FOLLOWING ARIADNE'S THREAD:

A qualitative exploration of the relevance of spirituality in experiences of problem substance use and of spiritual engagement in processes of recovery, with particular reference to the experience of men living in Scotland.

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UNIVERSITY of STIRLING

Declaration

I declare that I have composed this thesis myself and that it embodies the results of my own research. Where appropriate, I have acknowledged the nature and extent of work carried out in collaboration with others included in the thesis.

Nicholas William Fuller

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Abbreviations used in this thesis

AA	Alcoholics Anonymous
ABI	Alcohol Brief Intervention
ADP	Alcohol and Drug Partnership
ACMD	Advisory Council on the Misuse of Drugs
AOD	Alcohol and Other Drugs
ACE	Adverse Childhood Experience
CBT	Cognitive Behaviour Therapy
DRD	Drug-Related Death
EBP	Evidence-Based Practice
IPA	Interpretive Phenomenological Analysis
LSD	Lysergic Acid Diethylamide
MMT	Methadone Maintenance Treatment
MET	Motivational Enhancement Therapy
MI	Motivational Interviewing
NA	Narcotics Anonymous
NES	NHS Education for Scotland
OST	Opiate Substitution Therapy
PSU	Problem Substance Use
PWID	People Who Inject Drugs
PWEPWS	People Who Experience Problems With Substances
QES	Qualitative Evidence Synthesis
QOL	Quality of Life
RAG	Research Advisory Group
RCN	Royal College of Nursing
PUD	People Using Drugs
SBNR	Spiritual But Not Religious
SIMOR	Social Identity Model Of Recovery
SDF	Scottish Drugs Forum
SSA	Society for the Study of Addiction
UK	United Kingdom
US	United States (of America)

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Abstract

Aims

This study explored the relevance of spirituality to experiences of drug and alcohol addiction and recovery from addiction with specific reference to the experience of men in long-term recovery living in Scotland.

Methods

The study consisted of two phases. Phase One involved thematic analysis of interviews with individuals representing diverse standpoints. Phase Two involved Interpretive Phenomenological Analysis of interviews with men in recovery who identified spirituality as important to their process.

Findings

Phase One data provided an overview of the issues underpinning spirituality and addiction recovery and generated five superordinate themes: The Spiritual Quest; Addiction Narratives: from initiation to rock bottom; I Have My Life Back: the road to recovery; Supporting Recovery and Delivering Treatment; and The Spiritual Journey of Recovery. Phase Two described personal accounts from addiction to recovery via various spiritual paths and generated three superordinate themes: Myths and Archetypes; Darkness and Light; and Lessons for Recovery. This phase was also associated with development of a novel shamanically-informed adjunct to the qualitative data analysis. Spirituality also facilitated self-awareness, reflexivity and gender identity among study participants. These findings informed the development of a novel labyrinth model which reflects the inner journey of recovery.

Conclusions

For the participants of this study, spirituality formed an important dimension of addiction recovery. Concepts of spirituality that emerged were typically eclectic and characterised by deepening spiritual awareness and connection with self, others, nature and (a) higher power. While Scotland faces an epidemic of drug-related deaths, especially among older men from the most deprived communities, study findings suggest that spirituality may provide a protective function by enhancing hope, meaning and purpose. Practice and policy implications include raising awareness of the relevance of spirituality, embedding spirituality within addiction recovery programmes, and reducing barriers to spiritually informed interventions for people in recovery.

Chapter One: Introduction

> *By following an invisible thread we connect to the Source, to the Sacred. We can't see it, and yet some deep part of us knows it is there. This innate awareness gives us solace and peace during stormy times. But it is difficult to find at first, even difficult to believe.*
> (Artress, 1996)

The relevance of spirituality

A young man, Keith, crouches in the gloom of his ground-floor inner-city flat, isolated from the world by a blanket which covers both him and the flickering television before him. Beyond the safety of this cocoon lies uncertainty and fear. Gripped with a paranoia induced by drug withdrawals, Keith is certain that the outside world is out to get him; even venturing to the toilet is a terrifying prospect. Death, whether deliberate, accidental, or a fuzzy combination of the two, is a constant presence in the darkness of this personal 'rock bottom'. And yet, unlike so many of his contemporaries, Keith did not die. Some spark of inspiration propelled him to forsake the self-destructive life of drug use that had carried him into this darkness and, instead, to seek a path out. What guided this change? What inspired the journey of recovery that led this man not only to survive, but to guide others towards a similar path?

This thesis seeks to explore linkages between spirituality, addiction and recovery, largely through the experiences of individuals with lived experience of addiction and recovery. Accordingly, individual narrative is central to shaping this thesis. Accounts such as Keith's provide vivid insight into the arc of self-discovery that, from this work, characterises addiction, transformation and recovery. In this Introduction, I establish the relevance of researching spirituality, addiction and recovery, review the theoretical landscape covered by this thesis, and explicate the language and process decisions underpinning the final thesis. I begin by discussing the relevance and legitimacy of spiritualty to addiction research. Next, I discuss the use of language to describe problem substance use (PSU) and addiction and gender within this thesis, articulating the need to balance non-judgmental language with broader concepts of addiction and to situate men's experiences of addiction within contemporary concepts of masculinity. This then informs discussion of the relevance of gender in processes of addiction and

recovery, focusing on the experience of men in recovery. Following this, I review the oversight processes designed to ensure quality, consistency and relevance throughout this study, summarising my professional and theoretical background and spiritual orientation as context to the study. Finally, I conclude with an overview of the entire thesis.

Whilst completing the final draft of this thesis, I had occasion to describe my research to a senior academic colleague; a social scientist with research interests in problem substance use. I described the relevance, as I saw it, of spirituality to processes of recovery. 'I'm an old-fashioned atheist', my colleague wryly observed, encapsulating the challenge of researching spirituality as a dimension of PSU recovery. Spirituality is complex. It raises challenges of definition and legitimacy by scholars, and of relevance by those who work with people who experience drug problems, whether or not they are in recovery. Against the life and death challenge of drug and alcohol problems which Scotland currently faces, spirituality can seem irrelevant to the serious business of preventing drug-related deaths, reducing drug-related offending, minimising drug-related harm, and addressing myriad other health and social consequences of problem substance use. Furthermore, even if we can accept that spirituality is relevant to addiction recovery, its subjectivity makes it challenging to research. And yet, spirituality is part of the recovery landscape. It is an established central feature of 12-Step mutual aid approaches (Dossett, 2013, 2015, 2017, 2018), and religious and spiritual organisations have long argued for the relevance of spiritual exploration as part the recovery process. Moreover, countless individuals globally attest to the transformative potential of spiritual engagement in achieving recovery. In short, spiritualty is an inescapable, if hitherto less frequently researched, dimension of the addiction and recovery landscape deserving of scholarly attention. Indeed, research interest is increasing. The Higher Power Project (HPP), for example, is a large-scale qualitative research project which seeks to understand spirituality through exploration of the language of spirituality and Higher Power in 12-Step contexts (Dossett, 2013, 2015, 2018). This current study aims to add to the understanding of studies such as the HPP by exploring the meaning and relevance of spiritualty to processes of substance use and addiction recovery.

The language of addiction

In this section, I discuss the use of language to describe PSU within this thesis. PSU and addiction are well-researched topics within the social science and health fields that have informed a broad lexicon of overlapping terms, which includes 'addiction',

'dependence', 'substance use', 'substance misuse', 'substance abuse' and 'problem substance use'. Such terms describe different levels of risk, harm and behaviours, while also reflecting cultural and academic differences between authors. For example, Hughes *et al.,* (1999) distinguish between the term 'drug abuse' to refer to the use of drugs for non-medical purposes, and 'drug misuse' to describe the inappropriate use of medical drugs. Others employ the same terms to denote harmful or illicit use, with 'substance abuse' favoured by some authors, especially in the US. The terms 'substance misuse' and 'substance abuse' may imply a pejorative stance towards the consumption of drugs or alcohol, or those engaged in such behaviour which, regardless of authorial intent, is incompatible with the aim of objective inquiry (Botticelli and Koh, 2016). The challenge of writing about the behaviours associated with substance use intensifies when describing those who engage in those behaviours. PSU engenders strong feelings and attracts misunderstanding through descriptions which are often interpreted as pejorative and stigmatising. Terms such as 'addict', 'alcoholic' and 'junkie' are typical of the language used to describe individuals experiencing PSU in general contexts and (in the case of the first two) in academic contexts, at least in the past (Spiehs and Conner, 2018). While there may be academic consensus that such descriptors are stigmatising, and that alternatives such as 'people who use drugs or alcohol' or 'people who experience problems with drugs' are preferred, difficulties remain. The need to use language that does not further marginalise an already isolated population grouping is clear, as advocated by the Global Commission on Drug Policy (2017) and in recent commentaries by organisations such as the Scottish Drugs Forum. How, then, should we write about the problematic use of substances, and those individuals who experience such problems, in a way that is inclusive, unambiguous and non-stigmatising?

One approach is to retreat to narrowly defined physiological definitions of dependence, which is characterised by physiological 'tolerance' to a drug, such as alcohol, opiates or benzodiazepines, and withdrawal symptoms in its absence, and which implies relatively high levels of habitual use (Mulé and Brill, 2019). Dependence forms an important dimension of addiction for many individuals and can itself lead to further substance use through efforts to avoid unpleasant or harmful withdrawal symptoms (Twining *et al.*, 2015; Koob, 2019). The pharmacodynamic profile of substances often increases the potential for addiction, making understanding such effects important to drug and alcohol treatment programmes (Butelman *et al.*, 2015; Herron and Brennan, 2020). However, identifying dependence is not straightforward, and the difficulties of distinguishing between dependent and non-dependent harmful substance are reflected

in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), which collapses these designations into a single severity index under the *Substance-Related and Addictive Disorders* heading (American Psychiatric Association, 2013). Furthermore, using dependence as an identifier creates its own problems, arising from the challenge of diagnosis and the investment of power into medical gatekeepers that this implies.

'Addict' may be an unacceptable term, but what about 'addiction'? Is this a useful description of a problematic pattern of behaviour characterised by uncontrolled, urge-driven compulsion to engage in substance use or other habit-forming behaviour? Or has addiction, too, become sullied as an overgeneralising, stigmatising pejorative? What is meant by addiction anyway? 'Addiction' is potentially problematic, both because of its unspecific focus and its potential for use pejoratively. Nevertheless, the term 'addiction' is widely used within the academic and popular literature, as reflected, for example, in the name of the Society for the Study of Addiction (SSA) and its associated journals. Furthermore, 'addiction' increasingly encompasses forms of compulsive behaviour characterised by craving, impaired control over behaviour, and high rates of relapse not associated with drug or alcohol use (Bower, Hale and Wood, 2013), including gambling, food, work, sex, exercise and shopping (Wurm, 2003; Ahmed, 2005; Kearns, Gomez-Serrano and Tunstall, 2011; Olsen, 2011; Thomas *et al.*, 2011; Preedy, 2016). From this standpoint, if concepts such as 'gambling addiction' have utility, it is hard to argue that 'drug addiction' does not. This widening of what counts as addiction has informed an expansion of the 'substance abuse and addictive disorders' section of the DSM-5 (fifth edition) to include Gambling Disorder (American Psychiatric Association, 2013; Robbins and Clark, 2014), although the authors of DSM-5 note that there is currently insufficient evidence to support a wider category of behaviour addictions, beyond gambling. Furthermore, the concept of behaviour addiction has been criticised as widening the scope of addiction beyond reasonable levels (Frances and Nardo, 2013) and trivialising the seriousness of drug addiction (Preedy, 2016). Nevertheless, concepts of behavioural addiction serve a valuable role in this thesis by bringing focus to psychological experience, as distinct from the biochemical effects of drugs and alcohol, which are especially relevant to this thesis. Furthermore, the behavioural addiction concept is developed through the Buddhist idea that addiction is a universal human experience (and which is discussed later in the thesis).

In light of the foregoing discussion, in this thesis I will use the terms 'problem substance use' (PSU) and 'people who experience problems with substances'

(PWEPWS) to describe problematic drug and/or alcohol use and those undertaking such activity. However, it proved impossible to dispense with ‘addiction’ entirely, indeed, writing this thesis emphasised the salience of the term to exactly describe the combination of harmful compulsive behaviour that is the focus of this study. For this reason, I use the term addiction where this better describes the phenomena described. Finally, regarding the language of substance use, data in this study came from interviews with individuals reporting personal experiences of substance use and recovery. These individuals often referred to themselves and their own experiences using terms that might seem self-judgemental, for example, such as self-identifying as an ‘addict’. This accords with the practices of 12-Step mutual aid organisations, such as Alcoholics Anonymous (AA) or Narcotics Anonymous (NA), within which such self-identification is a crucial step in the recovery process (Dossett, 2015). Indeed, Cook and Dossett (2019) address the question of how best to refer to research participants who self-identify in potentially prejudicial or stigmatising terms in light of the current move toward ‘person first’ language, arguing for the ability of individuals to self-identify. In this respect, such language sits alongside similar areas of social and political discourse, such as sexual orientation (Coles, 2016; Fasoli, 2017), disability (Slater, 2018), race (Pryor, 2016), and mental health (Rowland, 2015), whereby marginalised groups consciously reclaim previously pejorative terms. I include participant quotations that reflect such self-descriptive language in that same spirit. The terms used to describe PWEPWS play a significant role in shaping public discourse with real consequences for those involved. For example, Liddell (2019) argues that the stigma associated with those in drug treatment contributes to the risks they face, in part by informing sub-optimal opiate substitution therapy (OST) leading to risky ‘topping up’ with illicit drugs.

Several of the people interviewed for this study used elements of Scottish dialect in their responses such as *“ken”* (know), *and “wee”* (small), as well as specific phraseology relating to substance use, such as *“rattle”* (opiate withdrawal). I chose to render these realistically within the excerpts included in this thesis to convey a sense of the authentic voices of these participants and to maintain close links with the data. A glossary of Scottish dialect terms and substance use phraseology is included at Appendix A for the benefit of readers unfamiliar with such language.

Men’s experiences, and the language of gender

For the men interviewed during this study, the addiction recovery process was typically associated with an evolving male identity whereby ‘traditional’ conceptions of

masculinity were modified by feminine qualities. The centrality of men's experiences to this thesis requires that concepts of masculinity and maleness are situated within contemporary gender theory, characterised by multiple genders, gender fluidity and that the idea that gender is contextual (Francis and Paechter, 2015). In this thesis, in common with many authors on sex and gender since Unger (1979), I use the term 'sex' to mean the biologically determined dimensions of male and female, and 'gender', which incorporates gender role and gender identity, to refer to the socially and psychologically determined constructs, denoted by masculinity and femininity (Lips, 2017). Given this background of gender concepts, I will now outline the context for focusing on men's experiences of addiction, recovery and spiritualty within this study.

Significant differences exist between women's and men's experiences of substance use, whereby men experience more PSU overall than women (Arpa, 2017) while, in general, women start using drugs later in life (although differences to this general pattern exist for specific substances) (National Treatment Agency for Substance Misuse (NTA), 2010) and experience a more rapid escalation to problematic use (Becker and Hu, 2008). Furthermore, PSU is more prevalent among men than women (Schulte, Ramo and Brown, 2009). For example, it is estimated that 71 percent of individuals with problem drug use in Scotland are men (Information Services Division (ISD) Scotland, 2019). Furthermore, in Scotland, over recent years the drug-related death (DRD) rate for women (although lower overall than for men) has increased faster than for men, which Tweed, Miller and Matheson (2018) attribute to multiple factors, including greater prevalence of health problems, history of child and adult violence, trauma and adversity, and barriers to accessing treatment. Biological, social, cultural, and environmental factors all impact a woman's substance use and recovery difficulties (Ait-Daoud *et al.*, 2019). It is reasonable to conclude, therefore, that men's and women's experiences of PSU vary considerably.

Gender differences in the development of PSU carry through into treatment. Women typically access treatment services earlier and, once in treatment, find themselves in the minority (NTA, 2010). Overall, the higher numbers of men accessing treatment programmes reflects the higher prevalence of PSU among men, however, women face significant institutional, cultural and practical barriers to accessing such services (Tuchman, 2010; Manuel and Lee, 2017), informing calls for additional targeted interventions to improve outcomes (Fernández-Montalvo *et al.*, 2017). Furthermore, women are more likely to experience relapse following treatment compared with men (Ait-Daoud *et al.*, 2019). These differences in engagement and treatment outcomes

inform gender-specific drug and alcohol treatment programmes, which are generally associated with improved retention and treatment outcomes for women, compared with mixed-gender programmes (Prendergast *et al.*, 2011; Hubberstey *et al.*, 2019)

Studies have indicated that men and women also differ in how they understand and express spirituality. Women report higher levels of engagement with formal religion compared to men (Schnabel, 2015), although this effect is observed most strongly in Christian groups. Gender differences in religious involvement are also highly specific to different cultural, religious and ethnic contexts (Ait-Daoud *et al.*, 2019). In spite of such cultural differences, men exhibit higher levels of religious mobility (changing religious preferences) than women (Hayes, 2016). Furthermore, the impact of religious involvement differs by gender, with men experiencing greater health and social benefits associated with religious involvement than women (Maselko and Kubzansky, 2006). Regarding spiritual responses to addiction, studies have shown that women, especially young women, form a minority of those attending 12-Step programmes, and, consequently, experience greater barriers to engagement than men (Sanders, 2019).

Despite more addiction research happening among populations of men (but not specifically about men) due to the greater number of men using drugs and alcohol, more is known about the specific experiences of women. Such research has identified differences between men and women in the causation, form and severity of PSU, and demonstrated that women experience more significant associated maladjustment (Fernández-Montalvo *et al.*, 2017). Given the nuanced evidence available describing the female experience of addiction and recovery, it is probable that equally relevant findings are relevant to male experiences. For example, Storbjörk (2011) asserts that directing research activity to understanding the experience of women may obscure problems among men, such as a higher propensity towards risk-taking and greater criminal justice involvement compared to women. The background outlined above informed the decision to research men's experiences of addiction, recovery and spirituality specifically within this study. Choosing to investigate the specificity of men's experience does not mean that women's perspectives are unimportant; indeed, the findings from this study identified areas for further research, including investigating women's experiences.

Oversight

In planning this research, it was important to consider how to ensure the quality, consistency and relevance of the research and subsequent findings. With this aim in

mind, I convened a Research Advisory Group (RAG) to supplement academic supervision and provide oversight to the project, in addition to the standard academic supervisory support and ethical processes. RAG members were selected to represent the academic, spirituality, treatment service and service user perspectives on addiction, recovery and spirituality, and comprised two academic supervisors; an individual in long-term recovery employed as a recovery support worker, a Christian minister employed as head of spiritual care within a National Health Service (NHS) trust, a consultant psychiatrist specialised in substance use, and a shamanic practitioner and teacher with personal experience of problem alcohol use.

The RAG proved most valuable early in the project by refining the research questions, identifying participant selection criteria and advising on participant recruitment. The group convened several times during the first two years of the project with an initial intention to meet regularly throughout the study. During the length of the study, however, two RAG members retired, and one moved overseas, making the RAG unsustainable. This is not surprising, given this was a seven-year part-time PhD process. These changes occurred around the time that I completed the main data analysis and was beginning to formulate tentative findings. Fortunately, I was able to meet individually with most members of the RAG to review my emerging findings. This was a valuable opportunity to test the relevance and potential application of my findings and to identify theoretical and practical linkages. Overall, the RAG made a valuable contribution to the quality and integrity of the study and helped to ensure that the research aligned to the service user perspective.

Personal background and profession and spiritual orientation

This study arose from the fusion of my professional background and my personal spiritual orientation. I qualified first as a nurse and later as a counsellor, eventually specialising in addiction and PSU work. I now work as a Lecturer in Nursing at a Scottish university. I have a personal interest in contemporary spirituality, especially shamanism and earth spirituality, and have completed training as a shamanic practitioner. Through my clinical work in NHS substance use treatment services, I became conscious of what I saw as the notable absence of a spiritual dimension within the ‘mainstream’ treatment and recovery services. I also became aware of an apparent disconnection between the explicitly spiritual stance of, for example, the 12-Step fellowship, and the secular underpinnings of publicly funded services, given the significant numbers of service users who also engage with the 12-step fellowship. At

the same time, I was aware that the spiritual underpinnings of the 12-Step fellowship deter many potential members. These perspectives led me to become interested in the potential relevance of spirituality to experiences of substance use addiction and processes of recovery from addiction.

Researcher positionality is relevant to all qualitative research (Hopkins, Regehr and Pratt, 2017) but is especially important to this study in view of the centrality of spirituality as a topic for investigation. Spirituality is a highly personal concept, characterised by multiple individual perspectives. It is therefore important that the reader is able to understand my personal positionality in relation to the topic, to understand how my world view informs my understanding of spiritualty as a dimension of addiction and recovery.

My own position on spirituality is characterised by an eclectic, non-religious perspective. I maintain a personal spiritual practice that centres on shamanism and includes meditation and yoga. The concept of 'transcendence' is central to my understanding of spirituality, although I recognise that this position is not universal and it is clear that significant debate surrounds the defining of spiritualty. Indeed, I consider this in depth in Chapter Two. I also draw a clear distinction between spirituality and religion. I understand spiritualty broadly as personal practice aimed at deepening connection with the numinous and enhancing meaning and purpose, while religion refers to an organised and structured framework characterised by common beliefs, codes and doctrines. Again, as with all these positional points, other people have equally justifiable positions.

This background and worldview informs my view that spirituality is a significant element in the process of recovery from addiction for many people. In adopting this position I am reflecting a position which is shared by many, including the large number of individuals for whom the 12-Step fellowships form a central element of the recovery journey. However, I am not asserting that spiritual engagement is a necessary condition for recovery, indeed many individuals achieve recovery without using spiritual processes. Setting out my own position here is intended to enable the reader to understand how this study is positioned and to understand the limitations that may arise from this positionality.

Introducing the labyrinth

The findings of this study informed the development of a novel labyrinth model, which reflects the process of addiction recovery as a spiritual journey, developed within this thesis. The labyrinth informed the title for this thesis and proved to be a compelling reflection of the research process. As the labyrinth began to encapsulate a theoretical response to the findings of this study, I became attentive to the parallels with the research process, inspiring me to structure this thesis as a labyrinth journey. My intention is to lead the reader through the themes that are revealed by the data in a way that is coherent with the findings. However, although I begin here by referring forward to the findings, it is important to emphasise that the labyrinth, with its layers of symbolism and meaning, emerged as the culmination of an iterative process of analysis, reflection, theory development and writing towards the end of the thesis.

Although the labyrinth theme emerged directly from the data, I was not entirely naïve to the form prior to commencing this study, as I now describe. In the years prior to commencing my PhD I became interested in the labyrinth and its potential as a tool for meditation, self-awareness and spiritual guidance, largely as a development of my shamanic practice. This interest led me to build several labyrinths, to incorporate labyrinth walking into my personal spiritual practice, and to facilitate labyrinth walking workshops on several occasions. Given this background, I was interested to discover that the University of Stirling campus includes a permanent outdoor labyrinth. I was inspired to incorporate a simple labyrinth ceremony into the first meeting of the RAG, during which each participant journeyed to the centre of the labyrinth, placing a stone into a bowl. Since then, the bowl of stones has sat on my desk symbolising the guidance of the labyrinth as I have followed the 'labyrinth' of this research. Considering this background, it may not seem coincidental that my findings led towards a labyrinth model. Was this conclusion informed by my prior knowledge of, and experience with, labyrinths? Certainly. Given the same data, would another researcher who did not have prior experience with labyrinths reach the same conclusions? Probably not. And yet, I am certain that the labyrinth model emerged from the data. In fact, I had, somewhat surprisingly, overlooked the labyrinth ceremony that marked the first RAG meeting, only recalling it when discussing my emerging theory with my supervisors in Spring, 2019.

The chapters that follow provide an account of the emergence of personal myth-making, and the labyrinth as part of a coherent response to the challenge of understanding addiction, recovery and spiritualty. The reader is invited to engage with

this exploration as a path of discovery. Structuring the thesis as a labyrinth requires a short digression to situate the work within the language, form and meaning of the form, which are developed later, especially in the Discussion chapter.

Labyrinthine designs feature in Palaeolith cave art dating back 32,000 years (Lorimer, 2009) emerging in the recognisable labyrinth form on petroglyphs, pottery and coins around the world dating back to at least the seventh century BCE (Harris, 2014). Labyrinth designs featured in Roman mosaics (Molholt, 2011) and were developed within Medieval Christianity as a focus for spiritual contemplation, representing the path of life and pilgrimage (Hopthrow, 2010). There is currently a revival of interest in labyrinths as a tool for mindfulness, meditation and contemplation (Cook and Croft, 2015; Zucker *et al.*, 2016) and as part of the wider landscape of contemporary spirituality (McGettigan, 2016).

The terms ‘labyrinth’ and ‘maze’ are often used interchangeably to describe either a single-path (‘unicursal’) design or a multi-path puzzle, both of which lead to a central goal (Ullyatt, 2010). The ambiguity implicit in this usage informs a modern differentiation between ‘maze’ to describe a puzzle-like design comprising a choice of routes, and ‘labyrinth’ to describe a unicursal path intended as focus for contemplation and meditation (e.g., Artress, 1996; Stone, 1998; Peel, 2004; Sandor, 2005). However, Ullyatt (2010) contends that this distinction fails to account for the overlapping usage of maze and labyrinth, and instead argues that meaning is contextual. Ullyatt suggests that labyrinths serve two broad functions: as designs and as structures. By labyrinth as design, Ullyatt means forms that can be delineated by surface mark-making, for example, through drawing on paper, arranging stones on the ground or tracing in sand. This meaning equates to the concept of ‘labyrinth as unicursal path’ described above. The two best known forms of labyrinth as design are the 7-circuit ‘classical’ labyrinth (Figure 1.1) and the 11-circuit Medieval design, exemplified by the Chartres Cathedral example (Figure 1.2) (Higgins, 2018; Doob, 2019).

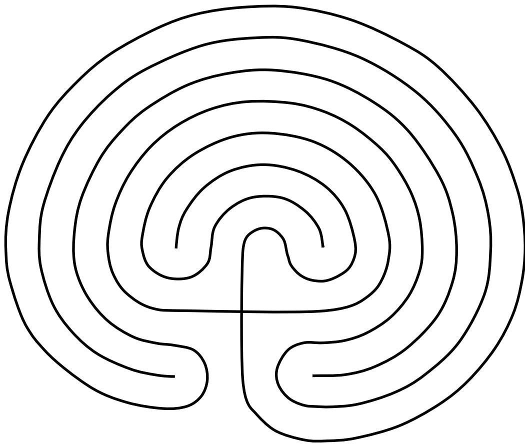

Figure 1.2 7-circuit classical labyrinth design

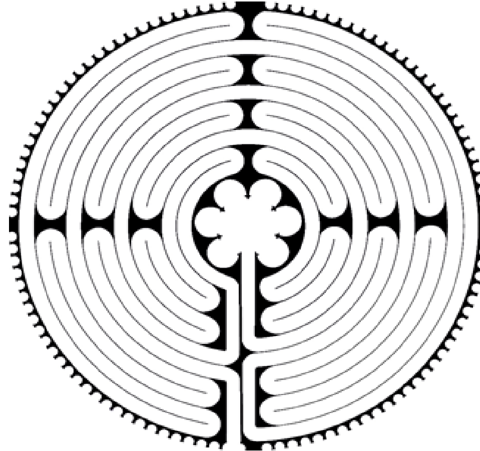

Figure 1.2 11-circuit 'Chartres' labyrinth design

By contrast, labyrinth as structure refers to complex buildings, characteristically underground, comprising a confusing network of passages intended to disorient. It is this structural form of labyrinth that is depicted in the Theseus myth and which, in Ullyatt's view, is represented by hedge mazes and similar structures, and which equates to the 'maze as puzzle' concept described above. An example of a labyrinth as maze-like structure designed by the author is given at Figure 1.3.

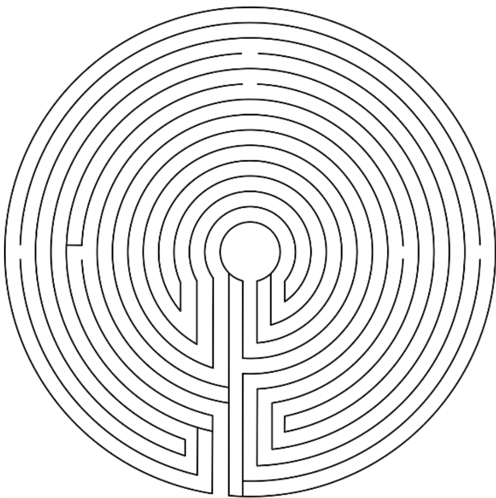

Figure 1.3 Example of labyrinth as structure

Research questions

In light of the early state of the evidence in this field, as well as national guidance on developing and evaluating complex interventions (Craig *et al.*, 2008), the current study is positioned as a small-scale, early stage qualitative investigation, focussing on establishing a framework within which to better understand the relationship between spirituality and addictions recovery. The aim of this study is to explore the relevance and significance of spirituality, both as a dimension of the addiction experience and as an element of the recovery process, in order to inform practice within recovery-orientated treatment programmes in Scotland. One objective of this study is to contribute to the possible development of a spirituality-informed intervention for use in addiction recovery settings; a stage which involves: 1) identifying existing evidence; and 2) identifying and developing theory related to processes of change by drawing on existing evidence and theory and new primary research (Craig *et al.*, 2008). In order to address these aims, the following initial primary and secondary research questions were developed.

Primary research question:

- What relevance does spirituality have in processes of drug and alcohol addiction and recovery from such addictions?

Secondary research questions:

- In what ways might lived experiences of problematic drug and alcohol use and addiction be understood with reference to spiritual health and wellbeing?
- What relevance do concepts of spirituality have for those using and providing drug and alcohol addictions services in Scotland?
- How are men's lived experiences of addiction and recovery informed by concepts and experiences of spirituality?
- What social, cultural and organisational considerations are relevant to the development of service approaches and interventions that take account of the spiritual dimensions of a person's life and recovery journey?

Research questions and methodology develop symbiotically, each informing the other iteratively (Burck, 2005), therefore cognisance of these questions has a determining influence in selecting the methodological approach. These research questions raise methodological challenges at two levels of abstraction; paradigmatic tensions arising from spirituality as a research topic, and epistemological tensions connected with the

complexity implicit in researching the intersection of spirituality and addiction. These tensions and the responses to them are addressed in Chapters Four and Five, which detail the methodological positioning of this study and the research methods used. A brief summary of the entire thesis is now given.

Thesis summary

The unicursal labyrinth engenders a three-part process comprising *release,* the walk inward and 'letting go' of the everyday; *receive* within the still space at the centre of the labyrinth; and *return*, whereby the experience is integrated and applied to life (Sandor, 2005). This three-part process describes the movement, from disengagement and despair through inner examination and transcendence to re-engagement and recovery, which characterises the addiction-transcendence-recovery arc and forms the focus for this study. Furthermore, however, the labyrinth encircles the journey of research and scholarship that has informed this thesis as a three-phase journey of discovery, which is reflected in the organisational framework of the thesis.

