

Mapping the Trajectory from Use to Abuse: Perspectives of Individuals With a Cocaine Use Disorder.

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A dissertation presented to the Department of Psychology, Faculty for Social Wellbeing in part fulfilment of the requirements for the Master of Psychology in Health Psychology

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“The question is not why the addiction, but why the pain.”

Gabor Mate

Abstract

This study aimed to explore how individuals with a cocaine use disorder (CUD) perceive their transition from recreational to problematic use, with a focus on the biopsychosocial processes that shape this trajectory. Nine participants were recruited through purposive sampling from rehabilitation services across Malta, with eligibility based on DSM-5-TR criteria and treatment engagement. Semi-structured interviews were conducted, and Reflexive Thematic Analysis was employed to identify patterns across participants' experiences. Findings revealed that cocaine use often began in socially sanctioned contexts, with initial use perceived as manageable or recreational. However, a gradual shift toward psychological dependency, compulsive behaviours, and interpersonal deterioration was consistently described. The transition to problematic use was not linear, but marked by accumulating vulnerabilities including trauma, emotional dysregulation, and neurodiversity. The biopsychosocial model and Five P's idiographic framework were applied to capture the complexity of these processes. Participants identified social reinforcement and internalised denial as key perpetuating factors, while protective influences, such as structured support and therapeutic intervention, were often activated only in moments of crisis. These findings underscore the importance of person-centred and contextually grounded approaches in treatment planning and highlight the need for earlier psychosocial intervention. This study contributes to local addiction literature and supports the call for culturally attuned, evidence-based policies in addressing CUD.

Keywords: cocaine use disorder, addiction, biopsychosocial model, reflexive thematic analysis, substance use trajectories.

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List of Acronyms

CUD	Cocaine Use Disorder
SUD	Substance Use Disorder
ADHD	Attention Deficit Hyperactivity Disorder
PTSD	Post Traumatic Stress Disorder
EUDA	European Union Drug Agency
UNODC	United Nations Office of Drugs and Crime
NIDA	National Institute on Drug Abuse
C-EHRN	Correlation – European Harm Reduction Network
ACEs	Adverse Childhood Experiences
CBT	Cognitive Behavioural Therapy
CM	Contingency Management
GDPR	General Data Protection Regulation
RTA	Reflexive Thematic Analysis
DSM-5-TR Revision)	Diagnostic and Statistical Manual of Mental Disorders (Text
MBRP	Mindfulness-Based Relapse Prevention
SAMHSA	Substance Abuse and Mental Health Services Administration

Chapter 1 - Introduction

Preamble

Cocaine use has emerged as a growing public health concern, with increasing numbers of individuals transitioning from recreational use to patterns indicative of dependence and addiction (EUDA, 2023). In Malta, this shift has become especially pronounced, with growing numbers of individuals seeking treatment for cocaine-related difficulties (Azzopardi et al., 2021). While public health data offer insight into prevalence, they reveal little about how individuals experience the progression of use on a personal level. The present study focuses on this often-overlooked perspective. It explores how individuals with a CUD understand their transition from recreational use to problematic patterns, with attention to the biological, psychological, and social dynamics that shaped their journeys. By foregrounding lived experience, this research aims to enrich current understanding of cocaine addiction in ways that are clinically relevant, locally informed, and attuned to the human aspects of use.

Key Terms

Recreational use refers to voluntary, often social, consumption of cocaine that occurs without immediate or visible disruption to functioning (Maynes & Grant, 2024). Problematic use, on the other hand, involves a shift toward compulsion, preoccupation, or sustained harm, even when consequences are recognised (Maynes & Grant, 2024). The term CUD is used in line with the DSM-5-TR (APA, 2022), which defines it by a set of behavioural and physiological criteria indicating significant impairment. Importantly, this study adopts a continuum view of cocaine use, hence, the term transition is used throughout, in order to denote the evolving process through which recreational use develops into problematic or

disordered use, acknowledging its often non-linear, cumulative nature (Sciicluna & Clark, 2019).

Theoretical Framework

Two theoretical lenses inform this research: the biopsychosocial model (Engel, 1977) and the Five P's model (Macneil et al., 2012). The biopsychosocial model offers a flexible but integrated view of health, useful for understanding substance use as more than chemical dependency or a behavioural choice. Instead, it frames addiction as the result of interactions between biological vulnerabilities, psychological needs, and social environments. The Five P's model provides a more structured framework for clinical analysis, categorising the different types of influences; presenting, predisposing, precipitating, perpetuating, and protective factors, that shape a person's engagement with substances. Used together, these frameworks supported both the interview design and thematic interpretation, allowing space for complexity without sacrificing coherence.

Research Agenda

While biological and epidemiological research on cocaine use is well developed, qualitative insight into how individuals themselves understand their use remains scarce, particularly in local contexts such as Malta. This study takes a step toward addressing that absence. It seeks to explore the stories and meaning making of individuals who have lived through the shift from controlled to problematic cocaine use, offering insight into how addiction develops over time from a first-person perspective.

This study is guided by the following research question: How do individuals with a cocaine use disorder subjectively perceive their transition from recreational use to problematic use? In addressing this question, the study aims to explore how individuals with

a CUD view their use and what biopsychosocial consequences they associate with it. Additionally, it seeks to identify the predisposing, precipitating, perpetuating, and protective factors that they believe influenced their progression from recreational experimentation to harmful and compulsive use.

Rather than searching for universal pathways, this research attends to individual complexity, how different factors converge or collide across people's lives to create vulnerability, momentum, or, at times, resistance to change.

Philosophical Underpinnings

The study is grounded in a critical realist ontology and an interpretivist epistemology. Critical realism recognises that while addiction has biological realities, such as cravings or brain changes, it is also experienced through personal and social lenses (Bhaskar, 2016). This allows the study to account for both structural determinants and subjective interpretation. From an interpretivist perspective, knowledge is viewed as constructed: people give meaning to their experiences, and those meanings shape behaviour (Guba & Lincoln, 1994). Semi-structured interviews and Reflexive Thematic Analysis (RTA) (Braun & Clarke, 2021) were chosen for their alignment with this perspective, allowing participants to speak in their own terms. Reflexivity was also integral; the researcher actively examined how personal assumptions and positionality might shape interpretation, ensuring transparency throughout.

Dissertation Overview

The dissertation unfolds over five chapters. Following this introduction, the literature review sets the foundation by discussing the pharmacological, psychological, and sociocultural dimensions of cocaine use, while highlighting key research gaps. The methodology chapter outlines the study design, ethical procedures, and analytic approach,

with emphasis on credibility and reflexivity. The findings and discussion chapter is organised thematically and integrates interview data with existing theory, revealing how participants made sense of their cocaine use over time. The final chapter reflects on the study's contributions, limitations, and implications for practice and policy. Taken together, the dissertation aims to bring the voices of people with lived experience into sharper focus, offering a perspective too often absent in addiction discourse.

Chapter 2 - Literature Review

Rising trends in the use and problematic use of cocaine continue to dominate discussions in public health, law enforcement, addiction research, and social policy due to its far-reaching impact on individuals and communities alike (EUDA, 2024). Its prevalence across diverse social contexts, from nightlife to professional settings, highlights the drug's versatility and the wide-ranging appeal that has fuelled its persistent misuse (SAMHSA, 2023). This chapter delves into the multifaceted nature of cocaine, tracing its evolution, diverse forms of use, and the devastating consequences of its addictive potential. Moreover, this chapter seeks to review the existing literature on cocaine and CUD, while identifying critical gaps in research and treatment approaches. Through this exploration, it underscores the value of integrating multidisciplinary perspectives to address one of the most pressing public health challenges of our time. By presenting a holistic and evidence-based view, the chapter lays the groundwork for understanding cocaine's grip on individuals and society and emphasizes the urgent need for effective and comprehensive intervention strategies.

A thorough literature search was conducted to establish a theoretical and empirical foundation for this study. The initial stages of the search took place between July and December 2024, using HyDi, the University of Malta's federated discovery system that enables simultaneous access to a wide range of academic databases and full-text journals.

The databases accessed included: PubMed, PsycINFO, Medline (ProQuest), Scopus, ScienceDirect, SAGE Journals, Wiley Online Library, and SpringerLink.

Priority was given to peer-reviewed literature published between 2016 and 2024, with a focus on empirical studies, systematic reviews, and theoretical papers relevant to substance use, addiction psychology, and qualitative methods.

Key search terms included: '*Cocaine use disorder*', '*problematic cocaine use*', '*substance use trajectory*', '*transition to addiction*', '*biopsychosocial model and addiction*', '*psychological impact of cocaine*' '*5P's model of formulation*', and '*lived experience of addiction*'.

Understanding Cocaine

From Coca to Cocaine: A Historical Perspective

Cocaine is a powerful stimulant drug derived from the leaves of the *Erythroxylum coca* plant, which contains the active alkaloid responsible for its effects (Roque Bravo et al., 2022). Its origin lies in the traditional practices of Andean civilizations, where coca leaves were chewed for their mild stimulant effects, helping civilians endure the high altitudes of the Andes mountains and sustain themselves through intense physical labour (Arias & Grisaffi, 2021).

The shift toward global recognition began in the mid-19th century, when chemists isolated the active compound from coca leaves (McLaughlin, 1973). As cited in Bauer (2019), Albert Niemann, a German chemist, is credited with identifying and isolating cocaine hydrochloride in 1859, a discovery that marked the transformation of coca into a substance with far-reaching applications. Following this breakthrough, the pharmaceutical potential of cocaine was rapidly explored. Companies then began manufacturing cocaine commercially in the 1860s, advertising it as a stimulant that enhanced physical performance and reduced fatigue (Bauer, 2019).

Soon after, European researchers and military forces also began to recognize the drug's unique properties (Pierce et al., 2018). In 1883, experiments were conducted in which war veterans were given cocaine dissolved in water, observing its ability to boost endurance

and resilience during manoeuvres. This period of experimentation laid the groundwork for widespread medical and military applications. Notably, Sigmund Freud's early experiments in the 1880s further popularized cocaine's use, as he promoted it as a 'miracle drug', mainly as a remedy for morphine addiction and mental fatigue, publishing his findings in *Über Coca* (1884).

However, the euphoric effects that initially garnered acclaim, soon revealed a darker side. Reports of dependence and adverse health effects began to emerge, leading to increased scrutiny (Levine & Kerrigan, 2020). By the early 20th century, cocaine transitioned from being a celebrated medical breakthrough to a substance of concern. Medical professionals and researchers began recognizing its addictive potential and the severe physical and psychological consequences of prolonged use, such as cardiovascular complications, paranoia, and psychosis (Levine & Kerrigan, 2020). This shift in perception marked the beginning of cocaine's long and complex journey into the illicit drug landscape, one that continues to evolve.

Today, cocaine remains one of the most abused substances worldwide, contributing significantly to public health and societal challenges (EUDA, 2024). The substance is often associated with recreational use in social settings, but its addictive nature leads many users down a path of dependence (Hogarth et al., 2020). Modern cocaine use is fuelled by organized drug trafficking networks, with large quantities smuggled globally, particularly into Europe and North America (EUDA, 2024). Despite efforts to reduce its availability through international drug control policies, cocaine use remains prevalent, with rising trends in certain regions and continued challenges in addressing the health and social consequences of its abuse (UNODC, 2024).

Types of Cocaine and Methods of Use

Cocaine exists in multiple forms, which vary in chemical structure, methods of administration, and patterns of use (Roque Bravo et al., 2022). The most recognized form of cocaine is cocaine hydrochloride, also known as powder cocaine, a water-soluble salt derived from the coca plant, typically processed into a fine, white crystalline powder (NIDA, 2024). Before being distributed, powdered cocaine is often diluted with various adulterants, such as local anaesthetics, sugars, inert substances, or other drugs (UNODC, 2021). It is commonly sold in small quantities, typically by the gram. When snorted, powder cocaine is rapidly absorbed into the bloodstream, delivering a euphoric effect that peaks within minutes and lasts for approximately 15 to 30 minutes (NIDA, 2024).

Cocaine hydrochloride may also be dissolved in water and injected intravenously (NIDA, 2024). This method of administration is less common than snorting, yet it delivers an almost immediate and intense high, as the drug bypasses the slower nasal absorption process and enters the bloodstream directly. Intravenous cocaine use is particularly dangerous due to the rapid onset of effects, which significantly increases the likelihood of addiction. Furthermore, repeated intravenous use can lead to severe cardiovascular complications, heightened risk of infections, and transmission of bloodborne diseases, such as HIV and hepatitis, due to needle sharing (Wang & Maher, 2019). Despite its risks, recent research on intravenous cocaine use remains limited, suggesting a gap in the literature and a need for updated data on injection-related harms and trends.

Freebase cocaine is a non-salt form of the drug that is chemically modified to remove the hydrochloride component, resulting in a substance that is smokable (NIDA, 2024). Unlike powdered cocaine, freebase cocaine is lipid-soluble, allowing it to vaporize at lower temperatures and be absorbed rapidly through the lungs when inhaled (SAMHSA, 2023). This leads to an intense but short-lived euphoric high, often described as more potent than

snorting. However, the intense high is followed by a rapid comedown, as there is a sudden drop in dopamine levels, which can result in profound physical and psychological discomfort (Roque Bravo et al., 2022). Users often experience symptoms such as fatigue, irritability, anxiety, and depression during this phase, commonly referred to as the “crash” (p.8).

Crack cocaine, a crystallized form of freebase cocaine, emerged in the 1980s as a highly potent and inexpensive variant (Butler et al., 2018). Crack is typically ‘cooked’ by dissolving powdered cocaine in a mixture of water and a base, most commonly baking soda, or ammonia, and then applying heat until a solid precipitate forms (UNODC, 2024). Once cooled and hardened, this precipitate is broken into ‘rocks’ that can be smoked. These rocks are usually smoked using a small glass or metal pipe, which allows for rapid inhalation of the vapour. Smoking crack cocaine delivers a nearly instantaneous euphoric effect, as the drug rapidly crosses the blood-brain barrier via the lungs (Crane & Milby, 2024).

Despite their differences in chemical form and route of administration, a common denominator across all types of cocaine is the brevity of the intensely euphoric effect that fades quickly, often fuelling compulsive patterns of repeated use (Khalid et al., 2020).

Patterns and Demographics

The global consumption of cocaine has surged in recent years, with approximately 23 million users worldwide (UNODC, 2024). In Europe, cocaine is now the second most used illicit drug after cannabis, although prevalence rates vary across countries (EUDA, 2024). According to the European Drug Report, around 2.5 million young adults aged 15–34 years in the European Union reported using cocaine in the past year, accounting for approximately 2.5% of this age group (EUDA, 2024).

Cocaine enters Europe mainly as powdered or crack cocaine, produced predominantly in Colombia, Peru, and Bolivia (EUDA, 2024). It is trafficked via transatlantic routes and overland channels, with large quantities smuggled through major seaports like Rotterdam, Antwerp, and Hamburg. These ports, often exploited through commercial shipping containers, play a key role in the drug's widespread availability and distribution across Europe.

The consequences of this increasing availability are reflected in local treatment trends reported in the National Drugs Report (Azzopardi et al., 2021). In 2020, 39% of individuals seeking treatment for substance use in Malta cited cocaine as their primary drug, marking a 21% increase since 2017. This rise highlights a shifting pattern in drug use locally, with cocaine now the second most commonly reported substance after heroin among those entering treatment. The scale of high-risk cocaine use further underscores the severity of the problem. In the same year, an estimated 1,465 individuals in Malta were identified as high-risk cocaine users, with 312 of them engaging in daily use. Alarming, only 21% of daily cocaine users were enrolled in treatment programs, leaving a significant portion of this population without adequate support. This gap in access equates to approximately 3.98 individuals per 1,000 people aged 15–64 years actively receiving treatment for cocaine-related issues.

Insights from Malta's Department for Probation and Parole illustrate the demographics of cocaine use within the criminal justice system (Azzopardi et al., 2021). Of the 465 individuals registered for probationary services in 2022, cocaine was the primary substance of choice for 55% of these clients, highlighting its significant role within this population.

A critical factor exacerbating the issue is the high accessibility of cocaine within local communities. According to the Eurobarometer: Impact of Drugs on Local Communities, 35% of respondents in Malta reported that obtaining cocaine within 24 hours is easy (European Commission, 2024). This widespread availability lowers barriers to both initial and sustained consumption, contributing to the drug's escalating public health impact.

Recent investigative reports have shed light on the increasing accessibility and normalization of cocaine use within Malta's nightlife scene. An article in the Times of Malta revealed the prevalence of cocaine in Valletta's entertainment venues, indicating a shift in public perception and availability of the drug (Galdes, 2025). The article highlighted that cocaine consumption is no longer confined to secluded areas but has permeated mainstream nightlife, with patrons openly using the drug in clubs and bars. This normalization has been attributed to the drug's affordability and the perception of it being a 'social' substance, leading to its widespread use across various demographics. Furthermore, the report emphasized the challenges faced by law enforcement in curbing this trend, citing limited resources and the evolving tactics of drug traffickers who exploit the bustling nightlife to distribute cocaine discreetly.

This social acceptance of cocaine use in Malta is echoed in findings from the Correlation – European Harm Reduction Network (C-EHRN), which reported that powdered cocaine consumption is increasingly common in social environments beyond nightclubs, including during culturally significant events such as weddings and baptisms (2019).

Cocaine Use Disorder

Definition of CUD

Cocaine use and CUD exist along a continuum, with the distinction lying in the frequency, intensity, and consequences of use (Schwartz et al., 2022). While casual cocaine use refers to occasional consumption without significant impairment, CUD is characterized by a compulsive pattern of use that leads to substantial physical, psychological, and social consequences (Schwartz et al., 2022). According to the DSM-5-TR, CUD is diagnosed when an individual meets at least two of 11 specified criteria, leading to significant impairment or distress within a 12-month period (American Psychiatric Association, 2022). These criteria fall into four categories: physiological responses such as craving, tolerance, and withdrawal; inability to control use; prioritization of cocaine over daily responsibilities (e.g., work, school, family); and experiencing other negative consequences due to its use. The DSM-5-TR specifies 11 individual symptoms across these domains. Based on how many of these 11 criteria are met within a 12-month period, CUD is classified as mild (2–3 symptoms), moderate (4–5 symptoms), or severe (6 or more), illustrating the disorder's progression from occasional use to compulsive and harmful patterns of behaviour.

From Use to Problematic Use

The transition from recreational to problematic cocaine use is shaped by a combination of personal, relational, and contextual factors (Belfiore et al., 2024). Rather than a single turning point, this process is better understood as a dynamic and nonlinear trajectory that evolves over time (Scicluna & Clark, 2019). Initial use is commonly motivated by curiosity, peer influence, or the desire for increased energy and sociability (DiClemente, 2018). During this phase, individuals often perceive their use as controlled and situational, with minimal awareness of the drug's potential to lead to dependency (Maynes & Grant, 2024).

Sciicluna and Clark (2019), describe how individuals' substance use pathways emerge as longitudinal life trajectories influenced by early vulnerability, social context, and identity formation. Their work illustrates that the shift to problematic use is rarely abrupt but is characterised by accumulating behavioural changes and adaptations. For instance, what begins as experimentation may develop into habitual use when cocaine is repeatedly employed to manage distress, boredom, or interpersonal challenges. This aligns with the career model of addiction, which frames substance use as an evolving process shaped by identity, opportunity structures, and cumulative experience (Blumstein & Cohen, 1987; Clark, 2011).

