing his feelings of a lack of control regarding his problematic mephedrone use, as that of reciprocated abuse from mephedrone:

"…cos I abused that, so now it should start to abuse me." (p.21, L118)

What is being expressed here is the participant's powerful biopsychosocial experience causing him psychic pain. It is acknowledged that Daniel in turn may identify as a victim, though the experience outlined is personal to his subjective experience. His metaphor moves beyond generalisable concepts such as identity that relate to grand narratives but, in line with the essence of IPA, access the participant's lifeworld to gather rich data, not only of influential social processes, but of real life events e.g. financial strain.

5.4 Limitations of this Research

In this study participants were all male and predominantly from the LGBT community (see Table 1, p.48). Although this demographic group was not deliberately sought out, existing evidence can suggest why this may have occurred. Research has evidenced that out of the general population in the UK, men (1.3%) were significantly more likely to have used an NPS, including club drugs, compared to women (0.4%; Lader, 2015). Moreover, evidence suggests that gay and bisexual men surveyed by the CSEW (2014) were more likely to have used drugs in the last year compared to heterosexual men. This could be because the UK and international

evidence suggests that rates of substance misuse are higher amongst the LGBT groups than in the general population, where LGBT people have also been 'early adopters' of some new drug trends, such as club drugs (Measham, Wood, Dargan & Moore, 2011).

It was explained to the participants in the consent form (Appendix K, p.123-124) that confidentiality would be broken if the participants disclosed the following: the possession of illegal drugs, the supply of illegal drugs and information about activities (e.g. theft, prostitution) that they may have engaged in to fund their drug use. This requirement was deemed necessary by Derby NHS ethical committee to manage risk while conducting this research. This requirement is not introduced during treatment, to allow the client to freely express themselves with regards to the activities outlined that are thought to be commonly associated with drug use. The introduction of such a requirement in this research, could have potentially limited how much information the participants disclosed when they discussed their mephedrone use, as they may have been concerned with potential punishment. Consequently, this may have limited the researcher's understanding of the participants subjective lifeworld, and limited the material collected and the research outcomes. As discussed earlier (section 2.2.3, p.27-28) club drug users are often suppliers themselves, it appears to be an integral process in understanding problematic club drug user. It could be that the narratives that reflect mephedrone as harmless, as highlighted in this study, could be generated via the user's relationship with their supplier which could warrant further research.

Furthermore, as suggested by Derby NHS ethical committee, in an effort to manage risk, research interviews were conducted at a drug treatment service in North London where the participants were having or had had treatment. This may have primed the participants to provide responses in relation to the treatment setting, a process referred to as 'subject-expectancy effects'. Participants may have also been reluctant to discuss their potential negative experiences of treatment; however, this was not a topic of interest in this research. Despite holding interviews within a treatment setting, what was evident and welcomed was the participants' forthcoming nature to disclose and explore difficult topics. It could be argued that having held interviews within a treatment setting could have also affected how the researcher responded to the data, perhaps as a practitioner. However, the researcher's responses were monitored by employing reflective practices (see section 1.5, p.19-21) to ensure the researcher remained as close as possible to the participants' lifeworld, while acknowledging that it is impossible for a reflexive researcher to be completely objective (Milton, 2010).

5.5 Recommendations for Future Research

Future research could focus on the stigmatising beliefs that operate within the drug-using community that prevent mephedrone users from self-identifying with PSM, which further discourages mephedrone users from accessing services where treatments are based on traditional drug use. As Adlaf, Hamilton, FeiWu and Noh (2009) explained, little research has explored how such stigma could be managed in order to reduce its effects as a barrier to seeking treatment.

Although not included as a significant feature in the results of this study, some participants explained how they felt treatment was not readily available for club drug users.

"*I think they believe there is no help for people [that] take mephedrone…*" (Daniel, p.34, L196)

Perhaps further research could explore how club drug users perceive the current treatment available, and how such treatment could be made more accessible or be improved.

Further research could adopt a discursive approach that could shed light on the use of language in the social construction of mephedrone as safe and fun, and highlight further implications of this in terms of the beliefs held with the drug-using community and the wider society. This could highlight the importance of language and help establish an understanding of how language could be used to reframe the image of mephedrone and club drugs alike.

Future research may also explore how individuals experience marginalisation, a common precipitating factor to substance misuse, in relation to acculturative stress, stigmatising beliefs in relation to their sexual orientation and financial difficulties. Findings could develop professionals' understanding of such experiences so that they can better help clients develop healthier strategies to enhance their self-esteem and sense of self.

This study focused on mephedrone use specifically. However, since the "consequences [of use] differed by type of club drug…future research should explore the reasons for club drug use by individual drug" (Parks & Kennedy, 2004, p.301). Perhaps further studies could explore the use of other club drugs to help establish commonalities or differences among experiences and motivations to use different club drugs. Such research could also help shed light upon whether a hierarchal belief system operates within the club drug-using community, which could elucidate whether such beliefs prevent or encourage individuals to use certain club drugs, how users develop ideas concerning the harms of club drugs, and how such thoughts may encourage or prevent them from identifying their PSM and subsequently accessing appropriate treatment.

Lastly, it appeared that difficulties in identity development greatly impacted users' vulnerability towards recreational drug use, seeing it as a hope for a "quick-fix" or a way to quickly escape from their identity distress. Further quantitative research could potentially help to validate such a relationship, perhaps by exploring the relationship between identity distress and PSM.

5.6 Recommendations for Training, Practice and Policy

Training ought to be provided to professionals working with club drug use concerning the harms associated with mephedrone use, e.g. loss of social network, negative impacts on one's wellbeing, financial strain, its addictive nature, and its similarity in terms of its negative impact to that of traditional drugs. As a consequence, it is hoped that the "training gap" (Wise, 2011, p.1) among professionals in the UK will be addressed, and support provided for psychological practitioners to improve their psychoeducation for mephedrone users. It is also hoped that users' lack of knowledge concerning mephedrone use as highlighted by this study will be addressed. That could demystify the extremely seductive and false mythology that continues

to be socially constructed by the users of the drugs and the influence of the contexts within which it is used (i.e. recreational party spaces).

In line with this study's findings, psychological practitioners may find that clients experience an ambivalence while debating whether to change their problematic mephedrone use (examples of ambivalence, see section 4.2.3.3, p.72-73). Ambivalence can be defined as the recognition that a change in behaviour is necessary, but causes distress in an individual; and that individuals alternate between approaching and avoiding the tasks necessary for change (Arkowitz, 2002). Psychologists are reminded to provide clients with guidance in acknowledging, confronting and coping with their ambivalence (Glidden-Tracy, 2005).

Moreover, this study highlighted that issues concerning identity development were the primary motivation to use mephedrone (examples of difficulties in identity development, see section 4.2.1, p.55-62). Psychological practitioners could view the therapeutic relationship as a transitional identity which may serve to change the client's identity from that of a drug user (Kellog, 1993). A positive therapeutic relationship will enhance collaboration, with the result that ambivalence and challenges are likely to be expressed more openly by clients. Studies have shown that through having an emotional bond with a therapist, clients can begin to internalise a belief in "alternative selves" (Kellog, 1993). Some literature suggests a need for continued identity work extending years into recovery from PSM (Koski-James, 2002). Therefore, the formation of structured support groups orientated towards the use of club drugs, mirroring the supportive environment fostered by the mephedrone-using community, could provide a place for continued self-reflection, support and growth.

It is suggested that government policy be introduced that serves to reframe the socially constructed image of mephedrone as safe, an image which influences society's perception of mephedrone and the stigmatising belief system that operates within the drug-using community. Such a reframing of perspective could be reinforced by changing the terminology used by professionals to classify such drugs, e.g. "club drugs", "party drugs" and "legal highs", by using a name that reflects the potential harms of such drugs. Moreover, it is proposed that primary prevention interventions be introduced to offer education concerning the harms of club drug use, in order to increase the awareness of the problematic nature of such drugs before they are used. Again, hopefully this could demystify the safe and fun image associated with club drugs so that individuals consider the reality of the negative impacts of such drugs prior to their use. If done post-use, this could enable them to feel less individualised and isolated by their own painful experience of mephedrone use.

5.7 Summary and Conclusions

To summarise, this research presented an interpretative account of the data collected through semi-structured interviews. The data was analysed using IPA in order to explore how mephedrone users experience and make sense of their problematic use. Three superordinate themes were identified: (1) mephedrone as a credulous fix for ongoing identity vulnerability and distress, initiating a vicious cycle of deliberate use, (2) the paradoxical experiences of progressive mephedrone use, and (3) making sense of one's problematic mephedrone use via self-reflective processes. This study attempted to provide the reader with a sense of the relationships and similarities between these themes and the subordinate themes that support them.

This study highlighted that individuals may use club drugs who do not represent the typical profile of a club drug user (see section 1.2.3, p.18; see Table 1, p.48). Perhaps this shows the necessity for this qualitative research, which looks beyond specific socio-demographic characteristics to achieve an understanding of club drug use and users alike. As a consequence, this study also highlighted that club drug use may not be motivated primarily by age-specific issues such as peer pressure, but could be related to wider concepts that are significant in the area of substance misuse. For example, this data suggested that issues concerning difficulties in identity formation were the primary motivation to use mephedrone, a common reason found for substance misuse including traditional drug use (Etherington, 2006; Bruce, 1990; Larkin & Griffith, 2002). The secondary motivation to continue mephedrone use was to appease the symptoms of withdrawal, a common reason for PSM (Hsieh et al., 2015; Shinebourne & Smith, 2009; Shinebourne & Smith 2010).

The subjective experience of mephedrone use appeared to be similar to that of traditional drugs, when compared with research concerning the experience of PSM and its negative impacts. This implied that club drug users were not "high-functioning addicts" as Winstock suggested (LDAN, 2012; NTA, 2012), and that club drug use did negatively affect relationships, wellbeing, and ability to maintain a job. Hence, club drug users appeared to have the same amount of recovery capital, not more as suggested by Simpson (2012), as that of traditional drug users and, therefore, their psychological treatment needs also appeared to be similar.

The findings of this research suggested that the necessity for club drug clinics was not so much related to the proposed uniqueness of treatment needs of club drug users, as suggested by Bowden-Jones (Hawkes, 2012, p.1; NTA, 2012), but was because of significant barriers that prevented club drug users accessing treatment. This study found that stigmatising beliefs operated within the drug-using community and, more significantly, in the mephedrone-using community, that promoted the misleading perception that traditional drug use was more problematic than club drug use; and these prevented club drug users from self-identifying with the stereotypical perception of a problematic drug user. This stereotypical perception potentially inhibited mephedrone users from accessing generalised treatment services based on the needs of traditional drug use, as they thought such services were not equipped to meet the assumed different needs of mephedrone users. However, as this research confirms, the psychological treatment needs of club drug users are similar to that of traditional drug users, although club drug clinics allow such users to access treatment without the stigma associated with traditional drug use. This identifies the need for further research exploring how such stigmatising beliefs could be managed in order to reduce their effects as a barrier to seeking treatment, and perhaps also how club drug users perceive club drug clinics.

A unique and significant finding of this study was that mephedrone may be socially constructed by users and professionals alike as benign, non-addictive, recreational, and safe (or at least qualitatively different from other "more serious" drugs that are widely associated with the stereotypical perception of an "addict"). This research suggests that stigmatising beliefs held within the drug-using community, the lack of information available concerning the harms associated with mephedrone use, and the terminology used when describing such drugs, all helped to maintain mephedrone's seductive position in the substance misuse landscape as safe and fun. Importantly, this study has also highlighted the paradoxical dynamics by which users related to

mephedrone that may have also actively contributed to the social construction of the "benign" and "recreational" false-identity of the drug, which could indeed subtly mirror the identity predicament of users. While this warrants further research, it also suggests three significant steps that should be taken. These are, firstly, the need for reframing the public image of club drugs by the sensitive use of language by professionals when describing such drugs; secondly, the implementation of primary prevention interventions associated with the promotion of information concerning the harms associated with club drug use, and thirdly, the training of psychological practitioners to provide psychoeducation to users of the harms associated with club drugs.

5.8 Reflexive Section: Part Three

Conducting this research has been a difficult learning journey of becoming and transforming (Etherington, 2004). I aspire to what Carl Rogers refers to as immersing ourselves as researchers in phenomena under study and "this means a tolerance for ambiguity and contradiction, a resistance for closure, the valuing of unbridled curiosity" (Rogers, in Kirschenbaum & Henderson, 1996, p.269). The process of research taught me to tolerate contradictions and uncertainties, and to embrace my "unbridled curiosity" in how mephedrone users experience their problematic use.

Receiving ethical approval for this research was the most difficult process in my research journey. I underwent many administrative difficulties while awaiting ethical approval, although I persevered in a systematic and rigorous manner. During this time, I learned to tolerate uncertainty about the likelihood of the fruition of my pending research and this further enriched the "process of becoming a reflexive researcher" as I wrote my worries in my reflective journal (Etherington, 2004, p.81).

During the research process, I noticed how I could establish rapport with participants with ease. This was signified by the participants wanting to relate to me, specifically John (example, see section 4.2.1.2, p.58-60). Reflecting on this incident, I noticed how my involuntary self-disclosure of my ethnicity, evidenced by the colour of my skin, positively affected the interview process. It could be assumed that participants, particularly John, felt that I could associate with their experience of marginalisation as I may have experienced marginalisation due to my ethnicity, hence facilitating rapport between us. Nevertheless, I made it a priority to maintain the boundaries within my professional relationships with participants. I did so by not disclosing any of my personal experiences, by sensitively redirecting questions back to the participant to understand the significance of what they were trying to communicate, and by recording and exploring my feelings regarding such incidents to make sure they did not impact on the research.