In Part I, *Entering the Labyrinth*, the literature on spirituality and addiction is reviewed, research questions identified, and methodology and methods described. The thesis begins with two literature review chapters covering spirituality and PSU. In Chapter Two, I identify the key literatures covering spirituality and define the topic in the context of this thesis. I also discuss the complexities of investigating spirituality and health, the relevance of instruments to such research, and the challenges posed by the secularity of public healthcare provision. In Chapter Three, I review the literature on PSU and addiction, beginning by considering bio/psycho/social accounts of PSU and recovery. I then explore substance use and addiction as spiritual phenomena which inform experiences of altered states of consciousness and process of recovery. The two literature chapters inform research questions which focus on the relevance and significance of spiritualty to experiences of PSU and recovery, especially as relating to the experience of men living in Scotland. Chapters Four and Five establish the methodological positioning and describe the research methods used within this study. I first identify the methodological tensions associated with researching spirituality in the context of PSU; tensions that I respond to through a two-phase qualitative research design. This comprises an initial phase aimed at generating an overview of the research topics using a framework approach followed by a second phase using Interpretive Phenomenological Analysis (IPA). I then discuss the research implications of this methodological choice, including my decision to select an all-male sample for

the second phase. I also outline a novel adjunct to standard qualitative analysis, using shamanic journeying, aimed at enhancing the analytic depth and aligning data analysis with the spiritual dimensions of the topic. In Chapter Five, I describe the participant selection and recruitment, data collection and analytic process applied to each of the two study phases, along with a matrix analysis process that I developed to synthesise the findings from the two phases. I also review the ethical dimensions and considerations concerning this study and describe the ethical approvals obtained.

In Part II, *The Centre of the Labyrinth*, the findings of each of two phases of research are described. Phase One, described in Chapter Six, focused on developing a broad understanding of the connections between spirituality and processes of PSU and recovery through interviews with individuals with personal experience of drug or alcohol addiction, professionals working in the field of addiction treatment and recovery, and spiritual practitioners and teachers. This led me to develop five superordinate themes: *The Spiritual Quest; Addiction Narratives; I Have My Life Back; Supporting Recovery and Delivering Treatment;* and *The Spiritual Journey of Recovery.* Phase Two, described in Chapter Seven, involved one-to-one interviews with six men living in Scotland, in long-term recovery from drug or alcohol addiction, who identified spiritual practice as important to their recovery process. These data were analysed using IPA, which led to the development of three superordinate themes: *Myths and Archetypes*; *Darkness and Light*; and *Lessons for Recovery*. The men interviewed during this phase were remarkable in that they described personal processes of recovery which went well beyond simply achieving and maintaining abstinence to embrace a spiritually guided fulfilling way of living. This contrasts with experience of many of their contemporaries, evidenced through the rising DRD rate in Scotland, particularly among older cohorts of male drug users.

Part III, *Emerging from the Labyrinth*, includes the discussion and conclusions, which speak to the wider relevance and future applications of this research. In Chapter Eight, I link the findings of both phases to the relevant literature through a novel theoretical model based upon the labyrinth, informed by study data. The emerging labyrinth model provides a framework for understanding processes of addiction, recovery and spirituality, and for situating challenges such as those posed by the current epidemic of DRDs in Scotland. Finally, in Chapter Nine, I review the process and findings of this study and identify potential applications of the emergent labyrinth model as a novel response to problem drug and alcohol use with potential relevance to theory and to practice, worthy of further research. I conclude by discussing the strengths and

limitations of the study and making recommendations for policy, practice, further research and research methodology in response to the original research questions.

Part I: *Entering the Labyrinth*

“The path though known
Flows darkly, circling slowly
As a velvet river at midnight.
Familiar turns thrill the burning heart
With carefulness and searing joy.
The relentless walking begins.
What miracle this time
Escapes the darkness
To enlighten the Soul?
The misty shapes form just
Beyond the edge of vision
As the known flies by
Leaving only the silent self.
My soul at last is home.”

– Carole Ann Camp (Schaper and Camp, 2013, p61)

Chapter Two: Spirituality

Introduction

The labyrinth journey represented by this thesis begins by situating this work within existing scholarship about spirituality and establishing a working definition for this study. The aims of this chapter are to describe and define the main concepts underpinning scholarship on spirituality and to position this study within the wider literature on the topic. The chapter also addresses the challenges, issues and questions concerning spirituality among men. The chapter begins with an account of the approach taken in searching the literature, followed by an overview of the background to human spirituality. The literature on spirituality as a dimension of healthcare is then reviewed thematically to provide narrative to a complex body of literature. This starts with the need to define spirituality and the challenges that this entails. Several theoretical standpoints and models inform a working definition of spirituality for use within this study. Next, the relationship between spirituality and religion is examined, following which the implications and challenges of undertaking research on spirituality and health are outlined. This review reveals a lack of rigour among much of the current research in this field, informing discussion on the implications for measuring spirituality. The main instruments available for this purpose and significant empirical studies in this field are appraised. Following this, the position, relevance and legitimacy of spirituality within secular, publicly funded healthcare systems is examined. Finally, the main conclusions of this review are summarised and implications for this study are discussed.

Mapping and searching the key literatures on spirituality

This section describes the approach taken for selecting, searching and reviewing the literature on spirituality. The search strategy used is described, the key relevant literatures are outlined, and an account of how spirituality is conceptualised within relevant disciplines is developed. Spirituality is a broad subject, encompassing several areas of scholarship each with a distinct body of literature. The scope of this project necessitated giving detailed attention to some elements and less focus to others in order to locate this study within a complex field of enquiry. The anthropological, historical and sociological aspects are briefly reviewed, while the spirituality and spiritual care literature relating to nursing and healthcare is covered in detail. The

literature on the spirituality of PSU and recovery is reviewed in the following chapter. Additionally, an inclusive approach has been taken towards non-academic 'grey' literature which often reflects important perspectives on spirituality. Consequently, this review encompasses governmental and health service reports and guidelines, literature targeting a non-academic audience and other elements of the grey literature where relevant.

The following strategy was used to search the literature described in this chapter and the following one: during 2012 and 2013, the electronic databases ATLA Religion Database, British Humanities Index, CogNet Library, Cogprints, Health Source: Nursing/Academic Edition, MEDLINE, PsycARTICLES; and PsycINFO were searched using the terms *spirituality*, *addiction, PSU* and *recovery* and their derivatives and synonyms. The titles of resulting papers were reviewed to produce a short-list of potentially relevant papers. The abstracts of these papers were then reviewed to identify the most relevant, which were included for review. The reference lists of these papers were searched for further relevant papers which were also reviewed. Where available, 'cited by' and 'find related papers' functions within search databases were used to identify other relevant publications. In addition to these formal procedures, further relevant papers were identified through hand searching reference lists of identified papers, information sharing with colleagues, supervisors and others, and more general reading on the topic. The results of this search strategy were updated periodically through the course of the research and the specific search procedure was repeated as part of preparing the final thesis in 2018 and 2019. As the research process progressed, new themes and ideas arose, which informed further search terms. This search strategy identified a diverse range of literatures relevant to spirituality and PSU, which include anthropology, sociology, psychology, spiritual care and healthcare. The chapter begins by establishing the background to spirituality before focussing on the health care dimensions of spirituality.

Background to human spirituality

The spiritual quest has captivated humans for millennia (Torrance, 1994; O'Murchu, 1997). It is impossible to know when spirituality and religion emerged in our evolutionary past, however, archaeological evidence suggests that rituals were practised by pre-human hominids prior to the upper Palaeolithic period at least 100,000, and perhaps as long ago as 200,000, years ago (Clottes and Lewis-Williams, 2007). This evidence includes the use of red-ochre dyes, deep cave exploration and ancestor worship through cannibalism. Such ritual practice was probably restricted to

ecstatic rituals aimed at reinforcing group or tribe identity and connection with the natural elements to facilitate social bonding (Rossano, 2006). Anatomically modern humans emerged during the upper Palaeolithic period around 40,000 to 30,000 years ago (Rossano, 2006; Clottes and Lewis-Williams, 2007). During this period, it is postulated, brain function evolution led to intensified altered states and reinforced dissociative abilities, which included apparitions, waking and sleeping ESP and out-of-body sensations, creating the evolutionary conditions for experiences of the supernatural (Bulbulia, 2004). These cognitive developments were associated with increasing sophistication in ritual practice, facilitating the emergence of shamanism as humankind's first religion (McClenon, 2004; Rossano, 2006).

Anthropological literature supports the view that pre-modern human society was characterised by shamanism and earth religions in which sophisticated spiritual practices and beliefs were intrinsic to social structure and organisation (McClenon, 2004; Winkelman, 2004; Rossano, 2006). For example, among the African !Kung people, it is estimated that half the men and a third of the women were shamans (Lewis-Williams, 1982). The cognitive and evolutionary psychology of religious belief and practice was reviewed by Bulbulia (2004), who outlined two competing theories: religion as a 'spandral' of the evolved mind (a kind of by-product of the evolutionary process), or religion as an evolutionary adaptation of early cognitive development. Bulbulia concludes that conceptions of God and the supernatural evolved as adaptations that positively mediated social relationships and group cohesion. Such spiritual and religious instincts remain strong in the modern world, despite the ascent of rationalist thought. One expression of the spiritual quest in human culture, relevant to the findings of this thesis, is the emergence of the labyrinth as a form for spiritual contemplation. Examples have been traced to 4,000BCE in Europe, India, Scandinavia and north America (Harris, 2014), and although the exact use of these ancient examples is not known, it is likely that they were used ceremonially as a method for connecting with a higher power.

The history of religion and spirituality also reflects wider gender roles and identity, whereby men historically exerted power and influence within religious organisations (Avishai, 2016). Indeed, although priestly ordination is now open to women in many Christian denominations, men continue to occupy most positions of authority (Hill, 2018) (in some cases perpetrating abuses of that power (Blakemore *et al.*, 2017)). Moreover, men's 'religious' identities may conflict with their 'masculine' identities, especially where their sexual behaviour conflicts with religious teachings (Burke and

Hudec, 2015). The gendered nature of religious power has led some feminist scholars to portray religion as a patriarchal impediment to liberation, and to embrace non-religious forms of contemporary spiritualty, which are assumed to reject 'traditional' gender power imbalances. For example, Longman (2018) identifies the rise of 'women's circles' as an emerging combination of spirituality and feminism. This and similar developments reflect tensions between secular and religious feminists, informing the 'lived religion' approach, as a way of reconciling these two positions (Aune, 2015; Nyhagen, 2017). Furthermore, the growth in women's circles has inspired development of an equivalent movement for men, often focussed on processes of initiation (Kimmel and Kaufman, 1993).

It seems likely that early spiritual practice played a therapeutic function, whereby shamans undertook individual and group healing (Eliade, 1964; Harner, 1996; Winkelman, 2004; Rossano, 2006). The association between spirituality and healing continues in settings where 'traditional' indigenous culture interfaces with modern Western medicine (Plotnikoff *et al.*, 2002; Hodge and Horvath, 2011). Indeed, a continuous thread can be traced linking spirituality and healing from early pre-history to the present, through the emergence of the profession of medicine in the ancient period (Cushing, 2000), through Medieval Christian and Islamic religious institutions to the development of the modern hospital (Cheshire, 2003; Riva and Cesana, 2013). These religious origins became increasingly marginalised during and following the Enlightenment as medicine emerged as a science, establishing the secular principle (the separation of religion from the state and public institutions) within healthcare (Watson, 2006). However, links between spiritual practice and healthcare delivery persist through hospital chaplaincy and the emergence of spiritual care as a healthcare discipline (Kelly, 2002, 2013; Paterson and Kelly, 2013).

Links between spirituality and healing are also evident within the nursing literature, which includes important contributions to scholarship on spirituality as a dimension of healthcare. Clinical specialities such as end-of-life care and oncology are important in this respect and nursing literature on spirituality in mental health nursing is also growing. The broader nursing literature in this area includes debate about the legitimacy of spirituality as a topic for academic study and clinical practice, for example a series of articles by Paley (Paley, 2007, 2008a, 2008b, 2008c, 2009a, 2009b, 2009c, 2010) and responses by various authors (Newsom, 2008; Pesut, 2008a, 2008b; Pesut *et al.*, 2008; Betts and Smith-Betts, 2009; Hussey, 2009; Nolan, 2009) reflect the discourse on these topics. The limited consensus among theorists, researchers and

practitioners on defining spirituality is especially significant to this debate and is addressed in the next section, which establishes a definitional position for this study.

Defining spirituality

Need for definition

Defining and measuring spirituality is an enduring challenge, especially for research, where definitions vary greatly (Kelly, 2017; Dossett, 2018). Given the centrality of spirituality to this study, it is essential to clearly define the term. The complexity of spirituality as a research topic suggests that any definition is necessarily provisional and subject to critique from alternative positions. The aim here, though, is to establish a working definition of spirituality that fits this study as an exploratory qualitative investigation on spirituality and PSU. This section begins by outlining the definitional challenges and need for clarity associated with spirituality. Next, key definitional debates on spirituality are described. Finally, three conceptual models for spirituality are appraised before presenting a working definition for use within this study.

It is clear from several review articles that there is no definitional consensus within theoretical scholarship, research or practice for the term ‘spirituality’, which is used to cover a wide range of loosely connected ideas, concepts and phenomena (Meraviglia, 1999; Reinert and Koenig, 2013). For example, Greene and Nguyen (2012) identify spirituality as an expression of connectedness, while the concept of spirit as life force is emphasised by Kelly, who references the Latin root 'spiritus', describing a force that 'gives animation or breath of life' (Kelly, 2002, p12). A more radical (and minority) viewpoint positions spirituality as being entirely defined by the individual (Rose, 2001; Monson, 2012), although this position has been criticised as confusing and lacking in clarity (Paley, 2008a, 2008b, 2008c, 2009a, 2009b, 2009c; Koenig, 2009; Reinert and Koenig, 2013). The need for definitional clarity is noted by researchers studying spirituality within several healthcare specialities, including oncology (Egan *et al.*, 2011), mental health and psychology (McFarland, 1984; Galanter, 2007), nursing (Pesut, 2008a; Reinert and Koenig, 2013) and spiritual care and healthcare chaplaincy (Kelly, 2002). This lack of clarity has been identified as a source of confusion, obfuscation and even mis-representation within scholarship in this field, which is often criticised for lacking rigour and coherence (Paley, 2008a, 2008b, 2008c, 2009a, 2009b, 2009c). Furthermore, lack of definitional consensus has been linked to wider methodological difficulties which include inadequate measures of spirituality (Monod *et al.*, 2011), problems with construct measurement, study design and data analysis (Berry, 2005),

limited applicability of research findings (Chiu *et al.*, 2004), conflation of spiritual and psychological concepts (Zinnbauer, Pargament and Scott, 1999; Hill and Kilian, 2003), and limitations on the development of models and theory (Lapierre, 1994).

Meraviglia (1999) likens spirituality to clouds, which have apparent form and substance when viewed from afar, but become misty and vague on close examination. This description encapsulates the central definitional difficulty and is developed by Rose (2001), who argues that the act of seeking clarity on the many broadly held general concepts of spirituality that exist simply increases confusion. Furthermore, spirituality is not fixed but continuously shifts with time and is applied to a widening range of phenomena (Kelly, 2002; Bendomir and Morrison, 2005). In particular, the 'New Age' movement has expanded to attach spiritual relevance to a disparate range of seemingly unrelated ideas (Helminiak, 2006; Timmins and McSherry, 2012), which include complementary and alternative therapies (Drobin, 1999; Sjöberg and af Wåhlberg, 2002) and ecology (Taylor, 2011). Included also in this wider spiritual movement is the current revival of interest in the labyrinth as a tool for contemplation, meditation and therapy, which informs aspects of this thesis (Artress, 1996; Acheampong *et al.*, 2016). The broad and nebulous character of the topic leads some scholars to argue that spirituality is a uniquely individual and dynamic dimension of existence, suffused in existential mystery, meaning that any attempt to reach a generalisable definition will necessarily fail (Khantzian and Mack, 1994; Pesut, 2008a). Such an open-ended notion of spirituality poses challenges to researchers seeking to understand this dimension of human experience, underscoring the importance of developing a clear definitional framework which balances the individual perspective with the need to situate the research within wider scholarship on spirituality and health.

Definitional debates

The quest to define spirituality is characterised by three main themes encompassing the nature and significance of transcendence as a key spiritual concept, the interface between spirituality and psychology, and the spiritual dimensions of personhood, which are now described in turn. There is general agreement within the literature that *transcendence* is central to spirituality. For example, Battey (2012), Chiu *et al.* (2004), Gall *et al.*, (2005), Kelly (2002), Koenig (2012a), Lapierre (1994), Piedmont (1999), and Reinert and Koenig (2013) all identify transcendence as a key element of spirituality. Indeed, Koenig and colleagues argue that definitions of spirituality should be restricted to transcendence and exclude dimensions such as the search for meaning and purpose or the psychosocial aspects of religious engagement, as such phenomena are

examples of behaviours arising from spirituality, but are neither necessary, nor sufficient, for defining it (Koenig, 2012a; Reinert and Koenig, 2013). Ideas such as *'standing outside'* or *'going beyond'* the immediate reality are common to many conceptions of transcendence. As a spiritual concept, transcendence describes experience of, and connection with, existence beyond everyday physical reality, and is essential to the 'quest' for ultimate meaning and purpose described by many writers on spirituality (e.g., Torrance, 1994; O'Murchu, 1997). Experiences of connection with God, a supreme being or higher power, are emphasised in many descriptions of transcendence which may be framed in religious terms but often express a supra-religious reach that goes beyond specific religious traditions (Reinert and Koenig, 2013). Piedmont (1999), for example, identifies spiritual transcendence as extending beyond religion and religiousness, and encompassing:

> *… the capacity of individuals to stand outside of their immediate sense of time and place to view life from a larger, more objective perspective. This transcendent perspective is one in which a person sees a fundamental unity underlying the diverse strivings of nature and finds a bonding with others that cannot be severed, not even by death.* (Piedmont, 1999, p998)

The concepts of 'objective perspective' and 'fundamental unity', introduced by Piedmont, identify transcendence as expanding consciousness, from dualistic separation of 'self' and 'other' to experiencing reality as a unified whole. The non-duality concept at the centre of this shift challenges the dualism underpinning much Western thought, but accords with central elements of Asian philosophy (Kyriakides, 2011). Non-duality as a philosophical construct originated within the Advaita Vedanta-tradition and is embodied in Yoga, Daoist and Buddhist (especially Zen) philosophy (Loy, 1988; Gyatso, 1993; Kochumuttom, 1999). It is a philosophical position that is encapsulated within the Buddhist definition of enlightenment as an enduring perception of the oneness of all things (Gyatso, 1993). Non-duality has been a feature of Asian philosophy and spiritualty for millennia, however is currently attracting renewed interest within contemporary western thought (Loy, 1988) and is reflected in the concept of Gaia, developed by James Lovelock, which describes the natural world as a single, interconnected meta-organism (Lovelock, 1979; Taylor, 2011). Furthermore, within psychological theory, non-duality resonates with Jungian collective unconscious, suggesting, as it does, a single unified human consciousness expressed through universal archetypes (Jung, 1968).

Transcendence is a psychological concept as well as a spiritual one. Piedmont (1999), for example, identifies transcendence as a potential sixth factor of personality alongside the existing dimensions of the Five Factor Model (Neuroticism, Extraversion, Openness, Agreeableness, and Conscientiousness) (Costa and McCrae, 1992; McCrae and Costa, 2004). Such links between the psychological and spiritual realms underpin transpersonal psychology. Walsh (1992) and Walsh and Vaughan (1993) describe the emergence and development of transpersonal psychology as a discipline distinct from mainstream psychology and related disciplines such as philosophy, phenomenology and comparative religion. Shamanic elements have also been identified in some branches of the transpersonal approach (Clement and Trott, 1998; Almendro, 2000). Transpersonal psychology emerged from developments in humanistic psychology, especially Maslow's work on human motivation (Maslow, 1943). In his well-known seminal work, Maslow proposed a five-level hierarchy of needs encompassing physiological (survival), safety, belongingness and love, esteem, and self-actualisation (Maslow, 1943). As Koltko-Rivera (2006) shows, Maslow later reconfigured his model to add a sixth level, self-transcendence, which he described as comprising spiritual and psychological dimensions (Maslow, 1969). The linkages between spirituality and psychology, particularly around core human motivation as described by Maslow, suggest that striving to experience transcendence is a fundamental human motivation, with important spiritual connections.

The extent to which transcendence is either a psychological phenomenon, or a spiritual or numinous one, characterised by a higher power, is a significant debate with implications for healthcare research. As a psychological phenomenon, transcendence is not *ipso facto* incompatible with the reductionist positivist perspective advanced by, for example, Paley (2008b, 2008c, 2009c, 2010), but is explicable in terms of mainstream psychological theory and links to other spiritual psychological dimensions such as meaning and purpose. By contrast, positioning transcendence as a spiritual phenomenon, characterised by connection with non-material realms or a higher power, disrupts this reductionist position which excludes the supernatural. This fundamental incompatibility underpins theoretical tensions concerning spirituality as a topic for healthcare research and practice within publicly funded healthcare (Paley, 2007, 2009a, 2009b, 2009c; Koenig, 2009, 2012a). The positioning of spirituality within healthcare is developed further within the section *Spirituality within secular healthcare.* Meanwhile, transcendence as a key element in definitions of spirituality, brings us to the interface with psychology.

In contrast to the consensus on transcendence, the inclusion of psychological and social dimensions to definitions of spirituality present wider conceptual challenges which reflect methodological and ontological disagreements about the boundaries of spirituality. Koenig (2009, 2012a) and Reinert and Koenig (2013), who focus on empirical research, argue for a narrow definition of spirituality concentrating on transcendence, to avoid confounding spirituality with mental health dimensions such as meaning and purpose, and wellbeing. This informs a concept of spirituality which excludes areas conventionally claimed by psychology and mental health, and while Koenig and colleagues argue for this approach for research, others advance differing viewpoints. For example, the concept of 'meaning and purpose' is identified by both Meraviglia (1999) and Delgado (2005) as an element of spirituality, while Heyse-Moore's notion of 'life force' (1996) is another concept which Koenig and colleagues frame in psychological terms. Clients within psychotherapy and counselling often conflate spiritual and psychological processes whereby psychological therapy is ascribed spiritual significance (Griffith, 2005; Dein and Littlewood, 2008; Galanter *et al.*, 2011). Other scholars conceptualise the psychological dimension as intrinsic to, rather than separate from, spirituality, which they suggest can only exist as a combined concept. Monson (2012), for example, who is concerned with wellbeing and 'flow', identifies spirituality as one dimension of a holistic whole (body, mind and spirit). In contrast, O'Murchu (1997), who focusses on the existential nature of spirituality, identifies the pursuit of meaning and purpose as an intrinsically human endeavour which is fundamentally *spiritual* in nature. In a similar vein, Heyse-Moore (1996) does not separate spirituality from psychology, but instead conceptualises a 'spectrum of consciousness', disrupting conventional ideas about the psychological realm and the relevance of spirituality to it:

> *It is not surprising, therefore, that there is an overlap such that some psychological and spiritual themes are expressed in similar language. Furthermore, there has been a tendency in Western medicine to place anything to do with the inner state of a person, for want of anything better, in a psychological pigeon-hole. This ignores the subtlety and complexity of the relationships between body, mind and spirit. Thus, depression may be psychological in origin, such as from a bereavement, but cause spiritual distress. Conversely, spiritual distress, such as from an existential crisis of meaning, may itself cause depression.* (Heyse-Moore, 1996, p304).

Links between spirituality and psychology are increasingly found within the psychology and counselling literature which describe growing interest in spirituality as part of mental health and psychology practice. For example, mindfulness and meditation, which are gaining credibility as psychologically-based interventions, are informed by Buddhist and other Asian spiritual practices (Kabat-Zinn, Lipworth and Burney, 1985). The interface between psychology and spirituality is, thus, characterised by conceptual complexities, a reciprocal flow of theoretical ideas and interdisciplinary territorial debate informed by context. Indeed, debate in this area extends to existential questions of personhood and embodiment, the next definitional theme.

The question of what it is to be a person has exercised spiritual seekers, philosophers and scientists for millennia (O'Murchu, 1997). It is a question that extends beyond biology or psychology to underpin the apparently innate human motivation to seek meaning and purpose through spiritual questing (Torrance, 1994; Green, 2009). The literature on personhood and health describes an evolving relationship in which developments in the health field inform revisions in the concept of personhood. McGoldrick applies a Catholic evaluation of current developments in neuroscience to suggest that freewill is central to personhood and that therapies that affect consciousness (and therefore freewill and dignity) are ethically problematic (McGoldrick, 2012). Personhood is recognised as being central to mental health recovery by Atterbury (2014), who defines personhood in terms of fundamental rights and values. End-of-life care is identified as being significant to conceptions of personhood by Bryson (2004), who argues that spiritually informed interventions assist patients at the end of life to develop meaning through rediscovering the mind-body connection. Sterk (2010) describes the process of dying as three stages – imaginary, real and symbolic – which mirror Van Gennep's (1960) seminal work on rites of passage, through which conceptions of personhood are socially as well as biologically constructed. Green (2009) reviews theoretical nursing conceptions of personhood, suggesting that nursing theories build upon one another iteratively and concluding that further work is required to synthesise a comprehensive version of personhood in nursing theory.

For monotheistic religious traditions, the embodied character of personhood has often informed a view that the baseness of human physicality hinders connection to the numinous (Hood, 2002). By contrast, within contemporary spirituality, embodiment is more typically embraced as being essential to spiritual experiences. For example, Giordan (2009) describes a shift from a traditional Catholic Christian position in which

body and spirit are separate (and physicality becomes an obstacle to numinous experience), to a new spirituality in which spirit and body are united as an integrated whole. Hood (2002) characterises the stance of Christianity and other religious traditions as denying the body, in contrast to that of feminist, pagan and alternative forms of healing which, he argues, embrace the body as intrinsic to the spiritual experience.

The three themes of transcendence, the interface with psychology, and personhood serve to circumscribe discourse on defining spirituality in the healthcare context. Transcendence emerges as a necessary dimension, separating spirituality from other concepts. Indeed, some readings argue for transcendence as both necessary and sufficient for defining spirituality. Exploring the interface with psychology highlights the 'fuzziness' surrounding spirituality, emphasising the subtlety of the concepts involved and the challenges intrinsic to articulating uniquely individual experiences. This point is reinforced by the link with personhood and embodiment, which emphasises spirituality as a phenomenon to be experienced and the impossibility of fully articulating or defining such experiences. These themes are invaluable as building blocks in defining spirituality and have been used by several authors in developing conceptual models of the concept.

Three conceptual models

Competing models present spirituality as different combinations of linked elements, which describe a multiplicity of positions on the nature of the topic. Divergence about what constitutes spirituality is reflected in the gamut of definitional frameworks and models that have developed to describe this area of theory. To illustrate, the work of three authors; Meraviglia (1999), Heyse-Moore (1996) and Delgado (2005), are now reviewed. These authors have been selected because, by portraying contrasting viewpoints on spirituality, they collectively contribute to deeper understanding of the concept. Meraviglia presents a comprehensive framework for positioning and mapping theory on spirituality which is grounded in interdisciplinary scholarship. Heyse-Moore develops a model which reflects the existential and numinous dimensions of spirituality as applied to healthcare (primarily end-of-life care settings). Delgado, by contrast, describes spirituality as specifically related to nursing practice by synthesising ideas drawn from the relevant literature. Naturally, other models exist; Stewart and Koeske (2006), for example present a multi-dimensional measurement of religiousness/spirituality aimed at research applications and which is reviewed in the later section on instruments. McSherry (2006a) advances a six-factor model focussing

on spirituality and spiritual care within nursing and healthcare. The three models have been selected in order to try to provide a balanced depiction of theoretical scholarship on modelling spirituality within healthcare which, while emphasising distinct aspects of spirituality, share some important elements. These three models are now described in turn.

Meraviglia (1999) develops Stoll's (1989) multidimensional model of spirituality, in which the vertical aspect reflects an individual's relationship with a higher power through a transcendent connection with God, while the horizontal aspect depicts humanistic values and beliefs incorporating relationships with self, others and nature, meaning and purpose, and social dimensions of spirituality. Stoll's model is depicted at Figure 2.1 below, with the theoretical positions of several key authors plotted for illustration. Keonig (2012a), who advocates a narrow view of spirituality is represented as high for transcendence, but low for the social dimensions; O'Murchu (1997), who emphasises the numinous and relational aspects of spirituality, is illustrated as high on both variables; Paley (2008b, 2008c, 2009a, 2009c), who eschews the transcendence perspective for a rationalist-humanist stance, is illustrated as low for transcendence but high for the social and relational aspects. Other theorists, Heyse-Moore (1996), Meraviglia (1999) and Delgado (2005), are depicted in intermediate positions, reflecting the multidimensional aspects of their respective models.

The horizontal and vertical elements described by Stoll, and adopted by Meraviglia, all appear in work by other authors that include transcendence (Kelly, 2002; Koenig, 2012a), search for meaning and purpose (Delgado, 2005; Reinert and Koenig, 2013), and the social dimensions of spirituality and religious involvement (Lapierre, 1994; O’Murchu, 1997; Timmins and McSherry, 2012). Among the available models, however, Meraviglia's draws the strongest qualitative distinctions between transcendence and the other aspects and, therefore, has greatest value as a framework for conceptualising and positioning dimensions of spirituality from a range of theoretical positions. By separating transcendence from the social and psychological dimensions of spirituality, Meraviglia develops a notion of spirituality in which these different aspects are equally important. In contrast to Koenig (2012a), who identifies transcendence as the *only* legitimate aspect of spirituality, Meraviglia's position recognises the central importance of transcendence to spirituality while contexualising other (non-transcendent) aspects of spirituality.

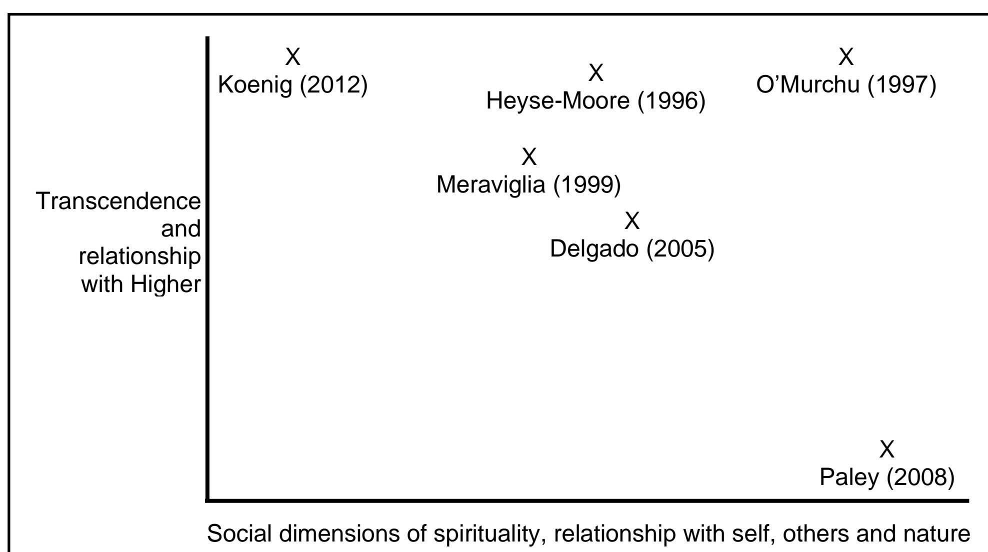

Figure 2.1 Multidimensional model of spirituality (after Stoll, 1989) illustrating positions of various theorists

Heyse-Moore (1996) advances a definitional framework for spirituality from an existential and numinous perspective aimed at informing understanding of spiritual pain and suffering in the context of terminal illness. This conceptualisation reaches beyond establishing a definition, to situating spirituality through five distinct perspectives on the subject. These dimensions are: spirit as 'life force'; spirit 'as essence' transcending the physical body; spirit and immortality; spirit as the deepest level of consciousness; and spirituality as a concept in comparison with religion. Unlike other theorists, Heyse-Moore does not explicate the interrelationships between these dimensions, leaving them instead as dimensions of experience that may layer upon one another through an individual's unique situation. Heyse-Moore emphasises the transcultural dimensions of spirituality to support the concept of spirituality as a unique and individual concept. She selects divergent examples of religious and spiritual practice and custom globally, which she deploys to describe spirituality as comprising universal truths, transcending specific faith perspectives. The claims to universality implicit in this approach are clear, nevertheless, from this position, Heyse-Moore returns to the specific aim of identifying and understanding the concept of spiritual pain and suffering in end-of-life contexts. Heyse-Moore presents a rich account of spirituality and spiritual pain amongst dying patients which reflects the numinous and transcendental aspects of the phenomenon. Many of the ideas presented may have relevance for other areas of practice, however this is not established in Heyse-Moore's paper and highlights the need for further theoretical work in this field.