While research frequently underscores the gradual nature of this progression, some individuals appear to move through these stages more rapidly. A phenomenon known as telescoping, the rapid progression from initial use to dependence, has been observed particularly among women, though it is not exclusive to them (Piazza et al., 1989). Telescoping refers to the accelerated timeline in which certain individuals develop compulsive patterns of use and related harms compared to others. This faster trajectory has been linked to a range of factors, including early exposure to trauma, emotional dysregulation, relational vulnerability, and heightened sensitivity to cocaine's reinforcing effects (Sciicluna & Clark, 2019). While some individuals engage in sporadic use for extended periods before encountering negative consequences, others quickly transition into addiction, often within months of initial experimentation (Sciicluna & Clark, 2019).

The Clinical Profile of Individuals with a CUD

In alignment with evidence-based guidelines for compassionate and non-stigmatizing communication, this dissertation adopts the term "people with a substance use disorder," as recommended by the Public Health Agency of Canada (2019).

Individuals with a CUD typically present with a complex clinical picture characterised by intense cravings, cognitive impairments, emotional dysregulation, and functional decline. CUD is marked by a persistent pattern of compulsive use, high impulsivity, and difficulty regulating behaviour, even in the face of severe psychosocial, occupational, and health consequences (Kampman, 2019; Sofuoglu & DeVito, 2018). Craving episodes are frequently cue-induced, triggered by emotional states or environmental reminders of past use. Neuroimaging studies reveal heightened activation in reward-related brain regions when exposed to cocaine-related cues, contributing to the high relapse rates observed in CUD (Zilverstand et al., 2018).

Cognitive impairments are commonly reported among individuals with a CUD and represent a key clinical concern. Executive functioning deficits, including impaired decision-making, attention, working memory, and inhibitory control, have been consistently documented (Mahoney, 2019). These impairments not only increase vulnerability to continued use but also hinder engagement in treatment, particularly when cognitive-behavioural strategies require reflection, planning, and behavioural regulation. While some deficits may improve with sustained abstinence, others may persist long after cessation of use (Mahoney, 2019).

Emotional dysregulation is another central feature of the clinical profile. Unlike substances that produce strong physical withdrawal symptoms, such as alcohol or opioids, cocaine withdrawal is primarily psychological and marked by a profound emotional crash (Koob et al., 2016). During periods of withdrawal or abstinence, individuals frequently experience symptoms such as irritability, restlessness, anhedonia, and dysphoria (Lerner & Klein, 2019). Crucially, this dysphoric withdrawal phase is also associated with increased suicidal ideation and behaviour. Studies have shown that individuals with a CUD are at elevated risk for suicide, particularly during early abstinence, when mood dysregulation and

hopelessness are most intense (Kelly et al., 2020). Further evidence highlights a strong link between recent cocaine use and suicidality, with research indicating that individuals who had used cocaine within the month prior to death exhibited a significantly higher risk of dying by suicide compared to those with more distant or no history of use (Sosa et al., 2025).

Consistently, multiple studies have demonstrated a robust association between cocaine use and both suicidal ideation and completed suicide, underscoring the critical mental health risks posed by the substance (Abdalla et al., 2019; Arias et al., 2016; Bohnert et al., 2017; Icick et al., 2018).

Functionally, individuals with a CUD often experience significant disruption across major life domains. Many report job loss, financial hardship, interpersonal conflict, and involvement with the criminal justice system as a result of their cocaine use (EUDA, 2023). Disordered sleep, irregular eating habits, and neglect of self-care are also common, particularly among users (Bjorness & Greene, 2021).

Importantly, ambivalence is a recurring theme in clinical presentations. Many individuals acknowledge the harms associated with their cocaine use yet struggle with letting go of its perceived benefits, such as increased confidence, productivity, or emotional numbing (Duopah et al., 2024). This ambivalence is particularly common among individuals who function well in professional or social roles despite their substance use, further complicating readiness for treatment and long-term engagement.

The Biopsychosocial Framework for Understanding CUD

The biopsychosocial model, first introduced by George Engel in 1977, offers a holistic framework for understanding complex health conditions. This model has been widely applied in addiction research, as substance use disorders (SUDs) are inherently multifaceted, involving the interplay of biological, psychological, and social factors (MacKillop & Ray, 2017). By recognizing the interdependence of these factors, the model moves beyond

reductionist approaches and provides a comprehensive lens through which addiction can be studied and treated.

While this framework has been successfully applied to understanding general addiction processes, there appears to be a gap in its focused application to CUD (MacKillop & Ray, 2017). Research in the field of addiction often incorporates elements of this model, but studies specifically utilizing this framework to comprehensively address the biological, psychological, and social dimensions of CUD remain limited. For example, studies such as Robinson and Berridge's (2003) work on incentive sensitization provide critical insights into the neurobiological mechanisms underlying cocaine addiction, and Volkow et al.'s (2019) research highlights the dopamine dysregulation and neuroadaptations associated with chronic cocaine use. However, these studies primarily focus on the biological domain and do not always integrate psychological and social factors within a cohesive biopsychosocial framework. Addressing these interconnected factors in isolation often leads to fragmented care, emphasizing the potential value of applying the biopsychosocial framework more explicitly to CUD research and treatment (MacKillop & Ray, 2017).

This gap presents an opportunity to expand the application of the biopsychosocial model specifically to CUD, enabling researchers and clinicians to better understand the multifaceted nature of the disorder and to develop integrated, evidence-based treatment strategies.

The Biological Perspective of CUD

The biological underpinnings of CUD provide critical insights into the mechanisms driving its progression from recreational use to compulsive and pathological drug-seeking behaviour. Chronic cocaine use alters key neural pathways, particularly those involved in

reward, motivation, and decision-making, creating a cycle of addiction that is difficult to break (Koob et al., 2016; Volkow et al., 2019).

The mesocorticolimbic dopamine pathway, also referred to as the brain's 'reward circuit,' plays a central role in the development and maintenance of CUD (Cooper et al., 2017; Volkow et al., 2019). This pathway, which includes the ventral tegmental area, nucleus accumbens, and prefrontal cortex, evolved to prioritize behaviours essential for survival, such as eating and reproduction (Volkow et al., 2019). Cocaine, however, hijacks this system, elevating dopamine levels to a degree far greater than natural rewards. Over time, this reinforcement leads the brain to prioritize cocaine use over healthy, adaptive behaviours that are essential for survival. As a result, activities like eating, exercising, or forming relationships become less rewarding compared to the effects of the drug, driving compulsive use and addiction (Cooper et al., 2017).

Cocaine achieves its effects by blocking the dopamine transporter, leading to a build-up of dopamine in the synaptic cleft (Robinson & Berridge, 2003). This overstimulation of dopamine receptors amplifies the reinforcing properties of cocaine, driving compulsive drug-seeking behaviours (Robinson & Berridge, 2008). Importantly, environmental cues, such as people, places, or objects associated with cocaine use, become powerful triggers for cravings due to this sensitization, contributing to the high rates of relapse observed in individuals with a CUD.

The incentive sensitization theory, proposed by Robinson and Berridge, posits that repeated exposure to cocaine results in heightened sensitivity of the brain's reward system to drug-associated cues (2008). This process, referred to as 'sensitization', involves the mesolimbic dopamine pathway, particularly the nucleus accumbens and ventral tegmental area, which are responsible for regulating reward and motivation. Over time, this heightened

sensitivity increases the craving for cocaine, even as its euphoric effects diminish with tolerance (p.363).

Chronic cocaine use disrupts the homeostatic balance of neurotransmitter systems, particularly dopamine, leading to long-lasting structural and functional changes in the brain's reward circuits (Wang et al., 2025). Over time, the brain reduces its natural dopamine production and receptor density, a process known as downregulation, which diminishes the individual's ability to experience pleasure from natural rewards such as food, social interactions, and relationships (Volkow et al., 2019). This state, often referred to as anhedonia, drives individuals to use cocaine compulsively in an attempt to regain the pleasurable effects once experienced (Poisson et al., 2021).

Additionally, cocaine-induced neuroadaptations extend beyond the mesolimbic dopamine system to other regions, such as the prefrontal cortex, which is responsible for decision-making, impulse control, and self-regulation (Goldstein & Volkow, 2011). Neuroimaging studies reveal that individuals with a CUD often exhibit reduced activity in the prefrontal cortex, a region critical for executive functioning (Tondo et al., 2021). Impaired prefrontal functioning reduces the individual's ability to resist cravings and increases susceptibility to drug-seeking behaviours, further perpetuating addiction (Koob & Volkow, 2016).

The Psychological Mechanisms of CUD

CUD is influenced by a wide array of psychological factors that may both contribute to its onset and perpetuate its progression (Koob & Volkow, 2016). These elements form a complex interplay that not only increases an individual's vulnerability to cocaine use but also complicates recovery and contributes to the chronic nature of addiction.

Psychological trauma and exposure to stressful life events are among the most significant contributors to the development of CUD. Individuals with a history of psychological trauma, particularly Adverse Childhood Experiences (ACEs), such as abuse, neglect, or significant loss, are more likely to use cocaine as a way to self-soothe or avoid distressing emotions (Kim et al., 2017). Research conducted in both military and civilian populations has identified psychological trauma, or Post Traumatic Stress Disorder (PTSD) as a significant risk factor for the development of SUD (Haller & Chassin, 2014; McDevitt-Murphy, 2015). Findings indicated that individuals with PTSD often report using addictive substances, such as cocaine, as a coping mechanism to manage emotional distress. This phenomenon aligns with the self-medication hypothesis, which posits that individuals turn to substances, like cocaine, to alleviate psychological pain or dysregulated emotions (Khantzian, 1985). Substance use can evolve into a self-sustaining cycle, separate from the initial psychiatric symptoms. As a result, even when the underlying PTSD symptoms are well-managed, the substance use may persist, fuelled by the entrenched nature of addiction (Maria-Rios & Morrow, 2020). This can explain why stress and trauma are often central themes in the lived experiences of individuals with a CUD.

In addition to trauma, comorbid psychiatric conditions frequently co-occur with CUD, creating a bidirectional relationship between cocaine use and mental health (Levesque et al., 2016). Anxiety and depression are particularly common, with individuals often using cocaine to manage symptoms of low mood, fatigue, or heightened anxiety (Gwaltney et al., 2015; Paiva et al., 2017). While cocaine may temporarily elevate mood through its dopaminergic effects, chronic use disrupts dopamine regulation, leading to an exacerbation of depressive symptoms and emotional instability (Volkow et al., 2019). Bipolar disorder, with its characteristic impulsivity and shifts in mood, is another frequent comorbidity (Salloum & Brown, 2017). During manic phases, individuals with bipolar disorder are especially

vulnerable to cocaine use as they seek to amplify feelings of euphoria and energy (Preuss et al., 2021).

Maladaptive personality traits also play a key role in increasing vulnerability to CUD (Maria-Rios & Morrow, 2020). High levels of impulsivity, sensation-seeking, and novelty-seeking are commonly observed among individuals with a CUD. Impulsivity, in particular, has been shown to undermine self-regulation and increase the likelihood of engaging in risky behaviours, including drug experimentation (Grubbs & Chapman, 2019).

Finally, neurodevelopmental disorders, particularly Attention Deficit Hyperactivity Disorder (ADHD), are strongly associated with CUD (Victor et al., 2023). Individuals with ADHD may turn to cocaine to self-medicate symptoms of inattention, hyperactivity, or impulsivity (Dunne et al., 2014). The impulsive nature of ADHD, combined with the reinforcing properties of cocaine, creates a unique vulnerability that complicates treatment and recovery (Kozak et al., 2019).

The Social Context in CUD

CUD is not only influenced by biological and psychological factors but is also deeply rooted in social contexts. The social aspects of CUD are pivotal in understanding the development, progression, and maintenance of the disorder.

One of the most significant social determinants of CUD can be exposure to environments where cocaine use is normalized or encouraged (Mota et al., 2018). Peer influence is a key factor, particularly during adolescence and early adulthood when individuals are more susceptible to social pressures (Keyzers et al., 2020). Cocaine use often begins in social settings such as parties, clubs, or workplaces where it is framed as a tool for social enhancement, stress management, or productivity. Research shows that individuals

who are surrounded by peers who use cocaine are more likely to initiate use themselves, as social acceptance lowers perceived risks and increases the allure of the drug's short-term benefits (Volkow et al., 2019).

From his study, Micallef (2019) found that cocaine has become more accessible in Malta, influencing shifts in clubbing behaviour. While ecstasy was once dominant, the increased availability and perceived 'sobering' effects of cocaine have made it a preferred choice for certain social events. This 'sobering' effect was also seen in other studies where it was found that cocaine is also used to counterbalance alcohol intoxication, helping users regain alertness and maintain social performance (Pergolizzi et al., 2022).

CUD often leads individuals to prioritize cocaine use above all other aspects of their lives, creating a profound shift in personal values, relationships, and responsibilities (NIDA, 2024). As addiction progresses, cocaine use takes precedence over work, friendships, family obligations, self-care, and even basic needs such as food and water (Perry et al., 2013; Schwartz et al., 2013).

Cocaine's role as a dominant priority is also evident in the financial and social sacrifices made to sustain the addiction. Many individuals spend excessive amounts of money to acquire the drug, often leading to financial instability or criminal behaviour. In fact, cocaine addiction is often linked to criminal behaviour, including drug trafficking, theft, and violence. (Parent & Brochu, 2017; Pierce, 2017).

Treating CUD

The Psychological Grip of Cocaine

Individuals with a CUD often struggle with low motivation, emotional lability, and difficulty tolerating distress, traits that complicate engagement with structured interventions (Castine et al., 2018). As a result, behavioural therapies have been developed specifically to target such challenges. Cognitive-Behavioural Therapy (CBT), for example, helps clients break learned associations between triggers and use by restructuring beliefs such as needing cocaine to feel normal (Carroll & Kiluk, 2017). CBT also supports clients in building non-drug coping mechanisms for mood regulation and stress management. Beyond cognitive restructuring, CBT incorporates behavioural techniques such as stimulus control, problem-solving, and skills training to enhance self-regulation and promote adaptive behaviours. It emphasizes functional analysis of drug use episodes to help individuals identify antecedents and consequences, thus increasing awareness of the processes underlying their use (Boness et al., 2023). Additionally, CBT has shown effectiveness in reducing relapse rates by equipping individuals with practical tools to manage cravings, tolerate distress, and navigate high-risk situations without resorting to substance use (McHugh et al., 2019). The structured, time-limited nature of CBT makes it an accessible and scalable intervention, especially when delivered in individual or group formats, and it is increasingly adapted for digital platforms to widen its reach.

In tandem, Contingency Management (CM) has gained significant empirical support in recent years for directly targeting motivational deficits. CM programmes reward abstinence through vouchers or incentives, helping to override cocaine's short-term psychological rewards with alternative reinforcers (De Crescenzo et al., 2018). This is particularly effective during the initial phases of abstinence, where the risk of dropout is highest.

A systematic review by the European Monitoring Centre for Drugs and Drug Addiction (EUDA, 2024) identified CM as a promising adjunct to pharmacological and psychosocial interventions. Among cocaine users specifically, CM demonstrated effectiveness in reducing use and promoting continuous abstinence, although its impact on treatment retention was more variable. Importantly, CM has been shown to be particularly useful when individuals struggle with motivation and executive function, both of which are commonly impaired in those with CUD, factors that may otherwise limit the effectiveness of talk-based therapies alone.

Despite these benefits, concerns about cost-effectiveness and ethical considerations have hindered CM's widespread implementation in routine care (De Crescenzo et al., 2020). Nevertheless, its structured, reward-based format may make it especially suitable for engaging individuals with low distress tolerance and high impulsivity.

Mindfulness-Based Relapse Prevention (MBRP) is an integrative intervention that merges traditional relapse prevention techniques with mindfulness meditation practices, offering an alternative approach to addressing the psychological processes that drive continued substance use (Ramadas et al., 2021). Rather than focusing solely on behavioural triggers, MBRP encourages individuals to observe cravings and distressing thoughts without judgment or immediate reaction, fostering a more reflective and less impulsive stance toward relapse cues (Grant et al., 2017). Despite some limitations in the evidence base, including high attrition rates and variability in program implementation, MBRP appears to be a safe and acceptable option for enhancing relapse prevention strategies (Ramadas et al., 2021).

Given the psychological nature of withdrawal and relapse risk, effective treatment for CUD requires not only abstinence support but also targeted psychological interventions that address craving regulation, distress tolerance, and motivation. Long-term outcomes are best

when these therapies are delivered as part of a comprehensive, multi-phase treatment plan that includes relapse prevention and emotional skills training (Kampman, 2019).

Lack of FDA-Approved Pharmacological Treatments

Currently, there are no FDA-approved medications specifically designed to treat CUD, which creates a significant gap in treatment options (NIDA, 2023). While some pharmacological agents, such as disulfiram, topiramate, and modafinil, have shown promise in clinical trials, their effectiveness is inconsistent. The absence of a reliable pharmacological intervention leaves behavioural therapies, such as CBT and CM, as the cornerstone of treatment (SAMHSA, 2022). However, these therapies require sustained commitment and are not always accessible to individuals with lived and living experience of substance use or co-occurring disorders.

The Issue of Stigma

Stigma surrounding cocaine use and addiction continues to be one of the most damaging and under-addressed barriers to treatment for individuals with a CUD. Societal narratives often depict addiction as a failure of moral character or personal responsibility, rather than as a legitimate health condition shaped by neurobiological, psychological, and social influences (Muncan et al., 2020). This perception fosters social exclusion, discrimination, and judgment, creating an environment in which individuals with a CUD are often reluctant to disclose their substance use or seek professional help (Hammerlund et al., 2018). The fear of being labelled or criminalised contributes to delayed treatment entry, poor engagement with services, and greater psychological distress.

These barriers are further compounded by limited access to non-judgmental, specialised treatment services, particularly in marginalised communities or low-resource

settings. The EUDA notes that institutional practices in healthcare, criminal justice, and social services often reflect punitive attitudes toward people who use cocaine, making it more difficult for individuals to access consistent, compassionate care (2023). This is especially evident in settings where drug use is criminalised or heavily policed, where individuals may avoid seeking medical or mental health services due to the risk of legal repercussions or social exposure (Scher et al., 2023).

The impact of stigma extends beyond the individual to affect families and communities. Families of those with CUD frequently report feelings of shame and social withdrawal due to judgment from peers or institutions, which may reduce their ability to offer effective support or encourage help-seeking (Cazalis et al., 2023).

Studies also highlight how stigma can directly affect the quality of care provided. Health professionals may hold unconscious biases against individuals with a SUD, viewing them as more manipulative or less amenable to treatment than those with other diagnoses (Stone et al., 2021). These attitudes not only compromise therapeutic rapport but can lead to suboptimal clinical decisions, reduced referrals, and an overall erosion of trust in healthcare systems.

Conclusion

The next chapter will outline the methodological framework employed to explore individuals' lived experiences of the transition from recreational to problematic cocaine use, detailing the study design, participant recruitment, data collection procedures, and analytic strategy.

Chapter 3 - Methodology

Introduction

This study aimed to explore how individuals with a CUD perceive their transition from recreational cocaine use to problematic use. Given the complexity of SUDs, which involve biological, psychological, and social influences, a phenomenological approach was deemed most appropriate, allowing participants to articulate their lived experiences in their own words (Neale, 2021).

To analyse the data, Reflexive Thematic Analysis (RTA) was chosen as the primary analytical framework. Developed by Braun and Clarke (2019), RTA acknowledges the active role of the researcher in meaning-making while emphasizing flexibility and reflexivity in the interpretation of data. The study was grounded in critical realism as its ontological stance and interpretivism as its epistemological approach, ensuring that both the objective realities of addiction and the subjective meanings individuals assign to their substance use were considered.