I recall my assumption prior to conducting this research that club drug users were different from traditional drug users in terms of their treatment needs, since traditional drug use appeared to be more debilitating than club drug use, which is why different types of services were suggested. Using my reflexive journal and discussions during supervision, I feel I successfully bracketed this assumption and allowed the research to be guided instead by the experience of participants. I found it interesting to acknowledge that club drugs were as debilitating as traditional drugs, and that I was also duped by the socially constructed image of club drugs as safe, fun and non-problematic. This led me to reflect on two further conclusions. Firstly, there a

stigmatising belief system operating within the drug-using community in terms of how problematic a drug is perceived relative to traditional drugs. Secondly, this belief system may operate within the professional arena and is promoted using language such as club drugs.

Lastly, all the participants expressed their gratitude towards this research, and they were also appreciative of the opportunity to voice their experiences. The participants' enthusiasm was a great inspiration and motivation for me to complete this research. They enabled me, and hopefully other counselling psychologists and mental health practitioners, to better understand club drug use. I hope this better understanding can help implement findings and improve treatment provided for club drug users.

References

Aanavi, M. P., Taube, D. O., Ja, D. Y. & Duran, E. F. (1999). The Status of Psychologists' Training About and Treatment of Substance-Abusing Clients. *Journal of Psychoactive Drugs, 31*(4), 441-444.

Adlaf, E. M., Hamilton, H. A., FeiWu & Noh, S. (2009). Adolescent stigma towards drug addiction: Effects of age and drug use behaviour. *Addictive Behaviours 34*, 360–364.

Advisory Council on the Misuse of Drugs. (2011). *Consideration of the Novel Psychoactive Substances ('Legal Highs').* England: Advisory Council on the Misuse of Drugs.

Ainsworth, A. D. S. (1979). Attachment as Related to Mother-Infant Interaction. *Advances in the Study of Behaviour, 9*, 1-51.

Allan, G. (2014). *Working with Substance Users: A Guide to Effective Interventions.* England, London: Palgrave Macmillan.

Allen, D. J. & Oleson, T. (1999). Shame and Internalized Homophobia in Gay Men. *Journal of Homosexuality, 37*(3), 33-43.

Anderson, T. L. & Mott, J. A. (1998). Drug-related Identity Change: Theoretical Development and Empirical Assessment. *Journal of Drug Issues, 28*(2), 299-328.

Amato, L., Minozzi, S., Davoli, M. & Vecchi, S. (2011). Psychosocial and pharmacological treatments versus pharmacological treatments for opioid detoxification. *Cochrane Database Systematic Review, 7*(9).

American Psychiatric Association. (1994). *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, (DSM-4).* Washington, DC: APA.

American Psychiatric Association. (2013). *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, (DSM-5)*. Washington, DC: APA.

Arbona, C. & Power, T. G. (2003). Parental attachment, self-esteem, and antisocial behaviours among African American, European American, and Mexican American adolescents. *Journal of Counselling Psychology, 50*(1), 40-51.

Archer, S. L. (2008). Identity and Interventions: An Introduction. *Identity: An International Journal of Theory and Research, 8,* 89-94.

Ashley, H. (2010). Humanistic contributions to pluralistic practice. In M. Milton (Ed.), *Therapy and beyond: Counselling psychology contributions to therapeutic and social issues* (pp.123-138). Oxford, England: Wiley-Blackwell.

Babor, T. F. (2007). We shape our tools, and thereafter our tools shape us: Psychiatry epidemiology and the alcohol dependence syndrome concept. *Addiction, 102*, 1534–1535.

Bandura, A. (1977). *Social Learning Theory.* Englewood Cliffs, NJ: Prentice Hall.

Barrocas, J., Vieira-Santos, S. & Paixão, R. (2016). Parenting and Drug Addiction: Psychodynamic Proposal Based on a Multifactorial Perspective. *American Psychological Association, 33*(1), 161-178.

Baumeister, R. F. & Leary, M. R. (1995). The Need to Belong: Desire for Interpersonal Attachments as a Fundamental Human Motivation. *American Psychological Association, 117*(3), 497-529.

Bernstein, R. (1983). *Beyond objectivism and relativism: Science, hermeneutics, and praxis*. Philadelphia: University of Pennsylvania Press.

Berry, J. W., Poortinga, Y. H., Segall, M. H. & Dasen, P. R. (1992). *Cross-cultural psychology: Research and applications.* New York: Cambridge University Press.

Berzonsky, M. D. & Adams, G. R. (1999). Re-evaluating the identity status paradigm: Still useful after 35 years. *Developmental Review, 19*, 557-590.

Best, D., Ghufran, S., Day, D., Ray, R. & Loaring, J. (2008). Breaking the habit: a retrospective analysis of desistance factors among formerly problematic heroin users. *Drug and Alcohol Review, 27*, 619–624.

Borhani, Y. (2013). Substance Abuse and Insecure Attachment Styles: A Relational Study. *Journal of Transdisciplinary Writing and Research, 2*(1), 4.

Bourne, A., Reid, D., Hickson, F., Torres Rueda, S. & Weatherburn, P. (2014). *The Chemsex study: drug use in sexual settings among gay & bisexual men in Lambeth, Southwark & Lewisham*. London: Sigma Research, London School of Hygiene & Tropical Medicine. www.sigmaresearch.org.uk/chemsex

Bowden-Jones, Owen. (2012). *New generation, new drugs: the rise and rise of club drugs.* In Network (Eds.), April: Responding to change: the challenge of primary care (pp.3-4). England: Reckitt Benckiser.

Bowlby, J. (1969). *Attachment and loss: Vol. 1.* New York: Basic Books.

Bristol. (2013). *MMagik*. Retrieved on April 2014 from: http://www.mmagik.co.uk/

British Psychological Society. (2005). *The division of counselling psychology professional practice guidelines*. Leicester: BPS.

British Psychological Society. (2009). *Code of Ethics and Conduct.* UK, Leicester: BPS.

British Psychological Society. (2010). *Code of Human Research Ethics.* UK, Leicester: BPS.

British Psychological Society. (2014). *Standards of Doctoral Programs in Counselling Psychology.* Leicester: BPS.

Broyles, L. M., Binswanger, I. A., Jenkins, J. A., Finnell, D. S., Faseru, B., Cavaiola, A., Pugatch, M. & Gordon A. J. (2014). Confronting inadvertent stigma and pejorative language in addiction scholarship: a recognition and response. *Substance Abuse, 35*(3), 217-221

Bruce, A. (1990). The empirical and theoretical bases for an adaptive model of addiction. *Journal of drug issues, 20*(1), 37-65.

Burglass, M. E. & Shaffer, H. J. (1984). Diagnosis in the addictions I: Conceptual problems. *Addictive Behaviours, 3*, 19–34.

Burman, E. (1994). *Interviewing.* In P. Banister, E. Burman, I. Parker, M. Taylor & C. Tindall (Eds.), Qualitative methods in psychology. A research guide (pp.49-71). Buckingham: Open University Press.

Camden & Islington. (2014). *Grip.* Retrieved on April 2014 from: http://www.camdenccg.nhs.uk/News/grip-201402

Campbell, J. D. (1990). Self-Esteem and Clarity of the Self-Concept. *Journal of Personality and Social Psychology, 59*,538-549.

Cast, A. D. & Burke, P. J. (2002). A Theory of Self-Esteem. *Social Forces, 80*(3), 1041-1068.

Carhart-Harris, R. L., King, L. A. & Nutt, D. J. (2011). A web-based survey on mephedrone. *Drug and Alcohol Dependence, 118*(1), 19-22.

Carroll, F. I., Lewin, A. H., Mascarella, S. W., Seltsman, H. H. & Reddy, P.A. (2012). Designer drugs: a medicinal chemistry perspective. *Addiction Reviews, 1248,* 18-38.

Cellucci, T. & Vik, P. (2001). Training for substance abuse treatment among psychologists in a rural state. *Professional Psychology: Research and Practice, 32*(3), 248-252.

Central and North West London. (2010). *LGBT communities.* Retrieved on April 2014 from: http://clubdrugclinic.cnwl.nhs.uk/need-help/lgbt-communities/

Chiert, T., Gold, S. N. & Taylor, J. (1994). Substance Abuse Training in APA-Accredited Doctoral Programs in Clinical Psychology: A Survey. *Professional Psychology Research and Practice, 25*(1), 80-84.

Cieslik, M. & Pollock, G. (2002). *Young people in risk society: The restructuring of youth identities and transitions in late modernity*. Aldershot, England: Ashgate.

Cocking, C. (2008). *Distress Protocol.* England: London Metropolitan University.

Cole, M. (2011). Poison in party pills is too much to swallow. *Nature, 253*, 474.

Cooper, M. & McLeod, J. (2011). *Pluralistic counselling and psychotherapy.* London: Sage

Corbin, J., Gottdiener, W., Sirikantraporn, S. & Armstrong, J. L. (2013). Prevalence of training in addiction psychology and treatment in APA-accredited clinical and counselling psychology doctoral programs. *Addiction Research and Theory, 21*(4), 1-4.

Creswell, J. W. (2003). *Research design: Qualitative, quantitative, and mixed methods approaches.* (2nd Ed.) Thousand Oaks: Sage.

Daley, K. (2009). *The ethics of doing research with young drug* users. In (Eds), Lockie, S., Bissell, D., Greig, A., Hynes, M., Marsh, D., Saha, L., Sikora, J. & Woodman, D, 1-4 December: The Future of Sociology: refereed proceedings of the 2009 annual conference of the Australian Sociological Associations. Australian National University.

Dargan, P. I., Albert, S. & Wood, D. M. (2010). Mephedrone use and associated adverse effects in school and college/university students before the UK legislation change. *Qualitative Journal Medical, 103*, 875-879.

Delete, J. S. & Fararo, T. J. (1992). *Rational Choice Theory: Advocacy and Critique.* London: Sage.

Dew, B. J., Elifson, K. W. & Sterk, C. E. (2006). Treatment implications for young adult users of MDMA. *Journal of Addictions and Offender Counselling, 26*, 84-96.

Department of Health England and the Devolved Administrations. (2007). *Drug Misuse and Dependence: UK Guidelines on Clinical Management.* Department of Health, the Scottish Government, Welsh Assembly Government and Northern Ireland Executive.

DiClemente, C. C. (2003). *Addiction and change: How addictions develop and addicted people recover.* New York: Guilford Press.

Di Chiara, G. & Bassareo, V. (2007). Reward system and addiction: what dopamine does and doesn't do. *Current Opinion in Pharmacology, 7*, 69-76.

DiPlacido, J. (1998). *Minority Stress Among Lesbians, Gay Men, and Bisexuals: A Consequence of Heterosexism, Homophobia, and Stigmatisation.* G.M. Herek (Ed.), Stigma and Sexual Orientation: Understanding Prejudice Against Lesbians, Gay Men, and Bisexuals (pp.138-59). Thousand Oaks, CA: Sage.

Dodes, L. M. (2002). *The Heart of Addiction.* New York: First Quill.

Elliot, R., Fischer, C. & Rennie, D. (1999). Evolving guidelines for publication of qualitative research studies in psychology and related fields. *British Journal of Clinical Psychology, 38*, 215-29.

Erikson, E. (1963). *Childhood and society* (Rev. ed.). New York: Norton.

Erikson, E. (1968). *Identity: Youth and crisis.* New York: Norton.

Erikson, C. K. (2008). In defence of "dependence". *Alcoholism: Clinical and Experimental Research, 32*, 1–3.

Etherington, K. (2004). *Becoming a Reflexive Researcher - Using Our Selves in Research*. London: Jessica Kingsley Publishers.

Etherington, K. (2006). Understanding drug misuse and changing identities: A life story approach. *Drugs, education, prevention and policy, 13*(3), 233-245

European Monitoring Centre for Drugs and Drug Addiction. (2012). *Annual Report 2012: The state of the drugs problem in Europe.* Luxembourg: Publications Office of the European Union.

Evans, K. (2007). Relational-centred research: A work in progress. *European Journal for Qualitative Research in Psychotherapy, 2*, 42-44.

Flowers, P., Marriott, C. & Hart, G. (2010). The bars, the bogs, and the bushes': The impact of locale on sexual cultures. *Culture, Health & Sexuality: An International Journal for Research, Intervention and Care, 2*(1), 69-86.

Finlay, L. (2002). Negotiating the swamp: the opportunity and challenge of reflexivity in research practice. *Qualitative Research 2*(2), 209-230.

Finlay, L. (2006). *Mapping methodology.* In L. Finlay. & C. Ballinger (Eds.), Qualitative research for allied health professionals- Challenging choices (pp.9-29). Chichester: Whurr.

Finlay, L. (2011). *Phenomenology for therapists: Researching the lived world.* West Sussex, UK: Wiley, Blackwell.

Firestone, W. A. (1993). Alternative arguments for generalizing from data as applied to qualitative research. *Educational Researcher 22*, 16–23.

First, B. M. (2009). Harmonisation of ICD–11 and DSM–V: opportunities and challenges. *The British Journal of Psychiatry, 195*(5), 382-390.

Flores, P. J. (2004). *Addiction as an Attachment Disorder.* Oxford, UK: The Rowman and Littlefield Publishing Group.