Delgado (2005) presents a definitional framework for spirituality which is primarily aimed at nursing practice rather than research but that, nevertheless, has relevance to developing a conceptual and analytical framework. Delgado explores the concept of spirituality from a theoretical perspective through a review of the relevant literature, with the aim of identifying theoretical underpinnings to research on the nature, relevance and implications of spirituality as a concept for healthcare practice. In Delgado's view, spirituality describes aspects of human experience and relationships comprising four interconnected dimensions. First, she considers spirituality as comprising elements of *belief or faith.* This may relate to organised religious involvement or more personal or informal forms of spiritual belief systems. Second, Delgado identifies a *search for meaning and purpose* in life as a dimension of spirituality. Third, she identifies the concept of *connection* as important to spirituality, particularly connection with nature or other people. Finally, Delgado identifies *transcendence* of self beyond the everyday reality as being important to conceptions of spirituality. Delgado argues that these four dimensions describe aspects of a single interconnected concept of spirituality with relevance to nursing and healthcare.

Delgado establishes connections between spirituality and health which she uses to call for more attention on spirituality by nurses and nurse managers and for more research in this field. Delgado concludes that a strong spiritual connection enhances life-satisfaction, promotes inner peace and leads to successful adaptation or accommodation to disability:

> *Spirituality is a way of perceiving reality in its entirety, holding and realizing certain values and goals, and experiencing positive and satisfying behaviours and emotions in life. Through the study of spirituality, nurses will better care for their patients and themselves. Nursing needs to envision spirituality as a powerful resource for holistic care.* (Delgado, 2005, p161)

The aspects of Delgado's paper that concentrate on defining spirituality are well grounded in the relevant literature, however, her assertions about the nature of spirituality are only weakly supported, and the evidence cited for links between spirituality and clinical practice is largely descriptive rather than evidential. For example, she argues that one consequence of spiritual connection is successful adaptation and health, however, this position rests upon an account of the pre-historic and historic links between healing and religious or spiritual practice which falls short of establishing evidence for effect. Similarly, her section outlining 'inner peace' as a

potential benefit of spiritual practice is highly speculative and barely refers to any relevant supporting evidence. Despite these limitations, Delgado offers a useful framework for defining spirituality which is potentially relevant to this current study, both as a working definition and as a conceptual framework for analysis.

Research definitions

Several systematic reviews of research on spirituality and health identify a lack of definitional consensus in the research context (Koenig, 2009, 2012a; Monod *et al.*, 2011). In a review of quantitative research on spirituality and religion and mental and physical health, Koenig (2012a) observed that there is little agreement among researchers on defining or measuring spirituality. Indeed, spirituality is often not explicitly defined at all, but rather a common understanding is assumed or implied (Reinert and Koenig, 2013). Reinert and Koenig go on to call for definitional consensus among researchers investigating spirituality and health, arguing for a narrow definition of spirituality centring on transcendence and excluding conflation with mental health dimensions such as meaning and purpose or wellbeing. The aspiration to minimise confusion with mental health concepts is understandable, particularly in the context of empirical research, however, the feasibility of achieving such definitional consensus among researchers is questionable given the diversity of positions adopted on spirituality. Rather, within health research at least, a pragmatic response may be preferable in which definitional positioning reflects the individual and dynamic character of spirituality. It may be unrealistic to expect researchers to agree on defining spirituality given the lack of agreement on this concept more widely. It is vital, however, that researchers investigating spirituality should explicitly position their own work in definitional terms. An alternative to Reinert and Koenig's (2013) transcendent position locates spiritually as an intrinsic element of all dimensions of human existence, encompassing physical, mental, emotional and spiritual aspects (Heyse-Moore, 1996). This stance reflects common real-world expressions of spirituality and the views of practitioners and theorists within the spiritual care discipline who typically emphasise the personal meaning and psychosocial aspects of spirituality (Kelly, 2002). I suggest that this inclusive view of spirituality is more suitable for qualitative research, reflecting as it does the diversity of meaning applied to human experiences of spirituality. This resonates with the position advanced by theorists such as Betts and Smith-Betts (2009), Hussey (2009) and Newsom (2008), who argue for research on spirituality to be grounded in individual experience and meaning-making.

A working definition

The literature reviewed in this chapter presents contrasting conceptualisations of spirituality highlighting the discourse around this area of exploration. Examining these ideas has informed the following working definition for use within this study:

> *Spirituality is a dimension of existence centred on transcendence, which may be experienced and expressed through connection with self, others or nature, as well as through a search for meaning and purpose. Religious involvement is not a necessary condition of spirituality, however connection with, or belief in, a higher power is.*

This definition represents a distillation of the work reviewed within this chapter, however, the specific wording is original. The term *higher power* refers here to a source of inspiration, guidance or power greater than the individual imbued with numinous (or mystically spiritual) qualities, often, though not necessarily, identified as God. *Transcendence* refers to the experience of going beyond everyday reality to spiritual or supernatural experiences. The definition aligns with inclusive and holistic versions of spirituality which encompass psychological and social dimensions as part of a unified whole, and best reflect ideas of spirituality applied in healthcare practice settings. It is common for research on spirituality to position spirituality within or against religion, or indeed to use religious involvement as a proxy for spirituality. The commonalities and differences between spirituality and religion are the subject of the next section.

Spirituality and religion

That close linkages exist between concepts of spirituality and religion is evident from the literature in this field. For example, Heyse-Moore (1996) identifies close associations between spirituality and religion, Hill *et al.* (2000) regard the two concepts as inexorably intertwined, while Zinnbauer, Pargament and Scott (1999) conclude that the terms spirituality and religion in part describe different, but overlapping, concepts. There is, however, considerable divergence in how the relationship between spirituality and religion is conceptualised and described, highlighting a need for clarity in this area. Indeed, lack of clarity arising from the conflation of spirituality and religion is identified by several scholars as a source of confusion and potential obfuscation within the literature (Pargament, 1999; Hill *et al.*, 2003; Berry, 2005; Helminiak, 2006; Paley, 2007, 2008b, 2008c, 2009a, 2009b, 2009c). It is important, therefore, to position this study relative to both spirituality and religion to inform the identification and measurement of both concepts.

Attempts at disentangling spirituality and religion in the literature divide between authors framing spirituality as a dimension of religion (e.g., Helminiak, 2006; Koenig, 2012a), and those who regard religion as a dimension of spirituality (Heyse-Moore, 1996). The view that spirituality is a dimension of religion has important research implications as it underpins the idea that religious involvement can serve as a proxy for spirituality, as espoused by Koenig and colleagues, and which is examined in more depth further on in this chapter (Koenig, 2012a; Reinert and Koenig, 2013). In the alternative view, religion is positioned as one possible (but not necessary) dimension of spirituality, implying greater separation between the two concepts and allowing the possibility of spiritual phenomena occurring outside religious experiences. Zinnbauer, Pargament and Scott (1999) illustrate the nature and extent of the differences between spirituality and religion in empirical research comparing religiousness and spirituality involving 346 individuals in 11 groups. Their research participants identified religion with authoritarianism, religious orthodoxy, intrinsic religiousness, parental religious attendance, self-righteousness, and church attendance; while spirituality was associated with mystical experiences, New Age beliefs and practices, higher income, and the experience of being hurt by clergy (this latter point underpinning disillusionment or mistrust of organised religion). Zinnbauer and colleagues cite their research as evidence for the emergence of multiple 'spiritualities' as a feature of contemporary society (Zinnbauer, Pargament and Scott, 1999). They examine three ways in which religiousness and spirituality are polarised by contemporary psychological theorists: organised religion versus personal spirituality; substantive religion versus functional spirituality; and negative religiousness versus positive spirituality. These authors argue that such a polarised approach is ultimately counterproductive, calling instead for theoretical approaches that integrate these concepts:

> *Advances in this field will depend on the researcher’s willingness to grapple with the dual nature of religion and spirituality; they are a source of both problems and solutions.* (Zinnbauer, Pargament and Scott, 1999, p914)

Zinnbauer and colleagues highlight the importance of understanding the nuanced relationship between religion and spirituality in a field in which the research implications of using religiousness as a shorthand for spiritually have not been extensively explored. Positioning religion and spirituality as integrated, rather than polarised, informs a theoretical standpoint from which spiritual experience is formalised and organised through religion. For example, Heyse-Moore (1996) suggests that spirituality centres on

a universal preoccupation with meaning, depth and values that transcend body, mind, culture and race, while religion is the *"expression of spirituality, in particular ways and according to particular pre-existing sets of beliefs"* (p304). Similar comparisons are made by Koenig, King and Carson (2012) who present parallel definitions for religion and spirituality in which transcendence is central to both spirituality and religion. These authors emphasise the importance of culture and tradition to religion which is characterised by specific beliefs about life after death and rules concerning social conduct. Conversely, spirituality is framed as a wider concept, albeit one that may include religious elements:

> *Spirituality is intimately connected to the supernatural and religion, although also extends beyond religion (and begins before it). Spirituality includes a search for the transcendent and so involves travelling along the path that leads from non-consideration to a decision not to believe to questioning to belief to devotion to surrender.* (Koenig, King and Carson, 2012, p46)

Koenig and colleagues regard spirituality as primarily concerned with the supernatural, the mystical and the search for transcendence, positioning religion as an aspect of this wider concept of spirituality. In a separate paper, Koenig (2012a) adopts a pragmatic position by suggesting, along with Berry (2005), that it is functionally difficult to disentangle spirituality from religion and that therefore the combined term religion/spirituality (R/S) best describes this area of research and practice.

Koenig (2009, 2012b) and Blazer (2009) argue that transcendence is common to both spirituality and religion, but that, while spirituality is a subjective concept, religious structures are well-defined and measurable, which justifies the use of religious involvement as a proxy for spirituality in research applications. This position is open to challenge on two fronts. First, many accounts of spirituality and transcendence reference non-religious contexts, for example, those offered by individuals who do not identify with formal religion (SBNR) (O'Murchu, 1997; Zinnbauer *et al.*, 1997; Zinnbauer, Pargament and Scott, 1999; NHS Education for Scotland (NES), 2009a, 2009b; Tong and Yang, 2018). Zinnbauer *et al.,* (1997) distinguish between individuals identifying as spiritual *and* religious from spiritual *but not* religious, concluding that those in that latter group typically express criticisms of religion, but are more likely to report mystical experiences. Tong and Yang (2018) identify three distinct SBNR groupings: spiritual seekers or new spirituality practitioners; "Sheilas", who hold a mixture of beliefs and practices drawn from multiple sources ("religious bricolage"); and

“liminal nones”, who report no religious affiliation at one time but become religiously affiliated at another time. Tong and Yang argue that it is misguided to consider SBNR people as a homogeneous group because this fails to account for the differences *between* these groups. Similar arguments are made by Laird, Curtis and Morgan (2017), who describe the idiosyncratic nature of spiritual experience among specific social groupings which question normative assumptions about spiritualty and religion. The second challenge to using religion as a proxy for spirituality reflects that fact that not all aspects of religious involvement relate to transcendence: social and psychological experiences are important to religious experience for many people (O’Murchu, 1997; Ringwald, 2002). The links that Koenig, King and Carson, (2012) establish between spirituality and religion underpin their contention that religion provides a proxy for spirituality, for empirical research at least, which are examined below.

For the purposes of this study, spirituality is taken to be fundamentally concerned with the search for, and experience of, transcendence, which may occur within or separate from any religious framework. Religion provides a social and organisational framework for experiencing spirituality and may form the primary focus for spirituality; however, religious involvement is not essential for spiritual experiences, and involvement in religious organisations does not necessarily lead to experiences of spirituality. Spirituality is best understood as a subjective, individual construct, albeit one that may be informed by religious orientation. Having positioned this study both in terms of defining spirituality and in relation to the interface between spirituality and religion, the literature describing research on spirituality and health is now reviewed.

Researching spirituality and health

This section outlines increasing research interest in spirituality and healthcare and describes the challenges this entails, especially for quantitative research. Tensions between the transcendent dimensions of spirituality and the positivist underpinnings of Western healthcare are highlighted as the source of many of these challenges. Given the centrality of empirical research in healthcare, the need for instruments to measure aspects of spirituality is identified. A range of such instruments are reviewed along with their limitations. Finally, findings from some recent empirical research in this field are reviewed.

It is clear that research interest around spirituality and health is growing (Kier and Davenport, 2004; Baetz and Toews, 2009; Blazer, 2009; Koenig, 2009, 2015; Reinert

and Koenig, 2013). For example, between 1993 and 2002, publications focussing on "spirituality and health" increased by 600%, and those focussing on "religion and health" increased by 27% (Stefanek, McDonald and Hess, 2005), a trend that has only continued since (Shattuck and Muehlenbein, 2018). Several factors may have informed this trend, particularly attitudinal and practice changes towards spirituality and religion within healthcare. In recent years, existing organisationally focussed arrangements for delivering healthcare have been critiqued from person-centred and recovery-focussed positions, leading to the development of more individualised approaches to organising healthcare. Against this background, spirituality and religion have become increasingly relevant to clinical practice and research. However, as Daalemen (2012) identifies, this area of scholarship has, until recently, been poorly researched.

Spiritualty poses a challenge to healthcare researchers through the intrinsic subjectivity of its central feature, transcendence, which remains essentially untestable within the tenets of the empirical approach (Paley, 2008b). Although the importance of empirical evidence to healthcare provision has created demand for quantitative research on spirituality, the resulting scholarship often lacks rigor. Problems identified include inadequate definitional clarity, small non-generalisable samples (Koenig, 2009), a lack of conceptual modelling limiting application to practice (Berry, 2005; Reinert and Koenig, 2013), misrepresenting other work (Sloan and Bagiella, 2002); a lack of critical thinking, and the use of 'straw-man' arguments (Paley, 2008b, 2009a). Methodological problems identified by other authors include: the blurring of religious differences between faith traditions within instruments measuring spirituality and religion (Baetz and Toews, 2009); the use of structured research interviews to investigate experiences that are "*too deep for words*" (Blazer, 2009, p282); problems associated with ill-defined and inappropriate control groups in quantitative studies on spirituality (Kier and Davenport, 2004); and conflation of spirituality with psychological concepts (Koenig, 2009, 2012a; Reinert and Koenig, 2013). Other criticisms concentrate on the apparent tendency for research in this field to have been designed to confirm existing viewpoints, rather than testing theories against data or draw conclusions not justified by the findings of the research (Sloan and Bagiella, 2002). The need for improvements in the quality of research undertaken in this field is highlighted by Delgado (2005), who calls for further qualitative and quantitative research into spirituality as a dimension of nursing practice. Similarly, Berry (2005) argues that nurses are strategically placed to study religiosity and spirituality in health, given the dual nursing concern for the whole person and for research rigour. Indeed, rigorous evidence demonstrating positive associations between spiritual and religious engagement and health outcomes is

beginning to emerge in fields including cancer, hypertension and cardiovascular disease (Shattuck and Muehlenbein, 2018).

Research tools and measures

Research on spirituality attracts criticism on two fronts: from the positivist/rationalist perspective as unscientific and meaningless, and from the spiritual perspective as failing to capture the essential transcendent aspects of the phenomena. Spirituality's subjectivity leads some scholars to argue that attempts at measurement are inappropriate, advocating instead the use of qualitative research methods (Newsom, 2008; Pesut, 2008a; Betts and Smith-Betts, 2009; Hussey, 2009; Nolan, 2009). Indeed, this is the position adopted within this thesis. Others go further, arguing for non-traditional research methods (Gorsuch, 1984; McFarland, 1984), or questioning the logical basis for applying reductionist principles to spirituality. Walton, for example, contends that spirituality research is usefully informed by both consciousness studies and quantum physics, whereby the quantum principle of 'entanglement' reveals the futility of separating 'objectivity' and 'subjectivity', arguing instead for integration between inner and outer experiences of consciousness (Walton, 2017).

If quantitative research *is* relevant to inquiry into spirituality and healthcare, appropriate instruments are required. The need for suitable instruments to measure spirituality as a dimension of health has been widely identified (e.g. Hill *et al.*, 2000; Hall and Edwards, 2002; Berry, 2005; Egan *et al.*, 2011), however, developing such tools is challenging, given the significance of transcendence to definitions of spirituality (Koenig, 2012a). Transcendence as a spiritual concept, describing movement beyond ordinary reality or connection with a higher power, is arguably not amenable to direct observation and incompatible with the positivist, rationalist underpinnings of empirical enquiry. Consequently, empirical measures of spirituality necessarily focus on indirect markers including religious involvement, prayer and meditation, or self-report of religious and spiritual experiences, several of which are now described.

Early research into spirituality and health utilised existing psychometric instruments to measure dimensions such as wellbeing, meaning and values (The Fetzer Institute, 1999). However, locating spirituality entirely as a dimension of psychology fails to reflect the centrality of transcendence to spirituality, motivating development of specific instruments to measure spirituality. Initially, clinical measures of spirituality were developed for oncology and end-of-life care (Austin, Macdonald and MacLeod, 2018), reflecting the specific spiritual needs of patients in those settings (Hermann, 2006; Taylor, 2006). More recently, instruments have been developed for use in general

healthcare settings (Monod *et al.*, 2011). Growing interest has led to the development of several instruments to measure aspects of spirituality and religion, ranging from unidimensional measures addressing a single aspect, to sophisticated multidimensional instruments offering comprehensive assessment of spiritual orientation, experience and need (Idler *et al.*, 2003; Berry, 2005; Monod *et al.*, 2011). However, such work is inevitably subject to potential cultural bias and instruments also vary in respect of their validity, reliability and robustness.

In a systematic review, Monod *et al.* (2011), identified 35 instruments measuring spirituality and health, which they assigned to one of four categories, depending on the aspect of spirituality measured: *general spirituality*; *spiritual well-being*; *spiritual needs*; or *spiritual coping*. An additional functional classification was applied to record the expression(s) of spirituality targeted by instruments (*cognitive, behavioural* or *affective*). Monod and colleagues found that most instruments measure general concepts of spirituality as a dimension of a person's life, while three measure current spiritual state with potential to inform the need for spiritual intervention. Instruments varied in terms of reliability and validity. Six instruments were rated highly by Monod et al.: 1) The *Multidimensional Measure of Religiousness/Spirituality* (MMRS) was developed to measure key religious and spiritual domains across twelve dimensions in health research (The Fetzer Institute, 1999). It has been applied in research with older people (Idler *et al.*, 2003) and individuals undergoing treatment for PSU (Stewart and Koeske, 2006). 2) The *Index of Core Spiritual experience* (INSPIRIT) (Kass *et al.*, 1991) is an 18-item, unidimensional interview scale measuring the occurrence of experiences that convince one of the existence of God, that evoke feelings of closeness with God, and produce other religious actions and attitudes measured through frequency of religious involvement. When used with adult outpatients, INSPIRIT demonstrated that higher levels of spiritual experience are associated with greater positivity and fewer medical symptoms (Kass *et al.*, 1991). 3) The JAREL spiritual well-being scale (Hungelmann *et al.*, 1996), is a 21-item multi-dimensional scale assessing spiritual well-being in older adults encompassing relationship with Ultimate other/God, relationship with the self, and relationship with Others and Nature. JAREL is designed for assessing spiritual well-being by nurses and other healthcare professionals and includes guidance for clinical use. 4) The Spiritual Needs Inventory (Hermann, 2006) is a 17-item questionnaire aimed at measuring spiritual needs of patients at the end of life across five factors, which has been mostly used in end-of-life settings. 5) The spiritual interests related to illness tool (spIRIT) (Taylor, 2006) is a 42-item questionnaire to assess spiritual need among cancer patients using eight factors to categorise spiritual

need. 6) The System of Beliefs Inventory (SBI-15R) (Holland *et al.*, 1998) is a 15-item instrument to measure religious and spiritual beliefs as an aspect of quality of life for patients facing life threatening illness. Although initial validation of this instrument took place in oncology settings, this was followed by further work with healthy individuals with no history of cancer or serious illness. SBI-15R has potential to contribute to cross-cultural QOL studies, having been translated into Hebrew, German and Spanish.

Overall, the instruments reviewed by Monod *et al.* (2011) reflect the limitations of the measures of spirituality generally available. For example, many studies recruited participants who already scored highly, thus limiting scope for improvements in their score. Furthermore, many of these instruments were developed for, or applied within, oncology and end-of-life settings and it is unclear how transferable these tools are to general settings or indeed to the field of PSU recovery. Indeed, to date, no instruments have been developed specifically for use in the PSU context: clearly an area for future development. Additionally, many instruments measuring spirituality take religious involvement as a proxy for spirituality or fail to distinguish between religion and spirituality, leading to potentially misleading findings. Many of the available instruments were developed and applied in the US, where Judeo-Christian religious involvement is greater than in the UK, and where it may be more appropriate to use religious involvement as a proxy for spirituality. For example, the Religious Preference domain within the MMRS offers a choice of 63 Christian and Jewish categories compared to nine covering all other religious and spiritual orientations (The Fetzer Institute, 1999). This emphasises the need for instruments to measure spirituality in all settings which would facilitate cross-cultural and international comparisons. Such instruments would help disentangling cultural and religious specifics from spiritual commonalities, which current instruments available only partially achieve.

Monod *et al.* (2011) provide a useful review of instruments to measure spirituality and informs selection of such tools, based on topic focus, comprehensiveness and quality. Monod *et al.* conclude that further work is required before instruments measuring spirituality are suitable for application in research and practice settings. A further systematic literature review, undertaken by Austin, Macdonald and MacLeod (2018), also concluded that further work is required to develop meaningful instruments for spiritualty research.

Attitudes towards spirituality among healthcare practitioners

The emergence of spirituality and spiritual care in healthcare settings has accompanied changing attitudes towards spirituality among practitioners. International research on

spiritual care in nursing published between 2006 and 2010 was reviewed by Cockell and McSherry (2012). This overview depicted increasing interest and activity in spirituality in nursing practice, which the authors associate with a broader rejection of 'medicalised' approaches to care. Most studies were carried out in the US, and over half took place in oncology and end-of-life settings, emphasising the need for further research in a broader range of settings and cultures.

Research on spirituality and nursing applicable in the UK and by UK authors published between 2006 and 2010 was systematically reviewed by Pike (2011). This review suggested that, while spirituality is widely accepted as relevant to nursing practice, especially relating to 'holistic' care, widespread confusion exists about what spirituality means conceptually. The author concluded that increased attention to the language used by patients to describe spiritual experiences would facilitate understanding of spiritual concepts by nurses (Pike, 2011).

An online survey of UK nurse' perceptions of spirituality and spiritual care demonstrated that spirituality is an established concept within nursing practice (McSherry and Jamieson, 2013). Nurse' concerns identified included separating personal belief from professional practice, the legitimacy of spirituality within secular healthcare, and the need for guidance to address patients' spiritual needs (McSherry and Jamieson, 2011). Although interesting, this survey was limited by the fact that it was conducted with a self-selecting sample of Royal College of Nursing (RCN) members, highlighting the need for more rigorous work.

An earlier grounded theory study undertaken by McSherry (2006b) sought to develop an explanatory framework for factors influencing the advancement of spirituality and spiritual care within nursing and healthcare practice. This study informed development of a six-component 'Principle components' model, which postulates that adoption of spirituality is influenced by "individuality", "inclusivity", "integrated", "inter/intra-disciplinary", "innate" and "institution". McSherry concluded that, although the concept of spiritually receives considerable rhetorical attention, wider acceptance and application of spiritual care in nursing is limited by structural, organisational, political and social variables. Research on spirituality and health raises higher-level questions about the relevance of religion and spirituality within healthcare settings, such as those expounded by Paley (2009b, 2009c). The relevance of spirituality within secular healthcare systems is addressed in the next section.

Spirituality within secular healthcare

Thus far, the challenges and implications of conceptualising, defining and researching spirituality have been outlined. The topic is further developed now through an exploration of spirituality within contemporary Western healthcare systems, which are typically underpinned by strong secular principles, and in which the aspiration is for practice to be underpinned by science (although the systematic adoption of evidence-based practice (EBP) is a relatively recent innovation (Titler, 2008). Against this scientific and evidential background, attention is increasingly given to 'un-knowable' spiritual dimensions. In this section, religion and spirituality in Western healthcare is located within a historical context, with specific focus on the relevance of spirituality to nursing practice, the emergence of hospital chaplaincy, and the development of spiritual care as a healthcare discipline. Next, approaches to identifying and responding to spiritual need in healthcare settings are reviewed, revealing a lack of inter-disciplinary agreement as to the roles, responsibilities and relevance of spirituality as a dimension of care. Finally, the literature addressing the relevance and legitimacy of spirituality within a publicly funded healthcare system is reviewed.

Over the last two decades, the healthcare literature, particularity the nursing literature, has increasingly given attention to spirituality (Cockell and McSherry, 2012; Daaleman, 2012; Reimer-Kirkham *et al.*, 2012). While several authors identify a continuing tradition of spiritual care within nursing, albeit not always explicitly named as such (Battey, 2012; Biro, 2012; Connell, 2012), others identify spirituality as an emergent paradigm for nursing (Draper, 2012; Kevern, 2012). A few authors locate this growing nursing interest in spirituality, as part of a wider movement towards recovery-oriented, person-centred care, as a critical response to, as they see it, target-driven, mechanistic care management (Newsom, 2008; Pesut *et al.*, 2008; Nolan, 2009).

An example of the relevance of spirituality in nursing care is presented by Hodge and Horvath (2011) in a study of 860 ‘American Indians’ (their term for Native Americans) aged 50 years or older who had been discharged following hospital admission. This study found that spirituality and health are closely linked within First Nations culture, and that greater satisfaction with the level of spiritual care received is associated with higher overall satisfaction with the hospital experience for patients within this population group. They conclude that, given the greater time they spend with patients compared to other professional groups, nurses have a key role in meeting the spiritual care needs of hospital patients (Hodge and Horvath, 2011).

The role of nurse leaders and managers in providing clarity and direction to the development of spiritually informed nursing practice is identified by Reimer-Kirkham *et al.* (2012), who adopted a mixed methods approach to examine discourses of spirituality in nursing leadership contexts. The study combined review of 38 nursing literature sources, two qualitative studies examining plurality in hospital and home health settings, and philosophic analysis. The researchers concluded that there is a heterogeneous discourse in the nursing literature around spirituality and that nurse leaders, while aware of the influence of spirituality within inclusive health services, are cautious in integrating spirituality into leadership practices because of organisational and social influences and that, consequently, further work is required to apply this theoretical interest through developments in practice (Reimer-Kirkham *et al.*, 2012). The generalisability of these findings is limited by the context in which the qualitative research was undertaken (specific healthcare settings in Vancouver, Canada), characterised by a heterogeneous ethnic and social population, with a large immigrant population and a high proportion of people reporting no religious affiliation. Spirituality is a topic of growing significance within healthcare and nursing fields and this growing interest is reflected in developments in the hospital chaplaincy and health spiritual care disciplines which are outlined in the next section.

Hospital chaplaincy is a long-established feature of Western healthcare traditionally primarily delivered by ordained Christian ministers of various dominations (Kevern, 2012), but now incorporating representatives of many religions, including Muslim chaplaincy (Gilliat-Ray and Ali, Muhammad Mansur Pattison, 2013). In the UK, hospital chaplaincy is currently evolving into *spiritual care* as a healthcare discipline (NES, 2009a; Koenig, 2012b). This development reflects an aspiration to engage beyond secondary care end-of-life situations, where chaplaincy activity has traditionally been focussed, to encompass all healthcare settings (Appleby, Wilson and Swinton, 2018). It is notable that, although most spiritual care providers are ordained Christian ministers, public-facing portrayals of this discipline do not highlight this fact, nor do they focus on the numinous and transcendent aspects of spirituality, but instead emphasise the provision of support for those of ‘all faiths and none' to find meaning and purpose (NES, 2009b). This stance is consistent with the aim of repositioning the spiritual care discipline to meet the needs of an increasingly non-religious population (albeit one in which some people identify spirituality as important), but also raises criticisms about transparency. Furthermore, disagreement exists about responsibility for identifying and responding to spiritual need within healthcare settings. Clinicians, especially nurses, spend most time with patients and are well placed to identify and respond to spiritual

need. Indeed, spiritual care is regarded as implicit to the nursing role (Battey, 2012), is increasingly included in pre-registration nursing curricula (Cone and Giske, 2018), and is emerging as a legitimate and necessary dimension of many allied health care disciplines (Carey and Mathisen, 2018). By contrast, voices within psychology and counselling identify spirituality as an essentially psychological domain, focussed on meaning and purpose. Such debates expose tensions over territory and power within the emerging spiritual care discipline, between the view that spiritual care is everyone's responsibility and the idea that it is the sole preserve of hospital chaplains.

An attempt at guidance in this area is provided by NHS Scotland (NES, 2009b), which positions spiritual care as the responsibility of all clinicians, while emphasising the expert role of chaplains and spiritual care practitioners as a source of advice, support and expertise. This guidance reflects current developments in the spiritual care discipline and attempts a coherent depiction of spirituality and spiritual care in contemporary healthcare. It describes the key issues and debates yet is arguably less successful in establishing clear distinctions between spiritual care and, for example, psychological therapy or person-centred care. The NES guidance provides interesting insights into the state of development of the spiritual care discipline, although however, it would benefit from further refinement to become a resource for practice. Despite increasing interest in spirituality as a dimension of healthcare, this is a development that is not universally approved. For example, Paley (2009b, 2009c) argues that services delivered within publicly funded Western healthcare systems (especially the UK NHS) should be supported by robust evidence and delivered within a secular context. This position is used to question the use of public funds for chaplaincy and other forms of spiritual care provision, which is criticised as being both faith-based and for lacking supportive evidence of effectiveness (Paley, 2008c, 2009b, 2009c).

A detailed account of the scholarly and methodological challenges to research and theorising in this area is contained within a series of articles by nursing theorist John Paley published between 2007 and 2010, which are worthy of detailed review (Paley, 2007, 2008a, 2008b, 2008c, 2009a, 2009b, 2009c, 2010). Collectively, these articles, and the responses to them, represent a significant contribution to the debate within the nursing literature on spirituality in which Paley develops considered critical viewpoints on three main themes: the relevance and appropriateness of spirituality and religion to contemporary publicly-funded healthcare; a perceived lack of rigour in research and scholarship in this field; and the use of flawed logic, assertion, and occasionally personal attack in the conduct of discourse in this field. These contributions by Paley

prompted a series of responses from several scholars, most notably Barbara Pesut (Pesut, 2008a, 2008b; Pesut *et al.*, 2008), leading to the emergence of clear lines of disagreement between Paley's reductionist secular stance and the case for spirituality and religion advanced by his participants. Paley's contribution and critical responses are now reviewed.

Paley's first published contribution to the field of spirituality in nursing was a review (Paley, 2007) of McSherry's text, *Making Sense of Spirituality in Nursing and Health Care Practice: An Interactive Approach* (McSherry, 2006b). This was followed in 2008 with two articles. In the first, Paley (2008b) critiques the unscientific basis of many of the contributions to the nursing literature on spirituality which, he argues, rest on assertions about the transcendent and supernatural aspects of spirituality without the support of argument or evidence and which close off alternative ways of theorising spirituality in nursing. He uses this critical position to argue for adopting a naturalistic and reductionist approach which, he suggests, will reveal relevant resources in a range of disciplines with potential to inform the study of existential concerns within healthcare practice. This article prompted a number of responses, mostly opposing Paley's reductionist stance and arguing for the relevance of inclusive and non-reductionist spirituality to healthcare (Pesut, 2008b; Ross, 2008; Betts and Smith-Betts, 2009; Hussey, 2009; Nolan, 2009). One of these responses (Ross, 2008) promoted Paley to reply (2008a) with a critical analysis of the arguments and evidence deployed against him which he uses to argue that Ross' contribution is an example of a wider tendency to ascribe 'spirituality' and 'spiritual need' to an unwarrantably wide range of human experience. Perhaps the most original response to Paley (2008b) is provided by Nolan (2009), who addresses and challenges Paley's reductionist position by acknowledging the need for clarity in defining spirituality and arguing for spirituality as a non-reductionist discourse in which the central notion of transcendence describes a personal as well as a numinous aspect. Paley's final response to critics of his first 2008 article (Paley, 2010), address the flaws in logic, reason and argument that, as he sees it, typify discourse on spirituality, religion and healthcare, asserting that his critics are closed-minded and do not understand the nature and value of reductionism as an approach in theorising healthcare.