This section outlines the methodological framework of the study, including participant recruitment, data collection procedures, ethical considerations, and data analysis techniques. Additionally, the trustworthiness and rigor of the study are discussed, emphasizing credibility, transferability, dependability, and confirmability to ensure the integrity of the findings.

Research Questions and Rationale

This study aimed to explore the experiences of individuals with a CUD, focusing on how they perceive their transition from recreational to problematic cocaine use. To achieve

this, the research was guided by the following question: How do individuals with a CUD perceive their transition from recreational use to problematic use? Moreover, the research aims are:

- ii. How do problematic cocaine users interpret their substance use, and what biopsychosocial consequences do they associate with it?
- iii. What predisposing, precipitating, perpetuating, and protective factors do they associate with the trajectory from use to problematic use?

Given the complexity of addiction trajectories, this study employed a qualitative approach to gain rich, in-depth insights into how individuals construct meaning around their substance use experiences. Qualitative methodologies are particularly valuable when investigating personal and social aspects of addiction, as they enable researchers to capture the intricacies of subjective experiences that cannot be fully understood through quantitative measurement alone (Coyle & Lyons, 2021; Ritchie et al., 2013). While quantitative studies often emphasize generalizability, causality, and statistical trends, they may overlook the nuanced and individualized nature of addiction, which is socially, psychologically, and biologically embedded (Clark et al., 2021; Langdridge et al., 2013).

Unlike positivist approaches, which focus on objective measurements, qualitative research examines social life as a dynamic and evolving process, allowing for an exploration of how personal experiences, environmental influences, and internal struggles shape addiction trajectories over time (Clark et al., 2021). This study prioritized participants' narratives, acknowledging that substance use is a complex and multidimensional phenomenon that extends beyond clinical definitions of addiction. Through semi-structured interviews, participants were encouraged to share their perspectives in their own words,

offering a contextualized and personal account of their cocaine use trajectories (Njie & Asimiran, 2014).

The research was informed by the Biopsychosocial Model (Engel, 1977) and the Five P's idiographic framework (MacNeil et al., 2012), which provided a structured approach to understanding the interplay of biological, psychological, and social influences on CUD. These models allowed the study to systematically investigate the key factors that predispose individuals to cocaine use, contribute to its escalation, sustain ongoing use, and facilitate recovery. Through RTA, the study identified and interpreted patterns within participant narratives, ensuring that themes emerged organically from the data rather than being imposed by predefined frameworks (Braun & Clarke, 2021).

Epistemological and Ontological Positioning

Understanding the experiences of individuals with a CUD required a clear articulation of the study's philosophical foundations. This research was grounded in critical realism as its ontological stance, and interpretivism as its epistemological approach, ensuring that both the objective realities of addiction and the subjective meanings individuals attach to their substance use were adequately captured. Given the qualitative nature of this study, these philosophical perspectives provided a coherent framework for analysing the individuals' accounts, while acknowledging the broader systemic factors influencing their experiences (Braun & Clarke, 2021). Axiology, which considers the role of values and researcher positionality in shaping the research process, further ensured that reflexivity and ethical transparency were maintained throughout the study (Nowell et al., 2017).

Ontology: Critical Realism

Critical realism posits that an objective reality exists independently of human perception, yet our understanding of this reality is always mediated by social, psychological, and cultural constructions (Shoolman, 2017). In the context of CUD, this means that while addiction has identifiable neurobiological and behavioural components, individuals' experiences of substance use are deeply shaped by other factors such as personal history, economic hardship, criminalization, and healthcare access (Fletcher, 2017). Unlike positivist approaches, which assume that addiction can be measured solely through clinical assessments, and relativist perspectives, which argue that addiction is purely a social construct, critical realism provides a balanced lens that considers both the biological underpinnings of substance use and the way individuals interpret and make sense of their cocaine use trajectories (Archer et al., 2016).

Epistemology: Interpretivism

Interpretivism is rooted in the belief that knowledge is socially constructed and that meaning is derived through individuals' interactions with their environment (Guba & Lincoln, 1994). In addiction research, interpretivism allows for an exploration of subjective experiences, emphasizing how individuals with a CUD perceive their transition from recreational to problematic use. This study embraced an interpretivist epistemology by focusing on how participants interpreted their substance use and recovery within the context of their personal lives, treatment programs, and broader societal influences (Neale, 2021).

The use of semi-structured interviews aligns with this epistemological perspective, as it prioritizes participant-led narratives rather than imposing predefined categories of addiction or recovery. Participants were encouraged to share their experiences in their own words, reflecting on the meanings they assign to their cocaine use, the challenges they have encountered in their recovery, and the personal and external factors influencing their

substance use trajectories. Unlike quantitative approaches, which may reduce addiction to standardized criteria, an interpretivist approach allowed for a more nuanced and individualized understanding of substance use, ensuring that participants' voices remained central to the research (Smith & Osborn, 2015).

Furthermore, RTA reinforces the interpretivist stance by allowing themes to emerge inductively from the data, rather than applying a rigid coding framework (Braun & Clarke, 2019). By analysing participant narratives without forcing them into pre-existing theoretical models, the study captured the rich, subjective dimensions of CUD. Interpretivism, therefore, provided the epistemological grounding necessary to explore addiction as a lived experience, rather than a fixed or universally defined condition.

Axiology: Researcher Positionality and Reflexivity

Axiology concerns the values embedded in the research process, recognizing that all research is influenced by the researcher's positionality, biases, and ethical considerations (Finlay, 2002). Given the sensitive nature of addiction research, reflexivity is essential in ensuring ethical integrity, minimizing bias, and maintaining transparency throughout data collection and analysis. This study incorporated reflexive journaling (Appendix I) and regular supervision meetings to critically engage with the researcher's assumptions, preconceptions, and potential influences on the study (Nowell et al., 2017).

The involvement of drug treatment centres and the use of gatekeepers, such as rehabilitation program coordinators, introduced ethical considerations and potential power imbalances that required careful attention. Gatekeepers played a crucial role in selecting participants, which may have unintentionally shaped the sample by prioritizing individuals perceived as more 'stable' or better able to articulate their experiences. This selection process

could have led to a biased representation of the population by excluding those experiencing more severe struggles with addiction or those who do not align with expected recovery narratives. To address this, a reflexive approach was adopted, continuously examining how these recruitment decisions influence the study's findings and ensuring that participants' perspectives were authentically represented rather than filtered through institutional priorities or treatment program expectations.

Maintaining reflexivity involved acknowledging these potential influences and actively working to minimize their impact, ensuring the study captures a diverse range of experiences rather than a selectively filtered version of addiction and recovery (Treloar et al., 2021).

Reflexivity extended into the data analysis process, where the researcher actively engaged with their interpretations of the data, questioning how personal assumptions, academic training, and social perspectives may have influenced the themes identified (Olmos-Vega et al., 2023). By maintaining a reflexive journal and consulting with the academic supervisor, the study enhanced its trustworthiness, ensuring that participant accounts remained at the forefront of the analysis rather than being shaped by researcher bias or theoretical assumptions.

Participant Recruitment and Sampling

A rigorous and systematic approach to participant recruitment and sampling is essential in qualitative research to ensure that the data collected is rich, meaningful, and representative of the research aims (Lim, 2024). This study employed purposive sampling, a non-probability sampling technique commonly used in qualitative research to recruit participants with specific characteristics relevant to the research question (Palinkas et al.,

2015). Purposive sampling was particularly appropriate for this study, as it facilitated the selection of individuals who could provide in-depth, information-rich narratives that captured the complexity of the phenomenon under investigation (Patton, 2015).

Given that the study sought to understand the transition from recreational to problematic cocaine use, participants must have had direct experience of this process. To recruit suitable participants, communication channels were established with the CEOs of Sedqa, Caritas, and Oasi, three primary drug treatment agencies in Malta. These organizations received an information sheet outlining the research intentions and aims to obtain approval for conducting the study within their facilities (Appendix B). Once approval had been granted, liaison took place with the heads of treatment services, including community and residential programs, who acted as gatekeepers in facilitating participant recruitment. These gatekeepers approached individuals enrolled in their treatment programs for cocaine-related problems and informed them about the study, allowing them to decide whether they wish to participate.

Recruitment efforts prioritized diversity in participant backgrounds by selecting individuals from both residential and community treatment settings, thereby capturing a broad range of perspectives on cocaine use trajectories. The selection criteria also considered the clinical judgment of the gatekeepers, who assessed whether potential participants were in a suitable psychological state to take part in the research. Gatekeepers ensured that participation did not interfere with an individual's treatment progression or place them in a vulnerable position. While poly-drug users were also considered for inclusion, only those for whom cocaine is the primary drug of choice were eligible for participation.

The sample size consisted of nine participants. Braun and Clarke (2021) argue that it is impossible to estimate sample size a priori for RTA but suggest that a pragmatic upper and

lower limit should be established based on the research goals, time constraints, and available resources. This study adopted an eight-to-ten participant range, ensuring a balance between depth and manageability while allowing for rich, contextually grounded insights into the transition from recreational to problematic cocaine use. Previous research on SUDs suggests that similar sample sizes are often effective in phenomenological and narrative-based inquiries, as they allow for a detailed exploration of individual experiences while maintaining analytical rigor (Smith & Osborn, 2015). Addressing sample size concerns in RTA is essential for ensuring research credibility, particularly in scientific peer review and funding applications, where clear justifications for methodological decisions are necessary (Naeem et al., 2024).

To maintain methodological consistency and ethical integrity, strict inclusion criteria were applied. Participants needed to be 18 years or older, ensuring that they had the legal capacity to provide informed consent. They were also required to meet the DSM-5-TR criteria for CUD and be currently undergoing rehabilitation (American Psychiatric Association, 2022). These criteria ensured that participants had direct experience with the transition from recreational to problematic use, making them well-suited to contribute to the study's research questions. Recruiting individuals in treatment settings provided an added layer of ethical protection, as it ensured that participants had access to support services should they require them (Neale et al., 2021).

Data Collection

Semi-structured interviews were used as the primary method of data collection to explore participants' experiences with CUD. This method allowed for a detailed and flexible inquiry into participants' accounts while ensuring that key themes relevant to the research objectives were addressed (Adeoye-Olatunde & Olenik, 2021). Given that this study sought

to understand how individuals perceive their transition from recreational to problematic use, semi-structured interviews provided the depth needed to capture subjective interpretations, personal meanings, and contextual influences that shape this progression (Braun & Clarke, 2021). The flexible nature of this approach ensured that while a set of guiding questions was used, participants could elaborate on their own perspectives, leading to richer and more nuanced understandings of their substance use trajectories (Smith & Osborn, 2015).

Building on the theoretical frameworks already outlined, interview questions (Appendix A) were designed to elicit insights into the key factors influencing the transition to problematic cocaine use. Rather than imposing predefined categories, participants were encouraged to reflect on the experiences and circumstances they perceived as significant in their substance use journey. The interviews explored early exposure to cocaine and the influences that shaped initial use, the life events or psychological factors that contributed to escalation, and the challenges faced in attempting to reduce or stop use. They also examined the resources and support systems that have played a role in participants' attempts to regain control over their substance use. By structuring the interviews in this way, the study ensured that the discussion remains participant-driven while still addressing the central research questions (Neale, 2021).

Interviews were conducted face-to-face, with each session lasting between 60 and 90 minutes, allowing participants sufficient time to share their experiences in detail without undue fatigue or distress (DeJonckheere & Vaughn, 2019). Given the sensitive nature of the research, online interviews were not conducted, as face-to-face interactions provided a more secure and controlled environment that was particularly important when discussing substance use and personal experiences of addiction. Research has indicated that in-person interviews enhance rapport-building, which is crucial for eliciting open and honest narratives in studies

involving vulnerable populations (Adeoye-Olatunde & Olenik, 2021). The physical setting of an interview, particularly within a familiar and structured environment such as a treatment facility, helped to establish a sense of safety and confidentiality, reducing the risk of external distractions or concerns about digital security that may arise in virtual interviews (Janghorban et al., 2014). Additionally, non-verbal communication plays a crucial role in qualitative research, particularly when exploring emotionally charged topics such as substance use and recovery (Seitz, 2016). Facial expressions, body language, and pauses provided additional context to verbal responses, enhancing the depth of understanding and allowing for a more accurate interpretation of participants' emotions. Additionally, immediate support could have been offered when distress arose. In contrast, online interviews may have limited the ability to observe such cues, potentially affecting the depth and quality of the data collected (Gray et al., 2020).

Data Analysis

RTA provides a structured yet flexible approach to identifying patterns within qualitative data. The analytical process followed Braun and Clarke's (2021) six-phase framework. This iterative and reflective process ensured that themes emerge organically from the data while remaining grounded in the research aims.

The first phase of the analysis involved familiarization with the data, which included transcribing interviews, reading and re-reading transcripts, and making initial notes on key observations. This step allowed for immersion in the dataset, ensuring that the researcher developed a deep understanding of participants' accounts before beginning formal coding. It was at this stage that patterns and potential areas of significance began to emerge, guiding subsequent stages of analysis (Braun & Clarke, 2021).

The second phase consisted of generating initial codes, in which the dataset was systematically examined, and meaningful segments of text were assigned preliminary codes. Coding was conducted inductively, meaning that rather than applying a predetermined framework, codes were developed based on participants' descriptions of their experiences. This phase was essential in breaking down the data into manageable units while preserving the integrity of participants' experiences (Nowell et al., 2017). While some researchers opt to use qualitative data analysis software such as NVivo to manage and organise coding, this study did not utilise NVivo or similar programs. Instead, manual coding was adopted to support close and sustained engagement with the data, fostering a reflective and interpretive analytic process. Given the interpretive and flexible nature of RTA, manual approaches are compatible with the methodology and allow the researcher to remain actively immersed in the data and responsive to the nuances that arise throughout the analysis (Braun & Clarke, 2021; Castleberry & Nolen, 2018).

Following this, the third phase entailed developing themes, where codes were reviewed and grouped into broader conceptual categories (Appendix B). These themes represented patterns of shared meaning across participants' accounts, capturing key aspects of their experiences with CUD. This stage was particularly reflective, as it required moving beyond individual codes to identify relationships between them. The themes that emerged were sufficiently distinct while also interconnected enough to form a coherent analytic structure (Braun & Clarke, 2018).

The fourth phase involved reviewing themes, ensuring coherence, internal consistency, and alignment with the research questions. Themes were refined by assessing whether they were well-supported by the dataset and whether they sufficiently captured the complexity of participants' experiences. Any themes that lacked sufficient evidence or

overlap excessively with others were redefined or merged. This phase ensured that the analysis remained methodologically rigorous while still being flexible enough to adapt to the nuances of the data (Terry et al., 2017).

Once themes were reviewed and refined, the fifth phase focused on defining and naming themes, where the final thematic structure was clearly articulated. At this stage, themes were given precise definitions that encapsulated their core meanings, ensuring that each theme contributed uniquely to the overall account. This step involved refining thematic descriptions to ensure they effectively represented the dataset while maintaining analytical depth and coherence (Braun & Clarke, 2019).

The final phase of analysis involved producing the report, where the findings were presented in a structured format, illustrating how themes addressed the research questions. This stage involved selecting representative quotes from participants that exemplify each theme, ensuring that the voices of individuals with a CUD remained central to the analysis. The report included a detailed interpretation of the themes, drawing on existing literature to contextualize the findings while emphasizing the novel insights generated by the study (Nowell et al., 2017).

Throughout the analysis process, reflexivity was maintained to ensure transparency and critical engagement with the data. Given that RTA acknowledges the researcher's role in meaning-making, regular reflexive journaling and discussions with the academic supervisor was employed to mitigate potential biases and enhance the credibility of the analysis. The iterative nature of RTA ensured that the findings remained dynamic and grounded in participants' experiences rather than being constrained by preconceived notions.

Ethical Considerations

Ethical integrity is a fundamental aspect of research involving individuals with SUDs. This study adhered to the ethical guidelines set by the American Psychological Association (APA) Ethics Code (2017), the British Psychological Society (BPS) Code of Human Research Ethics (2021), and the Malta Psychology Professions Board (MPPB) Code of Ethics (2012). These frameworks emphasized the principles of respect for autonomy, beneficence, non-maleficence, and justice, ensuring that participants were treated with dignity and that the research upheld the highest ethical standards.

All participants provided informed consent before participating in the study (Appendix C). In line with APA, BPS, and MPPB ethical standards, consent was obtained in a manner that ensured participants fully understood the purpose of the study, the procedures involved, potential risks, and their right to withdraw at any stage without consequences. Participants received a detailed information sheet outlining the study's objectives, confidentiality measures, and how the data will be used (Appendix D). They were given the opportunity to ask questions before providing signed consent. To accommodate potential literacy concerns, consent was explained verbally in addition to being provided in written form. Ensuring that participation is entirely voluntary aligns with ethical principles of respect for individual autonomy and informed decision-making (BPS, 2021).

Confidentiality and anonymity were strictly maintained throughout the research process. No real names were used in interview transcripts, reports, or publications. Instead, pseudonyms were assigned, and any identifying details were omitted or altered to protect participant privacy. In accordance with ethical standards, all audio recordings, transcripts, and research data were securely stored in encrypted, password-protected files, accessible only to the researcher. Participants were informed that anonymized data may be retained for a specific period, as per institutional and legal guidelines, and that it will be securely deleted

thereafter. These measures ensure compliance with ethical and data protection regulations, including the General Data Protection Regulation (GDPR), which governs data security within European research contexts (Saunders et al., 2015).

Given the sensitive nature of the research, potential risks and safeguarding measures have been carefully considered. Participants were fully informed of the voluntary nature of their involvement and their right to withdraw at any stage. Discussing past experiences with cocaine use may evoke emotional distress for some participants. In recognition of this, interviews were conducted in a supportive and non-judgmental manner, with regular check-ins to ensure participants feel comfortable proceeding. Participants were explicitly informed of the voluntary nature of their involvement and their right to pause, skip questions, or withdraw from the interview at any point. Moreover, as a precautionary measure, referrals to appropriate mental health professionals or support services were made available in case distress arose. This aligned with the ethical principle of beneficence, ensuring that participant well-being was prioritized throughout the study (APA, 2017; MPPB, 2012).

Ethical approval for the study has been obtained from the Social Wellbeing Faculty Research Ethics Committee (FREC), confirming that the research meets institutional and professional ethical standards (Appendix E).

Rigour and Trustworthiness

Ensuring trustworthiness and rigour in qualitative research is essential for producing credible and meaningful findings. In line with Braun and Clarke's (2021) quality guidelines for RTA, this study prioritised transparency, reflexivity, and theoretical coherence throughout the research process. Specifically, attention was paid to the clear articulation of the study's theoretical positioning, the active role of the researcher in meaning-making, and the need for

a transparent, well-documented analytic process. Themes were developed to be rich, nuanced, and well-supported by data extracts, ensuring alignment between the research questions, analytic claims, and the data itself. These principles were upheld to enhance the credibility, coherence, and interpretive depth of the findings.

Credibility within RTA is conceptualised not as a pursuit of objective truth, but as the extent to which the analysis demonstrates coherence, transparency, and theoretical consistency (Braun and Clarke, 2021). Rather than aiming to represent a singular reality, the goal is to produce an insightful and plausible interpretation that is meaningfully grounded in the dataset and shaped by the researcher's reflexive engagement. Throughout this study, credibility was enhanced through deep and sustained immersion in the data, which involved multiple rounds of reading, inductive coding, and critical reflection on the evolving thematic structure.

This iterative process allowed for the development of a nuanced and context-sensitive analysis that remained anchored in participants' accounts while being shaped by the researcher's interpretative lens. Reflexivity was central to this approach. Analytic decisions were guided by ongoing consideration of how personal assumptions, theoretical positioning, and values influenced both the questions asked and the meanings constructed during analysis. Consistent with Braun and Clarke's framework, credibility was achieved not through external validation but through transparent documentation, epistemological coherence, and the construction of themes that offer interpretative depth rather than descriptive surface content (2021).