Freeman, T. P., Morgan, C. J. A., Vaughn-Jones, J., Hussain, N., Karimi, K. & Curran, C. H. (2012). Cognitive and subjective effects of mephedrone and factors influencing use of a 'new legal high'. *Addiction, 107*, 792-800.

Gahlinger, P. M. (2004). Club drugs: MDMA, Gamma-Hydroxybutyrate (GHB), Rohypnol and Ketamine. *American Family Physician, 69*(11), 2619-2627.

Geertz, C. (Ed.) (1973). *The interpretation of culture.* New York: Basic Books.

Gorwood, P., Le Strat, Y., Ramoz, N., Dubertret, C., Moalic, J. M. & Simonneau, M. (2012). Genetics of dopamine receptors and drug addiction. *Human Genetics, 131*, 803–822.

Gourley, M. (2004). A subcultural study of recreational ecstasy use. *Journal of Sociology, 40*(1), 59-73.

Grossman, A. & Kerner, M. S. (1998). Self-Esteem and Supportiveness as Predictors of Emotional Distress in Gay Male and Lesbian Youth. *Journal of Homosexuality, 35*(2), 25-39.

Guba, E. G. (1990). *The paradigm dialog.* Newbury Park, CA: Sage.

Hansen, J. T. (2004). Thoughts on knowing: Epistemic implications of counselling practice. *Journal of Counselling and Development, 82*(2), 131-138.

Haringey, Enfield and Barnet. (2013). *The Haringey Club Drug Clinic.* Retrieved on April 2014 from: http://www.beh-mht.nhs.uk/news-and-events/haringey-club-drug-clinic.htm

Harwood, H. J., Kowalski, J. & Ameen, A. (2004). The need for substance abuse training among mental health professionals. *Administration and Policy in Mental Health, 32*(2), 189-205.

Hawkes, N. (2012). UK drug service is ill equipped to deal with new 'legal highs' taken by clubbers, conference is told. *British Medical Journal, 1,* 1.

Health and Social Care Information Centre. (2014). *Statistics on Drug Misuse.* England: Lifestyle Statistics.

Hill, T., Smith, N. D., & Hoffman, H. (1988). Self-image bias and the perception of other persons' skills. *European Journal of Social Psychology, 18*, 293–298.

Health and Care Professions Council. (2012). *Standards of Proficiency: Practitioner psychologists.* London: HCPC.

Heidegger, M. (1927). *Sein und Zeit (Being and Time).* Trans. Macquarrie, J. & Robinson, E. New York: Blackwell publishing.

Heidegger, M. (1962). *Kant and the Problem of Metaphysics.* Trans. Kisiel, T. Bloomington, IN: Indiana University Press.

Hockenhulla, J., Murphy, K. G. & Patersona, S. (2016). Mephedrone use is increasing in London. *The Lancet, 387*(10029), 1719–1720.

Home Office. (2014) *Drug misuse: Findings from the 2013/14 Crime Survey for England and Wales London.* Retrieved October 2016 from: https://www.gov.uk/government/publications/drugmisuse-findings-from-the-2013-to-2014-csew/drug-misuse-findings-from-the-201314-crimesurvey-for-england-and-wales

Home Office. (2015). *Statistical News Release – Drug Misuse: Findings from the 2014/15 Crime Survey for England and Wales.* Retrieved October 2016 from: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/447548/snr-drug-misuse-1415.pdf

Hsieh, M. Tsai, S., Tsai, C., Hsu, Y. & Hsu, M. (2015). What Is the Addiction World Like? Understanding the Lived Experience of the Individuals' Illicit Drug Addiction in Taiwan. *Perspectives in Psychiatric Care*, 1-8.

Husserl, E. G. A. (1970). *Logical investigations, 2 vols.* (trans J.N. Findlay). London: RKP. (Original work published 1900, 1901, 1913 & 1921).

Husserl, E. G. A. (1982) *Ideas pertaining to a pure phenomenology and to a phenomenological philosophy: First book.* (trans F. Kersten). Dordrecht: Kluwer. (Original work published 1913).

Johnson, J. L. (1997) *Generalisability in qualitative research: Excavating discourse.* In J.M. Morse (Ed), Completing a qualitative project: Details and dialogue (pp.1912). Thousand Oaks: Sage.

Joint Commissioning Panel for Mental Health. (2013). *Guidance for commissioners of drug and alcohol services.* England: Raffertys.

Kahneman, D. (2010). *The riddle of experience versus memory.* Retrieved on May 2016 from: https://www.ted.com/talks/daniel_kahneman_the_riddle_of_experience_vs_memory

Kapitány-Fövény, M., Kertész, M., Winstock, A., Deluca, P., Corazza, O., Farkas, J., Zacher, G., Urbán, R. & Demetrovics, Z. (2013). Substitutional potential of mephedrone: an analysis of the subjective effects. *Human Psychopharmacology, 28*(4), 308-316.

Kasket, E. (2012). *The counselling psychologist researcher*. In G. Davey (Ed.). Applied psychology. London: BPS.

Kassel, J. D., Wardle, M. & Roberts, J. E. (2007). Adult attachment security and college student substance use. *Addictive Behaviours, 32*(6), 1164-1176.

Khantzian, E. J. (2003). Understanding addictive vulnerability. *Neuro-Psychoanalysis, 5*, 5–21.

Knapp, W. P., Soares, B. G., Farrel, M. & Lima, M. S. (2007). Psychosocial interventions for cocaine and psychostimulant amphetamines related disorders. *Cochrane Database System Review, 18*(3).

Koski-Jannes, A. (2002). Social and personal identity projects in the recovery from addictive behaviours. *Addiction research and theory, 10*(2), 183-202.

Krauss, S. E. (2005). Research Paradigms and Meaning Making: A Primer. *The Qualitative Report, 10*(4), 758-770.

Krueger, J. (1998). On the perception of social consensus. In: M. P. Zanna (Ed.), *Advances in experimental social psychology* (pp.163–240). San Diego, CA: Academic Press.

Krueger, J. (2000). The projective perception of the social world. In: J. Suls & L. Wheeler (Ed.), *Handbook of social comparison: Theory and research* (pp.323–351). New York: Kluwer Academic.

Lader, D. (2015). *Drug Misuse: Findings from the 2014/15 Crime Survey for England and Wales Statistical Bulletin 03/15* (2nd Ed.). UK: Home Office.

Laible, D. Carlo, G. & Roesch, S. C. (2004). Pathways to self-esteem in late adolescence: the role of parent and peer attachment, empathy, and social behaviours. *Journal of Adolescence, 27*(6), 703-716.

Lane, D.A. & Corrie, S. (2006). Counselling psychology: Its influences and future. *Counselling Psychology Review, 21*(1), 12–24.

Langs, R. (1982). *Psychotherapy: A basic text.* New York: Aronson.

Larkin, M. & Griffiths, M. D. (2002). Experiences of addiction and recovery: The case for subjective accounts. *Addiction research and theory, 10*(3), 281-311.

Larkin, M., Watts, S. & Clifton, E. (2006). Giving voice and making sense in interpretative phenomenological analysis. *Qualitative research in psychology, 3*, 102-120.

Larsson, P., Brooks, O. & Loewenthal, D. (2012). Counselling psychology and diagnostic categories: A critical literature review. *Counselling Psychology Review, 27*(3), 55-67.

Lea, T., Mao, L., Bath, N., Prestage, G., Zablotska, I., de Wit, J. & Holt, M. (2013). Injecting drug use among gay and bisexual men in Sydney: prevalence and associations with sexual risk practices and HIV and hepatitis C infection. *AIDS Behaviour, 17*(4), 1344-1351.

Legard, R., Keegan, J. & Ward, K. (2003) *In-depth Interviews.* In Ritchie, J. & Lewis, J. (Ed.), Qualitative Research Practice: A Guide for Social Science Students and Researchers (pp.138-170). London: Sage.

Lincoln, Y. S. & Guba, E. G. (1985). *Naturalistic Inquiry*. Newbury Park, CA: Sage.

Link, B.G., Phelan, J.C., Bresnahan, M., Stueve, A. & Pescosolido, B.A. (1999). Public Conceptions of Mental Illness: Labels, Causes, Dangerousness, and Social Distance, *American Journal of Public Health 89*, 1328–33.

Lloyd, C. (2013). The stigmatisation of problem drug users: A narrative literature review. *Drugs: Education, Prevention & Policy, 20*(2), 85-95.

London Drug and Alcohol Network. (2012). *News: London responds to growing 'club drug' treatment demand.* Retrieved on November 2013 from: http://www.ldan.org.uk/PDFs/LDANNewsDec12.pdf

Mackay, K., Taylor, M. & Bajaj, N. (2011). The adverse consequences of mephedrone use: a case series. *The Psychiatrist, 35*, 203-205.

Maslow, A. H. (1943). A Theory of Human Motivation. *Psychological Review*, 50(4), 370-96.

Maslow, A. H. (1954). *Motivation and personality*. New York: Harper and Row.

Marcia, J. E. (1966). Development and validation of ego-identity status. *Journal of Personality and Social Psychology, 3*(5), 551-558.

Mariezcurrena, R. (1994). Recovery from addictions without treatment: Literature review. *Scandinavian Journal of Behaviour Therapy, 23*, 3-4.

Marlatt, A. & Donovan, D. M. (2005). *Relapse prevention: maintenance strategies in the treatment of addictive behaviours.* London: The Guilford Press.

Martin C. S., Langenbucher J. W., Chung T. & Sher K. J. (2014). Truth or consequences in the diagnosis of substance use disorders. *Addiction, 109*, 1773–1778.

Maxwell, J.C. (2003). The response to club drug use. *Current Opinion Psychiatry, 16*, 279-289.

Maxwell, J.C. (2005). Party Drugs: Properties, Prevalence, Patterns and Problems. *Substance Use and Misuse, 40,* 1203-1240.

McLeod, J. (2003). *Qualitative research methods in counselling psychology.* In R. Woolfe, S. Strawbridge, B. Douglas & W. Dryden (Ed.), Handbook of counselling psychology (3rd Ed, pp.74-92). London: Sage.

McLeod, J. (2011). *Qualitative research in counselling and psychotherapy.* London: Sage.

Measham, F., Newcombe, R. & Parker, H. (1994). The Normalisation of Recreational Drug Use Amongst Young People in North West England. *British Journal of Sociology, 45*(2), 287–312.

Measham, F., Aldridge, J. and Parker, H. (2000). *Dancing on Drugs: Risk Health and Hedonism in the British Club Scene.* London: Free Association Books.

Measham, F., Wood, D. M., Dargan, P. I. & Moore, K. (2011). The rise in legal highs: prevalence and patterns in the use of illegal drugs and first- and second-generation 'legal highs' in south London gay dance clubs. *Journal of Substance Use, 16*(4), 263-272.

Mertens, D.M. (2005). *Research methods in education and psychology: Integrating diversity with quantitative and qualitative approaches.* (2nd Ed.) Thousand Oaks: Sage.

Merton, R. K. (1968). *Social Theory and Social Structure.* New York: Free Press.

Meyer, I. H. (1995). Minority Stress and Mental Health in Gay Men. *Journal of Health and Social Behaviour, 36*, 38-56.

Miller, W. R. & Brown, S. A. (1997). Why Psychologists Should Treat Alcohol and Drug Problems. *American Psychologist, 52*(12), 1269-1279.

Milton, M. M. (2010). *Therapy and Beyond*. Sussex. John Wiley and Sons Ltd.

Mirza, K. & Mirza, S. (2008). Adolescent substance misuse. *Psychiatry, 7*, 357-362.

Mollon, P. (2009). The NICE guidelines are misleading, unscientific and potentially impede good psychological care and help. *Psychodynamic Practice, 15*(1), 9-24.

Monk, R. L. & Heim, D. (2011). Self-image Bias in Drug Use Attributions. *Psychology of Addictive Behaviours, 24*(4), 615-651.

Morrow, S. L. (2007). Qualitative Research in Counselling Psychology: Conceptual Foundations. *The Counselling Psychologist, 35*(2), 209-235.

Moshier, S. J., McHugh, R., Calkins, A. W., Hearon, B. A., Rosellini, A. J., Weitzman, M. L. & Otto, M. W. (2012). The role of perceived belongingness to a drug subculture among opioid- dependent patients. *Psychology of Addictive Behaviours, 26*(4), 812-820.

Muller, C. P. & Homberg, J. R. (2015). The role of serotonin in drug use and addiction. *Behavioural Brain Research, 277*, 146-192.

National Health Service. (2014a). *What is mental illness?* Retrieved on June 2014 from: http://www.sabp.nhs.uk/advice/mental-illness

National Health Service. (2014b). *What is a serious mental health disorder*? Retrieved July 2014 from: http://www.mentalhealthwales.net/mhw/whatis.php

National Institute for Health and Clinical Excellence guidelines. (2007a). *NICE Clinical guideline 51: Drug misuse, Psychosocial interventions.* UK: NICE.

National Institute for Health and Clinical Excellence guidelines. (2007b). *NICE Clinical guidelines 52: Understanding NICE guidance, Treatment for drug misuse.* UK: NICE.

National Institute for Health and Clinical Excellence. (2012). *Quality Standard for Drug Use Disorders (Quality Standard 23).* UK: NICE.

National Institute for Health and Clinical Excellence. (2013). *Alcohol Use Disorders: Harmful Drinking and Alcohol Dependence (Clinical Guidance 115: Evidence Update).* UK: NICE.