Paley's next contribution (Paley, 2008c) addresses the relevance of spirituality (and, in particular, religion) to the secular principles that ostensibly underpin Western healthcare provision. He describes the inconsistency of an apparent growth in interest in spirituality among UK nurses at a time when it is adopting an increasingly secular

orientation. He reasons that confusion arises in the literature in this area through the conflating of literature relating to the USA and the UK, which, he concludes, are "*at opposite ends of the religion/secular spectrum*" (Paley, 2008c, p175). Paley develops his arguments on religion, spirituality and secular healthcare (Paley, 2009b, 2009c) by suggesting that proponents of a largely Judeo-Christian religious stance blur the boundaries between religion and spirituality in order to legitimise the adoption of religious perspectives in healthcare delivery, at odds with the secular principles of the UK NHS.

Paley continued the following year (Paley, 2009a) with a response to Pesut *et al.* (2008), who presented a conceptualisation of spirituality and religion for healthcare informed by the emergence of a postmodern spirituality emphasising the individual, rather than the societal or collective perspective. Paley interrogates the stance taken by Pesut and colleagues and argues that their position privileges a Christian theological perspective, to the exclusion of other potentially relevant disciplines. In a tightly argued rejoinder to the original article by Pesut and colleagues, Paley develops critical analysis of the "*rhetorical tricks and sleights-of-hand*" (Paley, 2009a, p3512) deployed by Pesut *et al.* (2008) in framing their arguments. Here Paley explicates specific criticisms about flawed logic in the arguments made by Pesut and colleagues to support his more general assertion that academic discourse in the field of spirituality, religion and healthcare lacks rigour, is subject to heavy bias, and is prone to errors in logic.

Paley's contributions to the literature on spirituality and religion in healthcare between 2007 and 2010 represent a timely and valuable contribution to discourse in this field that rigorously explores the philosophical, ontological and methodological dimensions of spirituality, and which emphasises the importance of reasoned argument. Paley particularly identifies what he describes as muddled thinking and obfuscation in the literature differentiating spirituality and religion, which he concludes is often the consequence of attempts to obscure or conceal religious (usually Christian) bias beneath the cloak of spirituality. Of most relevance to this study is the emphasis Paley places on academic integrity and quality by developing a coherent, reasoned and justifiable definitional stance within which to further explore the relevance and significance of spirituality with healthcare.

Theobiology

Awareness of the conceptual differences between science and religion (and spirituality) have led to efforts to integrate these apparently divergent approaches. These efforts have converged on the new paradigm of theobiology, which places central importance on the embodied nature of both science and religion. Although the theobiology term did not emerge until nearly two decades later, the origins of this approach are found in the early 1980s. Gorsuch (1984), for example, outlined the difficulties in applying measurement to the study of religion and describes development of new instruments for use within such research. Gorsuch concludes that a new paradigm is needed in research on religion to reflect the complexity and interconnectedness of religious experience. Writing in the same year, McFarland (1984) argues that neither nomothetic (generalised objective) nor idiographic (individual subjective) approaches offer comprehensive insight into the psychology of religion, concluding that measurement is a necessary, but not sufficient, aspect for research in this field. He calls for the development of a new paradigm capable of uncovering, containing and reflecting the depth of meaning associated with religious experience. Approaching the subject from a critical feminist perspective, Rayburn and Richmond (1998) argue that the embodied nature of religious and spiritual experience has been suppressed through a dominant masculine theology, which is alienating and disempowering to women and distorts the masculine-feminine balance observed in the natural order. They argue that uncritical acceptance of Christian theology, characterised by a God exhibiting masculine attributes, inform patriarchal religious positions which often underpin incest and abuse of women and girls, warranting a research focus on the gendered dimensions of spirituality. Rayburn and Richmond argue for research that reflects a balanced perspective between science and religion in what appears to be the first use of the term 'theobiology'. Rayburn and Richmond are criticised by Otani (2002), however, for taking an exclusively Christian perspective, which ignores the role of women in many polytheistic doctrines and societies. Rayburn and Richmond develop their earlier work by arguing that spiritual and religious experiences are necessarily embodied and so must be understood through science, philosophy and theology collectively (Rayburn and Richmond, 2002). They use the philosophical differences between science and religion to develop the ideas of the theobiology paradigm:

> *Theobiology does not presume any primacy of the sciences over theology or the psychology of religion/spirituality or vice versa. Nor is*

> *revealed knowledge or divine revelation seen as any less important than scientific knowledge.* (Rayburn and Richmond, 2002*,* p1793)

The theobiology concept was further developed with contributions from theology, psychology, philosophy and science in a discourse centred on the embodiment of science and religion. Kanis (2002), for example, develops the idea of human spirituality as an embodied and necessarily gendered experience and highlights the embodied stories of the rhythmical nature of women's lived experience as a hereto neglected dimension in the study of spirituality. Hefner (2010) identifies the common goals of science and religion, especially the role of 'science as enabler for improving the world', which he explains as emerging from an awareness of the embodied nature of science and religion in which understanding the world also implies understanding of our being in the world. This position is developed by Haag (2010), who argues that the embodiment of science and religion is necessary to counter the contemporary trend towards naturalism.

The relationship between science and religion is conceptualised differently by various theobiology theorists. Teske (2010), for example, examines the significance of narratives within both science and religion, concluding that both the form and purpose of narrative are similar for each paradigm. Similarly, Pederson (2010) conceives theobiology as embodying both religion and science within a duologue (a conversation between two actors) in which each may learn through 'bearing witness' to the other's myths and symbols. The concept that religion and science exist in a duality is reflected by Brown (2002) who advocates 'nonreductive physicalism' as a theoretical approach which allows descriptions of the deepest forms of human experience and relatedness and resonates with a theological perspective. Gorsuch (2002) develops this idea by describing a post-modernist hierarchy of knowledge in which two parallel pyramids (one for science and one for humanities) describe in the world respectively either nomothetically or idiographically. Gorsuch concludes that each paradigm presents only a partial view and that methodologies to integrate nomothetical and idiographic knowledge are required for the studying human spirituality and religion. The importance of integration is developed by Nixon (2002), who takes a theological perspective to argue that natural order ascribes equal value to all things within an integrated system of non-duality. Derry (2002) reaches similar conclusions by outlining a world in which God is described (and possibly defined) in terms of the mathematical laws that govern the cosmos, offering a bridge between science and religion. Finally, Hallanger (2010) explores the methodological implications of giving theology more credence and making theology more scientific, concluding that engaging theologically with the natural

sciences creates opportunity to enrich theology while supporting science. Evolutionary biology is provided as an example for dialogue between religion and science on key existential questions.

Several practical research applications have emerged from the theobiology approach. Piedmont and Leach (2002) describe developing a validated, cross-cultural measure of transcendence, the Spiritual Transcendence Scale, which has been used to demonstrate the universality of spiritual experience. Ramirez-Johnson *et al.* (2002) used theobiological ideas to contextualise the meaning-making dimensions of religious experience of breast cancer patients, who describe how faith helped them cope with their breast cancer. The theobiology concept has attracted criticism, particularly from Helminiak (2010), who argues that including God as an explanatory factor leads to broad and poorly defined theological and spiritual concepts which distort the epistemological differences between science and religion and undermine evidence-based inquiry. Despite these criticisms, theobiology presents a novel way of knowing in which scientific and spiritual perspectives are of equal importance. Theobiology presents a 'both/and' alignment, bridging the natural sciences, theology, spirituality and psychology and drawing from both rational and intuitive stances. For this reason, theobiology has potential for providing a conceptual structure for this current study.

Chapter Summary

The aim of this chapter has been to situate this study within the literature on spirituality. In addressing this aim, the problems of defining and contextualising spirituality have been demonstrated, which include: a lack of definitional consensus among scholars and practitioners about spirituality; the difficulty in defining the interface with psychological and social dimensions; the challenge of differentiating spirituality from religion; and the tendency of much research in this field to use religious involvement as a proxy for spirituality. Addressing these challenges has informed the development of a working definition for use within this research, which emphasise transcendence as a core dimensions of spirituality, while incorporating meaning and purpose.

The challenges associated with researching spirituality were reviewed; especially difficulties in developing and applying instruments to measure dimensions of spirituality in empirical research. Furthermore, disagreement about the appropriateness of adopting a rationalist empirical approach within this field of scholarship has been identified. These definitional and research tensions were shown to be revealed within the current system for healthcare delivery. Predominantly Christian-based hospital

chaplaincy is becoming redefined as the spiritual care discipline, with an aspiration to identify and address the spiritual needs of all health care users. Such developments are subject to criticism as lacking supporting evidence and eroding the secular principle within publicly funded healthcare systems. The following chapter will position this study within the literature on PSU and recovery and situates the research questions within this review.

Chapter Three: Problem substance use

Introduction

The purpose of this chapter is to position this thesis within the addiction and PSU literature, with reference to the spiritual dimensions of drug and alcohol addiction and recovery. The chapter begins by developing an overview of the main theoretical lines underpinning the aetiology of PSU and an account of the social and legislative responses that these inform. The dominant theoretical constructs underpinning policy and treatment delivery are then examined and the differing standpoints of the abstinence and harm reduction positions are explored. The emergence of recovery within addiction theory is then traced from its mutual aid and mental health origins. Finally, an account of the spirituality of PSU is developed which includes the significance of the human pursuit of altered states of consciousness, spiritual explanations for PSU, and a review of the application of spiritual approaches and methods to treatment, including a review of the relevant empirical research. The chapter concludes by summarising relevant knowledge gaps identified within this and the preceding chapter and outlining research questions through which to approach them. As described in the Introduction chapter, in general, the term, problem substance use, abbreviated to PSU, is used except when reporting or commenting on the language of other authors, when other terms, including *addiction* and *substance misuse* may be used. Additionally, when it is necessary to specify drug use or alcohol use, this is made clear, otherwise PSU should be read as referencing both alcohol and drug use.

Problem substance use: definitions and aetiology

The origins of problem drug and alcohol use are the subject of intense debate, which encompasses biological, psychological and social dimensions in various competing and complimentary explanatory frameworks.

Biological accounts

Biological and physiological explanations for PSU are well developed and incorporate evidence for a genetic basis for PSU (Vink, 2016), the neurochemical effects of drug use (Addolorato *et al.*, 2005), evidence for brain plasticity (Olsen, 2011), and the

physiological effects of chemical dependence of specific substances (Mulé and Brill, 2019). Evidence from twin studies and other research underpin genetic predisposition explanations for PSU, which suggest that, under 'favourable' environmental circumstances, predisposed individuals are more likely to develop PSU (Bierut, 2011; Quadri *et al.*, 2014; Vink, 2016), and will develop more severe forms of PSU compared to non-predisposed individuals (Dick *et al.*, 2007). However, predisposition does not necessarily lead to PSU and the other neurochemical effects are relevant; the neurochemical effects of drugs and alcohol also effect the expression of any genetic predisposition. In particular, dopamine, opioids, glutamate, and serotonin are associated with craving among individuals experiencing PSU (Addolorato *et al.*, 2005; MacNicol, 2017). Furthermore, the behavioural changes associated with substance use provide evidence for brain plasticity, suggesting that neural regions associated with PSU undergo structural changes in response to drug use, which drive further addictive behaviour. For example, Robinson and Kolb (2004) demonstrate that repeated use of amphetamine, cocaine, nicotine and morphine is associated with the reorganisation or strengthening of synaptic connections in specific neural circuits associated with incentive motivation, reward and learning, and that these changes persist over time. Similar processes are associated with (non-drug) behaviour addiction (Mameli and Lüscher, 2011; Olsen, 2011), however, further research is required to fully explicate the relationships between PSU and non-drug addiction (Kearns, Gomez-Serrano and Tunstall, 2011). Undoubtedly, biological and physiological perspectives illuminate PSU and underpin important treatment approaches such as substitute prescribing. However, this stance supports oversimplifying a complex human process (Meurk *et al.*, 2013), and underpinning a 'disease' model which, according to some authors, undermines learning, choice and personal responsibility towards recovery (Satel and Lilienfeld, 2013; Lewis, 2017). However, this later point is itself contentious for failing to acknowledge the trauma and neglect underpinning much problem substance use.

Psychological accounts

Extensive psychological explanations for addiction have been developed which are reflected, for example, in the DSM-5, which lists 34 diagnostic codes in the *substance use disorder* category (American Psychiatric Association, 2013). Psychological explanations include seeking to identify and define personality traits associated with addiction (Davis and Loxton, 2013; Gunn *et al.*, 2013; Wang *et al.*, 2015), substance use as 'self-medication' psychological coping mechanism (Danielson *et al.*, 2009; Hyman and Sinha, 2009), and PSU as part of a common factor model of co-morbidity (Sabri, 2012). Psychological theories are certainly significant in developing explanatory

frameworks for categorising and understanding the inner dimensions of PSU and naturally underpin many therapeutic responses (McMurran, 2007), which include Cognitive Behaviour Therapy (CBT) (Penberthy, Wartella and Vaughan, 2011; Carroll *et al.*, 2016), Motivational Enhancement Therapy (MET) (Marín-Navarrete *et al.*, 2017), psychoanalytic therapy (Bower, Hale and Wood, 2013), and person-centred counselling (Bray, 2016). However, the trend towards identifying ever more substance use and addiction conditions has been criticised for over-extending the reach of psychology in this area with the risk of pathologising normal behaviour (Alexander, 2012; Frances and Nardo, 2013).

Sociological accounts

Moving beyond the level of the individual, sociological explanations for PSU are significant. This section briefly reviews the development of sociological theory on drug use and addiction, from Lindesmith's (1938) seminal work, via functional sociology, appreciative positions and rational choice theories, through to social constructivists theories. This leads to an exploration of stigma as a significant sociological theme in understanding PSU. Many sociological theorists seek to understand 'addiction' in the abstract, separate from substance use, and in so doing to create linkages with behavioural addictions such as food, gambling and sex. For this reason, the term 'addiction' is used within this section in preference to problems substance use.

Sociological interpretations of addiction and PSU began with seminal work by Lindesmith (1938), who sought to develop a sociologically informed response to what he saw as moralistic attitudes towards addiction current at the time. Focussing on opiate drug use, Lindesmith identified the social context within which drug use occurs in determining whether addiction develops, characterising the determining factor as loss of self-control. However, Lindesmith rejected the notion that addiction could exist separately from the biological effects of a drug. Lindesmith was followed by functionalist sociologists, who departed from Lindesmith's view that addiction was inextricably linked to the biological effects of drugs, and who redefined addiction from loss of control to rationally understandable deviance. Merton (1938), for example, suggested that individuals unable to achieve social goals via 'prescribed patterns of conduct' may, rationally, chose deviant means (such as drug use). Such positions took an increasingly 'correctional' stance, leading to the development of an appreciative ethnographic stance, exemplified by Matza (1969), who argued for understanding towards apparently deviant behaviour and empathy towards those undertaking such behaviour. The appreciative stance challenged both the assumption that behaviour

condemned by the mainstream was inevitably problematic for those engaging in it, and the assumption that the social mechanisms which produced such behaviours reflected a failure of the individual or society. Rational choice theories of addiction, exemplified by (Becker and Murhpy, 1988), argued that humans choosing to undertake 'addictive' behaviours, including using drugs, do so in full cognisance of the effects and consequences and make a rational choice to continue. The rational choice position is predicated on the assumptions that individuals act consistently over time to maximize utility and that addiction results when past consumption raises current consumption.

Finally, social constructivist theories position addiction as a culture-bound phenomenon and highlight the ways in which addiction has been used to justify stigma. Such studies especially emphasise the role that criminalisation plays in causing the suffering associated with drug use. However, as Weinberg (2011) argues, the social constructivist position rarely addresses whether some drug users sometimes do in fact lose control of their drug use, or how to understand this sociologically. Indeed, Weinberg suggests that the central failure of social science regarding addiction has been an inability to address the puzzle of self-control. Social constructivist understandings of PSU and addiction are especially significant, informing understandings of societal responses through, for example, stigma and legislation, which are now examined.

Stigma associated with PSU has drawn equivalence with the stigma associated with a range of psychological disorders (Luoma, 2011), with negative consequences that include barriers to treatment, poor treatment outcomes and limited life opportunities (Ahern, Stuber and Galea, 2007). Luoma (2011) describes the multi-layered character of stigma, incorporating self-stigma, enacted stigma, courtesy stigma and structural stigma, which are now described. Self-stigma is associated with shame and a negative self-image resulting from an individual's self-identification as a person with PSU and is associated with poor treatment and recovery outcomes (Link *et al.*, 2015). Furthermore, PSU self-stigma combines with other forms of discrimination. For example, Link and colleagues (2015) describe the socially and psychologically damaging effects of stigma associated with dual diagnosis of mental illness and substance abuse (their term), which persist even once other symptoms have improved following treatment. Although conventionally regarded as entirely detrimental, Luoma (2011) argues that the potential positive effect of self-stigma as a motivator to change is under-researched, in the sense that awareness among recovery workers of self-stigma may enhance client motivation.

Enacted stigma describes the stigma and discrimination directed by others at people who use drugs and alcohol (Luoma, 2011; Kulesza, Larimer and Rao, 2013). Such stigma is reflected in the language used to describe people living with PSU. Terms such as 'junkie' and 'addict' underscore the status as social underclass, fulfilling a role that in previous times has variously been occupied by, among others, witches, Jews and homosexuals; namely that of 'scapegoat' for perceived societal failings (Scottish Government, 2009; Luoma, 2011). Indeed, the idea that addiction equates to moral weakness contributes to the scapegoating of such individuals, at a time when discrimination against many other minority groups is in decline (Zick *et al.*, 2011). Thus the experience of PSU carries the experiential sequelae of exposure to collective social, political and legislative responses, which are informed by values and beliefs as much as by evidence (Berridge, 2012; Russell, 2012). Courtesy stigma, first identified by sociologist Erving Goffman (1963), refers to the stigma and discrimination experienced by people associated with the stigmatised person. This includes friends and relatives of individuals living with PSU (Luoma, 2011), but extends to workers in treatment and recovery services who may experience poorer employment conditions and limited opportunities for career development compared with equivalent fields of employment (Eaton, Ohan and Dear, 2015).

Structural stigma refers to intentional or unintentional discrimination within institutional, governmental and legislative responses to addiction that have the effect of limiting the opportunities available to people with addictions (Luoma, 2011; Livingston *et al.*, 2012). Such discrimination creates barriers to accessing treatment programmes and limits the success of treatment (Ahern, Stuber and Galea, 2007; Simmonds and Coomber, 2009). For example, PSU treatment services are typically separated from mainstream health and social care services and underfunded in comparison to similar services for other groups (UK Drug Policy Commission, 2010). Similarly, Harris and McElrath (2012) describe the social control and stigma associated with the design and delivery of Methadone Maintenance Treatment (MMT).

Drug legislation is a further area of potential structural stigma through which substance users are treated differentially dependent on the substances used. Societal explanations underpin legislative controls to drug and alcohol use, social interventions and the broader societal and attitudinal dimensions of addiction, however, such accounts are criticised for adopting an overly simplistic approach, failing to fully take account of individual experience and meaning (Haber *et al.*, 2010). Taking the UK drug categorisation system as an example, Nutt and colleagues demonstrate that there is

little correlation between the harms associated with a range of commonly used substances and the status of those substances in law (Nutt *et al.*, 2007; Nutt, King and Phillips, 2010). Nutt controversially pursued this theme by suggesting that addiction to horse riding, 'Equasy', causes more harm than Ecstasy (Nutt, 2009). In this respect Nutt is reflecting the majority social constructivist concern that drug policy largely derives from political ideology, rather than evidence (Gstrein, 2018). At the international level, policy is increasingly informed by evidence; for example, in April 2016, the United Nations adopted a resolution addressing and countering the world drug problem, which sought to strike a balance between controlling supply and promoting person-centred values through access to treatment and promoting recovery (United Nations, 2016). However, as Horton-Eddison and Whittaker (2017) show, there is divergence between this high-level international agreement and state-level policy which creates ambivalence in the policy direction. Similarly, Brewster (2018) argues that ambivalence in wider society about drug use, especially cannabis, is reflected in policy, resulting in muddled legislation. Others argue that recent policy responses characterised by legalisation, decriminalisation and regulation are not, as often portrayed, progressive, but in fact represent the 'metamorphosis of prohibition', whereby the structure of drug policy changes, yet the underpinning principles remain unchanged (Taylor, Buchanan and Ayres, 2016). Further commentators argue that UK drug policy fails to adequately take account of gender and the specific needs of women (and men) (Wincup, 2016).

Societal accounts emphasise the social context of addiction by highlighting associations between PSU and social deprivation (Daniel *et al.*, 2009), although disentangling cause and effect is not straightforward (Duff, 2013; Hellman *et al.*, 2015). The linkages between PSU and social deprivation are apparent in the UK (Bancroft, 2017), and are currently especially stark in Scotland, where an epidemic of drug-related deaths currently exists and is associated with social deprivation (Copeland *et al.*, 2012; McAuley, Robertson and Parkes, 2017; Parkinson *et al.*, 2018). Furthermore, the secondary effects of substance use impact communities, wider society and even exert a global reach (Costa Storti and De Grauwe, 2009; Csete *et al.*, 2016).

Although some proponents of biological, psychological and sociological explanations for addiction advance their own position exclusively, others aspire to combine these theoretical ideas within a general theory of addiction (Hammer *et al.*, 2012; Griffiths, 2014). The feasibility of such a unified theory of addiction is questioned by Johnson (1999), however, who argues that addiction is best understood by layering theories that each provide a different understanding of the same phenomena. This approach allows

the inclusion of new theoretical ideas into existing schemas. An example of this is the development of spiritually informed theories of addiction which, although less developed within the literature, are of key importance to this thesis and are described later in this chapter within the spirituality of addiction section.

Paths towards recovery: responses to PSU

It is estimated that the average duration of an addiction 'career' is 27 years (Dennis and Scott, 2007), leading Best, De Alwis and Burdett (2017) to argue for a diversity of interventions and approaches to match changing needs during an extended recovery process, and Arria and McLellan (2012) to argue that the typically chronic, relapsing, and heterogeneous nature of serious addiction requires continuing care and adaptive treatment protocols, in combination with medication where appropriate. The complexity, longevity and controversy that characterise PSU inform a range of responses, which vary by focus and objective. Bio/Psycho/Social/Spiritual responses inform pharmacological, psychological, societal and spiritual programmes and interventions, while the intended results of such interventions range between total abstinence and a variety of harm reduction outcomes. Currently, PSU scholarship and practice in the UK coalesces around the 'Recovery' concept, however, there is a lack of agreement about what this means in practice. To understand current responses to PSU in the UK, an account of the origins and relevance of recovery within addiction is now developed. This encompasses the emergence of recovery within the mutual aid movement, developments within the mental health field, current applications within addiction and the relevance of this to the spirituality of addiction. The divisions between harm reduction and abstinence positions is also described, especially with reference to the UK and Scottish contexts.

Recovery

Recovery is not easily defined. Even within the mental health field, where recovery is well established, there remains a lack of clarity about the term (Lakeman, 2010; Aston and Coffey, 2012). Definitions of recovery in the PSU field generally emphasise individual recovery journeys, the importance of recovery capital, and finding meaning and purpose beyond substance use (Center for Substance Abuse Treatment, 2009). However, such definitions are criticised for being overly broad, for failing to reflect the dynamic nature of change, and for excluding the subjective and personal dimensions of recovery experiences (Best, De Alwis and Burdett, 2017). Furthermore, there is disconnection between the aspirations for recovery expressed in policy and the

translation of those aspirations to real world settings, with little consensus about what recovery means in practice and a risk that recovery becomes 'all things to all people' (Stevens, 2011; Ashton, 2012; Berridge, 2012). Brennaman and Lobo (2011), for example, adopt a concept analysis approach to demonstrate that various everyday definitions inform ideas about recovery in mental health settings, leading to ambiguities over application to practice.

The origins of the recovery movement lie with the emergence of the mutual aid approach during the first half of the Twentieth Century, initially through Alcoholics Anonymous (AA) (Emrick, 2004; Kelly, 2017). The contribution of AA and related organisations was to assert that recovery from addiction is possible and to identify the *individual* as the primary agent of achieving recovery by following the '12-Steps' (Kurtz, 2002; Brown *et al.*, 2007). Paradoxically, however, while wresting the locus of control from professional disciplines such as medicine, the 12-Step approach reinforced a disease model of PSU, whereby an individual remains a 'recovering alcoholic' indefinitely, constantly at risk of relapse. A central criticism of the 12-Step approach is, therefore, that 'alcoholic' or 'addict' becomes a permanent, disempowering condition (Kurtz, 2002).

From these mutual aid origins, the recovery movement developed in the United States (US) where the generic recovery or self-help movement, exemplified by ‘The Power of Positive Thinking’ and the 12-Step movement, resonated with individuals with mental health needs (Jacobson and Greenley, 2001; Drake *et al.*, 2003). This informed the emergence of the mental health service user movement, underpinned by a philosophy of human rights and self-determination. Meanwhile, the psychiatric rehabilitation concept developed, which emphasised community integration and overcoming functional limitations. These largely North American developments were critiqued for advancing an individual focus, without considering social and collective values (Lapasley, Nikora and Black, 2002; O’Hagan, 2004). In response, New Zealand became the crucible for reworking North American concepts of recovery to reflect an egalitarian ethos by fostering the ethnic and cultural differences that inform individual needs, while minimising the self-help and psychiatric rehabilitation aspects of the US approach (New Zealand Mental Health Commission, 1998; O’Hagan, 2001). The social culture within New Zealand, which stresses diversity, human rights, anti-discrimination and community, has been identified as informing a distinct recovery approach notable for empowering service users and reflecting the social, cultural and spiritual needs of the population (Lapasley, Nikora and Black, 2002; O’Hagan, 2004).

The evolution of mental health recovery in New Zealand has informed policy and practice developments in the UK (Davidson, 2005), especially in Scotland (Bradstreet and McBrierty, 2012; France *et al.*, 2014). An influential contribution to mental health recovery was offered by the Tidal Model, within which recovery is a process of 'getting going again' and episodes of acute care are a rehearsal space for supporting individuals to live meaningful lives (Barker, 2003; Barker and Buchanan-Barker, 2010; Young, 2010). Bonney and Stickley (2008) reviewed the British literature on mental health recovery, identifying six themes, which largely also apply to the PSU context: 1) the importance of (re)defining identify within the recovery process; 2) the growing significance of outcome measures to service provision; 3) the importance of re-engagement with mainstream society; 4) power imbalances arising from disconnections between empowerment rhetoric and real-world practice; 5) the importance of sustaining hope and optimism in the recovery potential; and 6) the need to balance risk and responsibility to achieve independence. Bonney and Stickley identified tensions between the aspiration of individualised recovery and the rigidity of systems that operate in real-world settings emphasising the importance of philosophical orientation in determining the definition and meaning of recovery. They also described how mental health practice is informing other areas, including the PSU field (Bonney and Stickley, 2008). More recently, Best *et al.* (2016) developed the Social Identify Model of Recovery (SIMOR), which depicts recovery as a personal journey characterised by a process of identity transition.

Involving people with lived experience is especially relevant to the PSU context (Duke and Thom, 2014) and the implementation of recovery-focussed approaches has been welcomed for re-balancing treatment systems to emphasise after-care and wider support needs, for shifting focus from clinic to community, for developing community and collective/participative approaches, and for driving a transition from a deficit to a strengths-based model (Best, De Alwis and Burdett, 2017). However, the emphasis on self-reliance and mutual aid that characterise PSU recovery has prompted criticism that the approach has been used to undermine professional services and reduce costs, especially within the UK context, where recovery gained prominence in the PSU field during the global financial crisis (Best, De Alwis and Burdett, 2017). Furthermore, it is argued that recovery has become a proxy term for a new abstentionism and as such is part of a wider moral crusade for temperance (Best, De Alwis and Burdett, 2017), sharpening tensions between abstinence and harm reduction positions toward PSU.

The abstinence – harm reduction polarity

The prevalence of addiction across diverse cultural and societal contexts has led to the emergence of a wide range of responses which, until relatively recently at least, divided between two opposing paradigms: abstinence and harm reduction (McKeganey, 2011; Ashton, 2012; Robertson, 2012). Although the legitimacy of this division is contestable (Best, De Alwis and Burdett, 2017), the discourse between these apparently opposing positions has been central to PSU practice and policy debates in the UK since the 1980s (Kalk *et al.*, 2018). Arguably, the either/or character of the abstinence/harm reduction dichotomy has now been supplanted by the both/and positing of the contemporary recovery discourse, however, given the significance of this debate in shaping drug policy and practice, it is important to understanding current thinking around recovery in the UK, including in Scotland.

Abstinence has historically underpinned drug policy in the UK and, despite the emergence of the harm reduction approach in the early 1980s (Stimson, 2016; Kalk *et al.*, 2018), continues to exert a strong influence (Roberts, 2009; Taylor, Buchanan and Ayres, 2016). The link between substance use and physical, psychological and social harms informed the conclusion that abstinence is the most effective response to addiction. This position is often allied with a deficit or 'disease' model, suggesting that drug and alcohol addiction arises from brain disease characterised by impulsive, and compulsive behaviours (Volkow, Koob and McLellan, 2016). Within this approach, sustained abstinence is the principle measure of success, both for individual outcomes and when evaluating treatment programmes. Conversely, continued use or relapse is considered failure (McKellar, Harris and Moos, 2009; Tuten *et al.*, 2012). Abstinence is also influential within the 12-Step mutual aid approach, in which sustained abstinence has become the *de facto* goal (Bluma, 2018). Indeed, as Dossett describes, within 12-Step fellowships, recovery typically includes abstinence from alcohol and narcotics on the presumption that safe use is impossible (Dossett, 2018). Furthermore, abstinence underpins many religiously (particularly Christian) supported drug and alcohol treatment programmes, which often articulate philosophical difficulties with the alternative harm reduction standpoint (Emrick, 2004; McCoy *et al.*, 2004; Brown *et al.*, 2007). Despite its significant role in treatment, abstinence faces several criticisms: first, that abstinence-based approaches are ineffective in achieving the stated aim of long-term abstinence (Kalk *et al.*, 2018); second, that, by focussing disproportionately on the cessation of drug use, such approaches typically fail to address the severe risks of harm experienced by individuals who continue to use substances dangerously (Csete *et al.*, 2016); third, that abstinence-focussed programmes place insufficient weight on

positive non-abstinence outcomes, such as reductions in substance use (Kiluk *et al.*, 2019); and fourth, that and abstinence-based treatment framework is incompatible with effective psychological interventions, especially Motivational Interviewing (MI), despite the widespread adoption of MI in such settings (Gallagher and Bremer, 2018). An alternative to the abstinence approach suggests that it is preferable to minimise the harms associated with substance use, rather than necessarily pursue abstinence at all costs.