Credibility was also reinforced through rigorous data immersion during the analysis phase. Engaging deeply with the data over an extended period ensured that themes emerged organically rather than being prematurely imposed (Stahl & King, 2020). This process

involved iterative reading, coding, and thematic refinement to maintain a clear connection between participants' descriptions and the identified patterns. These combined strategies contributed to the trustworthiness and accuracy of the study, ensuring that the voices of individuals with a CUD were authentically represented.

Transferability pertains to the extent to which findings can be applied to other contexts (Lincoln & Guba, 1985). While qualitative research does not seek statistical generalizability, it ensures transferability by providing rich, detailed descriptions of participants' experiences, enabling readers to assess whether findings may be relevant to other populations or settings. Thick descriptions, which involve in-depth contextualization of participants' accounts, were employed to provide a nuanced account of the factors influencing the transition from recreational to problematic cocaine use. This method allowed for a comprehensive understanding of participants' realities, making it possible for researchers and practitioners to draw meaningful comparisons with similar populations (Smith & Osborn, 2015).

Dependability is achieved by ensuring that the research process is logically traceable and consistent over time. To enhance dependability, methodological decisions, coding processes, and thematic refinements were carefully documented throughout the study. This record included field notes, data analysis memos, and the rationale for interpretive decisions, ensuring that the research process remained transparent and that findings could be traced back to the original data (Nowell et al., 2017).

To ensure dependability, a logical and transparent research process was followed, with clear descriptions and documentation of each step taken throughout the study (Korstjens & Moser, 2018; Tobin & Begley, 2004). Engaging in continuous self-reflection and documentation allowed for consistency in data collection and analysis, reducing the risk of

misinterpretation. Additionally, regular supervision meetings were conducted, where methodological choices, coding frameworks, and emerging themes were critically reviewed and refined. Seeking review and feedback from an experienced research supervisor ensured that the study maintained analytical rigor, while their expertise and professional perspective contributed to the overall credibility and trustworthiness of the research (Stahl & King, 2020).

Confirmability involves ensuring that the researcher's interpretations and findings are directly grounded in the data, rather than influenced by prior assumptions or theoretical biases (Tobin & Begley, 2004). To uphold this principle, a transparent account of the analytic process was maintained, clearly detailing how conclusions were reached at each stage of data analysis. This included recording coding decisions, thematic development, and interpretations, ensuring that findings could be traced back to the original dataset. Additionally, rich and relevant participant quotations were incorporated throughout the findings, providing direct evidence to support interpretations and reinforcing the credibility of the study. By grounding conclusions in participants' own words and maintaining a rigorous, well-documented analytic process, the study strengthened its confirmability, ensuring that the research findings were reflective of participants' experiences rather than the researcher's subjective perspectives.

Reflexivity of the Researcher

In qualitative research, and particularly within RTA, the researcher is not positioned as a detached observer but rather as an active contributor in the meaning-making process (Braun & Clarke, 2021). RTA recognizes that themes are not simply discovered but are co-constructed through the researcher's interaction with the data, informed by their positionality, assumptions, and theoretical lens. As such, reflexivity is not optional but integral, ensuring

that the research process remains transparent, ethically grounded, and analytically robust (Nowell et al., 2017).

This study was shaped in part by a personal and academic interest in substance use and mental health, which developed through both prior educational experiences and broader exposure to clinical contexts. Having engaged with literature and professional discussions surrounding addiction, I entered the study with certain expectations about the factors that might contribute to the transition from recreational to problematic cocaine use, such as trauma histories, peer dynamics, or emotional regulation. These assumptions, while theoretically grounded, required continuous scrutiny to avoid narrowing the interpretative lens.

The topic also held personal relevance, as I had encountered individuals with a CUD substance use in personal or professional settings, which shaped my motivation to give voice to those often marginalized by dominant narratives around addiction. This personal connection added depth to my commitment to the research, but also necessitated a heightened level of reflexivity to ensure that empathy did not unintentionally lead to over-identification with participants or projection onto the data.

To support reflexive practice, I maintained a reflexive journal throughout the research process (Berger, 2015). This journal served not only as a methodological log but also as a space for emotional and cognitive reflection, documenting how certain participant accounts resonated with or challenged my expectations. After each interview, I recorded impressions, questions, and emerging thoughts on how my positionality might be influencing my interpretation of the data. These reflections proved especially important in moments where participant narratives diverged from conventional frameworks, for instance, when individuals

described their early use in positive or empowering terms, contrary to common deficit-based models of addiction.

Moreover, I remained conscious of the power dynamics that may have shaped the interview process. Although steps were taken to emphasize confidentiality and participant autonomy, I was aware that being situated within treatment settings might influence how participants chose to frame their experiences. Some may have withheld or softened aspects of their narratives, anticipating potential repercussions or assuming alignment with institutional perspectives. To counteract this, I adopted a conversational tone and non-directive questioning style, seeking to create a safe and open space where participants could speak candidly.

Reflexivity was also essential during data analysis, particularly as I engaged in theme development. Given the interpretive nature of RTA, I revisited my codes and emerging themes multiple times, questioning whether they truly reflected participants' meanings or if they were being shaped by my theoretical predispositions. Regular discussions with my academic supervisor provided a critical space to interrogate these interpretations, ensuring that they remained rooted in the data and not unduly influenced by personal bias.

By acknowledging my personal interest, prior exposure to addiction discourse, and emotional responses throughout the research process, I aimed to practice reflexivity not as a one-time declaration but as an ongoing, iterative engagement. This reflective stance strengthened the credibility of the study and helped ensure that participants' experiences were represented with authenticity, nuance, and integrity, rather than filtered through pre-existing assumptions or societal narratives. A structured reflexive diary was maintained throughout the research and an excerpt is included in Appendix E, documenting reflections on

positionality, assumptions, emotional responses, and methodological decisions at key stages of the process.

Conclusion

This chapter has outlined the methodology adopted in this study to explore in-depth how individuals with a CUD perceived their transition from recreational to problematic use. The use of semi-structured interviews facilitated flexibility in data collection, while RTA provided a rigorous yet adaptable approach to identifying patterns and themes. The next chapter shall present the findings and discuss them in light of the existing literature.

Chapter 4 - Findings and Discussion

This chapter presents the findings of the study, analysed using Reflexive Thematic Analysis (Braun & Clarke, 2019). The chapter is organised thematically, with each theme and subtheme introduced and discussed alongside relevant supporting quotations from participants. The Maltese verbatim quotations have been translated into English in the main text, however, the original Maltese transcript of these quotations is available in Appendix G. These quotations are embedded within the discussion to illustrate key patterns, while connections to the reviewed literature are drawn to situate the findings within the broader academic context.

Participants' Demographics

Nine participants were recruited for this study. Participants were individuals who either were currently attending or had recently completed a drug rehabilitation programme, recruited through Sedqa, Caritas, and OASI. The inclusion criteria required participants to be over 18 years of age, to have a history of problematic cocaine use, and not to be considered vulnerable by the gatekeeper. The sample consisted of two females and seven males, with ages ranging from early twenties to mid-forties. Further demographic details are outlined in **Table 1**.

Table 1***Participant Demographics***

Pseudonym	Age	Age of Initial Substance Use	Duration of Abstinence	Initial Illicit Substance Used	Duration of Substance Use History
Julian	46	19	3 years	Cannabis	24 years
Andrew	38	14	11 months	Cannabis	23 years
Paolo	27	11	9 months	Cannabis	15 years
Daniel	23	11	7 months	Cannabis	11 years
Mike	31	14	9 months	Cannabis	16 years
Ian	41	12	1 year	Cannabis	28 years
Carla	36	14	6 months	Heroin	21 years
Alexander	41	13	9 months	Cannabis	27 years
Nicola	27	13	9 months	Cannabis	13 years

Overview of Interview Findings

The interview guide was designed to explore how individuals with a CUD perceive their transition from recreational use to problematic use. Questions were organised to elicit participants' reflections on the early stages of their substance use, the progression toward problematic use and addiction, and the factors influencing their efforts toward recovery. Participants' accounts were analysed using Braun and Clarke's (2019) RTA, guided by the biopsychosocial model (Engel, 1977) and the 5P's framework (Macneil et al., 2012) to interpret predisposing, precipitating, perpetuating, and protective factors along their trajectory.

Through this analytic process, three major themes were identified:

- Theme 1: The Starting Line
- Theme 2: Crossing the Line
- Theme 3: The Finishing Line

Theme 1 describes the early stages of cocaine use, where biological vulnerabilities, psychological struggles, and social influences combine to normalize and reinforce drug-taking behaviors. This includes early initiation, progressive substance exposure, social acceptance, varying rates of escalation, early denial and rationalisation, and pre-existing emotional vulnerabilities. Theme 2 then captures the transition to problematic use and addiction, illustrating how cocaine gradually strips away autonomy, damages mental and physical health, erodes relationships, and provokes deep shame and alienation. Finally, Theme 3 focuses on the journey toward recovery, highlighting the painful cycles of relapse, drastic measures taken to quit, the crucial internal shift toward personal motivation, and the vital role of structured support systems in sustaining lasting change. The extracted themes and corresponding subthemes are outlined in Table 2.

Table 2

Theme	Subordinate Themes	Key Quotation
Theme 1: The Starting Line	A Head Start The Descent The Wrong Kind of Momentum Caught in the Chase Off Track	“Everybody started doing lines”
Theme 2: Crossing the Line	Disqualified from the Self Running on Empty Running in Circles between Cocaine and Heroin	“I cried because I wanted to stop... I’d smoke and cry, saying how will I ever break free from this [habit]?”
Theme 3: The Finishing Line	Back to the Start Line Radical Turns Internal Drives My Cheerleaders	“I stopped using only because I wanted”

The Starting Line

The first theme traces the initial stretch of the journey, what participants retrospectively recognised as the moment the ‘race’ toward addiction began. These early experiences were rarely marked by immediate chaos or crisis. Instead, cocaine entered quietly, folded into adolescence, experimentation, or social ritual, gradually gaining ground in ways that were often invisible at the time. What united participants across diverse backgrounds was the convergence of biological sensitivity, psychological vulnerability, and a permissive social environment, which together created the momentum for continued use. From an early age, drug-taking behaviour was normalised, rationalised, or framed as a coping strategy, yet beneath this surface lay a complex interplay of risk factors. Through the lens of the 5P’s model (Macneil et al., 2012) and the biopsychosocial framework (Engel, 1977), this theme explores the predisposing, precipitating, and perpetuating forces that shaped early encounters with cocaine. Whether it began with peer imitation, childhood trauma, or the search for belonging, crossing the ‘starting line’ marked more than the first use, it marked the subtle beginning of a trajectory that would later prove difficult to reverse.

A Head Start

For many participants, substance use began early, not as overt rebellion, but rather as a seemingly natural part of growing up. At the time, these early experiences appeared harmless; their significance only became clear in retrospect, recognised by participants as pivotal moments laying the groundwork for later problematic cocaine use. Daniel, who started smoking cannabis at age 11, described the early use as deceptively benign: “I was too young to understand the consequences. Back then, it felt like part of growing up.” Alexander echoed a similar sentiment, recalling that at 13, drug use simply represented youthful curiosity: “All I knew is that I wanted to experiment with something.”

These reflections align closely with established literature highlighting adolescence as a uniquely vulnerable period for initiating drug use due to ongoing neurodevelopmental changes. Specifically, the heightened sensitivity of adolescents' reward systems, coupled with underdeveloped executive functions, make them more receptive to the reinforcing effects of drugs (Levine & Kerrigan, 2020; Silvers et al., 2016).

Apart from one participant who began with heroin, the vast majority described a gradual and cumulative path toward cocaine use. Rather than starting directly with cocaine, which was their later drug of choice, most individuals initiated their substance use journey with cannabis and transitioned over time through a process of increasing exposure, access, and availability. This pattern aligns with findings from the National Institute on Drug Abuse (2023), which indicate that cannabis, alongside alcohol and tobacco, is often among the first substance individuals, particularly adolescents, are exposed to.

For many, cannabis use marked the first threshold into the world of illicit drug use. As their engagement deepened, participants often described experimenting with a broader range of substances before settling on cocaine as their preferred drug. Cocaine typically entered the picture later, gradually assuming a more dominant and central role in their drug-taking behaviours. Daniel's experience vividly illustrates this shift:

When I was 15 I started working and then I used to have money for myself and spent it on weed. Then I started going to parties and I started experimenting, using GHB, crystal meth, cocaine, ecstasy, all the drugs you name them... Then I shot up coke when I was 17 the first time. Coke became my drug of choice.

Cocaine became central only after familiarity with other substances had been established. Alexander echoed this pattern of progression:

I started with weed. When I turned 15 I started going to parties and started taking ecstasy and LSD...then I moved on to heroin. One day I couldn't afford heroin so being an addict, I said, since I don't have money for heroin I'll buy cocaine.

Even when heroin came into the picture, it was framed as part of an evolving sequence that eventually included cocaine.

In the early stages of cocaine use, the environments in which participants first encountered cocaine also played a crucial role. Many participants framed their initial experiences within recreational and social environments like bars, clubs, parties, and informal gatherings. These spaces not only made the drug easily accessible but subtly embedded it within the cultural script of leisure and belonging. Julian's reflection, "That was a time where everyone started doing cocaine, everyone going to bars, everyone wanted to do coke all of a sudden," captures the pervasiveness of cocaine in his social world.

This echoes data from the European Drug Report (2023) and local findings from the C-EHRN (2019), which documented a rise cocaine use among youth in Malta, particularly in recreational contexts such as parties, weddings, and other social gatherings. Similarly, Micallef's (2019) study emphasises that cocaine's growing accessibility in Malta has significantly influenced clubbing behaviour, further embedding the drug within accepted social rituals.

These social norms acted as a powerful precipitating factor, reinforcing initiation and continuity of use. For some, like Daniel, cocaine was a bridge to belonging: "I used to go out with people that did cocaine...I used to feel like I was a part of something." Such narratives align closely with research by Volkow et al. (2019), who demonstrate that peer groups strongly affect perceptions of risk and the desirability of cocaine, thus acting as significant

social determinants of CUD. This peer-driven normalisation was particularly impactful during adolescence and early adulthood, a period of heightened susceptibility to social influence and conformity pressures (Duopah et al., 2024; Loke & Mak, 2013).

Social modelling extended beyond peers. Several participants were exposed to substance use at home, where it was indirectly condoned or modelled by caregivers. Carla's account exemplifies this: "I used to see my dad [use drugs] and I always wanted to be like him." These intergenerational patterns suggest a predisposing factor, a home environment where substance use was observed, normalised, or even facilitated. Such familial patterns, where drug use is perceived as normative, amplify vulnerability and reduce resistance to experimentation, positioning early substance use as both acceptable and desirable within participants' social worlds (Branstetter et al., 2011).

The Descent

While some individuals described an almost immediate psychological attachment, characterised by a sudden and overwhelming desire to repeat the experience, others portrayed a more gradual progression. Despite this difference in pacing, both routes led to similar destinations.

For those who reported feeling immediately addicted, the impact of the drug was described as both intense and immediate. Mike's account encapsulates this sentiment succinctly: "I took my first sniff and I was hooked instantly." Similarly, Paolo reflected, "It felt like cocaine had taken hold of me instantly."

In contrast, others spoke of a more gradual trajectory. Mike recalled, "At first, it was just weekends. Then I started buying in advance, just to be sure I had it." Similarly, Daniel

reflected, “It started as a weekend thing, then became a reward after work, and before I knew it, I was using daily.”

Research does not pinpoint a single cause for why some individuals develop cocaine dependence rapidly while others progress more gradually. Instead, multiple factors contribute to this variability, including the interplay between genetic predispositions, environmental influences, and neurobiological mechanisms (Koob & Volkow, 2016)

In addition to individual differences in the pacing of escalation, gender appeared to shape the substance use trajectories of some participants. Female drug users may experience what is known as the telescoping effect, a faster transition from initial use to dependence, often accompanied by greater psychosocial burden and emotional consequences (Lewis et al., 2014; Scicluna & Clark, 2019). Nicola’s account typified this pattern. She described how her use accelerated: “When I had a hit from the pipe, that was it, I started taking every day.”

Additionally, A precipitating factor in Nicola’s increased cocaine use appeared to be the influence of a romantic partner. She reflected on how the relationship intensified her drug-taking and eventually led to involvement in selling: “When I started dating him, I started using more, because he was a heavy user.” In this case, the partner’s behaviour not only normalised heavier use but also facilitated deeper entrenchment in drug-related activities. Research conducted locally supports this, indicating that women’s substance use is often closely tied to intimate relationships (Scicluna & Clark, 2019).

A notable pattern across participant accounts was the psychological distancing that occurred in the early phases of cocaine use. Regardless of how quickly their use escalated or how intensely they engaged with the drug, many participants reflected on a period during

which they minimised, reframed, or rationalised their behaviour. This early use was not often perceived as problematic, but instead as controlled, deserved, or socially acceptable.

Carla, for instance, described the subtle nature of her use “In the beginning I didn’t even realise... every time I bought to sell, I ended up using, and I every time I take a bit more.”

This gradual shift was often masked by cognitive strategies that served to maintain a sense of normalcy. Some participants engaged in downward comparisons, distancing themselves from others whom they perceived as more heavily addicted. Ian explained, “Others were worse than me” while Alexander justified his continued use by compartmentalising it within his ability to maintain daily routines: “I was still working.” Mike stated, “I was living a lavish junkie lifestyle, because I had cash,” suggesting that financial means provided a distorted sense of control and even glamour, temporarily shielding him from acknowledging the severity of his substance use. As Pickard (2016) argues, such forms of denial are common in addiction and often function as protective mechanisms, allowing individuals to maintain an image of control while continuing to use.

Several participants openly acknowledged being in denial during the early stages. Andrew reflected, “I was in denial that I had a problem.” Denial, in this context, functioned as a psychological buffer, delaying distressing realisations while reinforcing continued use.

Rationalisation played a similarly protective function. Participants described constructing a series of justifications for their drug use, particularly linking it to reward or stress relief. Andrew explained: “You start making excuses... don’t we deserve it after a week of work?” Carla echoed this mechanism, recalling how she began habitually tying her use to

everyday events: “I would start making excuses, like if there was a family event, it’s a good excuse to smoke.”

Both denial and rationalisation functioned as early psychological defences, temporarily preserving the illusion of control and stability. From the perspective of Macneil et al.’s (2012) Five P’s idiographic model, rationalisation and denial can be viewed as perpetuating factors, sustaining use through misrepresentation of their situation. This was evident across participant accounts, nearly all of whom were engaged in recovery at the time of the interviews. It is this very position of emotional and cognitive distance that enabled them to look back and critically identify the ways denial and rationalisation had shaped their earlier use. Their insights were not merely confessions of past behaviour but meaning-making processes that highlighted how these internal justifications once served to preserve the illusion of control, even as use escalated.

The Wrong Kind of Momentum

For several participants, early cocaine use was not solely driven by curiosity or peer pressure, it was deeply rooted in underlying psychological vulnerabilities. Trauma, low self-worth, and neurodevelopmental conditions, such as ADHD, appeared to lay a fragile emotional groundwork, making the relief offered by cocaine particularly potent. Daniel reflected: “I had to grow up way before it was my time to... I was making bottles for my brother at three. Between 10 and 13, I was sexually abused by a priest.” These experiences of childhood adversity were echoed by many. Mike shared, “I felt like the black sheep of the family. I never felt wanted, needed, respected, loved... I did what I did to get what I didn’t have as a child,” while Ian recounted: “I had a difficult past and a lot of anger inside me. I endured a lot of abuse from priests, people that should be spreading the word of God.” Alexander also stated: “I used to see my mum and brother get abused.”