National Institute for Health and Clinical Excellence. (2014). *Behaviour Change: Individual Approaches (PH 49).* UK, NICE.

National Institute of Drug Abuse. (2013). *Drug Facts: Cocaine.* Retrieved on May 2016 from:https://www.drugabuse.gov/publications/drugfacts/cocaine

National Institute of Drug Abuse. (2014). *Drug Facts: Heroin.* Retrieved on May 2016 from: https://www.drugabuse.gov/publications/drugfacts/heroin

National Treatment Agency for Substance Misuse. (2005). *The Effectiveness of Psychological Therapies on Drug Misusing Clients.* England, NHS.

National Treatment Agency for Substance Misuse. (2010). *Drug Treatment 2009-10.* England: NHS.

National Treatment Agency for Substance Misuse. (2012). *Statistics on club drugs: club drugs data tables.* England: NHS.

National Treatment Agency for Substance Misuse. (2013). *Falling Drug Use: The Impact of Treatment.* England: NHS.

Neale, J., Allen, D. & Coombes, L. (2005). Qualitative research methods within the addictions. *Addiction ,100*, 1584–1593.

Nichter, M., Quintero, G. & Nichter, M. (2004). Qualitative research: Contribution to the study of drug use, drug abuse, and drug use(r)-related interventions. *Substance Use and Misuse, 39*, 1907–1969.

Nouroozifar, M. & Zangench, M. (2006). Mental Health and Addiction State of Ethnocultural/ Racial Communities. *International Journal Health Addiction, 4*, 288-293.

Novel Psychoactive Treatment UK Network. (2015). *Guidance on the Management of Acute and Chronic Harms of Club Drugs and Novel Psychoactive Substances.* England, London: NEPTUNE.

O'Brien., C. (2011). Addiction and dependence in DSM-V. *Addiction, 106*(5), 1-3.

O'Connell, D. C. & Kowal, S. (1995). *Basic Principles of Transcription*. In J. A. Smith, R. Harre & L. Van Langenhove (Ed.), Rethinking Methods in Psychology (pp.93-105). London: Sage.

Orlans, V. (2013). The nature and scope of counselling psychology. In G. Davey (Ed.), *Applied psychology* (pp.1-23). Chichester, West Sussex: Wiley Blackwell.

Orlans, V. & Van Scoyoc, S. (2008). *A Short Introduction to Counselling Psychology*. London: Sage.

Parker, H. (1997). Adolescent drug pathways in the 1990s. In J. Braggins (Ed.), Tackling drugs together: One year on (pp.25–211). London: Institute for the Study and Treatment of Delinquency.

Parker, H., Aldridge, J., & Measham, F. (1998). *Illegal leisure: The normalisation of adolescent drug use.* London: Routledge

Parker, H., Aldridge, J. and Egginton, R. (2001). *UK Drugs Unlimited: New Research and Policy Lessons on Illicit Drug Use.* Basingstoke: Palgrave.

Parks, K. A. & Kennedy, C. L. (2004). Club drugs: Reasons for and Consequences of use. *Journal of Psychoactive Drugs, 36*(3), 295-302.

Pavlov, I. P. (1928). *Lectures on Conditioned Reflexes.* (Translated by W. H. Gantt) London: Allen and Unwin.

Peele, S. (1987). A Moral Vision of Addiction: How People's Values Determine Whether They Become and Remain Addicts. *Journal of Drug Issues, 17*(2), 187-215.

Pennay, A. E. & Measham, F, C. (2016). The normalisation thesis – 20 years later. *Drugs Education & Prevention Policy, 23*(3), 187–189.

Pittman, J. F., Keiley, M. K., Kerpelman, J. L. & Vaughn, B. F. (2011). Attachment, Identity, and Intimacy: Parallels Between Bowlby's and Erikson's Paradigms. *Journal of Family Theory and Review, 3*(1), 32-46.

Plancherel, B., Bolognini, M., Stephan, P., Laget, J., Chinet, L., Bernard, M. & Halfon, O. (2005). Adolescents' beliefs about marijuana use: A comparison of regular users, part users, and never/occasional users. *Journal of Drug Education, 35*,131−146.

Potter, J. & Wetherell, M. (1987). *Discourse and social psychology: Beyond attitudes and behaviour*. London: Sage.

Power, R., Power, T. & Gibson, N. (1996). Attitudes and experience of drug use amongst a group of London teenagers. *Drugs: Education, Prevention and Policy, 3*, 71−80.

Prochaska, J. O. & DiClemente, C. C. (1984). *The Transtheoretical Approach: Towards a Systematic Eclectic Framework.* Homewood, IL, USA: Dow Jones Irwin.

Prochaska, J. O., DiClemente, C. C. & Norcross, J. C. (1992). In search of how people change. Applications to addictive behaviours. *American Psychology, 47*, 1102.

Rafalin, D. (2010). *Counselling psychology and research: Revisiting the relationship in the light of our 'mission'.* Chichester, UK: Wiley-Blackwell.

Ramo, D. E., Gov, C., Delucchi, K., Kelly, B. C. & Parsons, J. T. (2010). Typology of club drug use among young adults recruited using time-space sampling. *Drug and Alcohol Dependence, 107*, 119-127.

Rasinski, K. A., Woll, P. & Cooke, A. (2005). *Stigma and substance disorders*. In P. W. Corrigan (Ed.), On the stigma of mental illness: Practical strategies for research and social change (pp.219−236). Washington, DC: APA.

Reid, K., Flowers, P. & Larkin, M. (2005). Exploring lived experience: an introduction to interpretative phenomenological analysis. *Psychologist, 18*, 20-/23.

Reynaud-Maurupt, C., Pierre-Yves, B., Akoka, S. & Toufik, A. (2007). Characteristics and Behaviours of Ketamine Users in France in 2003. *Journal of Psychoactive Drugs, 39*(1), 1-11.

Rhodes T. & Moore D. (2001). On the qualitative in drugs research: Part 1. *Addiction Research and Theory, 9*, 279–297.

Rizq, R. (2008). Psychoanalysis revisited: A psychologist's view. *Counselling Psychology Review, 23*(1), 6–19.

Roberts, L. W. (2008). *The Book of Ethics: Expert Guidance for Professionals Who Treat Addiction.* Minnesota: Hazelden Foundation.

Roberts, L. W. & Dyer, A. R. (2004). *Concise guide to ethics in mental health care.* Washington, DC: APA.

Room, R. (2005). Stigma, social inequality and alcohol and drug use. *Drug and Alcohol Review, 24*,143−155.

Royal College of Psychiatrists. (2014). *One new drug a week: future trends in addiction.* UK: Royal College of Psychiatrists.

Shaw, J. (2012). Addiction to near death in adolescence. *Journal of Child Psychotherapy, 38*(2), 111-129.

Shidlo, A. (1994). *Internalised Homophobia: Conceptual and Empirical Issues in Measurement.* B. Greene & G. M. Herek (pp.176-205). Thousand Oaks, CA: Sage.

Shinebourne, P. (2011). *Interpretative Phenomenological Analysis.* In N. Frost (Ed.). Qualitative Research Methods in Psychology: Combining core approaches (pp.44-65). UK: Open University.

Shinebourne, P. & Smith, J. A. (2009). Alcohol and the self: An interpretative phenomenological analysis of the experience of addiction and its impact on the sense of self and identity. *Addiction Research and Theory, 17*(2), 152-167.

Shinebourne, P. & Smith, J. A. (2010). The communicative power of metaphors: An analysis and interpretation of metaphors in accounts of the experience of addiction. *Psychology and Psychotherapy: Theory, Research and Practice, 83*, 59–73.

Shiner, M. & Newburn, T. (1997). Maybe not: The normalisation of recreational drug use amongst young people. *Sociology, 31*(3), 1–19.

Simpson, M. (2012). London Drug and Alcohol Network Update. In LDAN (Ed.), *News: London responds to growing 'club drug' treatment demand* (pp.3). Retrieved on November 2013 from: http://www.ldan.org.uk/PDFs/LDANNewsDec12.pdf

Skinner, B. F. (1938). *The Behaviour of Organisms: An experimental Analysis.* London: Appleton-Century-Crofts.

Slutske W. S. (2006). Natural recovery and treatment-seeking in pathological gambling: results of two US national surveys. *American Journal of Psychiatry, 163*, 297–302.

Smedslund, G., Berg, R. C., Hammerstrøm, K. T., Steiro, A., Leiknes, K. A., Dahl, H. M. & Karlsen, K. (2011). Motivational interviewing for substance abuse. *Cochrane Database System Review, 11*(5).

Smith, J. A. (1996). Beyond the divide between cognition and discourse: Using interpretative phenomenological analysis in health psychology. *Psychology and Health, 11*, 261–271.

Smith, J. A. (2008). *Qualitative psychology: A practical guide to research methods*. London: Sage

Smith, J. A. & Eatough, V. (2006). *Interpretative phenomenological analysis.* In G.M. Breakwell, S. Hammond, C. Fife-Shaw & J. A. Smith (Ed.), Research methods in psychology (pp.322-341). London: Sage.

Smith, K. & Flatley, J. (2011). *Drug Misuse Declared: Findings from the 2010/11 British Crime Survey, England and Wales.* UK: Home Office.

Smith, J. A., Flowers, P. & Larkin, M. (2009). *Interpretative phenomenological analysis: Theory, method and research.* London: Sage.

Smith J. A., Flowers, P. & Osborn, M. (1997). Interpretative phenomenological analysis and the psychology of health and illness. In *Material Discourses in Health and Illness*, (pp.68–91). London: Routledge.

Smith, J. A., Jarman, M. & Osborn, M. (1999). Doing Interpretative Phenomenological Analysis. In M. Murray & K. Chamberlain (Ed.) *Qualitative Health Psychology: Theories and Methods.* London: Sage.

Smith, K. M., Larive, L. L. & Romanelli, F. (2002). Club Drugs: Methylene dioxymethamphetamine flunitrazepam, ketamine hydrochloride, and hydroxybutyrate. *American Journal of Health System Pharmacy, 59*(11), 1067-1076.

Smith, J. A. & Osborn, M. (2008). Interpretative phenomenological analysis. In J. A. Smith (Ed.) *Qualitative Psychology: A Practical Guide to Research Methods* (2nd Ed). London: Sage.

South London and Maudsley. (2010). *The Party Drug Clinic.* Retrieved on April 2014 from: http://www.national.slam.nhs.uk/services/adult-services/partydrugs/

Spinelli, E. (2005). *The Interpreted World: An Introduction to Phenomenological Psychology* (2nd Ed.). London: Sage.

Strawbridge, S. & Woolfe, R. (2010). *Counselling psychology: Origins, developments and challenges.* In R. Woolfe, S. Strawbridge, B. Douglas & W. Dryden (Ed.), Handbook of counselling psychology (3rd Ed., pp.3–22). London: Sage.

Suh, J. J., Robins, E. C., Ruffins, S., Albanese M. J. & Khantzian, E. J. (2008). Self-Medication Hypothesis: Connecting affective experience and drug choice. *Psychoanalytic Psychology, 3*, 518-532.

Sulkunen, P. (2007). Images of addiction: Representations of addiction in films. *Addiction Research and Theory, 15*(6), 543-559.

Sumnall, H. R., Woolfall, K., Edwards, S., Cole, C. J. & Beynon, C. M. (2008). Use, function, and subjective experiences of gamma-hydroxybutyrate. *Drug and Alcohol Dependence, 92*, 286-290.

Sussman, S. & Ames, S. L. (2001). *The social psychology of drug abuse.* Philadelphia: Open University Press.

Swanepoel, L. (2013). Counselling psychology in clinical practice. In G. Davey (Ed.), *Applied psychology* (pp.1-20). Chichester, West Sussex: Wiley Blackwell.

Tajfel, H. (1982). *Social Identity and Intergroup Relations.* Cambridge: Cambridge University Press.

Tajfel, H. & Turner, J. C. (1979). An integrative theory of intergroup conflict. *The social psychology of intergroup relations?, 33*, 47.

Thorberg, F. A. & Lyvers. M. (2010). Attachment in Relation to Affect Regulation and Interpersonal Functioning Among Substance Use Disorder in Patients. *Addiction Research and Theory, 18*(4): 464.

Van Hout, C. & Brennan, R. (2011). Plant food for thought: A qualitative study of mephedrone use in Ireland. *Drugs: Education, prevention and policy, 18*(5), 371-381.

Van Manen, M. (1990). *Researching lived experience: Human science for an action sensitive pedagogy.* Albany. The State of New York University Press.

Vespia, K. M., Sauer, E. M. & Lyddon, W. J. (2006). Special Issue: Counselling Psychologists as Scientist-Practitioners: Finding Unity in Diversity. *Counselling Psychology Quarterly, 19*(3), 223-227.

Volkow, N. D. & Muenke, M. (2012). The genetics of addiction. *Human Genetics, 131*,773-777.

Walker, T. (2008). Giving addicts their drug of choice: the problem of consent. *Bioethics, 22*(6), 314-320.

Waylen, A. E., Leary, S.D., Ness, A. R., Tanski, S. E. & Sargent, J. D. (2011). Cross-sectional association between smoking depictions in films and adolescent tobacco use nested in a British cohort study. *Thorax, 66*(10), 856-861.

Wilbanks, W. (1989). The danger in viewing addicts as victims: A critique of the disease model of addiction. *Criminal Justice Policy Review, 3*(4), 407-422.