While theoretical challenges to abstinence pre-date the 1980s, it was the HIV/AIDS challenge during that decade that drove the emergence of harm reduction as a coherent approach which prioritised the minimising of harm over promoting abstinence (Tammi and Hurme, 2007; Ashton, 2008; Berridge, 2012; Monaghan, 2012; Russell, 2012). Harm reduction was initially associated with the provision of clean injecting equipment (Parsons *et al.*, 2002), but has subsequently informed a range of interventions, including opioid substitution therapy (OST) (Ball *et al.*, 2014), provision of safe 'injecting rooms' (Hunt *et al.*, 2007; Lloyd and Hunt, 2007; Kappel *et al.*, 2016), prescribing of injectable heroin (Kalk *et al.*, 2018), provision of the opiate antagonist Naloxone (Hawk, Vaca and D'Onofrio, 2015; McAuley *et al.*, 2016), and interventions to reduce the risks associated with excessive alcohol consumption (Marlatt and Witkiewitz, 2002; Witkiewitz and Marlatt, 2006). Although commonly associated with practical interventions, harm reduction has strong philosophical and theoretical underpinnings which have given rise, for example, to 'harm reduction psychotherapy' (Denning and Little, 2011). Despite emerging as a significant movement within the drug and alcohol field, harm reduction remains controversial in some countries and contexts such as the US. (Des Jarlais *et al.*, 2009; Nadelmann and LaSalle, 2017), Russia, and some central European countries (Wall *et al.*, 2011), where people who inject drugs (PWID) frequently experience stigma and human rights abuses through punitive drug policing policies (Lunze *et al.*, 2015). Further criticism centres on the apparent disconnection between harm reduction theory, which is characterised as accepting and supportive, and the practical application, which is informed by twin public health *and* public order foci (Proudfoot, 2017). However, these criticisms of harm reduction are widely rebutted, for example, by Kimber *et al.* (2010) and Stockings *et al.* (2016), both of whom review the empirical evidence supporting harm reduction approaches.

The two decades up to 2010 saw a growing ideological divide within the PSU field in the UK, between the harm reductionist and abstinence positions, with significant consequences for the commissioning, design and delivery of services (Ashton, 2008,

2012). This led some commentators to conclude that, during this period, policy in this area was informed by ideology and belief rather than evidence or research (Russell, 2012). Such divisions are exacerbated by a lack of appropriate tools to measure recovery, both at the individual level and for evaluating programmes and services. Two such measures were identified by Burgess *et al.* (2011), who highlighted the need for further research in order for these instruments to become accepted in practice. In the absence of more sophisticated measures, self-report of drug and alcohol using behaviour remains the default indicator of success or failure. The ideological divide between harm reduction and abstinence underscores the distinction between grass-roots addictions recovery, as exemplified by the Scottish Recovery Consortium, in which recovery is associated with empowering service users to take control of their journey towards living more engaged, fulfilling lives (Best, 2010), and 'top down' interpretations of recovery which emphasise abstinence as the ultimate measure of recovery. For example, the Scottish Government report, 'The Road to Recovery' (Scottish Government, 2008), clearly positions recovery in abstinence terms. The different interpretations of recovery that characterise the current drug treatment environment are no more evident than for OST in Scotland. One review (Scottish Drug Strategy Delivery Commission, 2013) concluded that, despite overwhelming international expert opinion, underpinned by extensive empirical evidence to support the use of OST to achieve harm reduction objectives, there remains inertia among policy makers and service commissioners in implementing effective systems and enmity toward OST among some groups of service users, relatives and even professionals. Furthermore, this report noted that its recommendations were largely similar to those made in an earlier report (Scottish Advisory Committee on Drugs Misuse, 2007), but which were not implemented. A more recent UK-wide report which examined the case for imposing time limits on OST concluded that time-limiting treatment programmes are counter-productive and are associated with poorer treatment outcomes and relapse (Advisory Council on the Misuse of Drugs, 2014).

Although significant differences persist between the harm reduction and abstinence positions, the relevance of this polarisation is increasingly questioned. From the early 2000s, the concept of a continuum between harm reduction and abstinence was advanced by Kellogg (2003), who regarded the two paradigms as complimentary and symbiotic, rather than in opposition. This idea is developed by Best, De Alwis and Burdett (2017), who argue that the long-term nature of recovery requires a combination of harm reduction and abstinence approaches. Such thinking underpins the emergence of recovery as an organising principle within PSU treatment (Russell, 2012; Wardle,

2012) and its increasing acceptance among practitioners, theorists, educators, service users and policy makers (Scottish Government, 2008; Ashton, 2012; Berridge, 2012). Recovery thinking, thus, offers potential to bridge the ideological gap dividing harm reduction and abstinence, by focussing on the needs of the individual and though the application of collectively agreed principles in designing and delivering services. Indeed, examples of applications of this form of recovery thinking are beginning to emerge (Best, 2010; Cunningham, 2012; SMART Recovery UK, 2013). Applying recovery principles to real-world addiction settings takes various forms, reflecting ideological differences that characterise this field of work. For example, the SMART recovery programme (SMART Recovery UK, 2013), occupies a position between traditional mutual aid organisations, such as AA, and professionally led treatment and care agencies. SMART recovery applies elements of the mutual aid approach by establishing facilitated recovery groups, which in turn generate self-facilitated groups. And, like traditional mutual aid organisations, longer affiliation with SMART Recovery and higher meeting frequency are associated with enhanced substance refusal self-efficacy (O'Sullivan et al., 2016).

In Scotland, recovery has been identified as a potentiality unifying third force, and promoted as the future governing principle for Scottish drug treatment, which coalesced around the publication of the Road to Recovery policy document which positioned recovery at the centre of drug treatment policy (Scottish Government, 2008). However, little changed in service delivery since the inception of this policy, creating disappointment at the limited progress observed (Best, De Alwis and Burdett, 2017). Furthermore, the decade or so since the launch of this policy has seen a dramatic rise in DRDs in Scotland, leading many to conclude that the aim of full abstinence, implicit in the Scottish recovery approach, set recovery up as unachievable, thereby failing many people who use drugs. Arguably, in response to these perceived failings of Road to Recovery, policy makers in Scotland are now advancing a strategy that is more clearly aimed at addressing the harms caused by alcohol and drugs (Scottish Government, 2018). The thrust of this strategy is a public health first and rights-based response to treatment and prevention, focussed on supporting individuals to achieve recovery in their own terms (Scottish Government, 2018). Most specifically, the Scottish Government has recently established a Drug Deaths Task Force to tackle the crisis of drug deaths in Scotland (Scottish Government, 2019a) and has pledged specific targeted resource in its Programme for Government 2019 (Scottish Government, 2019b).

The spirituality of addiction

Spirituality is undoubtedly relevant to many aspects of the discourse around addictions recovery and is now examined here. This section locates addiction within the concept of spirituality developed in the previous chapter and is divided into who main parts. First, an account of the spirituality of drug use is given through reference to the human imperative to pursue altered states of consciousness which inform the use of psychedelic, hallucinogenic and entheogenic substances, both within indigenous cultures and as a feature of contemporary Western society. Second, the potential of spiritual approaches, methods and techniques to facilitate addiction recovery is reviewed. This includes a general overview of spiritual approaches to recovery combined with detailed reference to three specific spiritual traditions. This section is underpinned by a review of the relevant academic literature, but also references relevant non-academic 'grey literature'.

The pursuit of altered states of consciousness

The pursuit of altered states of consciousness is a common, but not necessarily universal, human endeavour, observed across cultures and throughout history and pre-history (Eliade, 1964; Winkelman, 2002, 2004). Traditional practices in indigenous societies commonly involve the use of plant medicines (Radenkova, Saeva and Saev, 2011) which collectively are described by the term entheogen (Ruck *et al.*, 1979; Shanon, 2002). Examples of use globally include: psychedelics, such as the peyote mushroom in First Nations culture (Halpern, 2004; El-Seedi *et al.*, 2005; Halpern *et al.*, 2005), psilocybin 'magic' mushrooms in Central America (Carod-Artal, 2011; Tylš, Páleníček and Horáček, 2014), San Pedro (De Feo, 2004; Bussmann and Sharon, 2006); the plant compound ayahuasca (Cummings, 1979; Tupper, 2009a, 2009b; R. Doyle, 2012) in the Amazon; psychedelic-dissociatives such as ibogaine in West Africa (Paskulin *et al.*, 2006; Alper, Lotsof and Kaplan, 2008); atypical psychedelics such as Ska María Pastora in Central America (Sheffler and Roth, 2003; Prisinzano, 2005); quasi-psychedelics such as cannabis, as used by Rastafari groups (C. Doyle, 2012) and Morning Glory in Central and South America (Mandarino, 1979); and deliriants such as Fly Agaric, as used by Siberian and Scandinavian shamans (Crundwell, 1987; Michelot and Melendez-Howell, 2003; Radenkova, Saeva and Saev, 2011). Although these examples differ in psychological effects and the cultural specifics of their use, they share the common aim of facilitating experience of, and connection with, spiritual and supernatural realms for the purposes of healing, divination and empowerment (Tupper, 2003; Dannaway, 2010; Goldsmith, 2010). Conceptually the use of these

substances is comparable to other non-drug practices aimed at invoking altered states of consciousness including fasting (Giordan, 2009; Monson, 2012), ecstatic dance (Rossano, 2006; Sexton and Stabbursvik, 2010), use of the sweat lodge (Wilson, 2003) and drumming (Winkelman, 2003).

In recent decades, the recreational or non-sacred use of many of these substances has developed, including san pedro (González *et al.*, 2006) and ayahuasca (Tupper, 2008, 2009a; Trichter, 2010); moreover, many recreational drugs include synthetic versions of traditional entheogens (Winstock and Ramsey, 2010; Zuba, Byrska and Maciow, 2011; Corazza *et al.*, 2013). Yet, while accounts of the traditional use of entheogens describe careful, reverential use, typically confined to ceremonies focussed on healing, guidance and empowerment (Eliade, 1964; Winkelman, 2004; Radenkova, Saeva and Saev, 2011), the use of psychoactive substances in contemporary 'Western' settings is characterised by problematic use and addiction (Winstock and Ramsey, 2010; Ayres and Bond, 2012). The contrast, between the use of psychedelic, hallucinogenic and entheogenic substances in 'traditional' cultures compared to 'Western' contexts, described above, bring the spiritual dimensions of substance use into sharp focus and, in so doing, raise the question of the ways in which the use of such substances in 'traditional' sacred contexts overlaps with and differs from the use of psychoactive substances in contemporary Western settings. The possibility that such apparently disparate experiences are conceptually and experientially linked suggests that the pursuit of altered states of consciousness is an innate human drive, common to all societies. This view is developed by scholars such as Du Plessis (2010), who argues that addiction arises from a distortion of a universal urge to pursue and experience altered states of consciousness.

On 19th April 1943, in Basel, Switzerland, Albert Hofmann ingested 250 micrograms of a compound that he had first synthesised five years previously: lysergic acid diethylamide (LSD). Hofmann's account of his subsequent psychedelic bicycle ride home (Hofmann, 1980) sits alongside other notable narratives, such as Aldous Huxley's (1954) description of his experience of Mescaline which opened the 'doors of perception', and Carlos Castanada's (1969) recounting of his (possibly apocryphal (Hardman, 2007)) experiences with peyote under the tutelage of the Toltec shaman don Juan. These narratives both reflect and inform the role of naturally occurring and synthetic psychedelics to awaken profound spiritual experiences that were to become a central feature of the counter-cultural revolution of the 1960s (Lee and Shlain, 1992). Although this time was characterised by the democratisation of spirituality, whereby

mysticism became available to all and no longer the sacred preserve of priests, shamans or medicine men (Mold and Berridge, 2008), the long tradition of mysticism in Christian, Jewish and Islamic/Sufi context should not be overlooked (Soltes, 2009). Although popularly described in revolutionary terms, this social, political and spiritual movement was in reality more *evolutionary.* Sherkat (1998), for example, argues that young adults of the 1960s did not reject the religious, spiritual and political ideas of their parents outright, but blended them with the radical thinking of the time. Historical accounts describe growing conceptual tensions between legislators and public attitudes and behaviour in response to the emerging psychedelic drugs (Chayet, 1968) which, Meier (1992) argues, led to the shaping of drug policy and legislation by political dogma rather than evidence, informed, for example, by views on race, the historical absence of user voices in shaping policy, and the influence of bureaucratic forces in applying such policy (Meier, 1992). This resulted in tighter legislative controls affecting a wide range of psychedelics and hallucinogens on both sides of the Atlantic (Brown, 1981; Roszak, 1995; Buchanan and Young, 2000); legislation that in the US had the effect of criminalising traditional peyote use among First Nations peoples (Simmons, 1969).

Initially, it perhaps appeared that the legacy of the 1960s would create a permanent shift in social attitudes towards drugs in the West. Parker, Aldridge and Measham (1998), for example, argue that the casual and recreational use of illicit drugs was no longer radical or counter-cultural, but had become normalised among populations of young people. It is apparent, however, that that current trend among young people, in Western countries at least, is towards lower prevalence of alcohol and illicit drug use (Babor *et al.*, 2018) (although specific population groups, such as university students in the UK, defy this general downward trend (Furtwängler and de Visser, 2017; El Ansari, Ssewanyana and Stock, 2018)). Furthermore, the relationship between substance use and spirituality, particularly among young people, is complex. The life course associations between religiosity and substance use were studied by Moscati and Mezuk (2014) through analysis of data from the US National Comorbidity Study. These authors found that significant increases or decreases in religiosity from childhood to adulthood were associated with substance use. They suggest that decreases in religiosity are associated with a more general rejection of parental values in the emerging adult, while increases in religiosity in adulthood may be in response to challenging situations for which substances become a coping mechanism. By contrast, Jang, Bader and Johnson (2008) report that childhood religiosity confers a cumulative advantage by decreasing the probability of using drugs during adolescence and early

adulthood. This finding accords with that reached by Hoffmann (2014), who analysed longitudinal data from the National Survey of Youth and Religion (n = 2,276) to conclude that religiousness, moral schemas and peer networks of non-drug users were associated with non-drug use.

Spiritual paths to recovery

Spirituality has long been a feature of PSU treatment, especially through the 12-Step approach, where the term 'higher power' is used to describe a source of strength beyond the self (Miller, 1990; Sterling *et al.*, 2007). Indeed, the relevance of spirituality to 12-Step programmes has been the focus of several early studies in this field (Geppert, Bogenschutz and Miller, 2007; Appel and Kim-Appel, 2009). Although, as Miller and colleagues observe, the emphasis on spiritual dimensions within 12-Step programmes such as AA and NA has emerged from tradition, rather than evidence of effectiveness (Miller *et al.*, 2008). Miller and colleagues tested the hypothesis that providing spiritual direction as part of addiction treatment improves outcomes. Manual-guided spiritual guidance was provided in addition to standard treatment, both during and following inpatient treatment, with treatment as usual providing a control. Contrary to expectation, spiritual guidance had no effect on spiritual practices or substance use outcomes. The authors suggested several explanations for this lack of measurable effect, including that spiritual growth is a natural process which cannot be hastened and that the intervention provided was of insufficient intensity to create a measurable effect in the population group studied (Miller *et al.*, 2008). This hypothesis is at least partially supported by Wolf-Branigin and Duke (2007), who evaluated the potential of spiritual involvement as a predictor of completion of a residential PSU treatment programme. These authors demonstrated that, within a sample of 46 programme participants, most of whom had been referred from the criminal justice system, higher levels of spiritual involvement were associated with longer lengths of stay, lower offending behaviour and less substance use at follow-up. These authors suggested that at least part of the utility of spiritual involvement in their research setting arises from the support and structure available within a faith-based residential facility. The authors acknowledged the difficulties of researching the effect of spirituality within a complex social system and also recognised that, given the religious underpinnings of the residential facility in question (the Salvation Army), a possible reason for non-spiritually involved participants leaving the programme early was experiencing feelings of isolation within a faith-based programme.

Further problems with research in this field were identified by Garcia, Babarro and Romero (2017), who undertook a systematic review of research on the inclusion of spirituality in addiction recovery treatment programmes. These authors identified 14 studies, which they found to be limited by several factors, including a lack of experimental research, poor quality research and diverse conceptions of the spirituality construct. These limitations mean that it is not possible to draw conclusions about the effectiveness of spiritual treatments *per se*, however, the studies reviewed did demonstrate that high levels of spirituality and spiritual practices are associated with reduced substance use and improvements in other areas of recovery. This last conclusion accords with the findings of Lee *et al.* (2016), that helping others and experiences of divine love predict reduced recidivism, reduced relapse, and greater character development among 195 adolescents with substance dependency court-referred to residential treatment. Similar findings arose from a study by Acheampong *et al.* (2016), demonstrated that religion and spirituality strongly protects against drug use, but that this effect is greater for women than for men, such that medium levels of religion/spirituality was associated with lower odds of simultaneous polysubstance use among women, however, the same reduction was only observed among men with high levels of religion/spirituality. An earlier review of the literature on religiosity and substance abuse published between 1997 and 2006 (Chitwood, Weiss and Leukefeld, 2008) showed that the majority of 105 articles reviewed found higher levels of religiosity to be associated with lower levels of substance use. Most of the studies investigated religiosity (rather than spirituality) and alcohol use (rather than illicit drugs) among adolescents and college students and most (87 of the 105 total) were carried out in the US. The focus on alcohol led the review authors to identify a need for further research on spirituality/religiosity among populations using crack and powder cocaine, opiates, amphetamines, and other major street drugs. The articles reviewed were largely based on cross-sectional studies which did not take account of changes in spirituality/religiosity or substance use over the life course.

The review undertaken by Garcia, Babarro and Romero (2017) highlighted a common feature of much research in this field, which is the US-centric nature of the available studies. This is also reflected by Ringwald (2002) who describes the multifaceted relationships between spirituality and addictions treatment by synthesising data derived from interviewing individuals with lived experience of addictions and professionals working in the field and reviewing relevant research. Ringwald shows that, while there is an established tradition of spirituality within the mutual aid sector, mainstream healthcare provision emphasises psychosocial and pharmacological interventions,

largely to the exclusion of spiritually informed approaches (Ringwald, 2002). Ringwald argues that spirituality is vital to the recovery journey for many individuals and that there is considerable variation in the form and content of such spiritually focussed recovery. Ringwald concludes that interest in diverse approaches to applying spiritually in addictions recovery is growing. Although Ringwald provides a rich description of the landscape of spiritual recovery as interpreted within discrete spiritual traditions, he does so from an almost exclusively North American perspective, whereby most of his interviews and research data are drawn from individuals and projects located within the US. Even the examples of indigenous spiritual approaches that Ringwald gives only refer to North American First Nations traditions. Despite this limitation, Ringwald does provide a useful framework for identifying areas for further research which invites cross-cultural comparison between the North American situation and European, UK and Scottish practice and scholarship.

In the UK, mainstream addiction treatment programmes, such as those available through the NHS, have generally concentrated on providing psychosocial and pharmacological interventions, while mutual aid organisations, such as AA and NA, emphasise the spiritual dimensions of recovery through identification with a 'higher power' (Khantzian and Mack, 1994; Nealon-Woods, Ferrari and Jason, 1995; Alcoholics Anonymous, 2002; Emrick, 2004; Galanter *et al.*, 2007). Over the last decade, however, support has grown for more widespread inclusion of spiritually informed interventions within mainstream addictions treatment programmes (Till, 2007; Scottish Government, 2008; Smith-Merry, Sturdy and Freeman, 2010; Berridge, 2012; Monaghan, 2012; Van Hout and McElrath, 2012). In particular, as addiction treatment becomes more recovery-oriented (Laudet and White, 2008; Center for Substance Abuse Treatment, 2009) and emphasises individual journeys within that process, the relevance of spirituality to mainstream programmes is increasing (Griffith and Griffith, 2002; Galanter *et al.*, 2007, 2011).

Increasingly, integration forms a central element in spiritually informed responses to PSU (Amodia, Cano and Eliason, 2005; Dupy, 2013). For example, Dodge, Krantz and Kenny (2010) identify spirituality as one part of a multidimensional comprehensive hypothetical model for PSU recovery, while Arnold *et al.* (2002) report spirituality as a source of strength and protection amongst PSU patients, and Watkins (1997) emphasises the potential of spirituality in empowering individuals to achieve and maintain recovery from drug and alcohol addictions. Integrated approaches such as these are underpinned by the holistic integration of body, mind and spirit (Patel, 1995;

O'Murchu, 1997; Maher, 2008) as an extension of the established bio/psycho/social model (MacKillop *et al.*, 2017). Such spiritually informed understandings describe addiction as the external manifestation of imbalance or maladjustment at the internal, spiritual, level and underpins the idea, common to many spiritual approaches, that addressing the spiritual root of addiction is necessary in order to achieve sustained recovery (Prezioso, 1987; Pardini *et al.*, 2000; Kurtz, 2002; Brown *et al.*, 2007; Galanter *et al.*, 2007; Andó *et al.*, 2016). Such integrated thinking informs comprehensive responses to PSU and non-substance addictions, which typically draw upon established and novel responses in various combinations to facilitate comprehensive re-evaluation and re-ordering of life by participants. One such programme, described by Du Plessis (2010), features six recovery dimensions defined as physical, mental, emotional, spiritual, social, and environmental and incorporates activities as diverse as walking on beaches and mountains, CBT, psychotherapeutic counselling, mediation, the use of ritual, and environmental service. Concepts of integration also extend to the spiritual 'journey' undertaken by recovery workers, which often mirrors that of their clients. Bray (2016), for example, reports that personal spiritual exploration and therapist reflection facilitates the delivery of spiritually based psychotherapeutic interventions for individuals in recovery from problem substance use.

Accounts of integration within substance use recovery programmes emphasise the importance of understanding the meaning applied to recovery experiences, which often arises through ritual, custom and culturally specific detail. This is illustrated now by reference to responses to addiction within three spiritual traditions which have been selected in view of their topicality and relevance to the field and are: the 12-Step mutual aid tradition; applications of Buddhism and Buddhist-inspired approaches in promoting recovery; and indigenous shamanic and entheogenic plant medicine approaches. For each of these three traditions, it is shown that a spiritually focussed explanatory framework for addictions informs application to recovery practice.

AA and related 12-Step mutual aid organisations such as NA, are one of the largest groupings within the addictions recovery field globally (Alcoholics Anonymous, 2002; Ringwald, 2002; Emrick, 2004). In 2017, the organisation claimed 2,103,184 members and 118,305 groups globally and activity in 173 countries (Alcoholics Anonymous, 2017). In 2015, 3,651 active groups were reported across the UK (Alcoholics Anonymous, 2015). The approach is underpinned by the '12-Steps': a series of personal processes undertaken by the person in recovery, aimed at developing

personal awareness of the impact of past behaviour, making amends and establishing positive patterns of living. This is a self-avowedly spiritual approach in which participants are supported in seeking and developing a personal connection with a higher power ("God as we understand him") (Alcoholics Anonymous, 2002, p59) and in which fellowship and confession are emphasised. Although emerging from North American Judeo-Christian origins (Emrick, 2004), AA espouses a broad and inclusive spirituality in which attendance and membership does not require or imply adherence to any faith or denomination (Ringwald, 2002). Although AA is popularly depicted as advancing a disease model of 'alcoholism', this is given scant reference within 'official' AA literature (AA, being a decentralised members' fellowship, reject centralised control but retain a machinery for communication and publication to support local activity public awareness). Instead, as Kurtz (2002) outlines, early publications (from the 1940s) refer to *'emotional maladjustment'*, and, by the 1950s, the term 'spiritual disease' was used. Kurtz argues that this change in language, far from representing a shift in the AA position, reflects a transition from a socially reserved decade, characterised by euphemistic language, to a more open time when the spiritual dimensions of the AA stance could be named explicitly. The AA conception of alcoholism as a spiritual disease frames the sufferer as powerless over the substance and describes a condition that can only be adequately addressed at the spiritual level (such as following the 12-Steps) (Khantzian and Mack, 1994; Kurtz, 2002; Emrick, 2004). Undoubtedly the organisation's global reach has been influential in the development of other mutual aid approaches and establishing spirituality as a dimension of addictions recovery more generally (Ringwald, 2002). The AA legacy is even evident within secular and ostensibly non-spiritual mutual aid organisations such as SMART Recovery, which has adapted many of the features of the AA approach (SMART Recovery UK, 2013). The 12-Step approach has also been applied within established spiritual disciplines, including Buddhism, which is now explored.

The idea that individuals experiencing drug or alcohol addiction are separated from the social mainstream is challenged by spiritual and existential ideas of addiction as a universal human experience. This perspective is exemplified by Buddhism, in which addiction is seen as a key cause of human suffering, released through acceptance and surrender of attachment (Dudley-Grant, 2003; Barker, 2008; Chen, 2010). In this respect, drug and alcohol addiction is a specific example of a universal human experience. As a non-deistic spiritual discipline, Buddhism provides a foil to monotheistic faith perspectives and offers a unique approach to addictions recovery, characterised by an internal locus of spiritual awareness, in contrast to the Judeo-

Christian preoccupation with an external higher power (O'Murchu, 1997). This is significant in light of the increased adoption of Buddhist (Dudley-Grant, 2003; Chen, 2010) and Buddhist-inspired approaches, such as mindfulness (Leigh, Bowen and Marlatt, 2005; Appel and Kim-Appel, 2009) in mainstream recovery contexts, particularly given the current emphasis on individuality within the recovery journey. Links connecting Buddhist philosophy, psychology and addictions theory with psychotherapy are developed by Dudley-Grant (2003), who describes Buddhism and psychotherapy as two disciplines concerned with the highest development of human potential and the alleviation of suffering. Dudley-Grant suggests that, in the research field, spirituality is often assumed to equate to the Judeo-Christian orientation, but that wider forms of spirituality are relevant to individuals in recovery. She argues that spirituality in the context of addition recovery does not necessarily refer to connection with a higher power external to the individual, but that the Buddhist view of paths to enlightenment provides alternative and effective ways of supporting sustained recovery (Dudley-Grant, 2003). The growing relevance of Buddhism to addiction recovery is reflected in the increasing application of meditation and mindfulness techniques within treatment programmes (Leigh, Bowen and Marlatt, 2005; Appel and Kim-Appel, 2009).

An instructive personal example of the application of Buddhist approaches to addiction recovery is given by 'Laura S' (2006), who presents an auto-ethnographic account of her experience of recovery from alcohol dependence ('alcoholism') through applying Buddhist principles within the 12-Step AA path. This work is divided into three parts, beginning with an account of the author's initial experience of working with the 12 steps, her growing awareness of the ethos of AA and the challenges she faced both in achieving sobriety and in coming to terms with the spiritual dimensions of the approach. The second section outlines the basic precepts of Buddhism illustrated with examples from the author's lived experience of alcohol dependence and recovery. In the final section, a Buddhist interpretation of the AA journey is presented as a framework to guide others facing addiction problems. Laura S seeks to link the precepts of the 12-Step approach with those of Buddhism, and in so doing develops an understanding of both concepts. She builds an explanatory framework to describe real-world experiences of addiction and recovery as a spiritual journey, albeit a framework limited by the subjective nature of a personal account which is not explicitly grounded in research. Another 12-Step Buddhist approach was developed by Chen (2010), who identifies Buddhist ideas of suffering as a key dimension of the addiction experience and describes how an understanding of Buddhist spirituality can inform engagement with the 12-Step recovery process. This perspective disrupts the notion that addiction is

only relevant to minority population groups, suggesting instead that addiction is a near-universal human experience, taking many forms (which may include drugs or alcohol). Buddhism has established a degree of acceptance within mainstream addiction recovery practice in contrast to other spiritually informed approaches, which are viewed more contentiously. These include traditional, indigenous and shamanic approach to addictions.

Increasingly, people who use drugs and alcohol problematically are looking beyond established interventions, whether from Asia or the West, to embrace approaches informed by indigenous healing practices (Struthers, Eschiti and Patchell, 2004; Struthers and Eschiti, 2005; Chen, 2010). Such practices include shamanic journeying and shamanic healing (Morse, Young and Swartz, 1991; Winkelman, 2004; Rich, 2011), First Nations drumming (Winkelman, 2003), First Nations healing and cleansing rituals (Ringwald, 2002), and the use of indigenous entheogenic plant medicines (Jilek, 1993, 1994; Metzner, 1998; Winkelman, 2009). Examples include the use of ayahuasca (Tupper, 2002, 2003, 2009b, 2011), ibogaine (Winkelman, 2001, 2009; Rodger, 2011; Schenberg *et al.*, 2014), and peyote (Winkelman, 2009; Díaz, 2010). Although diverse in form and custom, shamanic healing approaches are characterised by remarkable similarities in underlying cosmology, concepts of disease and approaches to healing (Eliade, 1964; Harner, 1980, 2002; Ingerman, 1991), and to the structures underpinning healing rituals (Van Gennep, 1960; Turner, 1982). In the shamanic view, addiction is the manifestation of spiritual loss or deficit, expressed as the linked concepts of soul-loss and power-loss, and through stale or stuck energy expressed as spiritual intrusion (Eliade, 1964; Ingerman, 1991).

Shamanic and traditional healing approaches, have a common intention of restoring balance at the spiritual level (Winkelman, 2001, 2002). These techniques and approaches are often accessed by individuals travelling to locations traditionally associated with their use, however, increasingly, such interventions, including entheogens, are available in the Western world and are being introduced into non-indigenous structured treatment settings to address psychological and spiritual distress (Halpern, 2004). This activity has prompted increasing research interest in the therapeutic use of entheogens. For example, Rosa, Hope and Matzo (2018) describe the therapeutic use of psilocybin (the active component in magic mushrooms) in palliative care settings where high levels of care and support are provided to facilitate exploration of deep spiritual experience in contrast to unstructured private use of entheogens, which is often associated with unpleasant or unpredictable results. Similar

conclusions are reached by Cruz and Nappo (2018), who attribute the positive results of ayahuasca among crack cocaine users to its use within a religious and ceremonial context, and by O'Shaughnessy (2017), who suggests that positive outcomes in addiction treatment associated with using ayahuasca alongside Western medicine and psychotherapy are in part mediated by the sacredness of the process. Similarly, dos Santos *et al.* (2016) identify potential therapeutic effects for ayahuasca use in problem substance use, anxiety and depression. Positive results are also reported by Schenberg *et al.* (2014), who describe ibogaine treatment for dependence on stimulant and other non-opiate drugs. The evidence supporting the use of ayahuasca for the treatment of addiction and mental health disorders is reviewed by Hamill *et al.* (2019), who report promising evidence of effectiveness and a mild side effect profile, and by Re *et al.* (2016), who identify physical purging, personal integration and connection with natural, the divine or Universal Consciousness as central to ayahausca's effectiveness and evidence of a growth of interest in the therapeutic potential of entheogens and other spiritually informed approaches to recovery.

Chapter summary

This review of the literature on addiction, recovery from addiction and the spirituality of addiction has described several competing and complementary theoretical frameworks which conventionally concentrate on biological, psychological or sociological explanations for addiction. It has described how the commissioning, design and delivery of substance use recovery services are characterised by tensions between the abstinence and harm reduction perspectives and that recovery is emerging as a dominant paradigm within the addiction field. Furthermore, spirituality is emerging as a potentially significant alternative paradigm, albeit one with an under-developed evidence base. Spirituality has been central to the 12-Step mutual aid tradition since the inception of Alcoholics Anonymous during the first half of the Twentieth Century, however, to date, mainstream publicly funded addiction treatment programmes have not placed importance on spiritual dimensions of recovery. Against this background, theoretical and practical interest in the relevance of spirituality to the recovery process and is growing, particularly through the application of approaches informed by traditions such as Buddhism and shamanism. The pursuit of altered states of consciousness, including the use of substances, is identified as a long-established feature of human behaviour, originating during the pre-historic era. In this respect, recreational and experimental drug use may be conceptually linked with the use of sacred plant entheogens in prehistoric and contemporary indigenous contexts,

although modern popular substance use has generally abandoned the sacred and reverential dimensions that characterise such traditional practice. The therapeutic potential of traditional entheogens is being explored in several contexts, including in facilitating PSU recovery. While evidence supporting the use of these and other spiritually informed approaches is growing, there remains a need for further research in this field.