These accounts resonate with literature highlighting the role of ACEs as a major predisposing factor for substance misuse. Exposure to trauma, household dysfunction, or neglect during developmental years significantly increases the likelihood of engaging in problematic substance use later in life, as such experiences dysregulate affective systems and reduce resilience to stressors (Kim et al., 2017; Volkow & Morales, 2015). This is supported by Khantzian's (1985) self-medication hypothesis, which proposes that individuals may use substances like cocaine not merely to seek pleasure, but to soothe psychological pain or compensate for affective dysregulation stemming from early adversity. In fact, Ian explained this clearly: "This is what we're like, when an addict feels upset, we would want to alleviate this by taking drugs."

This emotional vulnerability was often compounded by neurodevelopmental conditions. Several participants shared that they have an ADHD diagnosis, linking impulsivity and emotional dysregulation to early drug experimentation. Daniel described how cocaine functioned as a form of self-medication for his ADHD symptoms, noting, "When I first tried stimulants, I felt calm, super normal." This further illustrates how substance use may be driven by attempts to manage underlying neurodevelopmental or psychological difficulties, as outlined earlier through the self-medication hypothesis (Khantzian, 1985). The connection between ADHD and SUD is well-established in addiction literature, as dysregulated dopamine function and executive deficits are known to increase the appeal of psychostimulants like cocaine (Kozak et al., 2019; Victor et al., 2023).

Additionally, several participants described how feelings of inadequacy and social anxiety preceded their drug use, with cocaine functioning as a tool to artificially elevate self-worth and confidence. Andrew reflected: "I had low self-esteem, so with it [cocaine] I felt confident, even to speak to a woman." Similarly, Paolo explained: "One of the reasons why I

started using drugs was because of my low self-esteem and to look cool...I was weak. I wasn't assertive." Research also supports the link between low self-esteem and vulnerability to substance use, particularly in adolescence and early adulthood, a period when social validation is paramount (Mann et al., 2022).

Thus, pre-existing psychological vulnerabilities, which can be understood as predisposing factors, created fertile ground for cocaine use to take root (Macneil et al., 2012). It was not simply consumed, but unconsciously sought, as a salve for unseen wounds, a coping mechanism for inner turmoil, and a misguided form of emotional regulation that laid the groundwork for addiction.

Caught in the Chase

Alongside the psychological and social forces that shaped participants' early encounters with cocaine, many described a visceral, almost transcendental bodily response that went far beyond mere pleasure. This initial high was not only euphoric, it was captivating, and for some, even life-altering.

Paolo recalled, "I really liked the feeling," while Alexander shared: "I used to feel like the best person alive, almost like I was right next to God." For many, this sensation was deeply embodied, physically elevating, mentally clarifying, and emotionally numbing all at once. It was, as Ian expressed, "like an orgasm, but it lasts all the time".

Despite the euphoric feelings, these moments were short-lived. The abrupt comedown intensified the craving for another high, setting in motion a pattern of compulsive repetition. Alexander described this cycle clearly: "After those 10 minutes, the crash hits three times harder than the high. So you keep chasing that feeling, just trying to get back up there."

Similarly, Andrew explained, “it lasts just a few minutes. And then you want more, trying to recreate that first hit”.

These narratives mirror existing addiction models. Cocaine triggers a rapid spike in dopamine within the mesolimbic reward pathway, particularly in the nucleus accumbens, a brain region critical for reinforcement and motivation (Volkow et al., 2017). This surge creates a neurochemical ‘high’ that can be so compelling that it eclipses all other rewards. As Koob and Volkow (2016) describe, this results in a distorted reward system, one where ordinary pleasure no longer registers, and the user becomes neurologically primed to seek cocaine as the only reliable source of gratification. This idea maps closely onto the 5P’s model (Macneil et al., 2012), with the initial high functioning as both a precipitating and perpetuating factor, triggering immediate gratification, and laying the groundwork for repeated behaviour reinforced by neurobiological change.

In retrospect, many participants acknowledged that this first high became a reference point, an unattainable state they kept trying to reach. Thus, this subtheme highlights how the euphoric early experiences with cocaine planted the seed for a compulsive pursuit: not simply to feel good, but to feel right, even if only for a moment.

Crossing the Line

While Theme 1 captured the beginnings of cocaine use, this theme explores what happened when participants moved along the addiction trajectory. It marks the shift from using to cope or belong, to using because they ‘felt’ they no longer had a choice. In their words, a line had been crossed, sometimes quickly, sometimes without even realising it, where cocaine stopped being a tool and became a trap.

This theme delves into the slow but steady erosion of control, identity, health, and relationships. Participants spoke of losing their sense of self, pushing loved ones away, and watching their physical and mental wellbeing unravel.

Off Track

As participants' relationship with cocaine deepened, a striking and consistent shift emerged: what initially appeared as voluntary and recreational use gradually gave way to a sense of being overpowered by the drug. Over time, cocaine was no longer something they chose to take, it became something they felt compelled to use. Paolo encapsulated this shift with stark clarity when he said, "the addiction took over me". His words reflect more than just compulsion, they point to a profound surrender of agency. Addiction, in this context, is not portrayed as a behaviour to be managed, but as an external force that invades and consumes the self. Paolo's phrasing evokes a loss of, suggesting that the drug no longer operated as something he used, but as something that used him.

This perceived hijacking of control echoed across multiple accounts. Participants described how cravings and compulsions would override logic, needs, and even suffering. Nicola shared, "I cried because I wanted to stop... I'd smoke and cry, saying how will I ever break free from this?". Alexander similarly explained, "I take it and I cry. Instead of taking for pleasure, I take because the drug is telling me to, but I didn't want to."

These insights resonate with the DSM-5-TR conceptualisation of CUD, which outlines impaired control as a core diagnostic feature, reflected in the inability to cut down or regulate use despite distressing consequences (American Psychiatric Association, 2022). Schwartz et al. (2022) argue that the reinforcing neurochemical effects of cocaine, particularly its action on dopamine in the brain's reward system, heighten compulsion while

eroding rational judgement. With repeated drug use, the brain's mesolimbic dopamine system becomes sensitised making the brain hyper-responsive to drug cues. The sensitised dopamine system assigns excessive motivational value (incentive salience) to drug-related cues. This means that these cues grab attention and trigger intense craving, even if the person no longer finds the drug pleasurable (Robinson & Berridge, 1993). This framework reframes addictive behaviour as the product of lasting brain changes that impair voluntary control, offering a compassionate and scientifically grounded understanding of the progression from use to problematic use.

Disqualified from the Self

A profound theme that reverberated across participant accounts was the sense of self-alienation that emerged as cocaine use deepened. Many described a gradual erosion of identity, whereby the person they believed themselves to be became increasingly unrecognisable. The experience of addiction was not solely about losing control over the substance, it was also about losing connection with one's values, integrity, and inner sense of self.

Daniel reflected: "It takes your soul away; you don't even know who you are anymore." Similarly, Paolo spoke of how addiction stripped him of the traits he once took pride in: "all the values you're born with, you lose them." Additionally, Alexander stated: "you lose your sense of shame and strips you off your values". The language here conveyed not just regret, but a deep existential rupture. Drug use was not only destructive, but it was experienced as dehumanising.

Mike shared a moment of painful clarity: "I was stealing charity boxes for crack. That's not me at all. I used to give money to charity." The juxtaposition between past and

present selves reveals an internal moral conflict, reinforcing the extent to which participants felt they had betrayed their own identities. As Carla put it: “you lose all trace of being human.”

This alienation brought with it an intense sense of shame. Paolo explained, “People used to stare at the way I look”, while Julian stated: “People start to despise you, and they’re right to”. Alexander further explained:

if you saw me 9 months ago you would either call me disgusting or poor man. People see you as a junkie in the street, instead of helping you they make fun of you. They will tell you why don’t you go jump?

Shame became a constant companion, both as a consequence of the damage done and as a painful reminder of how far they had strayed from themselves.

These descriptions reflect findings which identifies shame and stigma as central elements that deepen psychological distress and maintain cycles of substance use (Luoma et al., 2019). Matthews et al. (2017) similarly highlight how public stigma and resulting self-stigma amplify feelings of inadequacy, perpetuating further isolation and drug use. Personal behaviour is scrutinised in Malta’s close-knit society (Clark, 2012). According to Scicluna and Clark, (2017), people who engage in substance use have severe stigmatising reactions that affect their identity and social standing, and that Malta’s small population makes it more challenging to control the effects that branding and shaming have on people who use drugs and transgress from social norms.

In recovery, these same individuals began to articulate a reconstitution of self. However, the scars of shame remained, often reframed as cautionary markers of how far they had strayed. As Andrew admitted: “I was the fool”. Through this lens, shame was both a burden and a signal, a painful but illuminating consequence of alienation from the self.

In parallel with this deepening sense of alienation and shame, many participants also experienced a profound psychological unravelling, as cocaine began to intensify rather than alleviate their underlying mental health struggles.

Reflexively, participants described the drug not only as failing to soothe their pain over time, but as becoming the source of suffering. Carla, who because of heavy cocaine use, struggled with a long-standing history of depression, noted that cocaine led to frequent psychiatric admissions: “Coke messes with your head, it brings paranoia, it drives you mad. Depression almost always comes with it. I used to end up in Mount Carmel.”

Others described psychotic symptoms, hallucinatory experiences, and disconnection from reality, often fuelled by intense binges or the transition to crack cocaine. As Daniel painfully recalled: “I started stabbing myself in the foot because I started seeing worms coming out of my skin.”

Cocaine also played a role in triggering suicidality. Several participants spoke of feeling hopeless and emotionally bankrupt during or after prolonged periods of use. Ian shared: “Before I started the programme, I tried to hang myself.” Nicola also stated, “I’m not joking, I’ve tried to attempt suicide many times, I was tired of living.”

These accounts reflect the emerging evidence that stimulant use, particularly chronic cocaine use, is significantly associated with higher rates of depression, anxiety, suicidality, and psychotic symptoms (Gwaltney et al., 2015; Paiva et al., 2017). Cocaine’s neurochemical impact on the brain’s dopamine system can deplete reward sensitivity, contributing to anhedonia and worsening mood dysregulation over time (Garavan et al., 2021). This pattern mirrors Volkow et al.’s (2019) findings, which emphasise how chronic stimulant use disrupts the brain’s reward circuitry, contributing to sustained mood deterioration over time.

As participants advanced further down the line of cocaine use, they began to speak not only of psychological distress, but also of mounting physical deterioration. The drug's toll on the body was profound, described in terms of chronic illness, organ damage, infectious diseases, and persistent exhaustion. In these accounts, cocaine was no longer just an emotional crutch or compulsive habit, it had become a corrosive force, weakening the body with each use.

Julian captured this vividly when describing the physical consequences of preparing and using crack cocaine:

Your health takes a serious hit, your heart, your stomach, everything starts failing.

You're supposed to wash the ammonia out when cooking it, but in the moment, you just take it anyway. I ended up on about 11 pills a day, just to keep my heart and other things going.

Participants described repeated hospitalisations, sepsis, and an alarming disregard for personal health, exacerbated by the drug's immediacy and compulsive urgency. Alexander reflected: "There were moments I felt like my heart was going to stop... I ended up in hospital so many times, I had sepsis as well."

Intravenous cocaine use posed an additional layer of risk, especially for those who shared or reused needles. Two participants contracted Hepatitis C, and Ian recounted the desperation that drove such actions: "I got Hep C because I shared needles, and sometimes I'd collect them from the floor, that's how mad it makes you."

The long-term impact also included cardiovascular complications, exhaustion, and visible signs of physical decline. As Alexander described, "I felt like I was dying; I was

exhausted, bleeding all over, wounds on my feet from walking so much, trying to get cocaine.”

These accounts are consistent with literature describing the physical risks of long-term cocaine use, particularly its cardiovascular toxicity, elevated risk for stroke, and immunosuppressive effects that increase vulnerability to infection (UNODC, 2021; Volkow et al., 2019). Furthermore, as noted in the literature review, the urgency and immediacy of cocaine’s effects can override basic self-preservation, leading to practices that exacerbate health risks and neglect of medical needs (Sumnall & Brotherhood, 2019).

Cocaine didn’t just consume participants’ time, relationships, and mental health, it degraded their physical wellbeing, too. In the race that began with thrill-seeking and escape, their bodies became collateral damage, pushed to the brink, often ignored, until they broke down completely.

Running on Empty

As participants’ cocaine use escalated, it wasn’t just their own wellbeing that suffered, yet also of their relationships. A consistent and painful theme across accounts was the gradual reordering of priorities, with cocaine rising to the top and pushing loved ones into the background. Intimate partners, children, and family members were not only side-lined, but often sacrificed in favour of sustaining drug use. Cocaine became the main relationship, demanding attention, loyalty, and obedience above all else. This aligns with findings from the National Institute on Drug Abuse (2024), which state that individuals with a CUD often prioritise the drug over personal responsibilities and close relationships. Ian shared that cocaine “comes first and before everything.”

In addition, Nicola described how this pull altered her behaviour even during visits with her daughter:

Before going to meet my daughter at Appoġġ, I'd go get my fix, I'd use as much as I could handle. Then, while I was with her, I'd start making excuses to leave, saying I had to go smoke. I'd go to lift her, and she wouldn't even want to be near me. And that's when it hits you, she starts crying, and you think: is this really my daughter? And did I really cause this?

Her reflection captures not just absence, but an agonising awareness of how cocaine had replaced maternal instincts with compulsive urgency.

Julian described a moment when the drug overshadowed even his role as a father: "One time I had the kids with me... and I had just finished preparing the bottle and everything, and I ended up sending them away, it was like I kicked them out." Even love, in these accounts, wasn't strong enough to compete with the dominance of addiction.

In addition to the profound psychological and relational impacts described, participants also reflected on the severe financial toll that cocaine addiction exacted over time.

Alexander described the rapid and overwhelming drain on his finances: "if I had 2000 euros, I would spend them in one day" His reflection highlights the compulsive immediacy with which money was spent once it became available, offering little room for financial planning or restraint. Carla's account similarly revealed how cocaine use eroded not only her own possessions but also those of her family: "I had cars, I sold everything. Every single part I could sell, I did. Gold, even my mother's gold. Then when I had my daughter and I'd get money meant for her, I'd use it for coke." This aligns with research indicating that as

addiction progresses, spending becomes increasingly impulsive and tied directly to drug availability, often with little regard for future consequences (Hogarth et al., 2020).

Reflexively, this underscores the moral dissonance participants experienced, while many had once upheld values of respect and protection toward loved ones, addiction distorted these priorities. The drug's hold became so powerful that even deeply personal or sentimental items were sacrificed without hesitation, echoing how SUDs can dismantle relational trust and identity (Korecki et al., 2020).

The insidious erosion of decision-making was further captured when Ian stated: “Even if you only have 20 euros and you're dying of thirst, you won't buy a drink, you'll hold off, just to spend it on that instead. You'd rather stay thirsty.” This exposes how addiction reshapes basic hierarchies of need, with cocaine taking precedence even over critical aspects of health and survival (Volkow & Blanco, 2023).

Running in Circles between Cocaine and Heroin

Several participants who had also used heroin made striking comparisons between the two substances, often portraying cocaine as more psychologically destabilising and addicting. Ian articulated this distinction vividly: “With heroin, you take a gram, and you relax, but coke doesn't tire you, you just keep wanting.” This relentless drive was framed not only as exhausting but deeply frightening. “It's better to take anything else than this cocaine.” Alexander echoed this sentiment, describing how heroin gives a more sustained and mellow high, while cocaine delivers a short, intense rush followed by a sharp crash: “Heroin is a downer, cocaine is a high.” For him, the aftermath of cocaine use also came with more profound mental health deterioration: “The comedown from cocaine is heavier than from heroin, because with cocaine you get a lot of suicidal thoughts.”

These distinctions between the effects of heroin and cocaine are reflected in research, which notes that while both drugs alter the brain's reward systems, cocaine's rapid dopamine surge followed by abrupt depletion contributes to heightened impulsivity, dysphoria, and suicidality (Garavan et al., 2021; Volkow et al., 2019). Moreover, stimulant withdrawal tends to lack the visible physiological symptoms seen in heroin withdrawal but is often marked by severe psychological distress which can delay help-seeking (SAMHSA, 2021).

Nicola critically highlighted this treatment disparity: "I started taking heroin because there was nothing else, there's no treatment specifically for coke. The treatment is only for heroin, and they used to tell me that it would also help a bit with the coke." Her reflection points to a systemic shortfall: the imbalance in pharmacological and psychosocial treatment options available for stimulant use versus opioid use. As confirmed by the EUDA (2024), while opioid substitution therapies such as methadone and buprenorphine are well-established across Europe, no pharmacological equivalent currently exists for cocaine use. Treatment for CUD primarily relies on psychosocial approaches such as CBT, motivational interviewing, and especially contingency management, which is considered the most effective in promoting abstinence (Kampman, 2019). However, these approaches often yield modest outcomes and are not effective for many individuals, prompting the search for pharmacological options, none of which have yet been officially approved.

These comparisons reveal more than just personal preferences, they reflect real differences in how the drugs affect the brain and how the system responds. While heroin tends to slow the body down, cocaine creates a more chaotic and compulsive experience, made even harder by the lack of dedicated treatment options.

The Finishing Line

Having crossed the line into problematic and pervasive use, participants eventually found themselves at another critical threshold: the search for a way back. Yet, recovery was not a straight sprint to the finish. Instead, it was marked by false starts, relapses, and difficult reckonings with the emotional and relational wreckage addiction had left behind. For many, reaching this ‘finishing line’ meant confronting their deepest failures, rebuilding motivation from within, and piecing together new foundations for living.

This final theme captures the pivotal turning points where the direction of participants' journeys began to change. It explores the painful experiences of relapse, the drastic measures taken in desperate attempts to stay clean, the internal shift toward self-driven recovery, and the vital role of supportive networks in sustaining hope and change. Together, these subthemes illustrate that recovery was not simply about stopping drug use; it was about reclaiming agency, rebuilding fractured identities, and finding new ways to belong, both to themselves and to others.

Back to the Start Line

As participants moved from addiction toward recovery, the journey was rarely linear. For several participants, relapse not only marked the return to substance use, but it also intensified feelings of failure and hopelessness. Despite periods of abstinence, participants described how even a brief relapse could unravel the progress they had made, often triggering a vicious cycle of guilt, self-blame, and heightened drug use.

Daniel’s account, where he relapsed after five years of abstinence, captures the profound impact of even a brief period of use: "Then I spent 5 years clean, and I relapsed. I only spent 3 weeks using but in 3 weeks I lost everything. I became a junkie way more." This powerful statement reflects how relapse exacerbated feelings of failure, igniting a devastating

spiral where addiction reasserted its control. The struggle to reconcile with the feeling of failure led to increased use, as he explained: "Because the relapse made me feel like such a failure to my work, family, and to myself. I just wanted to beat myself up for it." This resonates with findings from Sobell & Sobell (2018), who emphasize how internalized shame can perpetuate addictive behaviours, making recovery harder to maintain in the face of setbacks.

Mike reflected on his relapse after a period of sobriety: "I wasn't entitled to any COVID benefit because I wasn't paying tax in Ireland. So, I had to start selling cocaine again and I started sniffing again." Similarly, Alexander shared: "I was clean and sober for four years. I relapsed about four years ago, around the time COVID hit." Both experiences underscore the role of environmental stressors in triggering relapse, reinforcing the idea that precipitating factors, such as life changes, financial strain, or limited support systems, are critical in relapse trajectories (Pace et al., 2021).