Wiley, R. E. & Berman, S. L. (2012). The relationships among caregiver and adolescent identity status, identity distress and psychological adjustment. *Journal of Adolescence, 35*(5), 1203-1213.

Willig, C. (2001). *Introducing qualitative research in psychology*. Maidenhead: Open University Press.

Winstock, A., Mitcheson, L., Ramsey, J., Davies, S., Puchnarewicz, M. & Marsden, J. (2011). Mephedrone: use, subjective effects and health risks. *Addiction, 106*, 1991-1996.

Winnicott, D. W. (1960). The Theory of the Parent-Infant Relationship. *International Journal Psychoanalysis., 41*, 585-595.

Wise, J. (2011). First NHS club drug clinic opens its doors. *British Medical Journal, 1*, 1.

Wood, D. M., Measham, F. & Dargan, P. I. (2012) 'Our favourite drug': prevalence of use and preference for mephedrone in the London night-time economy 1 year after control. *Journal of Substance Use, 17*(2), 91-97.

Woolfe, R., Strawbridge, S., Douglas, B. & Dryden, W. (2010). *Handbook of Counselling Psychology* (3rd Ed). London: Sage.

World Health Organisation. (2010). *Dependence Syndrome.* Retrieved on March 2013 from: http://www.who.int/substance_abuse/terminology/definition1/en/

Yardley, L. (2000). Dilemmas in qualitative health research. *Psychology and Health, 15*, 215–228.

Yardley, L. (2008). *Demonstrating validity in qualitative psychology.* In J. A. Smith (Ed.), Qualitative psychology. A practical guide to research methods (pp.235-251). London: Sage.

Yeung, J. W., Chan, Y. C. & Lee, B. L. (2009). Youth religiosity and substance use: a meta-analysis from 1995 to 2007. *Psychological Reports, 105*(1), 255-266.

Appendix A

DSM-4 (APA, 1994) definition of problematic substance misuse

Table 4:

DSM-4 Criteria for Substance Dependence and Substance Abuse (APA, 1994).

Dependence (3 or more in a 12-month period)	**Abuse (1 or more in a 12-month period) Symptoms must never have met criteria for substance dependence for this class of substance.**
Tolerance (marked increase in amount; marked decrease in effect)	Recurrent use resulting in failure to fulfill major role obligation at work, home or school
Characteristic withdrawal symptoms; substance taken to relieve withdrawal	Recurrent use in physically hazardous situations
Substance taken in larger amount and for longer period than intended	Recurrent substance related legal problems
Persistent desire or repeated unsuccessful attempt to quit	Continued use despite persistent or recurrent social or interpersonal problems caused or exacerbated by substance
Much time/activity to obtain, use, recover	
Important social, occupational, or recreational activities given up or reduced	
Use continues despite knowledge of adverse consequences (e.g., failure to fulfill role obligation, use when physically hazardous)	

Appendix B

WHO (2010) definition of problematic substance misuse

Substance dependence

ICD-10 Clinical description

A cluster of physiological, behavioural, and cognitive phenomena in which the use of a substance or a class of substances takes on a much higher priority for a given individual than other behaviours that once had greater value. A central descriptive characteristic of the dependence syndrome is the desire (often strong, sometimes overpowering) to take psychoactive drugs (which may or may not have been medically prescribed), alcohol, or tobacco. There may be evidence that return to substance use after a period of abstinence leads to a more rapid reappearance of other features of the syndrome than occurs with nondependent individuals.

ICD-10 Diagnostic guidelines

A definite diagnosis of dependence should usually be made only if three or more of the following have been present together at some time during the previous year: A strong desire or sense of compulsion to take the substance; difficulties in controlling substance-taking behaviour in terms of its onset, termination, or levels of use; a physiological withdrawal state when substance use has ceased or have been reduced, as evidenced by: the characteristic withdrawal syndrome for the substance; or use of the same (or closely related) substance with the intention of relieving or avoiding withdrawal symptoms; evidence of tolerance, such that increased doses of the psychoactive substance are required in order to achieve effects originally produced by lower doses (clear examples of this are found in alcohol- and opiate-dependent individuals who may take daily doses sufficient to incapacitate or kill nontolerant users); progressive neglect of alternative pleasures or interests because of psychoactive substance use, increased amount of time necessary to obtain or take the substance or to recover from its effects; persisting with substance use despite clear evidence of overtly harmful consequences, such as harm to the liver through excessive drinking, depressive mood states consequent to periods of heavy substance use, or drug-related impairment of cognitive functioning; efforts should be made to determine that the user was actually, or could be expected to be, aware of the nature and extent of the harm.

Harmful use

ICD-10 Clinical description

A pattern of psychoactive substance use that is causing damage to health. The damage may be physical (as in cases of hepatitis from the self-administration of injected drugs) or mental (e.g. episodes of depressive disorder secondary to heavy consumption of alcohol).

ICD-10 Diagnostic guidelines

The diagnosis requires that actual damage should have been caused to the mental or physical health of the user. Harmful patterns of use are often criticised by others and frequently associated with adverse social

consequences of various kinds. The fact that a pattern of use or a particular substance is disapproved of by another person or by the culture, or may have led to socially negative consequences such as arrest or marital arguments is not in itself evidence of harmful use. Acute intoxication, or 'hangover' is not in itself sufficient evidence of the damage to health required for coding harmful use. Harmful use should not be diagnosed if dependence syndrome, a psychotic disorder, or another specific form of drug- or alcohol-related disorder is present.

Appendix C

DSM-5 (APA, 2013) definition of problematic substance misuse

1. Taking the substance in larger amounts or for longer than the you meant to
2. Wanting to cut down or stop using the substance but not managing to
3. Spending a lot of time getting, using, or recovering from use of the substance
4. Cravings and urges to use the substance
5. Not managing to do what you should at work, home or school, because of substance use
6. Continuing to use, even when it causes problems in relationships
7. Giving up important social, occupational or recreational activities because of substance use
8. Using substances again and again, even when it puts you in danger
9. Continuing to use, even when the you know you have a physical or psychological problem that could have been caused or made worse by the substance
10. Needing more of the substance to get the effect you want (tolerance)
11. Development of withdrawal symptoms, which can be relieved by taking more of the substance.

The DSM-5 allows clinicians to specify how severe the 'substance use disorder' is, depending on how many symptoms are identified. Two or three symptoms indicate a 'mild substance use disorder', four or five symptoms indicate a 'moderate substance use disorder', and six or more symptoms indicate a 'severe substance use disorder'. Clinicians can also add "in early remission," "in sustained remission," "on maintenance therapy," and "in a controlled environment."

Appendix D

Mirza and Mirza (2008) stages of substance misuse

Table 5:

Stage of drug use (Mirza & Mirza, 2008).

Stage of drug use	Motive	Setting	Frequency	Emotional impact	Behaviour	Impact of functioning
Experimental	Curiosity and risk taking	Alone or with peer group	Rarely or very occasionally	Effect of drugs is usually very short-term	No active drug seeking behaviour	Relatively little; may rarely result in dangerous consequences.
Social	Social acceptance	Usually with peer group	Occasional	Mind altering effects of drugs are clearly recognised	No active drug seeking behaviour	Usually no significant problems, but some can go on to show features of the early at risk stage
Early at risk stage	Social acceptance / peer pressure / beliefs valuing substance-led experiences, based on pleasurable early experiences	Facilitated by peer group	Frequent, but variable, depending on peer group	Mind altering effects of drugs are clearly recognised and sought	No active drug seeking behaviour – but develops a regular pattern of drug use	Associated with significant dangers problems associated with acute intoxication (e.g. accidents related to recurrent binge drinking)
Late at risk stage (substance use is dominating mental state)	Cope with negative emotions or enhancing pleasure through wider experimentation	Alone or with an Altered /-selected peer group (e.g. drug or alcohol using)	Frequent / regular use	Uses drugs to alter mood or behaviour	Active drug seeking behaviour is a key indicator of this stage	May be impairment in functioning in some areas (e.g. school and family)

Table continued overleaf…

Stage of drug use	Motive	Setting	Frequency	Emotional impact	Behaviour	Impact of functioning
Harmful use or substance abuse (similar to ICD-10 or DSM-4)	Drug use is the primary means of recreation, coping with stress or both	Alone or with an altered peer group (alcohol or drug- using)	Regular use, despite negative consequences	Negative effects on their emotions and ability to function	Active drug seeking behaviour, despite negative consequences across many areas of life	Impairment in almost all areas of life and or distress within families or close relationships
Dependence (Similar to ICD-10 and DSM-4)	To deal with withdrawal symptoms, and stop craving.	Alone or with likeminded peer Group	Compulsive, regular or often daily use to manage withdrawal symptoms	Emotional impacts of drugs are very significant. Withdrawal symptoms prominent	Active drug seeking behaviour, often loss of control over use, pre-occupation with drug use, craving, and behaviour may involve criminality	Physical and psychological complications, impairment in all areas of life

Appendix E

Transtheoretical model (Prochaska & DiClemente, 1983; Prochaska, DiClemente, & Norcross, 1992)

These stages include:

(1) Pre-contemplation: Individuals may be under informed of the consequences of their substance misuse, and do not intend to act in the foreseeable future.
(2) Contemplation: Individuals intend to change their problematic substance misuse behaviour in the next six months. They are more aware of the pros of changing, but are also acutely aware of the cons. This weighing between the costs and benefits of changing can produce profound ambivalence that can cause people to remain in this stage for long periods of time. This phenomenon is often characterised as chronic contemplation.
(3) Preparation: Individuals intend to act in the immediate future, usually measured as the next month.
(4) Action: Individuals have made specific overt modifications in their lifestyles within the past six months e.g., access treatment services and engage in psychosocial interventions.
(5) Maintenance: Individuals have made specific overt modifications in their lifestyles and are working to prevent relapse of their problematic substance misuse.
(6) Relapse: Individuals may relapse, and the cycle of change starts over again.

Often, individuals recycle through the stages or regress to earlier stages from later ones.

Appendix F

Summary of evidence for the effectiveness of psychosocial interventions for substance misuse

Table 6:

Summary of evidence for the effectiveness of PSIs for substance misuse

Document	Content and conclusions
NICE (2007a; 2007b; 2012) recommendations on drug misuse	Brief interventions (motivational interviewing) Information on self-help groups Behavioural couples therapy Contingency management Evidence-based PSI for co-occurring psychological problems
Government clinical guidelines on drug misuse (Department of Health and the Devolved Administrations, 2007)	NICE 51 plus: CBT-based relapse prevention Community reinforcement approaches Social behaviour network therapy Family therapy Psychodynamic therapy
NICE (2013) recommendations on alcohol misuse	Motivational interviewing Information on self-help groups CBT-based relapse prevention Behavioural therapies Social network and environmental therapies Behavioural couples therapy Evidence-based psychosocial interventions for co-occurring psychological problems
Cochrane reviews: Smedslund et al. (2011) and Knapp, Soares, Farrel & Lima (2007) on cocaine and psycho-stimulants	Motivational interviewing Contingency management CBT Community reinforcement approach

Table continued overleaf…

Document	Content and conclusions
National Treatment Agency (2005)	CBT – coping skills Motivational interviewing Relapse prevention Community reinforcement Contingency management Supportive expressive psychotherapy Family therapy Social behaviour network therapy#
NICE (2014)	Proven behaviour change techniques: goal setting and planning feedback and monitoring social support

Appendix G

Inclusion and exclusion criteria

- Participants that were not fluent in English were excluded. The importance of the richness and meaning of language is emphasised in qualitative research, which is in jeopardy of being lost if a translator is used (Smith, Flowers & Larkin, 2009).
- Participants were excluded if they did not self-rate their mephedrone use as problematic, since the aim of this study was to explore subjective problematic mephedrone use.
- Participants were recruited that were engaged with a treatment service, giving participants a point of contact if they became distressed or required further support.
- Participants were not required to have had psychological treatment, since the aim of this research was to explore their experience of problematic mephedrone use, not their experience of treatment.
- Participants were recruited that used mephedrone, as this is the club drug under investigation. It is unlikely that a participant will use one drug in isolation due to polydrug use. Therefore, like other studies, participants were recruited where their primary drug of choice was mephedrone i.e., the most frequently used or favoured drug (Sumnall, Woolfall, Edwards, Cole & Beynon, 2008; Winstock et al., 2011; Reynaud-Maurupt, Pierre-Yves, Akoka & Toufik, 2007).
- Participants were recruited if their keyworker and participant felt that their substance misuse and recovery was stable, in order to minimise any potential interference this study may have caused to the participant's recovery. For example, the participant would have well-developed coping strategies to manage the potential triggering of cravings when discussing their experience of problematic mephedrone use.
- Participants that had a serious co-morbid mental health condition were not recruited, to minimise potential interference with their recovery and since participants may not have been competent enough to give informed valid consent. There is no agreed definition of the term 'serious' mental health problem (NHS, 2014a), though for the purpose of this study a serious mental health disorder was defined as any mental health disorder that:
    - causes substantial disability such as an inability to care for themselves independently, sustain relationships or work;
    - results in the current display of obvious and severe symptoms;
    - results in continuous remitting/relapsing;
    - causes recurring crisis leading to frequent admission/intervention;
    - results in the significant risk to their own safety and that of others (NHS, 2014b).
    - All of these factors do not have to be experienced simultaneously for the participant's mental health problem to be deemed serious. Examples of serious mental health problems include psychotic disorders e.g., schizophrenia, bipolar disorder or personality disorders (NHS, 2014a).