This review of the literature on addiction and the spirituality of addiction underscores the need for further research in this field, particularly research with the potential to inform practice in treatment and recovery services. Specific areas revealed by this review which are worthy of further investigation include: the development and testing of instruments to measure the spiritual dimensions of addictions recovery in multicultural European/UK settings; the translation of learnings from spiritually informed mutual aid approaches to secular, publicly-funded addictions treatment programmes; and the development and adaptation of drug-free enthegenic techniques to support addictions recovery for individuals motivated to pursue altered states of consciousness. The approach taken to addressing the specific research questions identified for this project is developed in the next two chapters.

Chapter Four: Methodology

Introduction

The need to position this study methodologically is established in view of the specific methodological tensions implicit to spiritualty research arising from the challenges to defining spirituality and the uniqueness of spiritual experience. Second, the decision to adopt a two-phase qualitative research design, and the reasoning behind this decision, are described. An overview of the methodological positioning informing Phase One follows this. This provides an overview of the topic using a framework analysis approach. This informs the Phase Two methodological discussion and decisions to develop Phase 2 using Interpretive Phenomenological Analysis (IPA). The reasoning underpinning the choice of IPA is given, which includes the rationale for selecting this approach in preference to possible alternatives. The methodological implications of this decision are then analysed in terms of sampling and bracketing. It is important to note that, while the methodological process undertaken is described as a linear narrative, this was the result of an iterative process of theoretical review, fieldwork, analysis and further methodological review. The Phase Two methodological positioning was informed by the Phase One findings.

Identifying and responding to key methodological tensions

It is essential that research on complex and potentially controversial topics is underpinned by solid methodological foundations, consistent with the aims and topic of the investigation (Maxwell, 2005; Carter and Little, 2007). This section identifies the ontological and epistemological factors which create methodological tensions for addressing the research questions for this study. These include: paradigmatic tensions arising from researching spirituality; methodological tensions arising from the complexity implicit in the topic of addiction and spirituality; and the state of the evidence base. Two key sources of methodological tension are relevant to this study. This chapter responds to these methodological tensions and selects an appropriate methodological approach consistent with the aims of the research.

Spirituality: paradigmatic tensions

Fundamental tensions arise from the ontological and epistemological challenges implicit to researching spirituality. These challenges concern methodology, but also touch on philosophical discourse concerning the nature of knowledge. In this section, the methodological and philosophical challenges associated with spirituality as a research topic are described and a paradigmatic positioning for this study is established. Responding to the research challenge of spirituality requires that this study be situated within the paradigmatic landscape of social science and health research. Chapter Two established the significance of transcendence to concepts of spirituality, defined as an experience of psycho-spiritual movement beyond 'ordinary' reality, typically associated with connection with a higher power, deity, or ultimate source (Lapierre, 1994; Delgado, 2005; Koenig, 2012a). Transcendence presents a central challenge to researching spirituality, eliciting a range of possible scholarly responses reflecting different paradigmatic positions. The challenge associated with positioning this study is illustrated by contrasting the view of spirituality and transcendence within the paradigms that conventionally characterise social science research: post-positivism on one hand, and constructivism/interpretivism on the other (Creswell, 2011).

Post-positivism emerged as a critical revision of positivism. Post-positivists retain the positivist principle of objective truth, discoverable through rational, quantitative inquiry, while understanding observation may be fallible and so theory may be revisable (Clark, 1998; Robson, 2002; Tharakan, 2006; Cruickshank, 2012). Post-positivists are typically sceptical about spirituality and transcendence, asserting that such apparent phenomena result from supernatural beliefs irreconcilable with an objective physical reality. 'Transcendence' experiences are understandable in terms of biological processes which are, theatrically, amenable to rational explanation informed by objective inquiry (Robson, 2002; Paley, 2008c, 2010). Indeed, endeavours to apply quantitative methods to investigate experiences of spirituality and transcendence confirm the challenge to positivism raised by these topics. For example, the research instruments that are available typically use behavioural markers as a proxy for direct measurement of the inner experience of transcendence and spirituality (Monod *et al.*, 2011; Koenig, 2012a), underscoring the impossibility of directly observing spiritual experiences.

In contrast, constructivist and interpretative positions adopt a different position on spirituality and transcendence, rejecting the notion of objective reality in favour of multiple, subjective realities (Guba and Lincoln, 1994; Creswell, 2011). From this

perspective, spirituality describes psychologically, socially and culturally mediated subjective belief systems, while transcendence describes a subjective, individual experience, the meaning of which is discernible through qualitative research informed by interpretivist epistemologies (Upadhyay, 2010).

The individual and subjective characteristics of spirituality might initially suggest that this study is naturally positioned within the constructivist paradigm. Spirituality as a subject for research, however, reaches beyond well-rehearsed arguments between qualitative and quantitative methodologies, creating paradigmatic tensions that are neither satisfactorily resolved by post-positivism, nor by constructivism, because the supernatural basis for some forms of spirituality runs counter to the idea of a single objective reality. Nor are these tensions resolved by constructivism, or even social constructivism, because, although accounts of spiritual experiences and phenomena vary regarding specifics, this apparent variation characteristically conceals deeper universalities which reach beyond the non-generalisable limitations of constructivist and interpretive analysis to, in some sense, reveal common features of spirituality observed in many religious and cultural contexts (O'Murchu, 1997; Zinnbauer *et al.*, 1997). Examples include the concept of trinity expressed in many religions (O'Murchu, 1997; Carrington, 2010a), the similarities between traditional shamanistic practices from different cultures around the world (Eliade, 1964; Harner, 1980; Winkelman, 1989; Ingerman, 1991), commonalities between creation myths (Levi-Strauss, 1955), and ritual and ceremony in diverse societies (Van Gennep, 1960; Turner, 1982; Levi-Strauss, 1991).

The paradox of spirituality, then, concerns the juxtaposition of the profound uniqueness of individual experience with universalities that transcend culturally specific custom and tradition. Researching spirituality creates a conceptual bind which highlights the need for spiritually informed paradigms capable of reconciling the universal with the subjective. Furthermore, the possibility of spirituality as a research topic raises an additional area of debate concerning the legitimacy, and indeed desirability, of informing such research with spiritual knowledge. Such a paradigm would be underpinned ontologically by a belief that spiritual reality exists alongside physical reality and that transcendence describes experiences of moving between these realms. Epistemologically, such a stance implies that knowledge is gained through spiritual procedures, such as ritual and ceremony, calculated to interface the physical realm with unseen, supernatural reality.

Exactly these paradigmatic questions are addressed by Ann Carrington (2010a, 2010b, 2014), who develops a set of spiritual paradigms to inform and frame spirituality research. Carrington argues that, not only is spirituality a relevant and legitimate subject for research, but also, to achieve academic credibility, such research requires clearly articulated spiritual paradigms, positioned alongside established paradigms such as post-positivism, constructivism and critical theory. In this respect, she proposes that 'The Spiritual' offers a unique contribution to 'qualitativism' in establishing different ways of knowing and perceiving truth (Carrington, 2014). Carrington approaches the subject from the perspective of social work, however, her ideas have relevance to the wider debate on researching spirituality.

As Carrington sees it, the three physical paradigms of positivism, constructivism and critical theory are mirrored by their spiritual equivalents, which she identifies as 'spiritual positivism', 'spiritual constructivism' and 'conscious spiritual theory'. These initial six paradigms interrelate within a framework created by two duality pairs: the masculine-feminine, and spiritual realm-physical realm, which collectively form the 'spiritual triadic whole', comprising masculine, feminine and other, which Carrington labels androgynous. The space between Carrington's original six paradigms is occupied by a seventh paradigm, 'Integrated Spiritual Theory', which she positions as "an ultimate reality that is the sum [of] the multiple physical and spiritual realities" (p 307), capable of bridging the gap both between the spiritual and physical realms and between the masculine (positivist) and feminine (constructivist) positions. Carrington illustrates the relationships between the seven paradigms diagrammatically (Figure.4.1).

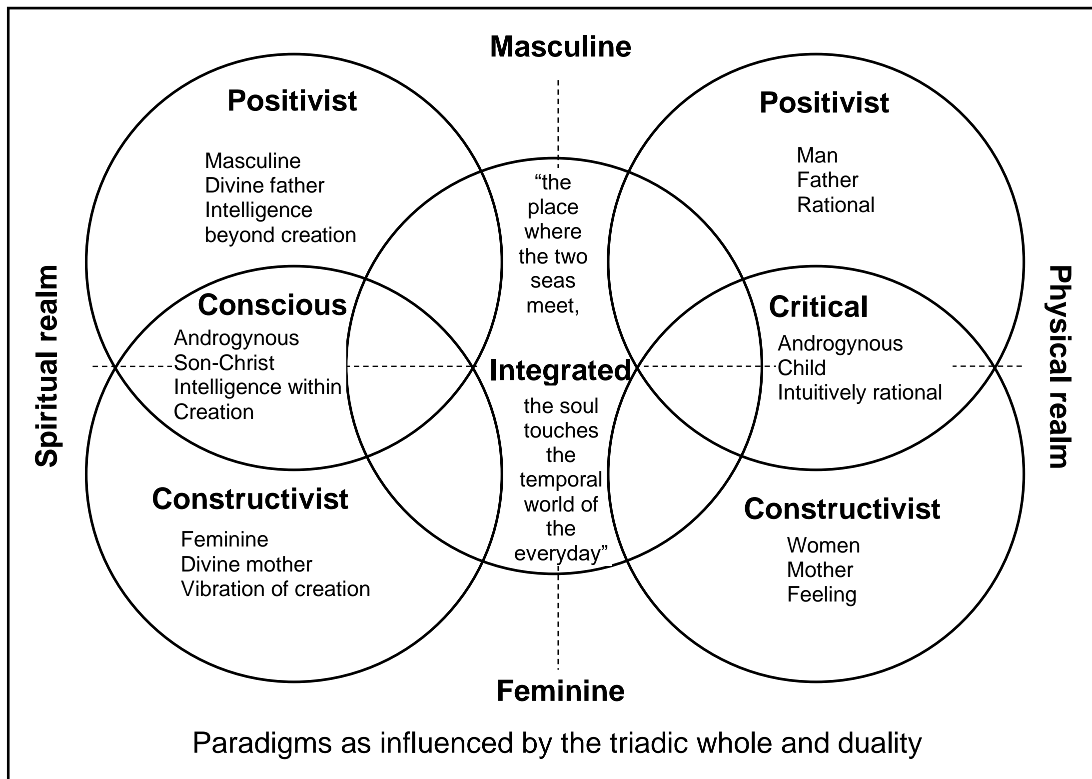

Figure 4.1 Integrated Spiritual Theory reproduced from Carrington (2010a)

Carrington develops ontological, epistemological and methodological positions for each of the seven paradigms, including the Integrated Spiritual Theory. She argues that, ontologically, Integrated Spiritual Theory is grounded in an ultimate reality which arises from the combination of the multiple physical and spiritual realities. This informs an epistemology in which knowledge is understood through existing perspectives which all exist simultaneously as multiple reflections of the ultimate truth and inspires a methodological position aimed at discovering the ultimate truth through the 'acknowledgement, exploration, and integration of all aspects of reality both physical and spiritual' (p307). It is worth clarifying that the masculine and feminine duality that Carrington invokes here is not primarily concerned with gender identify, theory or politics, but reflects the archetypal duality, encapsulated in the Daoist concept of yin-yang, which is expressed through the interaction of complementary elements in nature such as dark-light, night-day, moon-sun, and water-fire (Unschuld, 2009; Liu and Harrell, 2015). Although originating with Asian medicine, philosophy and spirituality, the yin-yang concept is applied to an increasingly diverse range of topics, such as business management (Fang, 2012) and theoretical physics (Johnson, 2010). However, it is unclear whether Carrington does enough to support her contention that positivism equates to the masculine and constructivism and interpretivist positions equate to the feminine. Carrington includes a further layer of complexity to her model in

the version presented in her doctoral thesis (Carrington, 2010a), which is not fully explicated in her shorter published articles (Carrington, 2010b, 2014). In the expanded version, the two-axis model incorporating the masculine-feminine and spiritual-physical dualities (the 'modes of consciousness’) is overlaid by seven 'areas of spiritual evolution and growth', represented by concentric rings, derived from the seven-element chakra system (Figure.4.2). Chakras are central to a theory of physical energy centres and levels of awareness, originating with the earliest vedic texts from India in the second millennium Before the Common Era (BCE), which has emerged in modified form as a feature of 'New Age' spirituality (Judith, 1999). Carrington positions her model as appropriate for assessing and mapping individual spiritual growth and development which she illustrates by charting her own personal process prior to entering academia. Carrington both develops and evaluates her Integrated Spiritual Theoretical Model through immersion in four spiritual traditions: Sufism, Hinduism, Buddhism and 'integrated spiritual', concluding that specific spiritual traditions are, at least partially, the cultural expression of spiritual universals.

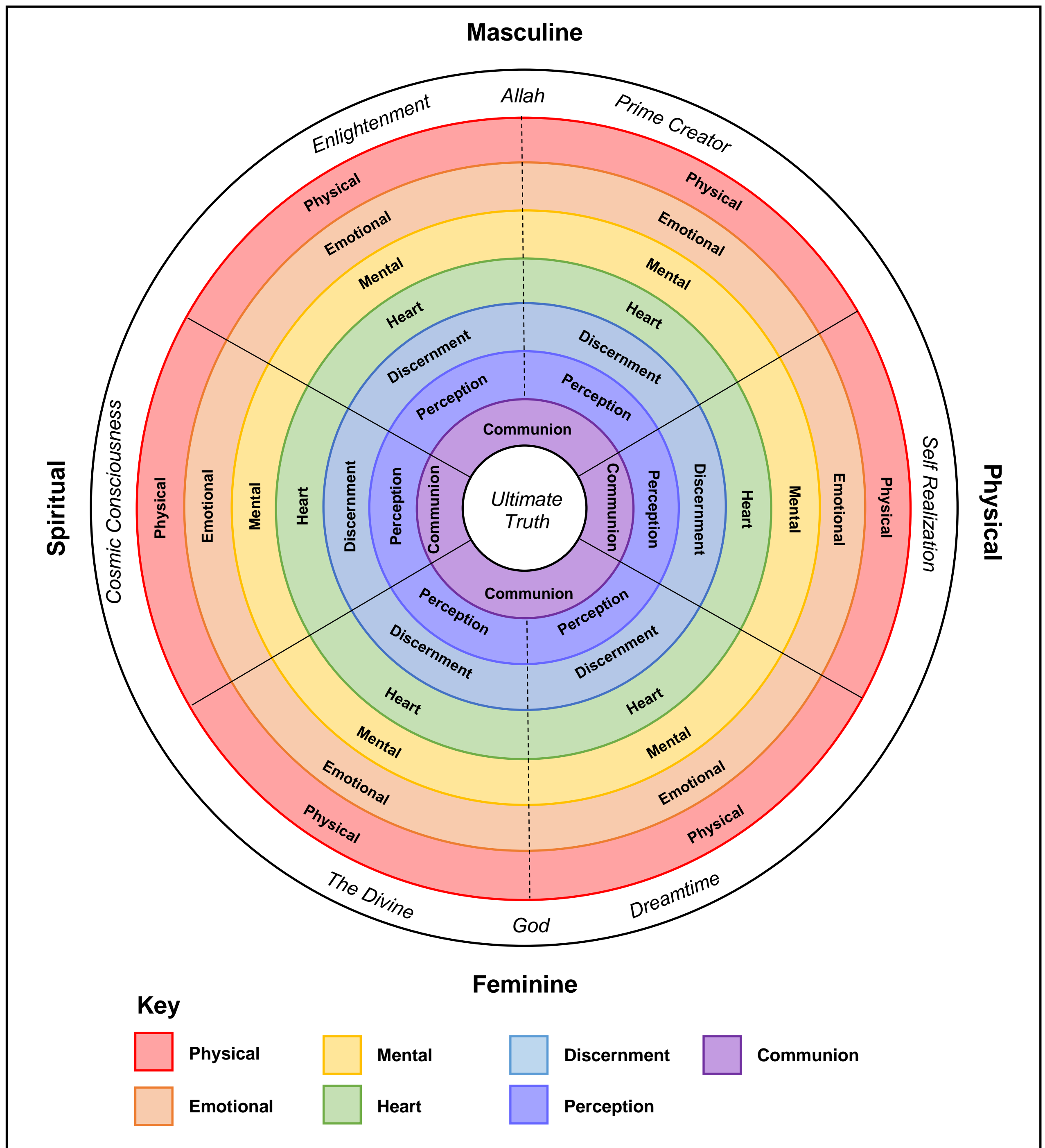

Figure 4.2 Areas of spiritual evolution and growth and modes of consciousness reproduced from Carrington (2010a)

Carrington's work is controversial. She aspires to establish the legitimacy of spirituality as paradigm for academic enquiry and is careful to situate her work within a wider 'qualitativism' project. She includes extensive autobiographical and reflexive data in support of her arguments and appears transparent about the choices that informed both her data collection and theory building activities. The masculine-feminine and spiritual-physical dualities underpinning Carrington's work support a holistic

understanding of an individual's life, which DiReda and Gonsalvez (2016) consider to have practical relevance to substance use treatment. However, identifying and applying paradigms within this framework is possibly the weakest element of Carrington's theory, at times seeming over-laboured in the effort to fit the evidence to the model. As a paradigm, Carrington's work is not fully developed, however, she raises important questions for this thesis regarding the relevance of spiritual epistemologies within qualitative research, particularly regarding her model of spiritual evolution and growth and modes of consciousness, which have potential for describing and explaining these dimensions of existence. These ideas inform novel applications of shamanic journeying as part of the analysis process for part of this thesis.

Methodological tensions arising from researching complexity

A second level of methodological tension is associated with the complexity arising from researching two topics which are each complex and nuanced and emerge from different research and methodological traditions. The addictions field has given rise to a rich and diverse cannon of research, which reflects a plurality of theoretical and explanatory frameworks. Thus, for example, positivist thinking leads to research on the biological and physical basis for addiction, while social constructivism informs analysis of the meaning applied to experiences of addiction such as stigma or legislative responses to drug and alcohol use. By contrast, spirituality is less established as a research topic, at least within the health field, and is methodologically challenging because it does not readily fit within established paradigms or conventional methodological approaches. Furthermore, research on the intersection of spirituality and addiction is in its infancy, meaning that there is limited existing research to inform this study. Extensively researched topics are the natural setting for methodological pluralism and analytic innovation, in which new approaches are evaluated against an existing body of knowledge. Conversely, novel or under-researched topics require well-established methods through which findings may be contextualised against knowledge developed in parallel fields (Flick, 2009; Hennink, Hutter and Bailey, 2011). The different research traditions that inform the research topics have potential to pull in different directions methodologically. Furthermore, these tensions are compounded by potential pluralities in research focus, between an etic examination of relevant practice and policy implications, and an emic focus on individual narrative and meaning-making.

Resolving the methodological tensions through a two-phase design

After reviewing the relevant literature pertaining to spirituality and addiction, identifying relevant research questions, and considering the methodological tensions associated with researching this field of enquiry, it became apparent that a single phase of research would be inadequate to produce meaningful answers. In particular, the research questions, and the current state of the research literature, require a broad overview of the topics informed by different standpoints, while also calling for the unique insight afforded by personal experience. Such reasoning led to a two-phase design, whereby Phase One offers an overview on the topic, the findings of which informed focussed inquiry during Phase Two. This section describes the development and methodical positioning of these two phases and outlines the methodological implications of this study design.

Phase One: an overview of the topic

The limited available literature covering the subject of PSU and spirituality created a need to develop a broad study of the topic. With this in mind, the purpose of Phase One was to develop a broad understanding of PSU, recovery and spirituality with the following aims: 1) to develop a foundational overview of key themes which inform understandings of addictions, recovery and spirituality, through the experiences, views and opinions of relevant individuals; 2) to identify the most relevant and interesting areas for in-depth investigation in Phase Two of the study; 3) to trial a research interview schedule and use the results to inform development of a Phase Two interview schedule; and 4) to provide a focus for developing qualitative research interviewing skills in advance of undertaking in-depth IPA interviews in Phase Two of the study. A further aim for Phase One was to gain experience of using key qualitative research techniques, particularly practical experience with NVivo.

These aims were accomplished during Phase One through thematic analysis of interviews with individuals presenting diverse standpoints, leading to a broad-perspective on PSU, recovery and spirituality, drawn from three overlapping groups: individuals with personal experience of PSU recovery, who identify spiritual engagement as relevant to their recovery process; PSU recovery professionals; and spiritual practitioners, teachers and leaders. Framework analysis was selected as an appropriate approach to meet the aims of this phase and to create outputs to inform the

next phase. The research methods use in Phase One are described in the following chapter and the findings detailed in Chapter 6.

Phase Two positioning: between nomothetic or idiographic approach

The Phase One findings created a choice for Phase Two between two divergent methodological paths: either a nomothetic analysis of the policy, practice and treatment context and implications of the spiritual dimensions of addiction and recovery; or an idiographic analysis of the lived experience of addiction and recovery. As Starks and Trinidad (2007) demonstrate, methodological choice is critical in shaping the form, products and audience of research and, more than any other factor, this decision determines the overall form and direction of the research. While there is no 'right', answerer to this, it is essential that the selection of methodology is informed by the research implications of each choice and their associated research products. An account of the process of evaluating these two options, is now given, which describes how the methodological positioning for Phase Two was arrived at.

The nomothetic approach

The nomothetic approach aims to inform theoretical constructions based on groups and categories of people with some degree of generalisability. A well-established form of nomothetic qualitative analysis is Constructivist Grounded Theory. The constructivist version of grounded theory, as advanced by Charmaz (Charmaz and Bryant, 2011; Charmaz, 2014), draws on the grounded theory approach developed by Glaser and Strauss (Glaser and Strauss, 1967; Strauss, 1987; Strauss and Corbin, 1997). This is characterised by systematic analytic procedures driven by the constant comparative method, in which coding at increasing levels of abstraction lead eventually to theory that is 'grounded' in the data. Although emerging from this original version of grounded theory, the constructivist version represents a significant departure that rests upon very different assumptions. This approach, which is rooted in pragmatism and relativism, assumes that data and theories are not discovered, but are constructed by the researcher through interaction with the data and the field. The researcher makes decisions about the categories throughout the process, through an interpretive and questioning approach which advances personal values, experiences and priorities. This process typically emphasises the diversity and complexity of particular worlds, views and actions in which any conclusions are suggestive, incomplete and inconclusive (Charmaz and Bryant, 2011; Charmaz, 2014). This perspective takes full account of the researcher’s perceptions, biases, opinions and preconceptions in colouring the

construction of data and does not require that a review of the literature be delayed until the end of the research process, as is the case in 'classical' grounded theory.

A significant drawback of constructivist grounded theory for this study concerns the complexity of spirituality as a research topic. The grounded theory aim of first achieving data saturation and subsequently to reach theoretical saturation, emphasises the spread of the data, rather than its depth (Corbin and Strauss, 2008). This highlights the limitations of the constructivist grounded theory approach to reflect the complexity and depth of spirituality and spiritual experience. The research products expected from grounded theory approach typically emphasise broad themes informing theory with wide applicability and would preclude a deep exploration of the meaning given to individual experiences of spirituality and recovery. Evaluating constructivist grounded theory from this perspective brought the research aims for Phase Two into sharp focus, helping to identify personal experiences of problem substance use, recovery and spirituality as the central interest for this phase. For this reason, it was decided to reject nomothetic methodologies in favour of an idiographic and experientially focussed positioning.

The idiographic approach

In contrast to the nomothetic approach, idiographic research is concerned with detailed understanding of the meaning embedded in subjective individual experience. Possible approaches include narrative analysis, discourse analysis and interpretive phenomenological analysis (IPA), all of which have potential to yield findings relevant to understanding personal experiences of spirituality and recovery. While all these approaches focus on individual experience, narrative and discourse approaches are less concerned with the meaning applied to that experience compared with IPA. Understanding the meaning associated with experiences of PSU, spirituality and recovery became the central aim of Phase Two, leading to a deeper exploration of IPA as a potential Phase Two methodological choice.

IPA emerged from a synthesises of phenomenology and hermeneutics (Smith, 2004; Biggerstaff and Thompson, 2008; Smith, Flowers and Larkin, 2009; Pietkiewicz and Smith, 2014). Phenomenology was developed during the early 20th Century by Edmund Husserl, who was concerned with developing an epistemological framework for portraying the essence of pure consciousness through understanding the lived experience of individuals (Smith, 2004; Smith, Flowers and Larkin, 2009). Husserl was critical of psychology as a discipline for attempting to apply the approach and methods of natural science to human experiences, arguing that people do not respond

predictably to external stimuli, but are motivated instead by the meaning given to such stimuli (Laverty, 2003). This led Husserl to position phenomenology as the study of lived experience by focussing on phenomena as they appeared through consciousness (Laverty, 2003; Smith, 2004). Husserl developed an approach called phenomenological reduction which, he proposed, provided access to the fundamental structures of consciousness (essences) and which, he argued, requires 'bracketing' out both external elements and individual biases.

Hermeneutics has ancient and spiritual origins, but was developed in the modern epoch by Heidegger as an ontological response to the interpretation of texts (Smith, Flowers and Larkin, 2009; Wilson, 2014). Heidegger shared Husserl's focus on lived human experience with the aim of understanding the meaning applied to this experience, however, Heidegger, argued that consciousness arises from the contextual situated-ness of a person's existence in the world. Central to this position is the idea that we are simultaneously both constructed by and constructing the world (Laverty, 2003). The hermeneutic process of understanding is, according to Heidegger, underpinned by interpretation, giving rise to the hermeneutic circle, in which the parts inform the whole and the whole informs the parts (Smith and Osborn, 2008; Pietkiewicz and Smith, 2014).

Although emerging from similar positions, an apparent contradiction arises between phenomenology and hermeneutics. Phenomenology places importance on bracketing the researcher perspective as separate from the experience of the subject, while the hermeneutic position holds that it is impossible for the researcher to separate themselves from the text (van Manen, 2007; Kakkori, 2009) and that instead a new approach to bracketing is required in which the researcher suspends understandings of the phenomenon so as to cultivate reflective curiosity. By combining these two apparently conflicting positions with an idiographic approach to research, IPA provides a framework for understanding the meaning applied to individual subjective experience while also taking full account of the interpretive function of the researcher (Smith, 2004; Smith, Flowers and Larkin, 2009). Thus, IPA is concerned both with the meaning that individuals apply to their experiences and interpretation of that meaning by the researcher, the 'double hermeneutic' (Brocki and Wearden, 2006; Smith and Osborn, 2008).

Early applications of IPA centred on health psychology research, however, the approach is increasingly applied in other branches of psychology as well as social science research more generally (Smith, 2004). The approach offers a good fit with the

aims of this study for the following reasons. First, the capacity of IPA to reflect the individual and subjective nature of experiences is of particular relevance to studying spirituality which is, by definition, subjective and elusive. Second, IPA provides a framework for exploring the meaning-making dimensions of this among participants, which fits well with the intention to understand spirituality within experiences of drug and alcohol addiction. Third, IPA's interpretive stance emphasises the impossibility of separating the researcher from the data and the necessarily subjective character of data analysis, which accords with the subjective and individual nature of spirituality and transcendence. Finally, IPA typically yields rich data which reflects the depth of meaning and experience that other more 'superficial' approaches may miss, and, in so doing, are likely to suggest topics relevant for future research, which is appropriate in the context of the current state of the evidence in this area.

In view of this analysis, IPA was evaluated as best meeting the need for Phase Two methodology. This decision placed limitations on the study and its findings. First, IPA implies undertaking research with a small narrowly focussed group (i.e., people with a lived experience of PSU and recovery), in contrast to Phase One, which was characterised by a range of standpoints. Second, using IPA would imply a shift of focus away from the generation of theory with potential to inform practice, in favour of understanding the meaning-making associated with individual experience. Finally, a risk associated with using IPA is that interpretation exceeds what is justified from the data. For this reason, any decision to adopt this approach should be accompanied by a clear processes for ensuring research rigour (Flick, 2009; Smith, Flowers and Larkin, 2009; Hennink, Hutter and Bailey, 2011). On balance, though, it was concluded that IPA best meets the needs of the study. The ability of IPA to ascribe meaning to deep and subjective experiences fits well with the spirituality focus of the study. This decision enables the development of a tightly focussed, coherent, and informative study capable of generating stimulating and relevant findings with the potential to inform future inquiry.

Methodological implications of IPA

Phase Two of this study emerged as IPA investigation of the experiences of people in long-term recovery from PSU, who identify spirituality as central to their recovery process. The choice of IPA had implications for several important aspects, including the gender of research participants, the importance of reflexivity and bracketing and the relevance and legitimacy of knowledge derived by spiritual means within the data

analysis process. An account of the methodological implications created by these aspects and the methodological designs they led to is now developed.

All-male sample

Studying a mixed-gender sample of participants makes it difficult to disentangle gender-related differences between participants from other factors, particularly given the small IPA sample size (Smith, Flowers and Larkin, 2009). By contrast, a single-gender study provides more assurance that any differences observed between participants are *not* the result of gender. This accords with the IPA approach, which emphasises selecting narrowly focussed, homogenous samples. The interpretation of homogeneity is necessarily subjective and will reflect the specific topics under investigation. It is common, however, for gender to be used alongside other factors to identify a distinct grouping within the IPA approach. For example, Smith and colleagues identify selection by gender as an appropriate strategy to narrow the sample (Smith, Flowers and Larkin, 2009, pp48-51). In view of the gender-related differences that exist in experiences of PSU, recovery and spiritualty, a single-gender sample was decided upon for Phase Two as being consistent with the IPA approach. In recent years, PSU research has increasingly addressed women's experiences, largely in response to the challenges and barriers faced by women in accessing services and to recognition of women as a minority grouping within treatment (Tuchman, 2010). Paradoxically, the specific experiences of men are underrepresented in the literature, creating a fruitful area of potential research which is recognised by growing interest among qualitative researchers. A study focussing on men's experiences of PSU, recovery and spiritualty would make a timely contribution to the literature in this area. For this reason, an all-male sample was decided upon for Phase Two of the study. The decision to recruit an all-male sample carried implications for the findings of this research. The IPA approach emphasises developing theoretical transferability, rather than empirical generalisability (Smith, Flowers and Larkin 2009); it is, therefore, important to provide adequate contextual and background information to the study to inform decisions about the potential transferability of any findings beyond the study group. In the context of the all-male IPA sample, this potentially limits the extent to which the findings are transferable to mixed-gender or all-female settings. In conclusion, deciding upon an all-male participant sample accorded with the chosen Phase Two IPA approach and targets a gap in the literature on PSU, recovery and spirituality. The purpose of this decision was to enhance the value and robustness of the findings, while recognising the limitations created by this choice on the immediate transferability of findings to other settings.

Bracketing and reflexivity

Bracketing is a central concept to IPA and describes methods aimed at identifying and separating out potential sources of bias arising from the researcher's perspective. Qualitative research is characterised by, among other aspects, engagement by the researcher with the data. As Tufford and Newman (2012) point out, in qualitative research, the researcher is the 'instrument for analysis' (p81), a fact that highlights the subjectivity of qualitative research. It follows, therefore, that the researcher brings *a priori* knowledge, expectations, emotions, experiences, values and beliefs which can affect all stages of the research process. The question is not, then, whether researcher bias exists, but how to respond to it. The aim of minimising researcher bias is criticised by some scholars, for example, Guba and Lincoln (1994) argue that qualitative research is typically presented in quasi-positivist terms in an attempt to establish equivalence with positivism, when, in their view, these two approaches are fundamentally different. Further, Guba and Lincoln suggest that the intrinsic subjectivity of qualitative research *enhances* the quality, power and relevance of such enquiry. However, most scholars adopt a more moderate position, recognising that researcher bias is inevitable, while taking pragmatic steps to minimise its impact through a range of bracketing activities.