Radical Turns

For several participants, the journey towards recovery was marked by drastic steps, moving to new countries, distancing from social networks, and making life-altering decisions in an effort to break free from addiction. For several participants, the journey toward recovery involved taking drastic steps, such as relocating to new countries, distancing themselves from former social circles, and making life-altering decisions. These actions were attempts to create psychological and physical distance from triggers and environments associated with drug use, and thus served, in the participants' eyes, served as protective factors in their efforts to break free from addiction.

Mike, for example, described relocating in an attempt to disrupt his drug use: "I moved to Greece to try and stop cocaine." Similarly, the fleeting hope of a romantic

relationship led him to Malta, believing it might serve as a fresh start: “Then I had a girlfriend and thought it was a good idea to come to Malta for 3 weeks for us to stop sniffing.” For Nicola, geographical distancing was also a central strategy. She explained: “Then we reached a point where we couldn’t keep going like that, so we moved to Gozo, just so I wouldn’t find the pipe.”

These actions closely align with what literature identifies as antecedents to recovery, which are major decisions or transitions often undertaken in hopes of sustaining abstinence or gaining a new sense of identity (Korecki et al., 2020). However, as reflected in participants’ accounts, such measures, while sincere and sometimes necessary, were not always effective in the long term.

Julian’s experience illustrated this vividly: “Then we agreed to have a baby, hoping it would help us leave that life behind. But it wasn’t the solution, in fact, I think it was the worst decision I ever tried to make.” In his case, the decision to have a child was not enough to resolve his underlying struggles, leading instead to further disappointment and emotional burden.

Although these external changes were often taken with hope and determination, they rarely proved effective in sustaining recovery. Participants’ attempts to escape addiction by altering their surroundings or circumstances were frequently undermined by unresolved emotional and behavioural patterns. As DiClemente (2018) notes, without internal readiness and ongoing psychological work, external shifts alone are unlikely to lead to meaningful or lasting change. For these individuals, moving away or starting fresh often served as a temporary pause rather than a true turning point, highlighting the need to confront the deeper roots of addiction rather than relying solely on situational change (Clark, 2012).

Internal Drives

As participants progressed along their trajectory toward recovery, a pivotal shift emerged when they began to internalise their motivation for change. Unlike previous attempts at sobriety, often driven by family pressure, societal expectations, or legal mandates, most participants emphasised that meaningful and enduring recovery only began when the decision to stop cocaine use arose from within themselves. Paolo articulated the significance of intrinsic motivation clearly:

When the time came and I felt that I needed to enter a programme, I made that decision myself, not because anyone pushed me. If I hadn't truly wanted to change and had done it just for my mother, I wouldn't have reached this stage.

Paolo's reflection illustrates how externally enforced attempts at sobriety were ultimately insufficient to sustain behavioural change. It was only through self-determined decision-making that genuine progress became possible.

This finding resonates with Self-Determination Theory (Ryan & Deci, 2017), which posits that intrinsic motivation, where actions are governed by personal values and goals, is crucial for sustaining complex behavioural changes like addiction recovery. It critically challenges the notion that external pressure, whether from family or legal systems, can achieve deep, lasting transformation. While external motivators may catalyse initial entry into treatment, studies show they are rarely sufficient to maintain abstinence over time unless internalised (Ng et al., 2019).

Alexander similarly expressed a clear sense of personal agency in his decision to pursue treatment: "At the end of the day I decided to re-enter the programme." Nicola echoed this shift: "I stopped using because I wanted to." Their statements reflect not just a move toward action, but a reorientation of self-narrative, from seeing recovery as something

imposed from outside to something owned internally. This internalisation process is critically important; as Flannery et al. (2019) argue, individuals who engage in treatment due to intrinsic goals rather than external coercion demonstrate higher retention rates and better long-term outcomes.

However, these findings must be contextualised within the broader realities of recovery. Not all individuals may easily access the psychological conditions necessary to foster intrinsic motivation, particularly those burdened by severe trauma, low self-efficacy, or systemic barriers. Thus, while participants' internal shifts were crucial, it is equally important to recognise that treatment programmes need to actively facilitate environments that support the emergence of autonomous motivation, by promoting empowerment, offering meaningful choice, and respecting personal agency (Kelly & Greene, 2018).

My Cheerleaders

As participants moved toward sustained recovery, support systems emerged as pivotal protective factors that profoundly shaped their trajectories. These networks provided emotional containment, practical guidance, and a framework through which participants could rebuild a sense of identity beyond substance use.

Paolo vividly captured how structured support transformed his recovery experience, stating, “The programme gave me a new life. I found so much love, it felt like I was born again.” His words reflect not merely emotional relief, but deep transformation ignited by compassionate care. He further described the therapeutic approach that reshaped his perspective:

The programme welcomes you with immense love and teaches you every day. It instils a sense of positivity and opens your eyes. Where you expect to be shamed, they

teach you to see things through a different lens. They help you confront your weaknesses head-on.

Similarly, Daniel stated: “I think the tough love...sometimes they [rehabilitation team] put me in my place...The staff here are my role models because they’ve been through the same problems as me.” These insights suggest that the credibility and relatability of support providers, especially those with lived experience, may increase trust and therapeutic receptivity, reinforcing the relational foundation of effective treatment. This aligns with research emphasising the necessity of compassionate, person-centred approaches within therapeutic communities, approaches that facilitate lasting behavioural and emotional change by creating resilience, hope, and new skills (Kelly et al., 2020).

Carla’s reliance on structured recovery programmes further illustrates the multifaceted role of supportive frameworks in recovery maintenance:

NA helped me the most. It’s a 12-step programme. We have daily group meetings.

Apart from that I go in to give urine samples, and I attend recovery sessions with the social worker. I also started online therapy to work through issues from when I was younger.

Carla's experience echoes studies underscoring the effectiveness of structured support groups and their integral role in creating social belonging, emotional accountability, and ongoing personal growth (Zemore et al., 2018). In her case, both peer-led and clinical interventions worked in tandem, highlighting the value of integrating formal and informal support structures in sustaining recovery.

Moreover, Andrew described managing his recovery proactively through structured daily practices, underscoring addiction's chronicity, and the necessity for continuous engagement with recovery tools:

Addiction is like diabetes...Just like a diabetic has to watch what they eat, I have to be careful with what I do for my recovery. I meditate in the morning, attend meetings, and I also journal. There's the sponsor, the step work... and having a relationship with a higher power helps too.

This reflects current thinking in addiction research, which recognises that recovery is not a one-time event but a lifelong process that needs consistent effort and support (White et al., 2020). Andrew's account also reinforces the importance of practical recovery tools that people can use every day, not only during treatment but long after it ends.

Collectively, these experiences illustrate that robust social and therapeutic support systems functioned not merely as assistance in participants' recovery journeys, but as fundamental mechanisms for creating resilience, connection, and sustained growth, embodying protective factors as described by the Five P's model (Macneil et al., 2012).

Conclusion

This chapter has shown how cocaine addiction develops through a complex interplay of biological vulnerability, psychological challenges, and social influences. Early use often begins as social experimentation or coping, gradually escalating as denial and rationalisation mask the growing loss of control. Addiction strips away identity, damages relationships, and deteriorates both mental and physical health. Yet, amid these profound struggles, recovery emerges through a critical internal shift in motivation and the vital presence of supportive, compassionate care. These findings highlight the necessity of holistic approaches that address

the full spectrum of factors shaping addiction, and they affirm the enduring capacity for change and resilience even in the darkest moments of this journey.

Chapter 5 - Conclusion

This chapter has presented an integrated account of participants' subjective experiences, tracing their trajectories from early encounters with cocaine to the devastating consequences of addiction and the complex process of recovery. Through RTA, the study illuminated how cocaine use was shaped and sustained by a convergence of biopsychosocial factors. These findings were critically explored using the 5P's model (Macneil et al., 2012) and the biopsychosocial framework (Engel, 1977). Participants' reflections also revealed how internal motivation and support systems functioned as key protective factors, enabling recovery in the face of profound personal and structural adversity. The thematic structure presented in this chapter provides a nuanced understanding of CUD from the perspective of those directly affected, grounding the discussion in their own meaning-making processes. The final chapter will now reflect on the wider implications of these findings for theory, clinical practice, and future research.

Summary of Findings

This study set out to explore how individuals with a CUD perceive their transition from recreational to problematic use, a trajectory shaped by intersecting psychological, social, and biological factors. Through qualitative interviews and RTA, three overarching themes were developed: The Starting Line, Crossing the Line, and The Finishing Line. These captured the complexity of early exposure, loss of control, and efforts toward recovery.

Participants described initial use as experimental, socially driven, and often rationalised as harmless. However, deeper motivations, such as coping with emotional pain, trauma, or unmet psychological needs, were soon revealed. Over time, their use shifted from controlled to compulsive, echoing the reinforcing nature of cocaine's short-lived but intense

high (Volkow et al., 2019). The second theme documented a gradual erosion of personal autonomy, relational damage, and identity fragmentation. These narratives highlighted how biological urges, emotional dysregulation, and social isolation compounded to maintain addiction, consistent with research on the neuropsychological and relational toll of cocaine use (Bjorness & Greene, 2021; Zilverstand et al., 2018). The final theme explored recovery, marked not by linear progress but by recurring cycles of relapse and resilience. While external scaffolding such as treatment programs played a vital role, recovery appeared most sustainable when participants internalised motivation and reconnected with personal meaning, in line with the self-determination theory in addiction recovery (Deci & Ryan, 2017; Hennessy et al., 2022) Overall, the study underscored that addiction cannot be reduced to chemical dependence alone but must be viewed as a lived experience embedded in broader biopsychosocial realities.

Treatment Recommendations and Implications for Policy

Findings from this study suggest that treatment approaches for CUD must move beyond abstinence models and instead address the full spectrum of psychosocial influences that sustain addiction. CBT remains a strong evidence-based approach, especially for targeting cognitive distortions and building distress tolerance (Boness et al., 2023; Carroll & Kiluk, 2017). Yet, for many participants, it was the integration of trauma-informed care and peer support that offered the greatest sense of psychological safety.

Contingency Management (CM), which uses incentive-based reinforcement to promote abstinence, has shown increasing success in CUD populations (De Crescenzo et al., 2018). Its behavioural focus may be especially helpful for those in early recovery struggling with motivation and impulse control. However, participants in this study indicated that purely reward-based interventions might fall short if not accompanied by opportunities for

emotional processing and identity rebuilding, areas where narrative therapies or acceptance-based interventions (e.g., Acceptance Commitment Therapy or Mindfulness Based Relapse Prevention) might add value (Ramadas et al., 2021).

Policy should also prioritise treatment accessibility, particularly for daily users not currently engaged in services. The finding that only 21% of Malta's daily cocaine users are in treatment (Azzopardi et al., 2021) reveals a significant service gap. Outreach strategies, especially those rooted in harm reduction and delivered through trusted community channels, are essential to engage this hidden population. For example, culturally adapted psychoeducation campaigns could challenge normalised attitudes toward cocaine in nightlife and professional settings, which participants described as contributing to delayed help-seeking.

Finally, stigma emerged as a powerful deterrent to accessing care. Consistent with prior studies, participants feared being judged or criminalised for their use, which often prolonged their active addiction (Hammerlund et al., 2018; Muncan et al., 2020). Training for healthcare providers should emphasise compassion-focused care and challenge the implicit biases that hinder therapeutic rapport (Stone et al., 2021). Policies must also support the integration of addiction services within mainstream health and mental health care, reducing fragmentation and promoting a recovery-oriented system.

Recommendations for Future Research

This study opens several avenues for further investigation. Firstly, the progression from recreational to problematic use should be explored across a larger and more diverse sample, particularly among women, LGBTQ+ individuals, and those from marginalised

socioeconomic backgrounds, who may face unique vulnerabilities and barriers to care (Xin et al., 2023).

Secondly, while this research focused on subjective experience, future studies might benefit from a longitudinal design to capture how individuals' perceptions evolve over time, especially across critical turning points such as relapse, incarceration, or trauma exposure. Mixed-methods research could also help integrate the depth of qualitative insight with measurable clinical or neurological outcomes (Clark et al., 2021).

Finally, there is a pressing need for intervention studies to assess the local applicability and effectiveness of evidence-based treatments such as Contingency Management, Mindfulness Based Relapse Prevention, and Cognitive Behavioural Therapy. While these approaches have shown strong empirical support in international contexts, demonstrating efficacy in reducing relapse, enhancing motivation, and supporting long-term recovery, there is limited evidence of their use or adaptation within the Maltese treatment landscape. Malta's addiction services remain largely rooted in traditional therapeutic models, with minimal integration of structured, manualised interventions that could benefit individuals with differing levels of readiness and need.

Piloting and evaluating interventions like CM, MBRP, and digital CBT within local services could generate important insights regarding their cultural acceptability, feasibility, and clinical outcomes in Malta. Such research would be instrumental in informing evidence-based national treatment guidelines, helping to diversify intervention offerings and bridge the gap between international best practices and local service provision. Moreover, it could support the tailoring of these interventions to Malta's specific socio-cultural context, ultimately improving engagement and recovery outcomes for people with lived and living experience of substance use.

Limitations of the Study

While this study provides rich, contextualised insight into the lived experience of CUD, several limitations should be acknowledged. First, participants were recruited through gatekeepers, which may have introduced selection bias. Gatekeepers may have opted to refer individuals perceived as more articulate or emotionally stable, possibly skewing the data toward a recovery-oriented narrative. Although efforts were made to promote diverse representation, future studies should consider recruiting through non-clinical or peer-led networks to reduce this bias.

Second, interviews relied on retrospective self-reporting. While the use of RTA allowed participants to reflect freely, memory recall can be affected by current emotional states, cognitive distortions, or treatment narratives. As such, the findings should be interpreted as constructed accounts rather than objective timelines of use.

Lastly, while care was taken to maintain reflexivity throughout the analytic process, the researcher's background and interest in addiction may have influenced interpretation. Although supervision and journaling were used to minimise bias, all qualitative research carries the inherent subjectivity of co-constructed meaning.

Concluding Note

This work has shed light on what is too often lost beneath the weight of diagnostic labels and statistical prevalence: the human experience of addiction. Through the voices of those who lived it, this study revealed that the descent into a Cocaine Use Disorder was rarely abrupt or intentional. Instead, it unfolded gradually, shaped by psychological vulnerability, social influences, unresolved trauma, and a pursuit of escape, belonging, or emotional regulation.

Participants described how what began as recreational use evolved into a pattern marked by compulsion, loss of control, and personal cost. Their reflections offered insight not only into the grip of addiction but also into the emotional, relational, and existential struggles that accompanied it. Importantly, many also expressed moments of resistance, clarity, and a desire to reclaim agency, challenging static or deficit-based views of addiction.

This study reinforces the need for treatment and prevention efforts that are not only evidence-based but also contextually grounded, trauma-informed, and attuned to the meanings individuals attach to their substance use. Understanding these pathways in depth is essential for informing compassionate and effective interventions, ones that uphold dignity, support autonomy, and recognise the potential for change.

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Appendices

Appendix A

Interview Schedule

English

1. Sociodemographic characteristics (gender, age)
2. Relationship status
3. Highest level of education achieved
4. How old were you when you first used drugs (any form of drugs)?
5. How old were you when you first used cocaine?
6. What was your frequency of cocaine use?

Probe: Can you describe what your cocaine use looked like in the beginning, and how it has evolved over time?

7. When was the last time you used cocaine?
8. Can you please start by telling me a bit about your experiences with cocaine use?

Probe: How did you first come into contact with cocaine, and what led you to start using it?'

Factors Influencing the Transition to Problematic Use:

9. At what point did feel your use started becoming problematic?

Probe: What changes were you noticing at the time, if any?

Probe: Looking back, what do you believe were some of the factors that contributed to your transition from recreational use to problematic use?

Probe: Can you identify any specific events or circumstances that acted as triggers or tipping points in your journey towards problematic cocaine use?

10. Are there any patterns or trends you've noticed in your cocaine use that may have perpetuated or worsened your dependency?
11. On the other hand, were there any factors or strategies that you feel helped protect you from further escalating your cocaine use?
12. What was the motivating factor that led you to start a programme/ address the problem?

Perceptions of Cocaine Use:

13. How do you perceive your use of cocaine now, compared to when you first started using?
14. What are some of the reasons or motivations behind your cocaine use?
15. Can you describe any positive experiences or benefits you associate with cocaine use?
16. On the other hand, what are some of the negative consequences or drawbacks you've experienced as a result of your cocaine use?

Biopsychosocial Consequences:

17. How do you feel your cocaine use has impacted you physically?
Probe - Can you describe any changes you've noticed in your health or well-being since you started using cocaine?
18. Psychologically?
Probe - How has cocaine use affected your relationships with family, friends, and others in your life?
19. Socially?
Probe - Have there been any legal or financial consequences associated with your cocaine use?

Coping Strategies and Support Systems:

20. How do you typically cope with the challenges or cravings associated with cocaine use?
21. Have you sought any other form of support or treatment for your cocaine use? If so, what has been your experience with these resources?
22. Can you describe any changes or improvements you've made in your life to address your cocaine use?

Reflection and Future Outlook:

23. Looking ahead, what are your thoughts or goals regarding your cocaine use and recovery?
24. Is there anything else you'd like to share about your experiences with cocaine use that we haven't covered yet?
25. Lastly, do you have any suggestions or insights that you believe could help others who may be struggling with similar issues?

Malti

1. Karatteristiċi soċjodemografiċi (sess, età)
2. L-istatus tar-relazzjoni
3. L-ogħla livell ta' edukazzjoni miksub
4. Kemm kellek meta użajt id-drogi għall-ewwel darba (kwalunkwe forma ta' droga)?
5. Kemm kellek meta użajt il-kokaina għall-ewwel darba?
6. X'kienet il-frekwenza tal-użu tal-kokaina tiegħek?

Probe: Tista' tiddeskrivi kif deher l-użu tal-kokaina tiegħek fil-bidu, u kif evolviet maż-żmien?

7. Meta kienet l-aħħar darba li użajt il-kokaina?
8. Tista' jekk jogħġbok tibda tgħidli ftit dwar l-esperjenzi tiegħek bl-użu tal-kokaina?

Probe: Kif ġejt f'kuntatt mal-kokaina l-ewwel, u x'wassalek biex tibda tużaha?

Fatturi li Jinfluwenzaw it-Tranzizzjoni għal Użu Problematiku:

9. F'liema punt hassejt li l-użu tiegħek beda jsir problematiku?

Probe: X'bidliet kont tinnota dak iż-żmien, jekk kien hemm?

Probe: Meta tħares lura, x'taħseb li kienu wħud mill-fatturi li kkontribwew għat-tranzizzjoni tiegħek minn użu rikreattiv għal użu problematiku?

Probe: Tista' tidentifika xi avvenimenti jew ċirkustanzi speċifiċi li aġixxew bħala kawżi jew punti ta' bidla fil-vjaġġ tiegħek lejn l-użu problematiku tal-kokaina?

10. Hemm xi trends jew patterns li nnuttajt fl-użu tal-kokaina tiegħek li setgħu pperpetwaw jew aggravaw id-dipendenza tiegħek?
11. Min-naħa l-oħra, kien hemm xi fatturi jew strategiji li tħoss li għenu jipproteġik milli tkompli teskala l-użu tal-kokaina tiegħek?
12. X'kien il-fattur motivanti li wassall biex tibda programm/tindirizza l-problema?