Appendix H

London Metropolitan ethical approval

London Metropolitan University,
School of Psychology,
Research Ethics Review Panel

I can confirm that the following project has received ethical approval by one anonymous Reviewer, the Head of School of Psychology and the Dean of the FLSC to proceed with the following research study (Professional doctorate):

Title: How young adults experience and make sense of their problematic mephedrone use: An Interpretative Phenomenological Analysis
Revised proposal dated 1st November, 2014

Student: **Ms Gurjeet Kaur Bansal**

Supervisor: *Dr. Philip Hayton*

Ethical clearance to proceed has been granted providing that the study follows the most recent Ethical guidelines to dated used by the School of Psychology and British Psychological Society, and follows the above proposal in detail.

The researcher and her supervisor are responsible for conducting the research and should inform the Ethics panel if there are any substantive changes to the project that could affect its ethical dimensions, and re-submit the proposal if it is deemed necessary.

Signed: Date: 28 February 2015

Prof Dr Chris Lange-Küttner
(Chair - School of Psychology Research Ethics Review Panel)

Email c.langekuettner@londonmet.ac.uk

Appendix I

National Health Service ethical approval

noclor
RESEARCH SUPPORT

1st Floor, Bloomsbury Building
St Pancras Hospital
4 St Pancras Way
NW1 0PE

Tel: 020 3317 3045
Fax: 020 7985 6830/5788
www.noclor.nhs.uk

16 October 2015

Miss Gurjeet Bansal
London Metropitan University
166-220 Holloway Road
London
N7 8DB

Dear Miss Gurjeet Bansal,

This **NHS Permission** is based on the REC favourable opinion given on **06 October 2015**

I am pleased to confirm that the following study has now received R&D approval, and you may now start your research in **the trust identified below**:

Study Title: **How individuals' experience and make sense of problematic mephedrone use: Interpretative Phenomenological Analysis** **R&D reference: 182105** **REC reference: 15/EM/0375**		
Name of the trust	**Name of current PI/LC**	**Date of permission issue(d)**
Barnet Enfield & Haringey NHS Mental Health Trust	William Davies	16 October 2015
If any information on this document is altered after the date of issue, this document will be deemed INVALID		

Specific Conditions of Permission (if applicable)
If any information on this document is altered after the date of issue, this document will be deemed INVALID

Yours sincerely,

Pushpesh Joshi
Research Operations Manager

Cc: Principle Investigator(s)/Local Collaborator(s), Sponsor Contact

noclor
RESEARCH SUPPORT

1st Floor, Bloomsbury Building
St Pancras Hospital
4 St Pancras Way
NW1 0PE

Tel: 020 3317 3045
Fax: 020 7665 5830/5788
www.noclor.nhs.uk

May I take this opportunity to remind you that during the course of your research you will be expected to ensure the following:

- **Patient contact:** only trained or supervised researchers who hold the appropriate Trust/NHS contract (honorary or full) with each Trust are allowed contact with that Trust's patients. If any researcher on the study does not hold a contract please contact the R&D office as soon as possible.
- **Informed consent:** original signed consent forms must be kept on file. A copy of the consent form must also be placed in the patient's notes. Research projects are subject to random audit by a member of the R&D office who will ask to see all original signed consent forms.
- **Data protection:** measures must be taken to ensure that patient data is kept confidential in accordance with the Data Protection Act 1998.
- **Health & safety:** all local health & safety regulations where the research is being conducted must be adhered to.
- **Serious Adverse events:** adverse events or suspected misconduct should be reported to the R&D office and the Research Ethics Committee.
- **Project update:** you will be sent a project update form at regular intervals. Please complete the form and return it to the R&D office.
- **Publications:** it is essential that you inform the R&D office about any publications which result from your research.
- **Ethics:** R&D approval is based on the conditions set out in the favourable opinion letter from the Research Ethics Committee. If during the lifetime of your research project, you wish to make a revision or amendment to your original submission, please contact both the Research Ethics Committee and R&D Office as soon as possible.
- **Monthly / Annually Progress report:** you are required to provide us and the Research Ethics Committee with a progress report and end of project report as part of the research governance guidance.
- **Recruitment data:** if your study is a portfolio study, you are required to upload the recruitment data on a monthly basis in the website: http://www.crn.nihr.ac.uk/can-help/funders-academics/nihrcrn-portfolio/recruitment-data/
- **Amendments:** if your study requires an amendment, you will need to contact the Research Ethics Committee. Once they have responded, and confirmed what kind of amendment it will be defined as, please contact the R&D office and we will arrange R&D approval for the amendment. If your study is Portfolio Adopted, amendments must be submitted for R&D review via the NIHR CRN (CSP), please refer to the Amendments Guidance for Researchers: http://www.crn.nihr.ac.uk/can-help/funders-academics/gaining-nhs-permissions/amendments/
- **Audits:** each year, noclor select 10% of the studies from each service we have approved to be audited. You will be contacted by the R&D office if your study is selected for audit. A member of the governance team will request you complete an audit monitoring form before arranging a meeting to discuss your study.

Appendix J

Participant Information sheet

Participant Information sheet

Study Title: Individuals' experiences and sense-making of problematic mephedrone use.
Name of Researcher: Gurjeet Bansal

I would like to invite you to take part in this research study. Before you decide I would like you to understand why the research is being done and what it would involve for you. **I will go through the information sheet with you and answer any questions you have.** This may take about 15 minutes. Talk to others about the study if you wish. If you are unclear on any of the information or require more details, you are welcome to contact me or my Research Supervisor (contact details are available at the end of this form).

What is the purpose of this study?
Very little is known about mephedrone use, so this study hopes to achieve an understanding of how you have experienced mephedrone use, what your motivations were to use mephedrone in particular; how you noticed, understood and identified that your drug use had become problematic which prompted you to seek treatment.

Such information could potentially benefit healthcare professionals when trying to understand and support individuals who experience problems with mephedrone use and perhaps suggest how psychological interventions might be useful.

Why am I being approached for this study?
You are being approached to take part in this study, by the Line Manager, as you have had an experience of problematic mephedrone use. Therefore, your views and experiences are important to this study. In total, 6 participants will be recruited for this study.

Am I obliged to take part in this study?
It is solely your decision to part in this study or not. In the case that you agree, you will be requested to sign a consent form. If you decide to withdraw from the study following the interview, you can do so up to 6 weeks

after interview or until data analysis has begun (whichever length of time is the greater). If you decide to withdraw from the study this will not affect the standard of care you receive. Anything you have said during the interview will not be used in the study and will be destroyed.

What will happen if I decide to take part and what will I have to do?

I will contact you to discuss your interest in participating, answer any questions you may have about taking part in the study and to schedule a time so that we can meet so we can talk about your experiences. I will try to schedule appointments at your convenience. Before participating you will be asked to sign a consent form, which I will talk you through. You will attend one meeting, at the service, which will involve an interview where I will ask you questions about your experiences of problematic mephedrone use. This will last approximately an hour.

It is important that you understand that this interview is not a therapy session. If you would like therapy, then is advisable that you contact your General Practitioner or consult online mental health support. I am happy to provide you with further information regarding this should it be necessary.

Expenses

No expenses will be paid.

What are the possible risks or disadvantages of taking part?

It is unlikely that the issues discussed will evoke distressing thoughts and feelings, though in the event that this should occur you can take small breaks during the interview to help you feel more relaxed. Both you and I, the researcher, will have the right to end the interview if at any point, you become unduly distressed whilst talking about your experiences. This is to ensure that your wellbeing is safeguarded at all times.

It is possible that taking part in this study may bring about some upsetting feelings in you as you are asked to share your experiences of dealing with your problematic mephedrone use. In this case, information will be provided to you regarding relevant support services that you may wish to access. These will include drug support services, and helplines.

It is advised that you ought not to take part in this study if you have a *serious* mental health condition. This can be discussed further if you are unsure what a *serious* mental health condition may entail.

What are the benefits of me taking part?

I cannot promise the study will help you personally, but the information gathered from this study could help improve the treatment of people with problematic mephedrone use.

What if there is a problem?

Any complaint about the way you have been dealt with during the study or any possible harm you might suffer will be addressed. If you wish to make a complaint about any aspect of the study, please contact myself or my Research Supervisor, Dr Philip Hayton at London Metropolitan University or please contact PALS, an independent service (please see the contact details at the end of this form).

Will my taking part in the study be kept confidential?

With your permission, the interview will be audio-taped, transcribed and segments of this may be incorporated into a report that will be accessible to other individuals such as my Research Supervisor and other tutors who will be formally assessing the report. However, you will remain completely anonymous i.e., your name and identity will not at any point be made available and will be kept separate from the findings of the interview. No one will have access to this information except me.

All information that you provide will be secured in a safe place by the researcher. The tapes used to record the interview will be destroyed following transcription and once the study has been assessed and marked. Transcripts of the interview will be kept for a maximum period of 5 years in case the study is published and will then be destroyed. For your wellbeing, your Key worker will be aware that you are taking part in the study, though will *not* be present at interview.

However, confidentiality will be broken if any information is disclosed suggesting an imminent risk of harm to you or others, which includes the disclosure of information provided regarding the following: the possession of illegal drugs, the supply of illegal drugs and information about activities (e.g. theft, prostitution) that you may have engaged in to fund your drug use. If you have more questions about what this means, please do not hesitate to ask.

What will happen to the results of the research study?

If you wish to obtain a copy of a summary of the findings, please provide your contact details. These details will be kept separate from the material that you provide me during our interview. The results of the study may be published in a journal, and be accessible at the University Library. However, no information identifying you as a participant will be included.

Who is organising and funding the research?

This research is being carried out as part of my doctoral training in Counselling Psychology and is not receiving any external funding.

Who has reviewed the study?

All research in the NHS is looked at by independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and given favourable opinion by the East Midlands Derby Research Ethics Committee.

I am happy to answer any questions or queries you may have relating to the study.

Thank-you

Further information and contact details

1. General information about research.
http://www.hra.nhs.uk/patients-and-the-public-2/types-of-study/

2. Specific information about this research project.
Researcher: Gurjeet Bansal Email: clubdrugs@outlook.com
Mobile number: 07553241270

Research Supervisor: Dr Philip Hayton Email: p.hayton@londonmet.ac.uk
Contact number: 0207 133 2685

3. Advice as to whether they should participate.
Researcher: Gurjeet Bansal Email: clubdrugs@outlook.com
Mobile number: 07553241270

4. Who they should approach if unhappy with the study.
Research Supervisor: Dr Philip Hayton Email: p.hayton@londonmet.ac.uk
Contact number: 0207 133 2685

Patient advice and liaison services (PALS): Moorfields At St Ann's Hospital
Contact Telephone Number: 020 7211 8323
Address: St. Ann's Hospital, St. Ann's Road, London, Greater London, N15 3TH

Appendix K

Informed Consent Form

Patient Identification Number for this research:

Informed Consent Form

Study Title: Individuals' experiences and sense-making of problematic mephedrone use.
Name of Researcher: Gurjeet Bansal

This consent form is to ensure that you are happy with the information you have received with respect to this study. It is also important to check that you are aware of your rights as a participant to confirm that you wish to take part in the study.

To be completed by the participant:

Please read the following statements and initial the box.

1. I am presently not under the influence of any intoxicants e.g. drugs or alcohol. ☐

2. I confirm that I have read and understand the participant information sheet dated 21 September 2015 (Version 2.0) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily in order for me to decide whether I want to take part in the above study. ☐

3. I understand that all the information I provide will be kept confidential. However, I understand that confidentiality will be broken if the disclosure of any information appears to be an imminent risk to myself or someone else. This includes information provided regarding the following: the possession of illegal drugs, the supply of illegal drugs and information about activities (e.g. theft, prostitution) that you may have engaged in to fund your drug use. ☐

4. I have been shown and understand the plan of action, dated 21 September 2015 (Version 2.0). ☐

5. I understand that for my wellbeing my Key worker will be aware that I am participating in this research though will not be present at interview. ☐

6. I understand that I will remain completely anonymous and that my name and identity will *not* be revealed at any point and that this consent form will be kept separate from the transcript and findings of this study. ☐

7. I understand that my participation is voluntary. I am free to refuse to answer any question and that I am free to withdraw up to 6 weeks after interview or until data analysis has begun (whichever length of time is the greater), without giving any reason, without my medical care or legal rights being affected. ☐

8. I am clear that both the researcher and I have the right to terminate the interview if undue distress to me is evident. ☐

9. I agree for the researcher to audio-record my conversation, to allow the research to use verbatim quotations from my speech, which will be anonymised, in the writing up or publication of this study. ☐

10. I agree that my taped conversation and transcript will be kept up to a period of five years in case the study is published. ☐

11. I understand that the terms of this engagement are one of researcher and participant not therapist and client. ☐

12. I consent to take part in this study. ☐

_____	_____	_____
Name of Patient	**Date**	**Signature**
_____	_____	_____
Name of Person taking consent	**Date**	**Signature**

Appendix L

Demographic Questionnaire

Demographic Questionnaire

Title of research: Individuals' experiences and sense-making of problematic mephedrone use.

Researcher: Gurjeet Bansal

1. Age:
2. Gender:
3. Sexual orientation:
4. Other drugs used:
5. Education
6. Housing situation:
7. Employment status:
8. Mephedrone use:
    A. Length of time:
    B. Current usage (frequency, quantity):

Appendix M

Interview Schedule

Interview Schedule

1. **Can you tell me about how your mephedrone use began?**

- Event
- What was life like for you at the time? - stressors, peer pressure, relationships with family and friends, psychological, physiological, economic status, employment etc., and their effect
- What were your initial motivations to use mephedrone?