Bracketing originated within the phenomenology tradition as a way of approaching the 'essence' of a phenomenon (Spiegelberg, 1965). However, as Tufford and Newman (2012) observe, there is a lack of uniformity as to what constitutes bracketing. and the term is interpreted differently by different authors and variously encompasses dimensions of thoughts, emotions, beliefs and values about the research topic or subjects. Gearing (2004) outlines a typology of six distinct forms of bracketing, reflecting the process in different intellectual traditions: Ideal (Philosophical); Descriptive (Eidetic); Existential Analytic; Reflexive (Cultural); and Pragmatic. The reflexive form of bracketing is most closely aligned with IPA, being underpinned by a relativist orientation, informed by both hermeneutics and phenomenology and having developed from both phenomenological philosophy and qualitative research. Reflexivity is characterised by process through which the researcher sets aside their suppositions and in which values, culture and judgements are identified and made transparent. But, according to Gearing (2004), external suppositions of the phenomenon itself are impossible to set aside.

Thus, activities to engender reflexivity, such as journaling and memoing, play an important role, as does a commitment to a transparent depiction of the researcher's

role in the process (Hennink, Hutter and Bailey, 2011; Doyle, 2013). Tufford and Newman (2012) identify three main bracketing methods commonly employed by qualitative researchers. These are: memo writing, bracketing interviews with an outside source, and maintaining a reflexive research journal. This is not an exclusive list, however, and considerable scope exists for creative methods of bracketing and reflexivity. Indeed, Tufford and Newman (2012) consider bracketing not only as a way to mitigate adverse researcher bias, but also as a means of enhancing the depth and acuity of analysis and results by strengthening researcher capacity for deeper reflection at all stages of the research process. Journaling and memoing provided the main reflexivity and bracketing activities within this study, however, the spirituality focus of this study presented opportunity to develop spiritually informed methods for reflexivity, which are described in the next section.

Shamanic reflexivity and analysis processes

One indicator of quality in qualitative research is consistency between research topic and methodological approach. Within this study, positioning spirituality as a central topic for research invited exploration of the relevance and legitimacy of including spiritually derived knowledge within the research process, as argued for by Carrington (2010a, 2010b, 2014) and reviewed earlier in this chapter. As a shamanic practitioner, I was drawn to explore shamanic journeying's potential to contribute to reflexivity by identifying potential researcher bias alongside journaling and memoing and to supplement conventional qualitative analysis. Shamanic journeying is traditionally undertaken in indigenous societies for healing or guidance and is characterised by a light trance state attained through of monotonous drumming (Eliade, 1964; Price-Williams and Hughes, 1990; Kjellgren and Eriksson, 2008). In recent decades, it has emerged as a contemporary spiritual practice, informed by the 'core shamanism' approach developed by Harner (1980).

The relevance of shamanic journeying to reflexivity lies with its potential to access aspects of the deep unconscious and, thereby, to reveal concealed researcher bias; while its potential contribution as an adjunct to data analysis relates to revealing patterns, connections and interpretations within the data. To better understand the potential of the shamanic process within qualitative research, the researcher developed a process for recording shamanic journeying, adapted from methods developed by Rock and colleagues (Rock, Baynes and Casey, 2006; Rock and Krippner, 2008). This was deployed with the dual aims of bracketing researcher bias through awareness-raising and, following the methods of Tufford and Newman (2012), to enhance analytic

insight consistent with Carrington's Integrated Spiritual Theory concept (Carrington, 2010a).This process provided a means of incorporating a spirituality epistemology within the analysis process, thereby reflecting consistency between methodology and research topic.

The researcher undertook the shamanic process prior to starting initial free coding for each transcript and informed the subsequent analysis process. The researcher, who is trained and experienced in shamanic journeying, used a monotonous drum beat to facilitate a shamanic journey of between 10 and 20 minutes in accordance with the 'core shamanism' method initially described by Harner (1980) and developed by Ingerman (1991). The journey included two elements, first a general shamanic reflection on the transcript in question, aimed at highlighting material for consideration during data analysis. Secondly, a reflexive element, aimed at highlighting possible sources of researcher bias, through shamanic responses to following questions, adapted from Roller (2015).

Assumptions

- What assumptions did I make about the participant or their responses to my questions?
- How did these assumptions affect or shape my interventions and behaviour during the interview?

Values, beliefs and life story

- How did my personal values, beliefs and life story affect or shape my interventions and behaviour during the interview?

Emotional connection with the participant(s)

- To what degree did my emotions or feelings for the participant affect or shape my interventions and behaviour during the interview?

Physical environment & logistics

- How did the physical setting/location of the interview affect the conduct of the interview?

Outputs from the shamanic process include a written summary of the shamanic journey, notes in response to the four questions above (Appendix B), and a hand-drawn artistic interpretation of the shamanic journey made immediately following the journey (Appendix C). These outputs were positioned alongside research journal activity and the ‘standard’ IPA process. This application of the shamanic journeying method demonstrated potential to make a novel contribution to methodology in the qualitative research field and provided a framework within which to test the legitimacy of spiritually derived epistemologies within academic research (Carrington, 2010b, 2010a, 2014). The shamanic process proved to be more effective as an adjunct to data

analysis than to countering researcher bias, which is discussed further in the final chapter.

Chapter Summary

This chapter has reviewed the factors informing the methodological positioning of this study. Methodological tensions were identified at the paradigmatic level, arising from positioning spirituality as a research topic, and at the epistemological level, arising from the complexities implicit to investigating the intersection of spirituality and PSU. Exploration of the paradigmatic issues led to an exploration of Carrington's Integrated Spiritual Theory (Carrington, 2010a, 2010b, 2014) which, although controversial and somewhat problematic, provides a theoretical framework against which to position this study. A solution to the epistemological tensions was reached by way of a two-phase research design, incorporating an initial phase of inquiry aimed at developing an overview of the topics, followed by a second narrowly focussed phase of research centred on developing an idiographic understanding of the experiences of men with a personal experience of PSU, for whom spirituality was significant to recovery. IPA was identified for Phase Two in view of its idiographic focus on the meaning applied to experience and the flexibility that characterises its analytic form. The implications for research methods created by selecting IPA were reviewed from the perspective of sampling, sample size, data collection and analysis, particularly in regard to selecting a male-only Phase Two participant sample. Bracketing and reflexivity dimensions of IPA were also discussed. Finally, the potential to develop novel reflexivity techniques informed by shamanic journeying practice was identified to accord with the spirituality topic of research in line with Carrington’s legitimising of spiritual knowledge in academic research. The next chapter describes the research methods deployed within both phases of this study.

Chapter Five: Methods

This chapter describes how the overall methodology outlined in the previous chapter was applied through the selection of research methods. The chapter begins by describing the research methods used in each phase of the study. This is followed by an account of the ethical dimensions of the study, including the formal ethics approvals associated with the study.

Phase One methods

The purpose of Phase One was to establish a foundation from which to develop an understanding of the research topics and to inform more in-depth investigation during Phase Two of the study, with the following four aims:

- To develop a foundational overview of key themes which inform understandings of addictions, recovery and spirituality, through the experiences, views and opinions of relevant individuals;
- To identify the most relevant and interesting areas for in-depth investigation in Phase Two of the study;
- To trial a research interview schedule and use the results to inform development of a Phase Two interview schedule;
- To provide a focus for developing qualitative research interviewing skills in advance of undertaking in-depth IPA interviews in Phase Two of the study.

This section provides an account of the methods used within Phase Two and is divided into four sections. First, participant selection and recruitment are discussed. Next, the participants recruited to Phase One are described. Third, an account of the data collection process is given. Finally, the data analysis process is explicated ahead of Chapter Six, where the Phase One findings are presented.

Participant selection and recruitment

Individuals were recruited to Phase One who represented diverse standpoints on PSU, recovery and spirituality in three categories: service users, addiction professionals and spiritual experts. The Selection criteria and rationale are summarised in Table 5.1 below.

Table 5.1 Phase One participant inclusion criteria and rationale

	Inclusion criteria	Rationale
All participants	Aged between18 and 70	Adults currently active in their field of expertise
Service users	Current or former service users within substance misuse treatment or rehabilitation services.	Direct experience of PSU and treatment or rehabilitation services
	Self-identify spiritual engagement as relevant to recovery process.	Direct experience of research topic
	Self-identify as stable in recovery.	Capacity to reflect on personal experience. Minimise risk of research participation negatively impacting active treatment processes.
Addiction professionals	Professionals working within a range of disciplines within addictions recovery services, in both the statutory and non-statutory sectors.	Insight into relevance of spirituality in treatment and rehabilitation settings
Spiritual experts	Professionally involved some aspect of spirituality, such as publication, teaching or maintaining a spiritual practice or religious ministry.	Spiritual viewpoint on addiction and recovery

Purposive sampling during Phase One selection established a connected network of participants from the three categories (Hennink, Hutter, & Bailey, 2011; Kuzel, 1999). Participants were identified either though contacts provided by members of the RAG, or through subsequent network contacts provided by research participants. Potential participants in the 'professional' category (PSU workers and spiritual practitioners) were selected based on the relevance of their professional experience to the study aims. These individuals were contacted directly by the researcher via email or telephone to describe the study, provide an information sheet and arrange a research interview.

In view of their potential susceptibility to coercion or acquiesce to recruitment (Renzetti and Lee, 1993; Alexander, Pillay and Smith, 2018), individuals in the 'service user' category were initially identified by a gatekeeper employed within a recovery-focussed community rehabilitation programme (Hennink, Hutter and Bailey, 2011). The gatekeeper identified potential participants, informed them about the study, provided an information sheet and passed their contact details to the researcher with consent for

contact. The researcher then contacted potential participants by email, telephone or text and arranged a research interview. All participants were asked to suggest other relevant individuals within their network to participate in the research, whereby potential participants were invited to contact the researcher directly. Three participants (one 'service user' and two 'professionals') were recruited through this method during Phase One.

The decision to undertake part of the Phase One fieldwork in Thailand was informed by two of the initial Phase One interviews and also involved a degree of serendipity. During his interview, one of the Phase One participants (Steve) discussed his experience of undertaking an opiate detox programme at Thamkrabok monastery in Thailand. This clearly had an impact on Steve and was significant in shaping his subsequent recovery journey. A second Phase One participant (Vaughn) also had connections with Thamkrabok by facilitating individuals from the UK to travel there to undertake the detox programme. The relevance of Thamkrabok to these two participants, raised the possibility of undertaking fieldwork there. Serendipitously, the researcher was due to visit Thailand for a family holiday in December 2015/January 2016 providing opportunity to include further investigation of the Thamkrabok model.

Participants based at the Thamkrabok Monastery in Thailand were recruited through contact provided by Steve. The researcher contacted the monastery by email approximately two months prior to visiting Thailand requesting opportunity to visit and interview service users and monastery workers. In response to this email contact, an administrator within the monastery confirmed that undertaking research interviews would be possible and outlined arrangements for this. Once in Thailand, details were confirmed by telephone two days prior to the scheduled visit. On arrival at the monastery, a service user (Jon) and monk (Panit) were available to undertake interviews and these were conducted in a suitable room with the monastery.

Twelve participants were recruited using the procedures outlined above and research interviews were undertaken during in two stages: the first nine interviews were undertaken between 9th May 2013 and 28th August 2013, and the final three interviews were undertaken in person in Thailand between 22nd December 2015 and 5th January 2016. These later interviews contributed to the international dimension of the study. The practicalities of overseas travel meant that the interviews carried out in Thailand took place sometime after the UK-based fieldwork, however, these interviews all form part of the Phase One data activity with shared aims and common interview approach. The time between the two periods of fieldwork were spent engaging with the literature

to develop a deeper awareness of the theoretical dimensions underpinning PSU, recovery and spirituality. A brief description of each participant is given below, and pseudonyms are used throughout.

Steve
Steve is a PSUs worker with a personal experience of PSU and recovery. He has a history of drug use which included opiates, benzodiazepines, stimulants and alcohol. At one time he received Methadone opiate replacement therapy (OST). He is now abstinent of illicit drugs and employed at a community-based drug and alcohol rehabilitation project in Scotland. Steve practices meditation and mindfulness and teaches introductory techniques in his current role.

Geraldine
Geraldine is a Christian minister who specialised in healthcare chaplaincy in hospital and community settings

Brenda
Brenda is a Consultant Psychiatrist who specialises in substance misuse and PSUs treatment.

Beth
Beth is a single parent with a personal experience of drug PSU and recovery. Her history of PSU includes LSD, Ecstasy and Heroin. Beth used several spiritually informed approaches to support her in her recovery journey, which included learning Reiki healing.

Benedict
Benedict is a shamanic practitioner and counsellor who also has a personal experience of PSU and recovery and who has worked as a drug support worker in several settings, including harm reduction and 12-Step projects.

Vaughn
Vaughn is a teacher of Buddhism and PSUs recovery worker with personal experience of problem alcohol use and recovery. He currently leads Buddhist retreats for people in recovery and supports individuals to attend a Buddhist detox programme in Thailand.

Alex
Alex is an Occupational Therapist specialising in the mental health field. As part of his work within a day hospital, he runs a drumming group for people with mental health problems, including some in recovery from problem alcohol use.

Samantha
Samantha is a shamanic practitioner, teacher and author based overseas. She has used shamanic techniques to support people in drug and alcohol rehabilitation.

Edward
Edward initially trained as a medical doctor before becoming a Church of Scotland minister, which led him towards a career in hospital chaplaincy and spiritual care position within the NHS.

Jon
Jon has a recent history of recovery from problem use of crystal meth. He attended University in the United States before returning to Thailand to attend a Buddhist detox

programme. He works at a monastery in Thailand where he is planning to take orders as a Buddhist monk.

Panit
Panit is a Buddhist monk and works at a monastery in Thailand where he shares Buddhist teachings with individuals in drug and alcohol recovery.

Sebastian
Sebastian founded and runs a residential rehab centre in Thailand, which primarily accepts clients from Australia, the UK and other English-speaking countries. He previously worked in and ran several community PSU services in England and has a personal experience of PSU and recovery, including using heroin and crack cocaine.

The twelve individuals selected present a diverse range of viewpoints on the research topics, meeting the aim of a broad overview for this phase of the study. There was an even distribution of participants between the three participant categories (individuals with a personal experience of PSU recovery; those identifying as PSU workers; and spiritual practitioners). Individual participants also overlapped these categories to a considerable extent, with six of the twelve participants falling under more than one of the three categories. For example, of the eight participants who worked in the drug and alcohol recovery field, five also reported personal PSU experience, while five of the eight 'spiritual practitioners' also described working in the PSU recovery field. This is unsurprising, given that it is common for people in recovery to become addictions counsellors, support workers or recovery workers (Dossett, 2018). Three of the twelve participants were included in all three categories (had personal experience of PSU recovery, worked in the PSU recovery field and were categorised as a spiritual practitioner) (Table 5.2).

The broad nature of the categories created diversity between participants within each category. A degree of judgement was also required to determine which category or categories applied to each individual. The 'Personal Recovery Experience' category applies to individuals who described PSU and recovery from drugs or alcohol, taking PSU as a self-determined concept by the participant. Simply using drugs or alcohol is not sufficient to warrant inclusion in this category, so, for example, Samantha refers to experimenting with psychedelic drugs as a student in the 1960s, however, this is not described in problematic terms and so Samantha was not included in this category. The category of 'PSU Worker' describes individuals whose paid or unpaid work concerns promoting recovery among individuals experiencing PSU. Individuals who undertook this role in the recent past were also included. For example, Benedict does not currently practice in the PSU field, but did so until recently and so was included in this category. The 'Spiritual Practitioner' category refers to individuals whose paid or

unpaid work includes a central spiritual dimension, such as practising as a spiritual or religious leader, writing or teaching on spiritual topics, or practising spiritually informed methods of healing for the benefit of others. It is important to distinguish between personal spiritual practice, which would not of itself warrant inclusion in this category, and professional practice. Thus, Beth described drawing considerable personal strength from learning Reiki healing, however, she undertakes this as a personal healing practice, rather than for the benefit of others and so she was not included in the list of spiritual practitioners. By contrast, Steve introduces the service users he works with to simple mindfulness and meditation practices and so he is included in the 'Spiritual Practitioner' category.

Participants exhibited considerable diversity in spiritual orientation. The cohort included two shamanic practitioners, two Christians, three Buddhists, three describing eclectic spirituality and two who did not identify any spiritual orientation. It is also relevant to note that four of the participants have a connection with a specific Buddhist monastery in Thailand, which applies a Buddhist doctrine to drug and alcohol detox and recovery. The full participant categories and spiritual orientations are summarised in Table 5.2 below.

Table 5.2 Participant categories and spiritual orientation

		Participant category			**Spiritual orientation**					
Interview	**Participant name**	**Personal recovery experience**	**PSUs worker**	**Spiritual practitioner**	**Shamanism**	**Christian**	**Buddhist**	**Connection with Thai Buddhist Monastery**	**Eclectic spirituality**	**No identified spiritual orientation**
1.01	Steve	✓	✓	✓				✓	✓	
1.02	Geraldine			✓		✓				
1.03	Brenda		✓							✓
1.04	Beth	✓							✓	
1.05	Benedict	✓	✓	✓	✓					
1.06	Vaughn	✓	✓	✓			✓	✓		
1.07	Alex		✓							✓

1.08	Samantha			✓	✓					
1.09	Edward			✓		✓				
1.10	Jon	✓	✓				✓	✓		
1.11	Panit		✓	✓			✓	✓		
1.12	Sebastian	✓	✓	✓					✓	

The network-based recruitment strategy revealed networks of association between participants, which included experience at the same residential detox facility, connections through existing recovery networks and shared professional links. Of the twelve participants, nine formed an extended network, two formed a separate small network and one was unconnected to any of the others. The participant networks are illustrated together with the participant categories in Figure 5.1 below.

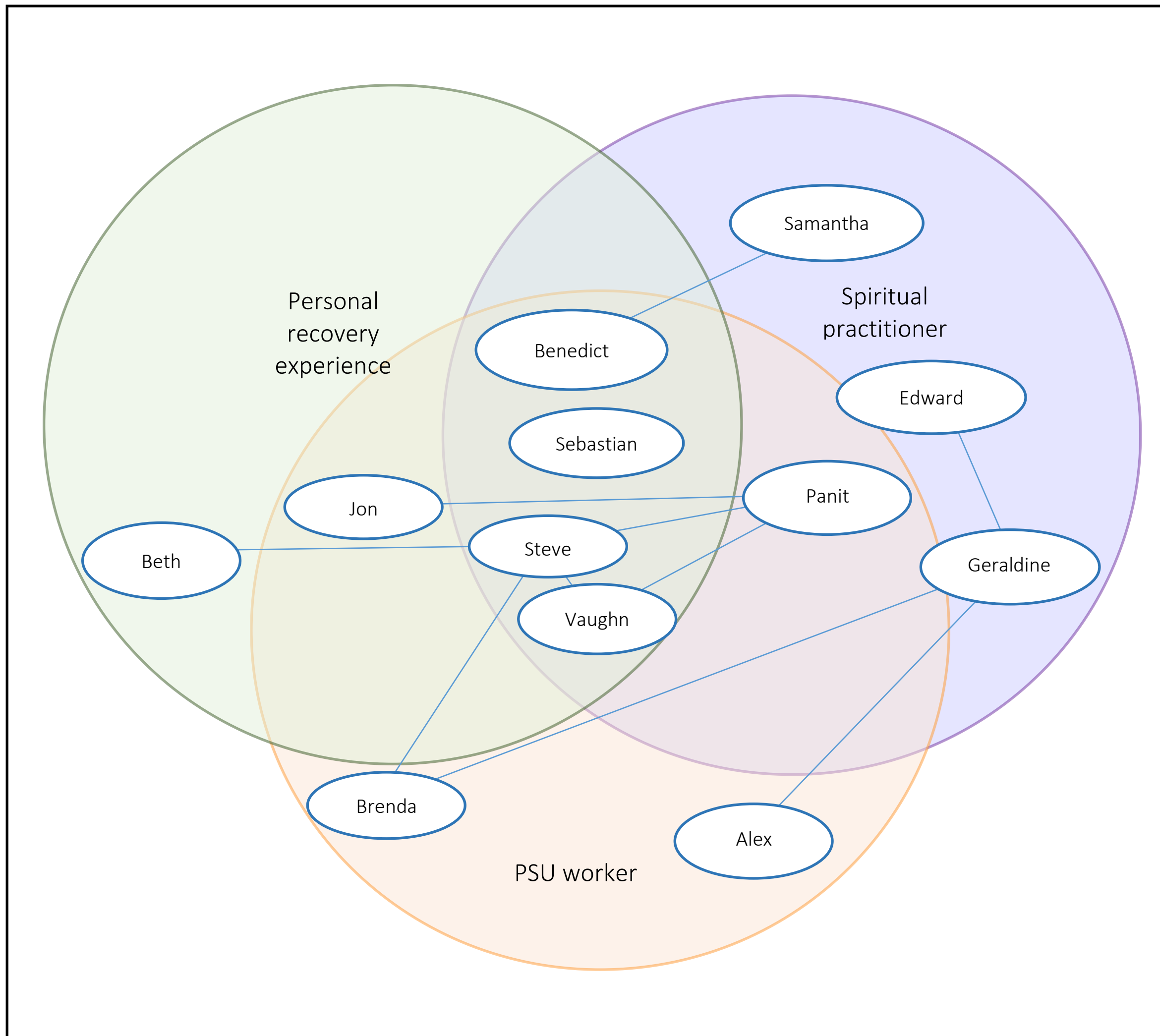

Figure 5.1 Participant categories and network connections

Data collection

Ten of the twelve interviews were conducted face-to-face in locations agreed between the researcher and participants, seven of which were carried out in Scotland and three in Thailand. The remaining two interviews were undertaken remotely via Skype, with participants in southern England and the US. Face-to-face interviews were generally arranged at the participant's place of work (for participants from the 'professionals' category) or the treatment service they attended (for 'service users'). In three cases, the interview took place in an alternative quiet private space agreed between the researcher and the participant.

Participants were issued an information sheet (Appendices D and E) describing the research and were asked to sign a consent form (Appendix F) agreeing to participate in a research interview and for the subsequent data to be analysed as part of the research project in anonymised form. Interviews lasted between 45 and 75 minutes

and were recorded using two Sony ICD-PX312 digital audio recorders. The audio recordings were transferred as MP3 files to a secure, password-protected computer and the originals deleted. Each interview was then transcribed by the researcher with the participant's name replaced with a pseudonym and other potentially identifiable information changed or removed to maintain participant anonymity. The audio files were then deleted, and the transcriptions stored within the University of Stirling's secure research data drive. This data will be retained for ten years before deletion. Should a participant have withdrawn consent, the relevant transcript would have been deleted and the data removed from the analysis.

Two interview schedules were developed, one for 'professionals' (Appendix G) and one for 'service users' (Appendix H), each of which included a series of open-ended questions and suggested prompts, linking to the research questions. The two schedules were structured similarly but differed regarding their content focus. The 'service users' schedule concentrated on participants' perceptions of the recovery process, the significance of spirituality to PSU recovery, and implications for practice. The professionals' interview schedule focussed on the theoretical and practical linkages between spirituality and drug and alcohol PSU and recovery, and implications for practice. Consistency within the interviewing process is an important dimension of quality within the research process, however, this must be balanced by the ability to respond dynamically to the data presented by participants during interviews. Consequently, as is common in qualitative research, these schedules were not followed rigidly, but were used a guide, with follow-up questions informed by participant responses (Hennink, Hutter and Bailey, 2011; Maxwell, 2005).

The international perspective

Phase One incorporated an international dimension aimed at enhancing the depth and breadth of the study. This included one interview undertaken via Skype with a participant in the US and three face-to-face interviews in Thailand. The international fieldwork highlighted the benefits and challenges associated with using internet video technology to facilitate qualitative data collection. The ability to undertake research interviews remotely and at minimal cost is a significant advantage in undertaking international research (Lo Iacono, Symonds and Brown, 2016; Seitz, 2016) and, indeed, the interview with Samantha in the US would not have been possible without Skype. However, this experience also revealed some of the technological and interpersonal shortcomings with Skype, which included a poor quality of the audio signal, a delay on the connection and limitations to non-verbal communication (Redlich-

Amirav and Higginbottom, 2014; Weller, 2015). Undertaking interviews in person overseas required considerable prior planning, which was rewarded by insight into the setting that only a personal visit can achieve. For example, two of the UK-based participants had attended a Buddhist monastery in Thailand, where the detox programme involved daily doses of a purging herbal tea. Whilst in Thailand, the researcher visited the monastery in order to undertake research interviews with a service user and one of the monks. During this visit, the researcher sampled a mild version of the herbal tea (insufficient to cause purging), contributing to his understanding of this aspect of the programme. Monastery premises including the area where purging occurs are depicted in photographs at Appendix I. Interviewing a non-English speaker at the monastery created further challenges, where interpretation between Thai and English was undertaken by someone whose English was limited, somewhat impeding data collection (Croot, Lees and Grant, 2011; Kapborg and Bertero, 2002; Squires, 2009). Nevertheless, this interview contributed a unique understanding of the Buddhist perspective to PSU. The experience of using Skype to undertake interviews and of interviewing non-English speakers, informed data collection decisions for Phase Two, leading to the conclusion that, in view of the depth and focus of IPA (Biggerstaff and Thompson, 2008; Brocki and Wearden, 2006), Phase Two fieldwork would comprise only face-to-face interviews with fluent English speakers.

Data analysis

A framework analysis approach (Furber, 2010; Ritchie *et al.*, 2013) was undertaken using NVivo 11. Interview transcriptions were coded in the order that the interviews took place to identify themes relevant to the aims of this phase of the study. Themes identified for each interview were categorised and placed within an emerging hierarchy prior to coding the next interview. Examples of this included '*Stopping drugs reveals vulnerabilities'*, '*Connection with nature*' and '*Self-medication*'. Once all transcriptions were initially coded, they were reviewed iteratively in light of codes created in later transcriptions to ensure relevant data had not been missed. Notes and memos were used within NVivo to capture relevant connections between themes, data and participants. Interview transcripts were also read reflexively, and relevant themes identified with the aim of developing the researcher's skills in qualitative research interviewing to inform the Phase Two of the study.

Phase Two methods

Phase One findings identified personal accounts of PSU and recovery to be a rich source of data, which was appropriate for in-depth exploration during the second phase. The purpose of Phase Two was to develop in-depth understandings of the experiences of individuals in long-term recovery from PSU, for whom spirituality played a significant role in their recovery process, and the meaning applied to such experiences. The choice of IPA to explore such narratives informed the selection of research methods, particularly sampling, sample size, data collection and analysis. This section provides an account of the methods used within Phase Two and is divided four sections. First, participant selection and recruitment are discussed. Next, the participants recruited to Phase Two are described. Third, an account of the data collection process is given. Finally, the data analysis process is explicated ahead of Chapter Seven, where the Phase Two findings are presented.

Participant selection and recruitment

IPA emphasises homogeneity among participants to concentrate on narrowly focussed participant experience. It was therefore necessary to identify and recruit individuals who shared characteristics and experiences relevant to this phase of the study. This involved taking account of participants' experiences of PSU, recovery and spirituality, but also entailed considering participants capacity to describe a reflective viewpoint on the recovery journey and factors including gender, location and age with the aim of recruiting a coherent sample, consistent with the IPA approach. The factors informing participant selection are now discussed, concluding with the Phase Two inclusion criteria.

Most obviously, participants needed to identify personal experience of PSU and recovery. Definitions of addiction and concepts of recovery vary widely, deciding upon a coherent definition was, therefore, important. Although it would have been possible to apply recognised diagnostic criteria, such as the ICD-10 codes *Mental and behavioural disorders due to psychoactive substance use* (World Health Organization, 1992) or the *DSM-V* category *Addictions and related disorders* (American Psychiatric Association, 2013), to identify PSU among participants, the idiographic approach underpinning IPA led towards a definition of PSU rooted in individuals' interpretations of their own experiences. Furthermore, the emphasis on identifying individuals in long-term recovery, rather than those actively experiencing PSU, meant that it would be have not been possible to apply formal diagnostic criteria retrospectively to individuals for whom

active substance use was in the past. For these reasons, participant self-identification was used to define PSU experiences among participants.

Second, participants were required to identify spirituality or some form of spiritual practice as central to their recovery process. The subjectivity of concepts of spirituality was discussed in Chapter Two (pages 34–52) and, as for the PSU criterion, participant self-identification was the chief measure of spiritual engagement. Several of the participants reported participating in formal religious activities either frequently or occasionally, while others described non-religious spirituality, which typically combined elements from several spiritual traditions. The key element was participant belief in the importance of spirituality to their recovery process.

It was important that participants had capacity to reflect upon their overall experience in long-term recovery, rather than being immersed in active PSU. As with PSU, recovery is a subjective concept and participant self-identification as being in recovery was emphasised. This implied individuals who described a degree of maturity in their recovery process, rather than those at the start of the journey, albeit with flexibility to reflect differing viewpoints about the nature of recovery. For example, the 12-Step fellowship characteristically informs a view of recovery as a life-long process, however, this did not exclude such individuals from participation. This viewpoint of recovery did not necessarily imply total abstinence from psychoactive substances and individuals who continued to use would not automatically have been excluded from the study if, overall, they described a meaningful recovery process. In fact, however, all the participants recruited viewed maintaining total abstinence to be important to their recovery process and in all cases reported several years of total abstinence from substance use.

Further criteria were selected aimed at identifying a homogenous, narrowly focussed sample, consistent with the IPA approach. As discussed in Chapter Four, it was decided to recruit an all-male study sample. Recruitment was also restricted to individuals resident in the East of Scotland and to individuals aged between 30 and 55 years, to ensure a homogeneous, focussed sample of participants most likely to be in the Middle or Late stages of recovery (O'Sullivan, Xiao and Watts, 2019). This age range also reflects the cohort of men at high risk of DRD (National Records of Scotland, 2019) . Finally, all participants were required to be fluent English speakers. This reflected the likelihood that engaging with individuals who were not fluent in English would hinder the communication of subtle ideas and deep experiences, which

were essential to the Phase Two fieldwork. Discussion of the foregoing factors informed development of the following inclusion criteria:

- Personal experience of PSU and recovery;
- Identify as in long-term recovery;
- Identify some form of spiritual practice as significant to the recovery process;
- Male;
- Live in Scotland;
- Aged between 30 and 55 years;
- English as first language.

Having established recruitment criteria, it became necessary to identifying an appropriate sample size. It is characteristic of qualitative research that sample size reflects a compromise between depth and breadth. While some approaches, for example, grounded theory, aim towards analysis of comparatively large samples, other approaches, including IPA, emphasise understanding individual meaning through a small number of cases. The in-depth idiographic perspective that characterises IPA creates natural limits on sample size. Although there are no absolute rules, studies involving between six and eight participants are common and it is unusual for IPA studies to report on more than 12 or 15 cases (Biggerstaff and Thompson, 2008; Smith and Osborn, 2008; Pietkiewicz and Smith, 2014). Indeed, Smith (2004) argues that single case studies are a valid (and valuable) application of IPA. The aim for Phase Two was to work with a sample small enough to undertake the in-depth case-by-case analysis that characterises IPA, while retaining the possibility of identifying cross-case emergent themes to inform tentative theory. An initial target of between six and eight participants was identified which was reviewed dynamically following initial data collection, with the final number being six.

A purposive sampling approach, consistent with established practice within IPA research (and other qualitative methodologies), was used to identify and recruit six individuals who met the inclusion criteria. The recruitment process was undertaken using a combination of direct introductions and 'network' recruitment, which is described in detail now. Initial contact with 'Pete' was via 'network' introduction from one of the Phase One participants. Following his interview, Pete then provided further network introductions to three further participants ('Sam', 'Martin' and 'Keith'). The remaining two Phase Two participants ('Sean' and 'Barry') were recruited after approaching the researcher directly, having become aware of the study via contact with PSU recovery workers familiar with the study. In both cases, these individuals became

aware of the research and, unprompted by the researcher, volunteered to participate in the study. Anyone expressing interest in participating in the research was provided with the research information sheet (Appendix J) and covering letter (Appendix K), given the opportunity to ask questions about their involvement in the study, and allowed time to decide whether or not to participate. Individuals who wished to participate were initially followed up by email and subsequently either by email or SMS message to confirm interview arrangements.