Perċezzjonijiet tal-Użu tal-Kokaina:

13. Kif tipperċepixxi l-użu tiegħek tal-kokaina issa, meta mqabbla ma' meta bdejt tuża l-ewwel?
14. X'inhuma xi wħud mir-raġunijiet jew motivazzjonijiet wara l-użu tal-kokaina tiegħek?
15. Tista' tiddekrivi xi esperjenzi pożittivi jew benefiċċji li tassoċja mal-użu tal-kokaina?
16. Min-naħa l-oħra, x'inhuma xi wħud mill-konsegwenzi negattivi jew l-iżvantagġi li esperjenzajt bħala riżultat tal-użu tal-kokaina tiegħek?

Konsegwenzi bijopsikososċjali:

17. Kif tħoss li l-użu tal-kokaina kellu impatt fuqek fiżikament?
Probe - Tista' tiddekrivi xi tibdil li ndunajt fis-saħħa jew fil-benessri tiegħek minn meta bdejt tuża l-kokaina?
18. Psikoloġikament?
Probe - L-użu tal-kokaina kif affettwa r-relazzjonijiet tiegħek mal-familja, ħbieb, u oħrajn f'ħajtek?
19. Soċjalment?
Probe - Kien hemm xi konsegwenzi legali jew finanzjarji assoċjati mal-użu tal-kokaina tiegħek?

Strategiji ta' Taffaċċjar u Sistemi ta' Appoġġ:

20. Kif taffaċċja normalment l-isfidi jew ix-xewqat relatati mal-użu tal-kokaina?
21. Qatt fittixt xi forma oħra ta' appoġġ jew trattament għall-użu tal-kokaina? Jekk iva, x'esperjenza kellek b'dawn ir-riżorsi?
22. Tista' tiddekrivi xi tibdiliet jew titjib li għamilt f'ħajtek biex tindirizza l-użu tal-kokaina?

Riflessjoni u Perspettiva Futur:

23. Meta nharsu 'l quddiem, x'inhuma l-ħsibijiet jew l-għanijiet tiegħek dwar l-użu u l-irkupru tal-kokaina tiegħek?
24. Hemm xi haġa oħra li tixtieq taqsam dwar l-esperjenzi tiegħek bl-użu tal-kokaina li għadna ma koprejniex?
25. Fl-aħħar nett, għandek xi suggerimenti jew għarfien li temmen li jistgħu jgħinu lil oħrajn li jistgħu jkunu qed jifhabtu ma 'kwistjonijiet simili?

Appendix B

Excerpt from Interview Transcript and Coding Process

Phase 2 of Braune and Clark's (2019) Steps

Data Segment	Interpretive Code	Reflexive Note
"Ghall-ewwel qisni kont nieħu darba f'gimġha..."	Early controlled use	Indicates initial perception of control, sets up contrast with later escalation
"Mill-ewwel rajt kbir."	Escalation and desensitisation	Suggests a rapid increase in tolerance or perception of quantity becoming "normal"
"kulhadd qabad jigbed... kulhadd irid jigbed il-coke..."	Social normalisation of cocaine use	Repetition of <i>kulhadd</i> (everyone) reveals pressure and cultural embedding of drug use
"Inbidlet il-ħajja"	Identity shift / lifestyle immersion	Implicit transformation in life roles and routine

Appendix C

Consent Form

I, the undersigned, give my consent to take part in the study conducted by Maria Aquilina a postgraduate student at the University of Malta who is reading for a Masters in Health Psychology. This consent form specifies the terms of my participation in this research study.

1. I have been given written and/or verbal information about the purpose of the study; I have had the opportunity to ask questions and any questions that I had were answered fully and to my satisfaction;
2. I also understand that I am free to accept to participate, or to refuse or stop participation at any time without giving any reason and without any penalty. Should I choose to participate, I may choose to decline to answer any questions asked. In the event that I choose to withdraw from the study, any data collected from me will be erased as long as this is technically possible, unless erasure of data would render impossible or seriously impair achievement of the research objectives, in which case it shall be retained in an anonymised form;
3. I am aware that as long as the researcher retains personal data (including consent forms) and codes linking the data to myself as a research participant, the data is considered to be pseudonymised, and I shall remain identifiable to whoever has access to the codes and personal data (the researcher, the supervisor and in exceptional circumstances, the examiners for verification purposes);
4. I understand that I have been invited to participate in an interview in which the researcher will ask about me questions about my cocaine use.
5. I am aware that the data gathered will solely be used for the purposes of this study;
6. I am aware that the interview will be recorded in audio form for later written analysis in the research;
7. I am aware that the researcher shall take all reasonable precautions to ensure that the participants' identity is not revealed in the research outputs;
8. I am aware that codes will be used to pseudonymise the research data in this study. This ensures that confidentiality of data is maintained, as personally identifiable data will be stored safely and securely, and separate from any pseudonymised data. Thus, my data will be pseudonymised so that my identity will not be noted on transcripts or notes from my interview, but instead, a code will be assigned. I am also aware that the organization name will not be mentioned in the dissertation.

9. I am aware that any digital identifiable data (including audio recordings) shall be stored securely in an encrypted manner, and identifiable data is only available to people who need it for research purposes. These include the researcher, the supervisor and (in exceptional circumstances) the examiners for verification purposes;
10. I am aware that the recording will be destroyed immediately post-transcription in the form of deleting and that transcripts will be destroyed one year (1st October 2026) after the completion of the dissertation by deleting and shredding the physical copies;
11. I understand that my participation does not entail risks and there are no direct benefits to me from participating in this study. I also understand that this research may benefit others by shedding light on the issue of problematic substance use and comorbid disorders in society; I am aware that while this research is not expected to cause any harm, should I experience any distress during the interview, I shall be able to access any service from a list of relevant support services that will be provided to me in the debriefing notes."
12. I have been provided with a copy of the information letter and understand that I will also be given a copy of this consent form;
13. Lastly, I understand that, under the General Data Protection Regulation (GDPR) and national legislation, I may withdraw from the study at any time and that I do not need to give my justification for opting out. If I choose not to participate in the study any data collected will be deleted and will not be included in the dissertation.

I have read and understood the above statements and agree to participate in this study.

Name of participant: _____

Signature: _____

Date: _____



Maria Aquilina
maria.aquilina.10@um.edu.mt



Dr. Anna Grech
anna.m.grech@um.edu.mt

Formola tal-Kunsens tal-Parteċipant/a

“Ninvestigaw it-triq mill-użu għall-abbuż: perspettivi ta’ individwi li għandhom vizzju tal-użu tal-kokaina”

Jiena, hawn taht iffirmat/a, nagħti l-kunsens tiegħi li nieħu sehem fl-istudju ta’ Maria Aquilina. Din il-formola tal-kunsens tispjega t-termini tas-sehem tiegħi f’ din ir-riċerka.

1. Inghatajt l-informazzjoni bil-miktub u/jew bil-fomm dwar l-iskop tar-riċerka; kelli l-opportunità nagħmel il-mistoqsijiet, u kull mistoqsija ngħatajt twegiba għaliha b’mod sħiħ u sodisfaċenti.
2. Nifhem ukoll li jiena liberu/a li naċċetta li nieħu sehem, jew li nirrifjuta, jew li nwaqqaf il-parteċipazzjoni tiegħi meta nixtieq mingħajr ma nagħti spjegazzjoni jew mingħajr ma nigi penalizzat/a. Jekk nagħzel li nipparteċipa, jaf niddeċiedi li ma nwegibx kull mistoqsija li ssirli. F’każ li nagħzel li ma nkomplix nieħu sehem fl-istudju, l-informazzjoni li tkun laħqet ingabret mingħandi tithassar dment li jkun teknikament possibbli (ngħidu aħna, qabel ma tiġi anonimizzata jew ippubblikata), u sakemm l-għanijiet tar-riċerka jkunu jistgħu jintlaħqu u ma jintlaqtux serjament. F’dak il-każ, l-informazzjoni tiegħi tintuża u tinzamm psewdonimizata.
3. Nifhem li ġejt mistieden/mistiedna nipparteċipa f’intervisti u l-persuna li qed tagħmel ir-riċerka se tistaqsi mistoqsijiet ġenerali dwar l-istudju li qed isir biex tesplora kif individwi li għandhom vizzju tal-użu tal-kokaina jharsu lejn it-tranzizzjoni tagħhom minn użu rikreattiv għal użu problematiku. Jiena konxju/a li l-intervista ser iddum bejn wieħed u ieħor siegħa. Nifhem li l-intervista se ssir f’post u f’hin li huma komdi għalija.
4. Nifhem li l-parteċipazzjoni tiegħi jaf *tinkludi dawn ir-riskji: skumdità psikoloġika meta nwieġeb mistoqsijiet tal-intervista.*
5. Nifhem li *bil-parteċipazzjoni tiegħi f’dan l-istudju, m’hemm l-ebda benefiċċju dirett għalija.*
6. Nifhem li, skont ir-Regolament Ġenerali dwar il-Protezzjoni tad-Data (GDPR) u l-leġislazzjoni nazzjonali, għandi dritt naċċessa, nikkoreġi u, fejn hu applikabbli, nitlob li l-informazzjoni li tikkonċernani tithassar.
7. Nifhem li l-informazzjoni kollha miġbura se *tithassar meta jintemm l-istudju f’temp ta’ sentejn minn meta jitlestha l-istudju (l-1 ta’ Ottubru 2026)*
8. Inghatajt kopja tal-ittra ta’ tagħrif biex inżommha u nifhem li se ningħata wkoll kopja ta’ din il-formola tal-kunsens.

Qrajt u fhimt l-istqarrijiet t’hawn fuq, u naqbel li nipparteċipa f’dan l-istudju.

Isem il-parteċipant/a: _____

Firma: _____

Data: _____



Maria Aquilina
maria.aquilina.19@um.edu.mt



Dr Anna Grech
anna.m.grech@um.edu.mt

Appendix D

Information Sheet

Dear participant,

My name is Maria Aquilina, a student at the University of Malta, presently reading for a Masters in Health Psychology. I am currently conducting a research study for my dissertation titled ‘ the Trajectory from Use to Abuse: Perspectives of Individuals with a Cocaine Use Disorder’, supervised by Dr Anna Grech. This letter is an invitation to participate in this study. Below you will find information about the study and about what your involvement would entail, should you decide to take part.

Research Description

This study shall explore how individuals with a cocaine use disorder perceive their transition from recreational use to problematic use. This study aims to make a meaningful contribution to the field of addiction research by focusing on the experiences and perceptions of individuals transitioning from recreational cocaine use to problematic use.

The target population thus is individuals with a problematic use of cocaine.

If you are interested to participate in this study, the required criterion is that you are over the age of 18 and not considered by the gatekeeper to be in a vulnerable position.

This study will use a qualitative method, through the use of interviews, to be able to offer a rich and more informative view into how individuals with a cocaine use disorder perceive their trajectory from use to abuse. Semi-structured interviews shall be carried out, lasting around an hour each, with approximately six to eight participants. The methodology to be adopted in analysing the data will be that of reflexive thematic analysis.

Research Procedures

Participation in this study is entirely voluntary; in other words, you are free to accept or refuse to participate, without needing to give a reason. You are also free to withdraw from the study at any time, without needing to provide any explanation and without any negative repercussions for you. Please also note that, as a participant, should you choose to withdraw, you have the right under the General Data Protection Regulation (GDPR) and national legislation to access, rectify and where applicable ask for the data concerning you to be erased, as long as this is technically possible, unless erasure of data would render impossible or seriously impair achievement of the research objectives, in which case it shall be retained in an anonymised form.

After the interviewing process has been concluded, the data will be transcribed and coded in order to precipitate its analysis. The data obtained from this study shall be pseudonymised. Therefore, codes will link the data to each research participant. The researcher shall take all reasonable precautions to ensure that the participants' identity is not revealed in the research outputs (including the dissertation). Confidentiality will be ensured; personally identifiable data will be stored safely and securely and separate from any pseudonymised data. Any digital identifiable data (including audio recordings) shall be stored in an encrypted manner.

Finally, the research will be handed over to the University of Malta in order to be reviewed by the examiners. After the research process has concluded, the gathered data will be destroyed accordingly by 1st October 2026, i.e., one year after the completion of the dissertation.

If after you read the information sheet you do agree to participate in the interview, you will be asked to sign a consent form detailing your rights.

Thank you for your time and consideration. Should you have any questions or concerns, please do not hesitate to contact me by e-mail on maria.aquilina.19@um.edu.mt or you can also contact my supervisor: anna.m.grech@um.edu.mt

Sincerely,

Maria Aquilina

maria.aquilina.19@um.edu.mt



Dr Anna Grech

anna.m.grech@um.edu.mt



Għażiż/a Sinjur/a,

Jiena Maria Aquilina studenta fl-Università ta' Malta, u bħalissa qed insegwi masters fil-Psikoloġija tas-Sahħa. Ir-riċerka għat-teżi tiegħi jisimha: “Ninvestigaw it-triq mill-użu għall-abbuż: perspettivi ta' individwi li għandhom vizzju tal-użu tal-kokaina”. It-tutor tiegħi hi Dr Anna Grech. B'din l-ittra nixtieq nistiednek tipparteċipa fir-riċerka. Hawn taħt issib aktar informazzjoni fuq l-istudju li qed nagħmel u fuq xi jkun l-involvement tiegħek jekk tiddeċiedi li tiegħu sehem.

L-għan tal-istudju hu li dan l-istudju għandu jesplora kif individwi b'vizzju tal-użu tal-kokaina jifhmu t-tranzizzjoni tagħhom minn użu rikreattiv għal użu problematiku.

Sehemek jgħin biex ikun hawn iżjed għarfien dwar sinifikanti lill-qasam tar-riċerka dwar il-vizzju billi jiffoka fuq l-esperjenzi u l-perċezzjonijiet ta' individwi li qed għaddew mill-użu rikreattiv tal-kokaina għal użu problematiku. L-informazzjoni kollha li tingabar fir-riċerka tintuża biss għall-fini ta' dan l-istudju.

Jekk taqbel li tipparteċipa, il-kriterji meħtieġa huma li inti għandek 'il fuq minn 18-il sena, tinqies li għandek problema tal-kokaina, u mhux ikkunsidrat mill-gatekeeper bħala f'pożizzjoni vulnerabbli.

L-informazzjoni miġbura se tibqa' kodifikata – u se jkollu aċċess għaliha jien u t-tutor tiegħi biss.

Il-parteeċipazzjoni tiegħek f'dan l-istudju tkun għalkollox volontarja; fi kliem ieħor, inti liberu/a li taċċetta jew tirrifjuta li tiegħu sehem, mingħajr ma tagħti raġuni. Inti wkoll liberu/a li twaqqaf

il-partecipazzjoni tiegħek fl-istudju meta tixtieq, mingħajr ma jkollok tagħti spjegazzjoni u mingħajr ebda riperkussjoni. Jekk tagħzel li tirtira mir-riċerka, l-informazzjoni li tkun laħqet ittiehdet fl-intervista miegħek tithassar dment li dan ikun teknikament possibbli (ngħidu aħna, qabel ma tiġi anonimizzata jew ippubblikata), u sakemm l-għanijiet tar-riċerka jkunu jistgħu jintlaħqu u ma jintlaqtux serjament. F'dak il-każ, l-informazzjoni tiegħek tintuża u tinzamm anonima.

Jekk tagħzel li tipparteċipa, jekk jogħġbok innota li m'hemm l-ebda benefiċċju dirett għalik. Il-partecipazzjoni tiegħek jaf tinkludi riskju li tesperjenza skumdità psikoloġika u għalhekk ser tiġi provduta lista ta' riżorsi ta' fejn inti tista taċċessa għajnuna psikoloġika. Barra min hekk, waqt l-intervista se nkun qed niċċekkja kull tant żmien biex nara kif qed tħossok u jekk tixtieqx tkompli jew le.

Bħala partecipant/a, għandek id-dritt, skont ir-Regolament Ġenerali dwar il-Protezzjoni tad-Data (GDPR) u l-legiżlazzjoni nazzjonali, li taċċessa, tikkoreġi u fejn hu applikabbli, titlob li l-informazzjoni li tikkonċernak tithassar. L-informazzjoni kollha li tingabar fl-istudju tinqered sal-1 ta' Ġunju 2026, jiġifieri, sena wara t-tlestija tat-teżi.

Qed ngħaddilek kopja ta' din l-ittra biex iżzommha bħala referenza.

Grazzi tal-ħin u l-kunsiderazzjoni tiegħek. Jekk ikollok xi mistoqsija, tiddejjaqx tikkuntattjani fuq maria.aquilina.19@um.edu.mt ; tista' tikkuntattja wkoll lit-tutor tiegħi fuq anna.m.grech@um.edu.mt.

Tislijiet,



Maria Aquilina

maria.aquilina.19@um.edu.mt



Dr Anna Grech

anna.m.grech@um.edu.mt

Appendix E

Evidence of Ethical Clearance from FREC



Maria Aquilina <maria.aquilina.19@um.edu.mt>

The status of your REDP form (SWB-2024-00355) has been updated to Approved

8 messages

form.urec@um.edu.mt <form.urec@um.edu.mt>
To: maria.aquilina.19@um.edu.mt

10 September 2024 at 10:25

Dear Maria Aquilina,

Please note that the status of your REDP form (SWB-2024-00355) has been set to *Approved*.

This status change was accompanied by the following explanation/justification: *Dear Maria Aquilina, Since the supervisor has confirmed via email that the minor changes have been carried out AND/OR all the gatekeeper's permissions have been obtained and uploaded, this application is Approved. Kindly check your UM inbox for an email with FREC's approval. Thanks and regards, SWB FREC*

You can keep track of your applications by visiting: <https://www.um.edu.mt/research/ethics/redp-form/frontEnd/>.

*****This email has been automatically generated by URECA. Please do not reply. If you wish to communicate with your FREC please use the respective email address.*****

Appendix F

Part of Reflexive Diary

Date of Reflection

This reflection is being written in March 2025, following a recent supervision meeting in which I received detailed feedback on my merged data analysis and discussion chapter. At this point in the research process, I have completed the interviews, conducted reflexive thematic analysis, and am in the advanced stages of refining my findings through close alignment with literature and theory. My thematic structure has been finalised, and I am now turning inward to critically examine my role as a researcher and how my assumptions, identity, and emotions may have shaped the research process.

Reflections on Assumptions & Biases

When I embarked on this research, I held a fundamental assumption that individuals who progress from recreational to problematic cocaine use do not do so in a vacuum, that their stories are shaped by complex biopsychosocial factors rather than a linear 'loss of control.' This assumption guided the development of my research question and informed my interest in exploring depth and nuance rather than categorisation or diagnosis.

Coming from a psychology background and with experience supporting individuals in clinical and rehabilitative settings, I noticed a tendency to search for meaning in people's choices and to empathise with the psychological pain behind substance use. This undoubtedly sensitised me to certain themes, such as self-alienation, trauma, and unmet psychological needs. At times, I may have given more weight to data that resonated with a compassionate or trauma-informed lens, possibly privileging interpretations that humanised the participants

over interpretations that might cast them in a less favourable light. I was wary of this, yet it required continual self-monitoring.

Furthermore, I brought into the analysis an implicit belief that addiction is not a moral failing but a condition that emerges in response to biopsychosocial vulnerabilities. This belief, while ethically aligned with my professional values, may have subtly influenced how I framed participants' disclosures, particularly when they described morally ambiguous behaviours or strained relationships.

Reflections on Positionality

As a health psychology trainee with no personal history of substance use, I occupy an outsider position with respect to my participants' lived experiences. However, my professional background includes supporting individuals with mental health and behavioural challenges, which enabled me to engage with the material with both empathy and clinical distance.