*(Aim: creates context, assists rapport by allowing the participant to describe an event, and establishes the participants' initial **motivations** to use mephedrone)*

2. **Can you tell me about your initial experiences of using mephedrone?**

- What did it feel like in your body/mind? – thoughts/feelings
- What were its effects? - positive/negative
- How did you take mephedrone? - frequency, quantity, route of administration, pattern of usage, in combination with other drugs, context

*(Aim: creates context by gaining an understanding of the practices implemented when using mephedrone and ascertains the participants' initial **experiences** of using mephedrone)*

3. **Can you tell me what role mephedrone had in your life during your initial stages of use?**

- How do you cope?
- What were your motivations to keep using mephedrone at this time? - social, psychological, physiological

*(Aim: establishes an understanding of the participants' **motivations/reasoning** to take mephedrone prior to their problematic use)*

4. **Can you describe how you felt about yourself at this time in the wider society?**

- Self-image and perception of society at the time

*(Aim: to position the participant within their lifeworld, to gain understanding of their identity and **experience** of the world prior to their problematic use)*

5. **Can you tell me how you noticed your mephedrone use had become problematic?**

- Yourself or someone else
- A particular event or a gradual process
- What was life like for you when your mephedrone use was problematic? - stressors, peer pressure, relationships with family and friends, psychological, physiological, health, economical status, employment, housing etc., and their effect

*(Aim: creates context and draws upon how the participant began to **make sense** of their problematic mephedrone use)*

6. **Can you describe your experiences of problematic mephedrone use?**

- What did it feel like in your body/mind? – thoughts/feelings
- What were its effects? - positive/negative/ risks
- How did you take mephedrone? - frequency, quantity, route of administration, pattern of usage, in combination with other drugs, context
- Liken experience of problematic mephedrone use to any traditional drug, or other drug

*(Aim: draws upon the participants' **experiences** of problematic mephedrone use)*

7. **Can you tell me what role mephedrone had in your life when your use was problematic?**

- How do you cope?
- What were your motivations to keep using mephedrone at this time? - social, psychological, physiological

*(Aim: establishes the participants' **motivations** to continue using mephedrone problematically)*

8. **Can you describe how you felt about yourself when your drug use was problematic?**

- Self-image and perception of society at the time

*(Aim: to position the participant within their lifeworld, to gain understanding of their identity and **experience** of the world whilst using mephedrone problematically*)

9. **Can you tell me how you decided you wanted to seek help for your problematic drug use?**

- What thoughts went through your mind when you were considering to stop? -readiness, fears
- What were your motives for stopping to use? -relationships, health, financial status, the effects of the drug, drug tolerance, loss of time, critical incident etc.

(Aim: understands how the participant concluded their usage was problematic enough to seek help)

10. **Is there anything else you might like to add, about your experience or understanding of mephedrone use, which you think is important that we have not spoken about?**

Appendix N

Debriefing Form

Written Debriefing Form

Title of research: Individuals' experiences and sense-making of problematic mephedrone use.
Name of Researcher: Gurjeet Bansal

Thank-you for your participation in this study. This debriefing is given as an opportunity for you to learn more about this research study, how your participation plays a significant part in this research and why this research is important.

Club drugs have many detrimental psychological, physiological and social implications. In the UK, there has been an increasing prevalence of club drug use, in particular mephedrone use despite its legislation. Club drug clinics have opened across the UK that are thought to cater to the specialised needs of problematic club drug users, which are thought to be different from traditional drug users (heroin and crack cocaine users). However, since each club drug has different psychological and physiological effects, it is thought that each club drug may be associated with different reasons for use that may have different treatment implications.

Little is known about the subjective experience of mephedrone use, and what can become problematic about the use of mephedrone. By exploring the thoughts and experiences of problematic mephedrone users, it is thought that a better understanding may be established about why mephedrone is used and how it is problematic. Such information could be useful when suggesting the psychological interventions that may benefit the recovery of problematic mephedrone users, and inform healthcare professionals that work within the area of substance misuse.

I understand that it may have been difficult at times to answer the questions as part of this research and your generosity and willingness to participate in this study are greatly appreciated. I do however ask that you do not discuss the nature of this study with others who may participate in it, as this could affect the validity of the research conclusions.

Sometimes people find the subject matter of these interviews difficult. If answering any of the questions has resulted in any distress, upset or concern and you would like to speak to someone about your thoughts and concerns, I have enclosed a list of useful counselling/therapeutic and substance misuse support services that you might find useful.

As explained, the information that you will provide will be kept anonymous. Thus, there will be no information that will identify you, i.e. pseudonyms will be used. The results of this study may be presented at academic conferences or published as an article. If you would like to receive a summary of the findings of this study or have any individual questions, you may contact either myself or my supervisor. Contact details are:

Contact details

Researcher: Gurjeet Bansal Email: clubdrugs@outlook.com
Mobile number: 07553241270

Research Supervisor: Dr Philip Hayton Email: p.hayton@londonmet.ac.uk
Contact number: 0207 133 2685

Support services

Samaritans
Website: www.samaritans.org
Contact number: 08457 90 90 90

Club Drug Clinic
Email: clubdrugclinic.cnwl@nhs.net
Contact number: 020 3315 6111

Westminster Drug Project
Email: enquiries@wdp-drugs.org.uk
Contact number: 020 7421 3100

Appendix O

Plan of Action

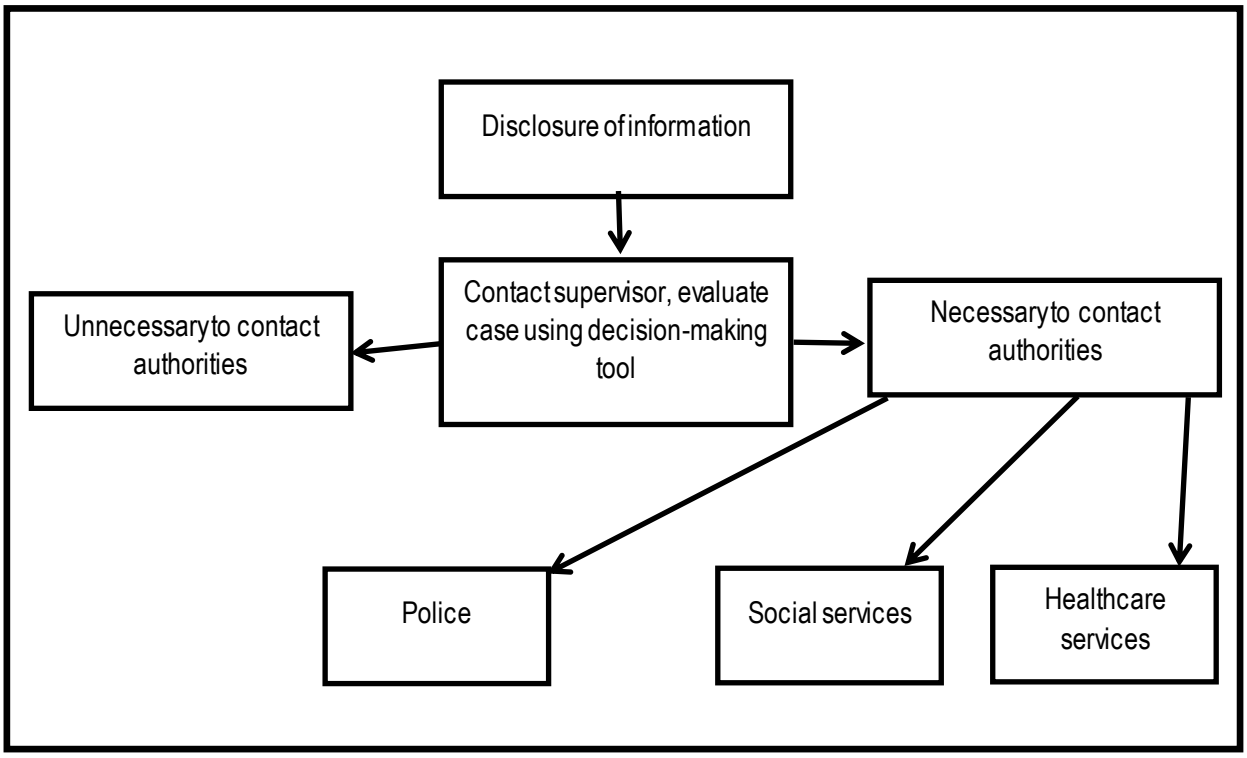
Barnet, Enfield and Haringey NHS Mental Health NHS Trust
A University Teaching Trust

LONDON metropolitan university

The Plan of Action

Confidentiality will be breached if the disclosure of the following information is made: the possession of illegal drugs, the supply of illegal drugs and information about activities (e.g. theft, prostitution) that addicts may be engaging in to fund their problematic substance misuse (Walker, 2008).

Figure 4: Plan of action.



Appendix P

Adapted version of the ethical-decision making tool (Roberts & Dyer, 2004)

Table 7:

Adapted version of ethical decision-making tool (Roberts & Dyer, 2004)

Factor	Case
Medical facts • Diagnoses • Treatment history • Comorbidity	
Participant preferences • Informed consent • Decisional capacity • Surrogate decision makers	
Interests of other parties • Family • Health care providers • Public • Researcher	
Information disclosed • Risks • Authorities to be informed	

Appendix Q

Distress Protocol

Distress Protocol to follow if participants become distressed during participation

This protocol has been devised to deal with the possibility that some participants may become distressed and/or agitated during their involvement in this research. There follows below a three-step protocol detailing signs of distress that the researchers will look out for, as well as action to take at each stage. It is not expected that extreme distress will occur, nor that the relevant action will become necessary. However, it is included in the protocol, in case of emergencies where professionals cannot be reached in time.

Mild distress:

Signs to look out for:

1) Tearfulness
2) Voice becomes choked with emotion/ difficulty speaking
3) Participant becomes distracted/ restless

Action to take:

1) Ask participant if they are happy to continue
2) Offer them time to pause and compose themselves
3) Remind them they can stop at any time they wish if they become too distressed

Severe distress:

Signs to look out for:

1) Uncontrolled crying/ wailing, inability to talk coherently
2) Panic attack e.g., hyperventilation, shaking, fear of impending heart attack
3) Intrusive thoughts of the traumatic event e.g., flashbacks

Action to take:

1) The researcher will intervene to terminate the interview/experiment.
2) The debrief will begin immediately
3) Relaxation techniques will be suggested to regulate breathing/ reduce agitation
4) The researcher will recognise participants' distress, and reassure that their experiences are normal reactions to abnormal events and that most people recover.
5) If any unresolved issues arise during the interview, accept and validate their distress, but suggest that they discuss with mental health professionals and remind participants that this is not designed as a therapeutic interaction
6) Details of counselling/therapeutic services available will be offered to participants

Extreme distress:

Signs to look out for:

1) Severe agitation and possible verbal or physical aggression
2) In very extreme cases- possible psychotic breakdown where the participant relives the traumatic incident and begins to lose touch with reality

Action to take:

1) Maintain safety of participant and researcher
2) If the researcher has concerns for the participant's or others' safety, he will inform them that he has a duty to inform any existing contacts they have with mental health services, such as a Community Psychiatric Nurse or their General Practitioner.
3) If the researcher believes that either the participant or someone else is in immediate danger, then he will suggest that they present themselves to the local Accident and Emergency Department and ask for the on-call psychiatric liaison team.
4) If the participant is unwilling to seek immediate help and becomes violent, then the Police will be called and asked to use their powers under the Mental Health Act to detain someone and take them to a place of safety pending psychiatric assessment. (This last option would only be used in an extreme emergency)

Appendix R

A worked example of Daniel's transcript

led to me dancing around the whole club, the most amount of confidence with the biggest smile on my face. Erm, buying everyone drinks, it was a great night [tone of voice heightens]. I didn't stay out for days it was literally that, that was enough for me

51. R: Mmm

52. P: And then erm, I remember going out the next following week, to the same place. It was a gay club, and er (..) I was looking for this guy like a, like a hawk in the sky, I couldn't find him, so I ended up erm just leaving

53. R: So, from the first time you used it, till that week, had you used in between?

54. P: I hadn't no, no

55. R: Mmm

56. P: But erm the curiosity, the curiosity was just on me so much to the point where I kept going out, but I just couldn't find this guy. I didn't realise how much people were using it until I went to another club and erm, I got offered it again by somebody else, and then I got taken, well I took it in the R'n'B club then we went to another club that was after hours, and erm yeh we (..) everyone in that club was taking it, so I literally felt well in my element, I felt yes I finally felt my flock

57. R: How did it make you feel, that first time you took it?

6

Increased confidence
feeling happy
Positive.

Ideal self
false self.