This dual positioning, outsider to the lived experience but insider to the psychological framework, placed me in a delicate space of interpretation. I was constantly negotiating the line between observing patterns through a theoretical lens (e.g., the Five P's model) and honouring the subjectivity of each participant's account. The power dynamic here was not between me and the participants per se, as the interviews were retrospective and anonymised, but between me and the data. I had the interpretive power to shape how stories were thematised, amplified, or relegated.

This positional authority required humility. I made a conscious effort to reflect on whether I was "speaking for" participants or co-constructing meaning with them through their own words. The inclusion of embedded quotations throughout the chapter was one way I

attempted to centre participants' voices rather than merely abstract their experiences into concepts.

Emotional Reactions

Engaging with the data was both moving and, at times, emotionally taxing. Some stories evoked deep empathy, particularly those that involved loss, of relationships, identity, health, or hope. I felt a strong emotional pull when participants described moments of collapse or shame, and I was surprised by how vividly I carried some of their phrases with me beyond the research context.

There were also moments of discomfort. Hearing accounts of behaviours that led to harm, for instance, neglect of children or aggression in relationships, elicited an internal tension between empathy and judgment. I had to sit with that discomfort and explore what it meant, both personally and professionally. Was I, even subtly, expecting a 'redemptive arc'? Was I filtering out morally uncomfortable data to preserve coherence in my themes? These were difficult questions that required me to revisit transcripts multiple times with fresh eyes and a commitment to emotional honesty.

I also experienced a sense of privilege, an awareness that I was entrusted with these deeply personal accounts. This engendered a responsibility to represent them with integrity, without sensationalism or reductionism.

Methodological Decisions

One of the most defining methodological decisions involved theme development. I chose to frame the themes metaphorically, such as "The Start Line" and "Crossing the Line," to reflect the journey-like nature of the participants' trajectories. This was not merely stylistic but

conceptual: it emphasised movement, thresholds, and turning points, which were recurring motifs across the data.

In some instances, choosing one theme over another required difficult trade-offs. For example, I initially considered a standalone theme on “Identity Fragmentation,” but realised its core ideas were better woven through subthemes on self-alienation, shame, and relational breakdown. Similarly, contradictions in the data, such as participants simultaneously recognising and denying their loss of control, were not omitted but reframed as tensions to be explored rather than inconsistencies to be resolved.

In these moments, I reminded myself that reflexive thematic analysis is not about forcing coherence but about embracing complexity. I also leaned on criticality, asking not just *what* is being said, but *why*, *how*, and *in what context*. Where contradictions appeared, I often interpreted them as reflective of the ambivalence and fragmentation that characterises addiction, rather than as analytic problems to be ironed out.

Appendix G
Translated Quotes

Participant	Maltese	English
Julian	“Kulhadd qabad jigbed”	“Everybody started doing lines”
Nicola	“Kont nibki għax irrid nieqaf... inpejjep u nibki, kif ħa neħles minnha din?”	“I cried because I wanted to stop... I’d smoke and cry, saying how will I ever break free from this?”.
Nicola	“Waqft nieħu għax ridt jien”	“I stopped using only because I wanted”
Alexander	“Jien bdejt nieħu d-droga ta’ xi 13, bil-ħaxixa... Kull ma kont naf jien li rrid nesperimenta b’xi ħaġa, li ma kontx naf x’inh”	“I started using drugs when I was 13. I started with weed... All I knew is that I wanted to experiment with something.”
Julian	“Dak iż-żmien kien żmien fejn kulhadd qabad jigbed, kulhadd imur gol-barrijiet, u kulhadd irid jigbed il-coke f’daqqa waħda”	“That was a time where everyone started doing cocaine, everyone going to bars, and everyone wanted to do coke all of a sudden,”
Daniel	“Kont immur ma’ nies li kienu jieħdu... kont inħossni parti minn xi ħaġa.”	“I used to go out with people that did cocaine...I used to feel like I was a part of something.”
Carla	“Kont nara lil missieri u dejjem ridt inkun bħalu... Minn hemm qbadt nieħu.”	“I used to see my dad [use drugs] and I always wanted to be like him.”

Paolo	“niftakar li minn l-ewwel darba li hadt, kienet mal-ewwel, kif ikolli l-come down, kont inkun lest naghmel kollox, mill-ewwel qisha haditni.”	“I remember that from the very first time I used, I was already willing to do anything just to use again the moment the comedown started. It felt like cocaine had taken hold of me instantly.”
Nicola	“Imbad meta ergajt hadt nifs tal-pipa, daqsekk, ergajt qbadt niehu kuljum.”	When I had a hit from the pipe, that was it, I started taking everyday.”
Nicola	“Meta bdejt nohrog mieghu imbad bdejt niehu iktar, ghax hu kien qed jiehu gravi.”	“When I started dating him I started using more, because he was a heavy user.”
Carla	“Qisu ghal bidu lanqas bdejt ninduna... kull darba li nixtri biex inbigh kont qed nuza, u dejjem inzid.”	“In the begininng I didn’t even realise... every time I bought to sell I ended up using, and I every time I take a bit more.”
Ian	“Ohrajn kienu aghar minni,”	“Others were worse than me”.
Ian	“Kont ghadni nahdem.”	“I was still working”
Andrew	“Jien nahseb kont in denial li ghandi problema”	“I think I was in denial that I had a problem”
Andrew	“Tibda anke ggib skuzi mbaghad biex taghmilha...”	“You start making excuses... I don’t we deserve it after a week of work?”

	issa ma ħaqniex wara ġingħa xogħol?”	
Andrew	“Kont nibda nagħmel skuzi, bħal jekk hemm xi event tal-familja, ha mmur inpejjep”	“I would start making excuses, like if there was a family event, I’d say I needed to go smoke’
Ian	“Jien kelli passat mhux sabiħ. Kelli balla rabja ġewwa fija. Jien ġarrabt ħafna swat u moħqrija mingħand qassisin, li suppost iwasslu l-kelma t’Alla.”	“I had a difficult past. I had a lot of anger inside me. I endured a lot of abuse from priests, people that should be spreading the word of God.”
Alexander	“kont nara l-ommi u lil hija jissawtu”	“I used to see my mum and brother get abused.”
Ian	“Ahna dik li ghandna, meta l-addict ikollu d-dwejjaq, inkunu rridu ntaffuh bid-droga.”	“This is what we’re like, when an addict feels upset, we would want to alleviate this by taking drugs.”
Andrew	“Jien kelli low self-esteem, allura biha [cocaine] tigi kunfidenti, anke biex tkellem tifla.”	“I had low self-esteem, so with it [cocaine] I felt confident, even to speak to a woman.”
Paolo	“Waħda mir-raġunijiet għalfejn qbadt nieħu d-droga kienet minħabba l-low self-esteem u biex nidher cool...Kont weak. Ma kellix assertività miegħi nnifsi”.	“One of the reasons why I started using drugs was because of my low self-esteem and to look cool...I was weak. I wasn’t assertive.”

Paolo	“Il-feeling kien jogobni ħafna”	“I really liked the feeling”
Alexander	“kont inhossni, inhossni, fil-verità mhux hekk, li jien l-aqwa wiehed, li qieghed ħdejn Alla”	“I used to feel like the best person alive, almost like I was right next to God.”
Alexander	“Il-feeling ma kontx tridu jispicca qatt... qisu l-feeling tal-orgazmu, kemm hu sabiħ, qisu hekk imma l-ħin kollu”	“You would want the feeling to never end...like an orgasm, so beautiful, but it lasts all the time”
Alexander	“Meta jgħaddu dawk l-10 minuti, se tinzel it-triplu ta’ dak li għollejt. Allura dejjem tigri wara dak il-feeling, biex titla’ hemm fuq”	“After those 10 minutes, the crash hits three times harder than the high. So you keep chasing that feeling, just trying to get back up there.”
Andrew	“qisek tinqata’ f’dinja... pero ftit minuti ddum. Fil-fatt inti li jiġrilek imbagħad tkun trid iktar, biex mingħalik tilhaq dak il-feeling li tkun ħadt fl-ewwel wiehed”	“You feel like you’re cut off in your own world... but it lasts just a few minutes. And what happens next is you want more, trying to recreate that first hit”.
Paolo	“Il-valuri kollha, li titwieled bihom, titlifhom”	“all the values you’re born with, you lose them”
Alexander	“Iggibek ma tisthix, iggibek bla valuri”	“It pulls you so low that you lose your sense of shame and strips you off your values”.

Carla	“ma jibqalek xejn fik sura ta’ nies”	“you lose all trace of being human.”
Paolo	“kont nara n-nies iharsu lejn il-mod ta’ kif nidher”	“People used to stare at the way I look”
Julian	“In-nies jibdew jistkerhuk, u għandhom raġun ukoll”	“People start to despise you, and they’re right to”
Alexander	“jien jekk kont tarani sa 9 xhur ilu kont tgħidli jaq jew miskin. jghaddu n-nies jarawk junkie fit-triq, minflok ara dak miskin, jitnejku bik. Jghidulek ghala ma tmurx taqbez.”	“if you saw me 9 months ago you would either call me disgusting or poor man. People see you as a junkie in the street, instead of helping you they take the piss at you. They will tell you why don’t you go jump?”
Paolo	“Il-fidil kont jien”	“I was the fool.”
Carla	“Il-coke tifqalek moħħok; paranoia, iġġibek miġnun. Depressjoni kważi dejjem biha. Kont nidhol Mount Carmel.”	“Coke messes with your head, it brings paranoia, it drives you mad. Depression almost always comes with it. I used to end up in Mount Carmel.”
Ian	“Qabel dħalt il-programm, jien pruvajt nitgħallaq.”	“Before I started the programme, I tried to hang myself.”
Nicola	“Mhux bic-cajt, suicide attempts kemm il-darba	“I’m not joking, I’ve tried to attempt suicide many times, I was tired of living.”

	pruvajt naghmel, gbajt nghix.”	
Julian	“Sahhtek taffettwahielek; qalbek, l-istonku tifqahulek ukoll... suppost ilahalhuha [l-ammonia], imma dak il-hin, inti u ssajjarha, tiehu tkun trid... Spiccajt niehu xi 11-il pinnola kuljum, tal-qalb u hekk.”	“Your health takes a serious hit, your heart, your stomach, everything starts failing. You’re supposed to wash the ammonia out when cooking it, but in the moment, you just take it anyway. I ended up on about 11 pills a day, just to keep my heart and other things going.”
Alexander	“Kien hemm mumentu fejn qalbi hassejtha ha tieqaf... Kemm-il darba dhalt l-isptar, kien ma nafx x’jigrili fid-demmi tieghi, sepsis.”	“There were moments I felt like my heart was going to stop... I ended up in hospital so many times, I had sepsis as well.”
Ian	“Hadtha din il-Hep C ghax tissharja l-labar, u gieli gbarthom minn mal-art tant kemm iggibek mignun.”	“I got Hep C because I shared needles, and sometimes I’d collect them from the floor, that’s how mad it makes you.”
Alexander	“Kont inħossni qed immut; inħossni ghajjen, kollni demm, infatet ma’ saqajja tant kemm nimxi ghax irrid	“I felt like I was dying; I was exhausted, bleeding all over, wounds on my feet from walking so much, trying to get cocaine.”

	nakkwista.”	
Ian	“tigi l-ewwel u qabel kollox”	“comes first and before everything”
Nicola	“Qabel sejra niltaqa’ mat-tifla l-Appoġġ, immur ninqeda, nieħu kemm niflaħ... inkun mat-tifla nibda ngħid igri nitlaq ’l hemm ħa mmur inpejjep... It-tifla kont niġi biex nerfagħha, għamlet ħafna ma tridx toqgħod fuqi. Imbagħad tibda twegġa’. Tgħid: din binti? U ġibtha hekk jien?”	“Before going to meet my daughter at Appoġġ, I’d go get my fix, I’d use as much as I could handle. Then, while I was with her, I’d start making excuses to leave, saying I had to go smoke. I’d go to lift her, and she wouldn’t even want to be near me. And that’s when it hits you, she starts crying, and you think: is this really my daughter? And did I really cause this?”
Julian	“Darba kelli t-tfal miegħi... u lhaqt lestejt il-flixxkun u kollox, u ridthom jitolqu t-tfal, qisni keċċejthom.”	“One time I had the kids with me... and I had just finished preparing the bottle and everything, and I ended up sending them away, it was like I kicked them out.”
Alexander	“Miskina l-mara... illum inħossni guilty ħafna... Vera nkun ħażin imma lilha ngenninha. Tgħidlek [referring to cocaine]: ‘u ħallik minnha.’ Imma mhux	“I pity my wife... today I feel so guilty. I really was in a bad place, but I drove her mad. It’s like the cocaine used to tell me to not care about her, but only care for

	għax ma kontx inħobbha, ta', ħafna wkoll.”	the drug. But it wasn't that I didn't love her, I did, a lot.”
Alexander	“jekk ghandi elfejn euro, kont nonfoqhom f'gurnata.”	“if I had 2000 euros, I would spend them in one day”
Carla	“Kelli karożzi kont inbigh kollox. Kull part li kienet tezisti li stajt inbigh, bihhejtha. Deheb, id-deheb t'ommi, imbad meta għibt it-tifla u jkolli l-flus tat-tifla, kont nuzhom għal hekk.”	“I had cars, I sold everything. Every single part I could sell, I did. Gold, even my mother's gold. Then when I had my daughter and I'd get money meant for her, I'd use it for coke.”
Carla	“Lil ommi għedt nippreferi ngħidilha ttini 20 euro biex immur ninqeda milli 20 euro biex nixtri l-pill.” “	I told my mother I'd rather ask her for 20 euros to go get my fix than 20 euros to buy milk.”
Ian	“Jekk ghandek 20 euro tkun bil-għatx u ma tixtrix x'tixrob halli tuzaha għaliha, toqghod bil-għatx.”	Even if you only have 20 euros and you're dying of thirst, you won't buy a drink, you'll hold off, just to spend it on that instead. You'd rather stay thirsty.”
Andrew	“wasalt f'punt fejn fqajt kollox għax uzajt is-savings kollha. Kont wasalt f'estremata li pakkett sigaretti kienet qed tixtrihuli	“I reached a point where I lost everything because I used up all my savings. I was in such a bad place that my mum was buying me my

	l-mummy, u gieli gbart ukoll sigaretti man barra.”	cigarette packets, and sometimes, I even picked up cigarettes from the street.”
Ian	“Il-heroin tieħu gramma u toqgħod relax, il-coke ma tgħejjikx, dejjem kont trid”	“With heroin, you take a gram and you relax, but coke doesn’t tire you, you just keep wanting”
Ian	“Ahjar ma nafx x’tieħu milli din il-kokaina. Tal-biża. Tant iġġibek tagħmel kollox għaliha li ġġennek”	“It’s better to take anything else than this cocaine. It’s terrifying. It makes you do anything for it, it drives you insane.”

Appendix H

Debrief Form

Dear Participant,

Thank you for your interest to participate in this study. Your time and effort are appreciated.

My name is Maria Aquilina and I am a student undertaking the Masters in Health Psychology at the University of Malta. The aim of this study is to understand the perspectives of individuals with a cocaine use disorder, while mapping their trajectory from use to abuse.

Your participation in this study is entirely voluntary and all information collected is strictly confidential. You have the right to withdraw from the research at any time and you also have the right to stop the session whenever you like, and not answer any questions, which do not feel comfortable answering. Your identity will not be included in the study. Moreover, the organisation's name will not be mentioned in the dissertation.

For the scope of this research, it is important that participants fulfil the following criteria:

- The individual must be over 18 years of age
- The individual must have a problematic use of cocaine
- The individual must not be considered by the gatekeeper to be in a vulnerable position

Poly-drug users may also be recruited if they meet the inclusion criteria, this being that cocaine would be their primary drug of choice.

Although this study should not cause any distress, if at any point during the study or after the interview you feel distressed, you may contact:

Caritas

2219 9000

Email: info@caritasmalta.org

Sedqa

2388 5110/ 9999 4357

sedqa@gov.mt

Oasi,

2156 3333

info@oasi.org.mt

or the following:

Free Services:

- **Richmond Foundation** : info@richmond.org.mt +356 21224580/ 21482336/
21480045

Supports both individuals who are experiencing mental health problems as well as those around them. Apart from supporting individuals by offering therapeutic help, Richmond Foundation also guides individuals by teaching the necessary skills to live and work independently. Their services include support groups, assisted living solutions, educational programmes, as well as counselling services.

- **Supportline 179 (24/7 access)**

This is Malta's national helpline acting to provide support, information about local social welfare and other agencies, as well as a referral service to individuals who require support. It is also a national service to individuals facing difficult times or a crisis. Their primary mission is to provide immediate and unbiased help to whoever requires it.

- **Kellimni.com (24/7 access)** : <http://kellimni.com/> +356 21244123/21335097

kellimni.com is an online support service in which trained staff and volunteers are available for support 24/7 via email, chat and smart messaging. This service is managed by SOS Malta.

- Crisis Resolution Malta : crisismalta@gmail.com/ +356 99339966. Offers immediate care. Crisis resolution 24/7. The team of volunteers who answer the phone are all professionals, and the consultation service is free.
- **Crisis Intervention Mater Dei** +356 25453950
Supports in various crisis situations related to mental health. Monday to Friday 7am-5.30pm.

Paid Professionals:

- **Counsellors:**
 - i. Malta Association for the Counselling Profession (MACP)
www.macpmalta.org
 - ii. Council for the Counselling Profession (CCP) ccp.msfc@gov.mt
- **Family Therapists:** www.ift-malta.com
- **Psychologists**
 - i. Malta Chamber of Psychologists mcp.org.mt
 - ii. Malta Psychology Profession Board mppb.msfc@gov.mt
- **Malta Association of Psychiatrists** : map.org.mt
- **Psychotherapists** : www.facebook.com/MaltaAssociationForPsychotherapy

Thank you for taking time to read this information sheet. Your participation is very important to conduct this study and highly appreciated.

If you require any information regarding the outcome of the research or if you have any further questions regarding the study, please contact the researcher via email on the following contact details:

Email: maria.aquilina.19@um.edu.mt

A handwritten signature in black ink, appearing to read 'Maria Aquilina', with a stylized flourish at the end.

Yours sincerely,

Maria Aquilina

Appendix I

Letter Granting Institutional Approval

To whom it may concern,

My name is Maria Aquilina and I am a student at the University of Malta, presently reading for a Master's degree in Health Psychology. I am presently conducting a research study for my dissertation titled 'Mapping the trajectory from use to abuse: perspectives of individuals with a cocaine use disorder'. The aim of my study is to understand study aims to understand the experiences and perceptions of individuals transitioning from recreational cocaine use to problematic use.

This work is being conducted under the supervision of Dr. Anna Grech.

I am hereby seeking your permission to recruit participants from your organisation, who have successfully completed a therapeutic program from one of your services, with the date of completion of the program being at least 12 months prior to the commencement of this study. Data collection methods will involve asking a set of questions about their experience. A copy of the interview schedule is being provided for your perusal.

Each interview will be audio recorded and is expected to last around one hour. Participants will be free to withdraw at any point, without any repercussions. Data collected will be transcribed and used solely for the purpose of this work. All names will be pseudonymised and all data will be destroyed within 1 year from the date it was collected i.e. 1st October 2026.

Should you require further information, please do not hesitate to contact me or my supervisor.

Our contact details are provided below.

Thank you for your kind consideration of this request.

Sincerely,

A handwritten signature in black ink, appearing to read 'Maria Aquilina'.

Maria Aquilina

maria.aquilina.19@um.edu.mt

A handwritten signature in black ink, appearing to read 'Anna Grech'.

Dr. Anna Grech

anna.m.grech@um.edu.mt