Purposefully seeking out this drug
A need for this drug
The drug has become important

A desire for the drug

A lack of awareness about the drug

A mainly towards drugs popularity

A growing sense of curiosity

curiosity

Acceptance of recreational drug use as normality

Growing popularity about the drug

Finding one's niche creates a sense of belonging

A sense of belonging

Sense of normality about using a CD with a clubb environment - sense of normality and acceptance about recreational, clubbing use

mephedrone is one encompassing
Powerful
mephedrone is good

mephedrone represents 'everything good'

58. P: Erm, it was, first it was, how I see is like the bag was so quiet, and the substance itself was really making a sound, it is like, when you'd sniff it, it's the loudest, the loudest noise you could hear, of everything good. Meaning you feel like you're being hugged, you feel like you wanna give hugs, you feel like your your mind is expanded too where you, erm, able to express yourself in the way you've always wanted to be able to express yourself, erm you get back to everyone's messages, then you may have been avoiding, emails that you haven't been getting back too, job erm, app- applications that I'd been wanting to fill out but didn't have the confidence. I had the confidence and would get the job interview, but cos when the job interview time came around, I would not be in the physical state to go, cos the come down wasn't, it just wasn't erm I swear I'd got the job if the come down aint there, it just wasn't how I thought I was gonna feel

sense of intimacy gives feeling of belonging - empathogenic qualities
ideal self being able to express yourself, being more efficient and confident - expansion of the mind

Intimacy / empathogenic qualities
Expansion of the mind
ideal self.

niavity
Niavity
A sense of regret about the drug
unwanted side - effects of the drug - Disintegrating self.

59. R: How did, how did the come down feel?

60. P: Well the come down feels like [exhale of breath and pause for 3 seconds] back then it felt, it wasn't so intense, it was felt more or less of (..) I felt like, okay, I know some things, I know I haven't eaten for 3 days, and that's maybe why I got the mouth ulcers, my skin complexion changed, erm I was obviously skinnier, ~~I lost, I~~ lost weight cos when I did go to the club where everyone else was taking it, they introduced me to chill outs, and chill outs was where they continued even more, and that's where normally your, your, your, your nights would come to an end, because erm [inhale of breath] you've been out for like five days by this point, so then you would get the mouth ulcers from not, from not, from not eating. I said I lost weight, complexion looking dreadful, really trying to sleep and you're just in your room sleeping, then your appetite comes back, your constantly blowing your nose, erm mucus, mucus, mucus, and the room becomes a different smell to then what your normally use too, erm your bedsheets smell of it, erm

A physical unwanted effects of mephedrone
this sense of secrecy underworld / secret society

A disintegrated self
A disintegrating self.
A sense of secrecy

you've got to keep going
recovery from the unwanted come downs developed a system around this.
Mephedrone is unique nuanced
A physically weak self.
unique view of meph.

Appendix S

Superordinate theme table with quotes

Table 8:

Superordinate themes with quotes

Superordinate theme	Subordinate theme	Quotes
1) Mephedrone as a credulous fix for ongoing identity vulnerability and distress, initiating a vicious cycle of deliberate use	1a) A way of connecting that creates a false-sense of belonging	"*I felt like a kid again, I felt like being back in school. I was around a lot of people, we was all around the same age, a bit younger. We were like a big crew, was like a big family and erm (…) nobody could tell us nothing, and we were just having the best, we were having the best amount of times. Erm people was like taking pictures, it was just like, people, everyone, like, became, everyone was defending each other. Like people would buy each other drinks, and just like, as much as it sounds trivial now it's really really really (..) a life that would love as a kid. Like whoever's in school now, if you got friends like the friends that I had back then, that was so supportive of you, made you feel like you's a part of something, and you was erm, you was, you was wanted, and that's how they made you feel and that is that, that's exactly the thing I holded onto.*" (Daniel, p.11, L76)
	1b) The externalisation of "deep psychological damage" allows for short-lived appeasement	"*You know just use more and get high (laughs), yeh then all these thoughts are gone.*" (Alexander, p.18, L120) "*And then they use that as an excuse as well to go on and on and on to numb you, block you out the past, block you out the reality, so you don't have to face your problems no more. Like any particular drug, like*

		every drug that people use as an excuse, as a shield to be behind that drug, you know, as an excuse." (Robert, p.7, L76)
	1c) The attempt to create of an empowered, idealised false-self through calculated mephedrone use	"*For me what I, because I did physics in Brazil for one year, to me it was good, cos I like the drug because of what it was does to my brain (..) it bombs my brain, my brain was like if I, there's a certain amount that drug that makes your brain like better. For example, calculus, I studied calculus it was 1996, between 96 yeh, I did, I did physics in one university, I did half a year for computers in another university. That's two courses at the same time. So when I was doing the calculus, calculus is very heavy at university, so I remember calculus since I put that drug back. So my brain was, that's the thing, I love the drug, because my intelligence, my brain was working like it never had before.*" (Robert, p.10, L100) "*…you feel like your your mind is expanded too where you, erm, able to express yourself in the way you've always wanted to be able to express yourself, erm you get back to everyone's messages, then you may have been avoiding, emails that you haven't been getting back too, job erm, app-applications that I'd been wanting to fill out but didn't have the confidence.*" (Daniel, p.7, L58) "*At first, it was, I can do anything erm, I was stupid but I went to class, a dance class, erm high, because it, I was finishing a party, what we call a party or session, and I had to get to class, because I was missing classes a lot, so I got to class and (..) I did the class and somehow after class everyone said that was amazing, you done the best you ever could, but I was high on mephedrone (laughs), and other drugs too, but I was really high, erm so it was kinda, it didn't help (laughs) it didn't help that my mind honestly went "ah I could do more", and so I kept that's, I kept taking it, I kept taking it as if its fine…*" (Josh, p.10, L72)

		"*Well it can go, also for example, if you feel, I already been paranoid little bit, as a person, as a personality I'm paranoid. But at work if you use mephedrone and your dealing with customers, it just blank yourself, you don't care about other things, it just like…it doesn't matter. I don't care. You keep going and you feel strong, and then you, no don't paranoia about washing, they think your clean or what. Sometimes you have an awkward moment with the customer, you know I should have said that or I shouldn't have, but then there I times when I think, good, I said, I said whatever, I don't mind, why you think like that, it's okay, it's up to you (laughs).*" (Greg, p.13-14, L116)
2) The paradoxical experiences of progressive mephedrone use	2a) "Love at first sight" versus a devilish mistake	"*…most amazing time of my life…*" (Greg, p.6, L50) "*It was love at first, first sight, I loved it. I loved it above everything else…*" (Daniel, p.10, L74) "*I don't wanna, I don't wanna do this, I kept fight against that.*" (Josh, p.4, L40) "*Oh at this point I start hate it. That's the time I started hating, and that the time I I face the drug, not like a good feeling for doing it anymore, but as a trap. So I faced it as an enemy.*" (Alexander, p.20, L186)
	2b) Naive control versus a sense of being out of control	"*…the small amounts will get more intense to the point you cannot control it anymore…*" (Robert, p.15, L144) "*…yeh I always have the thought that you're controlling it, when you want to stop, you stop but the mephedrone is controlling you…*" (Alexander, p.11, L82)

		"*I was, there was bags of it, and we would, er, it took like two of us, just going through it, going through it, it was more than 100grams I could go through…*" (Daniel, p.15, L88) "*I can control it I can control it, I can juggle it both, and it started getting to the point, I started realising you can't juggle it both…*" (Greg, p.10, L72)
	2c) A desirable need versus a "pointless" activity	"*…meph is addictive you have to have it, that's the upgrade, because when you have it it's amazing! Your fulfilling you want it more.*" (Josh, p.27, L158) "*Snorting its erm, you see mephedrone you might say it's not addictive, but if you take it, you feel like er you have to do it again.*" (Alexander, p.16, L106) "*…hustling, survival type way, because you know you're gonna want this substance to last for as…*" (Daniel, p.8, L66) "*…and we didn't even had sex and we just took it watched family guy. I guess that even made it even worse, taking drugs and doing nothing with it (laughs) it's not fun.*" (Josh, p.17, L92) "*I'm wasting my life…*" (Alexander, p.19, L104) "*So you start to realise all these things, after all those uses, all these nightlife, all these enjoyable ones that I'm not getting nothing out of it, I'm just destroying myself I'm not getting nothing…*" (Greg, p.7, L64)

3) Making-sense of one's problematic mephedrone use via self-reflective processes	3a) Stigmatising beliefs assist in the self-identification of problematic mephedrone use	"*Oh it's still looked at. Its different stages I mean, I would say, erm the straight community or the world in general look at injecting as bad I can't blame them, injecting drugs that sounds bad, straight away… When you snort with the same straw, (laughs) you might as well, it's the same thing as passing a needle, and I've had huge arguments about it because people don't see it like that. And the gay community most people see it bad as well. There's only a handful of people that inject…*" (Josh, p.29, L164) "*Oh it's still looked at. Its different stages I mean, I would say, erm the straight community or the world in general look at injecting as bad I can't blame them, injecting drugs that sounds bad, straight away… When you snort with the same straw, (laughs) you might as well, it's the same thing as passing a needle, and I've had huge arguments about it because people don't see it like that. And the gay community most people see it bad as well. There's only a handful of people that inject…*" (Josh, p.29, L164) "*Yeh, because their lifestyles completely different. You've gotta have, from what I've learnt, you've got to have, erm, a lot of money to supply that that addiction, and that means you man rob people's houses and their rob cars and st-, and their phones and stuff. You're even robbing at erm at the cash point. You're not gonna get someone on mephedrone tryna rob you at the cash point, or trying to erm, they haven't got to, they haven't got a £300 a day drug addict. Its £20 for a gram, [laughs] it's a bit of difference in the, in the value. And by the way they take it as well, and the way that erm heroin is easier easier easier to pass away on that drug…*" (Daniel, p.27, L154)
	3b) A critical incident that triggers the self-evaluation of one's mephedrone use as subjectively problematic	"*And when I got home, my mum was like "you look tired and grey", I'm like "Oh what do you expect, I just came back, I've been partying for 6 days". I'm saying it so casually like it's the normal thing. Erm I ended up going to sleep, and I just felt my body just go so limp, and I was like "oh mum what's going on" and I can remember hearing voices of my mum screaming when she was erm, being attacked by her boyfriend before*

		when I was younger. And I'm like "oh my god why could I hear that", I need to get up and help her, but I couldn't move. I was like "what? What is going on here? What is what is happening?" I thought no this cannot be happening. To me, I I really thought, all it was, I was passing away. I tried everything within me, to try and get out this limp feeling, and then I went [inhale and exhale of breath] a deep breath and woke up. So I started to cry. Then I went to hospital, and erm they told me, basically that I'm just so exhausted. So my body won't be willing to (..) sleeping, direct sleep but my mind was still active, so you've had that. Oh what's it called, I can't I can't, oh I forgot the word they mentioned, but after that episode I, I, I, ended up going hospital quite a few times after that. And I'm realising "what the hell, why am I always in hospital on a drip?"" (Daniel, p.14-15, L86) "*Oh the worst you can imagine. You you you think everything. You never gonna be cope in your life no more. Your life is done. You've damaged your family. All, all kind of things you know. It comes some in your mind.*" (Alexander, p.19, L180) "*I would come into the work high and he would instantly give me orange juice, cos it's a common thing that orange juice cuts it down. Erm, and he would let me go off sometimes, get off early because I would just be so tired. It wasn't until he took action erm because it got out of control, that he gave me a warning and it helped me, it pushed me in the right direction. I'm grateful for him.*" (Josh, p.11, L76) "*…what's it doing to my family? And then until I went to rehab, I didn't realise until they send back there questioning, how much I was actually hurting them, and I was hurting them a lot more then I was hurting me.*" (Daniel, p.15, L86)

		"*Probably when you come down off these drugs you feel bad because, you waste how many days, you don't go to work. You're gonna upset your manager and you have too many appointments you miss them, too many parents call you never answer*." (Alexander, p.17, L110) *"…(Laughs) You know, too many things happen. Like last time, some people I was using drugs with, they say I'm gonna stop, I'm not gonna use anymore. One of them came to my house, and they say you know last time when you brought your laptop I accessed your apple ID and stuff, and he's studying technology, and then I said connect to apple ID and he did it. He got all my contacts, and they say remember when you come out at this chill-out or sex party you never know what they are doing. So you remember when we took a computer picture, they say if you do not come back to that sex party and buy us drugs, were gonna send this picture to, and we spent almost the last two months together. You think you are friends and stuff. And you may think that that person is good, but once they use drugs they will do everything. So at that point I recorded, as soon as I seen that guy it was the afternoon, so we sit outside and I record his voice and when he knew that I recorded what he was saying, he kind of backed off. So this is an example of it, I knew him for 2 months, spent all our time together and you can feel that person is good, but for him to get drugs he'll do anything, so that makes you feel bad. It's a waste*." (Alexander, p.14, L92) "*I started missing two, three days of work together, two, three days, two, three days. You know it's going to be a problem, if you spend a lot of money and you're not going to work so there's no income, I'm just spending, spending…*" (Greg, p.17, L108)

	3c) An internal debate between desires versus' values and beliefs that motivates change	"*I felt guilty and good at the same time, it was a mix feeling like shouldn't have done it, but I done it and I liked it…*" (Greg, p.3, L30) "*Like always I think, I always believe I can do better than this, and that I know this is wrong but you keep doing it, you keep doing it, so yeh I always have the thought that you're controlling it, when you want to stop, you stop but the mephedrone is controlling you…*" (Greg, p.11, L82) "*I never brought it home into my home. I brought it home in ***, but I never brought it home in *** because that's my own, my family lives. Spiritually that's where I wouldn't wanna bring something, the devil made into the Gods home. Erm, and that's how I looked at it. I looked at it's a bad, it's the devils tool.*" (Josh, p.22, L136) "*I don't know, I always knew I was having a problem. Drugs for me were something very scary. I grew up in the middle of people that were scared about drugs. You know drugs and alcohol all meant nothing to us, were scared about it. So sooner or later that thing, will come back, doesn't matter how high you are*." (Robert, p.13, L126)