The Phase Two network source ('Pete') reported that at least one potential participant had refused to participate in the study and was not subsequently followed up. Similarly, the researcher had initial contact with a potential participant who eventually decided not to go ahead with the interview. Both these examples provide a measure of confidence that there were adequate opportunities for individuals to refuse to participate, or to withdraw prior to undertaking the interview. Furthermore, one participant ('Keith') suggested a potential contact, however, this was not followed up by the researcher as the individual did not meet the inclusion criterion for spiritual engagement. The time between initial contact and eventual interview varied between two and ten weeks. Lengthier time gaps were due to difficulties in finding times that suited both the researcher and the participants. Indeed, the participants all described varied work and personal commitments, reflecting the extent of their personal recovery, but which restricted their availability for interview.

Participants

Six participants were recruited using the procedures outlined above and research interviews were undertaken between 16th May 2016 and 5th January 2017. A brief description of each participant is given below; pseudonyms are used throughout.

Barry
Barry started using alcohol at the age of 13 and progressed within a few years to using Benzodiazepines, pharmaceutical opiates and street heroin. He first injected drugs at the age of 15. He had several episodes of inpatient treatment in mental health hospitals during which time he connected with the 12-Step fellowship. He maintains a personal spiritual practice which includes meditation, shamanism and yoga.

Pete
Pete began solvent use aged between 12 and 13 and later progressed to use alcohol, tobacco, cannabis, ecstasy, amphetamines, LSD, magic mushrooms, benzodiazepines pharmaceutical opiates and heroin. He describes a range of physical and mental health consequences of his substance use. He engaged with the 12-Step fellowship and practises mindfulness techniques and meditation, and he has also drawn spiritual inspiration from several authors.

Sean
Sean began using alcohol and tobacco at the age of 13 and progressed to solvents by the age of 15. He later used amphetamines, ecstasy, magic mushrooms and LSD. During his 20s he became a drug dealer, selling cannabis and amphetamine. His recovery journey led him to engage with Reiki, shamanism, Buddhism and mediation.

Sam
Sam began using alcohol aged 13 and progressed to using cannabis, benzodiazepines and opiates. He entered drug treatment and was on a methadone prescription for several years. He engaged with the 12-Step fellowship and an evangelical Christian church, through which he attended a residential Christian rehab programme.

Martin
Martin was initiated into illicit drug use at the age of 12. During his teenage years he used a wide range of substances including alcohol, cannabis, benzodiazepines and LSD, eventually developing dependence on opiate drugs. He was active in the local music scene in his late teens and 20s and was a member of several bands. He connected with the 12-Step fellowship and attended a 12-Step residential rehab facility also practices yoga and meditation.

Keith
Keith described using alcohol at the age of 13 and later progressing to cannabis, stimulant drugs and eventually opiate drug use. He connected with the 12-Step fellowship, which formed the basis of his recovery journey.

Participants all described using a range of substances, starting in their early teenage years, which included: tobacco, alcohol and solvents; psychedelics and hallucinogens such as cannabis, LSD, and mushrooms; stimulants including amphetamine and ecstasy; and ‘downers’ such as benzodiazepines, barbiturates, pharmaceutical opiates, street methadone and heroin. Several of the participants described injecting drugs and most received Opiate Substitution Therapy (OST), such as methadone, at some point. Participants typically started to pursue recovery in their late twenties and reported having achieved abstinence by their mid-thirties.

Participants described an eclectic approach to spiritually, characterised by engagement in more than one practice. All but one (‘Sean’) identified the 12-Step fellowship as of central importance to their recovery journey; other spiritual disciplines mentioned included: meditation and mindfulness; Buddhism; shamanism and nature spirituality; Christianity; Yoga; and Reiki. The spiritual practices reported by each participant are illustrated in Figure 5.2 below.

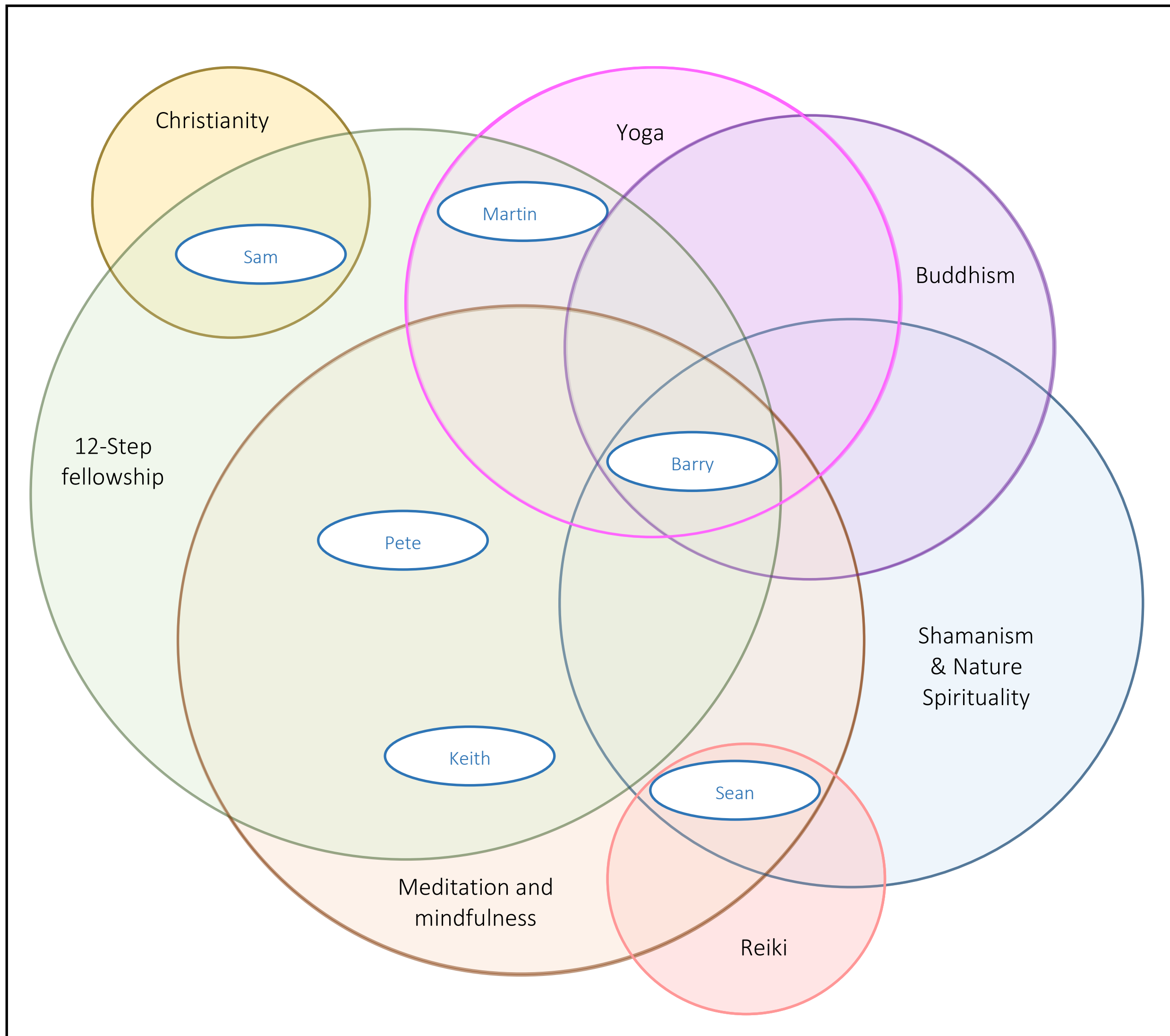

Figure 5.2 Spiritual practices reported by Phase Two participants

Data collection

In-depth individual semi-structured interviews are the most common form of data collection within IPA research, although other approaches including focus groups and textural analysis have also been used, and Smith (2004) argues that further work is needed to develop the potential of such sources of data within IPA. Nevertheless, here the focus lies with the *individual* meaning-making applied to *individual* experience. Within this context using focus groups would risk diluting the uniqueness of the individual experience, therefore, data collection was exclusively achieved through individual semi-structured interviews.

Times and locations for interviews were agreed between researcher and participants. Four of the interviews ('Pete', 'Sam', 'Martin' and 'Keith') were carried out at the researcher's work base, using an interview room furnished for counselling purposes.

The remaining two interviews ('Barry' and 'Sean') took place at the participants' homes at the invitation of the participants. The home visit interviews were carried out following initial face-to-face contact and the researcher 'checked in' and 'checked out' with a third party prior to and following each of these two interviews. Interviews lasted between 70 and 80 minutes and were audio recorded using two Sony ICD-PX333 digital recorders. Audio recordings were transferred as MP3 files to a secure, password-protected computer and the originals deleted. Interviews were then transcribed by the researcher, during which pseudonyms were applied and other potentially identifiable information was changed to maintain participant anonymity.

An interview schedule was prepared to guide the interview in a style consistent with the IPA approach (Appendix L). This schedule focussed on key topics aimed at addressing the research questions and was developed in the light of the Phase One interviews. In accordance with IPA principles (Smith and Osborn, 2008), the schedule was not followed rigidly, but rather guided a flexible response to participant content. The focus was also adjusted as fieldwork progressed (Smith, 2004), in response to initial interviews, particularly to include questions of gender and male identity which emerged as a significant topic.

Data analysis

Analysis was undertaken in accordance with the IPA approach, characterised by repeated reading of interview transcripts and case-by-case inductive analysis to identify emergent themes (Smith, 2004; Brocki and Wearden, 2006; Smith, Flowers and Larkin, 2009; Pietkiewicz and Smith, 2014). Conventionally, IPA analysis is undertaken either by hand-written coding or by annotating the document onscreen using a word processing application (Smith, Flowers and Larkin, 2009; Pietkiewicz and Smith, 2014). In this study, by contrast, NVivo 11 was used as the primary analytic platform for most of the analytic cycle from initial free coding to identification and organisation of superordinate themes, with only the final stage of refining and organising superordinate themes undertaken in Microsoft Word. Electing to use a computer-based analysis tool enabled coded data to be traced through all stages of analysis and aided the development of coherent thematic structures. Nevertheless, the ease with which NVivo enables connections between themes also creates the potential to jeopardise the idiographic foundation of IPA by undermining the case-by-case foundation to analysis. It was therefore important to ensure that the analytic method did not compromise the integrity of the study. For this reason, thematic coding of each transcript was

undertaken separately and emerging themes[1] were organised under separate headings for each transcript to avoid premature inter-case coding. Cases were analysed ideographically, rather than collectively, whereby analysis proceeded on a case-by-case basis initially, with cross-case themes only identified later. The NVivo-based IPA analysis process is illustrated in Appendices M–R, which include a series of 'screenshots', depicting the analysis process at different stages relating to a short extract from the interview with Barry, in which he described his early contact with the 12-Step fellowship.

Analysis began by performing a deep reading of each interview transcript and sequential 'free coding' to record initial responses to the experiential and meaning-making aspects of each account. Free coding was accomplished in NVivo using the 'annotate' function, whereby notes are attached to specified sections of text (Appendix M). This was equivalent to the conventional IPA free coding step of manually annotating printed transcripts. At the same time, 'tentative' cross-case themes were coded and retained for reference later when identifying recurrent inter-case themes. Parking these observations in this way served an important reflexive function by capturing potential inter-case connections while focussing on the idiographic analysis of individual cases.

Following the free coding stage, a three-part initial thematic coding process was undertaken in accordance with Smith, Flowers and Larkin (2009). This comprised descriptive coding, in which the main issues and themes within interviews were noted, linguistic coding in which participant's use of language to convey content and meaning was analysed, and interpretative analysis, aimed at scrutinising participants' content and meaning from the researcher's subjective perspective. This entire process was undertaken through detailed, line-by-line analysis, through which the essence of participants' narrative and meaning emerged. Appendix N illustrates the in-text coding process, while Appendix O illustrates the organisation of NVivo nodes into the three thematic categories (descriptive, linguistic and interpretive).

Initial thematic coding informed the identification and organisation of emergent themes within each transcript individually, through a process of summarising and revising existing coding and undertaking further analysis, depicted in Appendix P. This in turn informed identification of superordinate themes, reflecting commonality and divergence both within and between cases. At this stage, cross-case themes were identified by

[1] 'Nodes' in NVivo

combining existing themes, creating new overarching ones and reviewing the list of tentative cross-case themes to reflect the nuanced interplay between cases. Superordinate themes were developed by iteratively comparing and combining emergent themes from each of the six transcripts. Appendix Q depicts an early stage of this process, characterised by the emergence of cross-case superordinate themes, while Appendix R illustrates an intermediate phase during which these themes become more organised and coherent.

Having identified the superordinate themes in outline form, the analysis process transitioned from predominantly identifying and organising themes, to describing them within a coherent narrative structure. The utility of NVivo reduced at this stage, and I therefore transferred the final analysis process to Microsoft Word, within which I refined the high-level organisation of themes and their descriptions through an interactive process of writing and redrafting. Throughout the analytic process, repeated cross-checking with transcripts ensured that emergent themes remained rooted in the data, and informed development of a coherent structure to illustrate the relationship between themes and to frame a narrative, account evidenced by detailed commentary on relevant data extracts. Analytic integrity was assured through academic supervision as a forum to evaluate and develop thematic and narrative coherence.

Discussion chapter methods

The two phases of this study generated a wealth of themes and ideas, presenting the challenge of how to best organise the material coherently and identify relevant linkages between the findings from the two phases. This became especially relevant in writing the Discussion chapter, which set out to draw both phases of research together. Although arising from discrete phases of fieldwork and analysis, the second phase emerged, in the main, as a more detailed exploration of some of the themes generated in Phase One. In order to capture and reflect the linkages between two phases, and to provide a structure within which to discuss the findings, a data process was developed, informed by the theory on qualitative evidence synthesis (QES) (Hannes and Macaitis, 2012). This entailed creating an organisational structure within which to locate the analytic themes from both phases. This was done by first reviewing the themes from both phases (Appendices S and T), identifying areas of overlap and similarity as well as areas of conflict or discord and then combining these themes into a common matrix (Appendix U). The structure to emerge from this process was closely aligned to the thematic structure developed within Phase Two, into which the themes and sub-themes from both phases were mapped. Creating this matrix enabled an overview of the entire

study to be taken, facilitating a process of selecting the 'stand out' themes, which hold greatest relevance to theory and practice in the fields of problem substance use, recovery and spirituality. This process underscored the salience of personal narrative in shaping understandings of the spiritual dimensions of the addiction and recovery process (which was most relevant to Phase Two data) and helped structure understandings of the relevance of spirituality to practice (which emerged most strongly in Phase One). Through this process, a structure emerged which provided a framework for the Discussion chapter to contextualise the findings within debates within the published literature.

Ethical dimensions and considerations

Qualitative research is underpinned by widely agreed ethical principles, the most commonly mentioned in the literature being *autonomy*, *beneficence*, *non-maleficence*, and *justice* (Gelling, 1999; Pollock, 2012). In this section, the research methods are examined against these principles to demonstrate the ethical underpinnings of this study. The two phases of the study are considered collectively in this regard in view of the overlap in fieldwork methods between the two phases.

Autonomy describes the right of persons to be considered as individuals with personal agency to control their involvement in any research. Within this study, autonomy concerns participant recruitment, participant consent and the right to withdraw consent. The recruitment process was carefully considered by the researcher and doctoral supervisors and designed to eliminate coercion and ensure that participation in the study arose from active choice, rather than acquiescence. Potential participants were provided with a written information sheet which described the study and invited them to contact the researcher to discuss participation. It was emphasised that participants had a right to withdraw from the study at any time.

The principle of *beneficence* specifies that research involving people benefits either participants directly or the wider population. In this study, the main potential benefit is at the level of the wider population through knowledge to inform services for people in recovery. Benefits to individual research participants are probably minimal, but, nevertheless, are worth mentioning. First, taking part in research provides opportunity for participants to contribute to a study relevant to their interests and experience and thereby to help to develop practice in the field. Additionally, for individuals with personal experience of recovery, the process of telling their story to an interested person during a research interview may become a positive experience. The positive dimensions of

choosing to participate in qualitative research is explored by Lakeman *et al.* (2013), who highlight the therapeutic potential of storytelling in social science research.

The *non-maleficence* principle asserts that potential harm associated with the process, whether to participants or the researcher, is minimised. Potential harms to participants include giving up time to participate, distress arising from the interview process and inadvertent disclosure of individually identifiable data. Potential harms to the researcher include risks associated with lone working and distress associated with interviewing participants on personally sensitive topics. The research methods for this research were selected with the aim of minimising these risks and of safeguarding participants from harm.

It is essential that a decision to participate is informed by an appropriate understanding of the methods to be used. Potential participants were provided with a written description of the planned research interview and the topics to be covered, including that they would be asked to discuss their personal experiences of substance use. This information also included details of the time commitment, the interview topic focus and that fact that no financial compensation for participation was available. The participant information also described the risk of distress to participants, in view of the in-depth nature of the interviews, and advised participants that they could ask for the interview to be paused or stopped at any time and that support was available following the interview, if required, in the form of personal support provided by a member of the RAG. Participants were also provided with contact details for an independent named individual who was available to provide follow-up support after the interview if required. Understanding of this information was confirmed immediately prior to the start of each interview. The researcher is an experienced PSU clinician, registered nurse and qualified counsellor with considerable experience working with individuals on sensitive topics, including PSU, trauma, abuse and loss. Interviews were carried out sensitively, taking account of the potential impact on participants.

Participants faced potential indirect harm through failures to protect personally identifiable data collected as part of the research process. Standard measures were applied to secure participant data, which included the use of password-protected computers, deleting original interview audio files following transcription and limiting access to the raw data to the research team. Participant anonymity was assured by pseudonyms and removing or changing geographical and other references which might identify individuals. Careful judgement was used when writing up findings and selecting quotes to illustrate themes to minimise the risk of participant *self-identification* and the

risk of *misrepresenting* participants whilst preserving a rich description of the thematic data.

The potential risk to the researcher associated with this study is small, but includes harm associated with lone working whilst conducting research interviews and the risk of distress in response to interview content. Some interviews were conducted in participants' homes, creating risks associated with lone working. In such circumstances, standard lone working protocols were followed, which include undertaking appropriate risk assessment, and checking in and out with a third party prior to and following interviews. All participants were recruited through professional and research networks developed by the researcher, which provided a 'screening' function prior to their involvement. Several participant accounts included graphic descriptions of substance use and other potentially distressing situations. In these circumstances, the risk of distress to the researcher is relevant and was addressed through journaling, as already described in Chapter Three, and reflexive debriefing with research supervisors if necessary.

The *justice* principle establishes the need for fairness and equity towards research participants, particularly by ensuring that individuals recruited to the study are representative of groups likely to benefit from the research findings. Understanding and reflecting the viewpoint of individuals with personal PSU experience is central to this study and was achieved through the data collection process during both phases of the study. Additionally, meaningful user involvement was reflected in the establishment of an interdisciplinary Research Advisory Group (RAG). This group included a former service user with personal experience of PSU, treatment and recovery, whose input was invaluable in keeping the project grounded in the service user's frame of reference. The idiographic focus of this research restricts the generalisability of the results, nevertheless, the study has potential to inform treatment and recovery practice in the PSU field and, in so doing, meets the justice principle.

The relevance of the four ethical principles of *autonomy*, *beneficence*, *non-maleficence*, and *justice* has been examined and has been shown to provide a sound ethical framework for the study. Both phases of the study were approved by the School Research Ethics Committee (SREC) School of Health Science, University of Stirling (Appendix V). It was initially proposed that the study might involve NHS patients and, consequently, Phase One was approved by the NHS East of Scotland Research Ethics Service (EoSRES REC1) (Appendix W). In fact, neither phase involved NHS patients

and NHS ethics approval was not required for Phase Two. The University of Stirling sponsored the study (Appendix X) and provided indemnity cover (Appendix Y).

In this study the novel shamanic analysis process described earlier raised potential ethical risks which were only identified after the completion of fieldwork. While it is not common practice for qualitative researchers to provide potential participants with a detailed description of the analysis process planned for their data, it is arguable that the novel shamanic process, which formed part of this study was sufficiently unusual to require that participants should have been informed about this, particularly as this aspect of the work has potential as a contribution to the literature on qualitative research analysis. In this case participants were not specifically advised about the shamanic analysis process. This potentially limits their informed consent to data collection and subsequent analysis. Furthermore, an account of aspects of the shamanic process is provided at Appendix B which originally linked each participant pseudonym to an account. Potentially this could have enabled a participant to self-identify themselves by comparing general details about the study participants with those contained in the shamanic process description. To minimise this potential risk, the shamanic process appendices (B and C) were further anonymised by randomising the order of the shamanic accounts, replacing the pseudonyms with letters and removing potentially identifiable details from these sections.

Chapter summary

This chapter described the research methods deployed during this study, including participant selection and recruitment, participants, data collection and analysis for both phases of research. The method used to synthesise the findings from each phase within the Discussion Chapter was also described, and the ethical framework for this research discussed. The exploration thus far has led to the centre of the labyrinth represented by this thesis. Part II reveals the insight gained from exploring and analysing the data at the centre of the labyrinth.

Part II: *The Centre of the Labyrinth*

> *Reaching the centre of the labyrinth represents reaching the centre, not only of our own hearts and spirits but of the goal we seek: Spirit, release from emotional or physical pain, a solution to the challenging problem or creative task, the unobstructed Self.* (West, 2000, p6)

Chapter Six: Phase One Findings

Phase One encompassed interviews with 12 individuals who presented diverse standpoints on the research topics which were analysed following the method described in the previous chapter. This chapter summarises the findings, which are presented thematically.

Categories and Themes

Initial coding generated 986 references in 436 themes, from which five main categories emerged: *The Spiritual Quest, Addiction Narratives: from initiation to rock bottom; I Have My Life Back; Supporting Recovery and Delivering Treatment;* and *The Spiritual Journey of Recovery*. There was considerable overlap between these themes, leading to complex interlinkages between them, especially concerning the interface between spirituality and addictions. For example, several participants discussed Buddhism, both as a general spiritual practice and as a dimension of addictions recovery. In response, the general elements were positioned within the Spiritual Quest category, while ideas relating to the use of Buddhist approaches within addictions treatment were located within the Spiritual Journey of Recovery category.

As might be expected from the diverse range of participants that characterised the sample, some contributed more to certain themes than others, So Brenda, a Consultant Psychiatrist and addictions specialist, discussed the politics of delivering addictions treatment at length and, especially the political and structural barriers to delivering effective interventions. By contrast, other participants focussed on their experiences of delivering interventions in a variety of settings or reflected on personal experiences of addiction and recovery. Considerable variation was apparent in such individual descriptions of drug and alcohol use, addiction and recovery, for example, Jon described the rapid progression of his crystal meth addiction, triggered, in part, by the influence of a specific peer group whilst he was studying in Los Angeles, far from his native Thailand, whilst Beth described linked phases of experimentation with different drugs, a subtle mix of beneficial and harmful effects, and the eventual emergence of addiction in response to challenging life events. The five main categories are now each described with relevant illustrative quotations from the data.

The Spiritual Quest

Spirituality was clearly important to most of the participants, however, there was considerable variation in what was meant by the term. One common concept identified spirituality as a journey of exploration and discovery that is fundamental to the human condition: a spiritual quest. Four themes emerged under the main Spiritual Quest category. *We're spiritual because we're human* describes the concept that spiritual awareness and interest is described by participants as a fundamental dimension of human existence; *Connection with a source of power* describes spirituality in terms of connection with an internal or external source of power and inspiration; *Questions were the journey: the search for meaning & purpose* describes spirituality as a framework for seeking meaning and purpose in life; and, finally, *The hungry ghost: the shadow side of the spiritual quest* describes the destructive consequences that can result from recruiting psychoactive substances to assist with the spiritual quest, and the sense of 'spiritual bankruptcy' associated with addiction. Each of these four themes are now described.

We're spiritual because we're human

Spirituality emerged as an intrinsic dimension of human existence, one which, according to some participants, is fundamental to our collective human identity, but which also finds unique expression within each person:

> *We're spiritual because we're human. (Edward)*

Although spirituality is, fundamentally, an individual inner experience, the relationship between human existence and spirituality described in the data suggests that for some participants, spirituality is both an inevitable and a necessary condition of personhood which unifies the physical, psychological and social dimensions of life. In a similar vein, Geraldine identified spirituality as the 'glue' that holds the physical, emotional and mental wellbeing dimensions of a person's life together. In this way, spirituality casts light on the human condition yet remains essentially indescribable. The mystical quality of spirituality informed a discourse rich in imagery, metaphor and analogy as individuals endeavoured to put words to essentially subjective internal experiences. For example, descriptions of spirituality as a source of inner power were common, typically illustrated with metaphors involving *fire*, *spark*, *flame*, and *light*, which emphasised the embodied character of the spiritual experience. In one such example, Steve develops a fire metaphor to locate a source of inner power to the heart area of his body, which inspired him to discover alternatives to drug use:

I call it like my soul. There was a smouldering there. It never died; I mean, it was never extinguished properly, so I throw the logs on that instead … That's when that area starts to catch fire, and gizzus a feeling; sometimes it gizzus a feeling like nae drugs would be able to give us that.

Here Steve describes an unquenchable inner drive that may lie dormant during periods of apparent hopelessness, but one that, once brought to awareness, creates opportunity to consciously feed the inner fire through spiritually engaging activities.

Connection with a source of power

Developing and maintaining a relationship with a source of power was identified by many participants as being intrinsic to spirituality. Three overlapping categories emerged which summarise the focus for this spiritual connection: an inner connection to the Self; an outward connection with Nature; and a transcendent connection with a higher power. These three elements were generally not separate, but rather were typically described as existing together within a multi-layered spiritual framework:

For me [spirituality] *is very simply about a connection, and connections with yourself, with something greater than yourself, with the Earth, with all those things. And how that is fostered and, you know all your values: who you are and your identity. (Benedict)*

Here Benedict describes a spiritual framework informed by connection with and between the elements identified which, by fostering personal values and identify, shapes individual character and morality. In this way, spiritually emerged from the data through dynamic interplay in which the inner world of the individual is given form within the external world and the external world is given meaning by the inner world.

Many interviewees described the importance of an 'inner' source of power and inspiration, variously described as 'inner self', 'true self' and 'higher self'. Although these terms reference similar ideas concerning spiritual power as an aspect of the Self, they were used by interviewees to describe subtly different concepts. Inner self was used to signify an internal dimension of the self. Higher self referred to a spiritual aspect of the self that exists above everyday reality. True self was used to imply an 'authentic' version of the self, providing a non-judgmental and compassionate viewpoint on the human experience. Descriptions of the inner aspect of the self often emphasised the *embodied* nature of the phenomenon, through reference to locations in the body or

physical sensations of warmth or light. For example, Brenda associated spirituality with a person's 'heart' and suggested a synergy with wider existence:

> *I think, what I think about as spirituality is something that is in here [points of chest] it's something that is in a person's heart, if you like. So there's something internal that is, you know, synergistic with everything else.*

The concept of synergy described here identifies spirituality as a connecting element, which provides meaning to otherwise disparate aspects of existence: an example of the wider idea that spirituality concerns the search for meaning and purpose in life. The appropriateness of locating spirituality internally, without reference to any external power, was questioned by some interviewees, who suggested that an external, non-human source of spiritual power is essential. For example, Sebastian argues that exclusively identifying an internal or human source of spiritual power exposes individuals to the fallibility of human beings, and that connection with an external, non-human higher power is essential:

> *Whilst I like the idea of the inner self, the higher self, the observer, you know the healthy self – that's great, you know, get in touch with that. But, we're fallible human beings, we need something outside, and something that's not another human being.*

For many participants, this type of external guidance emerged being in, and connecting with, Nature, which typically is traced to an early stage in life. For example, Edward describes the solace and spiritual inspiration he experienced through time spent in natural environments:

> *Even as a teenager I was drawn to wandering. Wandering about, being in and drawn to Nature. Being outside in Nature; connecting and feeling alive.*

The authenticity and sense of aliveness ascribed to nature within this description implies also that isolation from nature deadens the senses and leads to a loss of vitality. This is reflected, for example, by Samantha, who established close links between inspiration from nature and spiritual awareness. She described her childhood in a large city during which she developed both spiritual awareness and connections with nature "even in the midst of living in the city". She went on to outline the potential benefits of connecting with nature in supporting individuals to develop spiritually:

> *How to teach people about their own level of creative brilliance. How to get people back into nature again. If you just … there are endless stories of healing and miracles of people who just go and live in the woods.*

This account identifies nature as an inspiring source of spiritual power which creates the conditions for positive personal transformation. A similar sense of inspiration characterised several accounts of early substance use, which described the effects of psychedelic drugs in intensifying perception of, and wonder at, the beauty of nature. For example, Beth describes the experience of watching the sun rise after staying up all night having used psychedelic drugs:

> *We would quite often be up all night, so even watching the sun come up when you are still feeling a bit that way in the morning was an experience as well. Everything just looked so much more beautiful.*

This description reflects the idea that psychedelic drug use may intensify perceptions of nature, positioning such drug use as a potentially spiritually enhancing activity. This contrasts, however, with other accounts (both by this and other participants) that emphasise the spiritually deleterious effects of drug use, which are described further on. Some of the same participants returned to nature in descriptions of later, post-recovery, experiences, whereby Nature provided a template for the type of inspired and authentic living that drug use became a proxy for:

> *I'm starting to wonder if that's how we're supposed to see things normally, you know! [laughs] … because I'm seeing them like that now, today. (Beth)*

Nature as a source of spiritual inspiration engendered, for some participants, connection with a higher power. The notion of connecting with '*something greater than yourself'* raises the idea of the numinous aspects of spirituality, connection with dimensions that were variously described by participants as '*higher power', 'higher self', 'God', 'source'* and *'spirit'*. Connection with a higher power was a central dimension of spirituality for many participants, but one that highlights differences between participants who engage with organised religion and those who are 'spiritual but not religious'. For example, Sebastian describes an eclectic personal spirituality informed by many philosophies and practices, characterised by a mix of inner self, higher self and 'source' elements:

I have a bit of a combination. You know, I've got Karma in there, Higher Self, Force Outside of Myself, that Universal Good, you know, and Energy. So, you know, I put together my little package; works for me.

By contrast, participant accounts of engaging with organised religion described connection with a more narrowly defined higher power. For example, Panit, speaking from a Buddhist perspective, described the certainty provided by his spiritual path:

The Buddha have the fact, have the truth. The truth is, the truth.

Such certainty can also be challenging. In particular, the language of religion and especially the word 'God' is troubling to individuals who do not subscribe to conventional religious spirituality. For example, Sebastian describes his experiences of signposting individuals in recovery from drug and alcohol addiction to 12-Step mutual aid meetings:

I would suggest that they went to a [12-Step] meeting. But to try to get them, because I had good relationships with people, I would say, 'Go to this meeting and come back tomorrow or next week and tell me what it was like. Go on, do me that,' and they would be, 'Alright Seb, I'll do that, I'll do that.' And they did, they did it, but more often than not they'd come back and they would say, 'Saw God written on the wall, people went on about God, did my head in, can't go.'

The sceptical response of Sebastian's clients to encountering the spiritual elements of 12-Step fellowships echoes the findings of The Higher Power project, which described how some people are put off on first encountering references to God within the approach (Dossett, 2018). These differences were reflected in the language used to discuss aspects of spirituality. For example, Geraldine describes different meanings that apply to the word 'spiritual' by individuals from a Christian perspective and those of no faith:

If you speak about spiritual, people from a very deep Christian faith think of that to do with the Holy Spirit. If you think about spiritual and have no faith, you might think of spiritualism. You know, we all use words for completely different reasons, so the language is very important, but it's actually the biggest challenge we have.

Concepts and definitions of spirituality varied as widely as the individuals describing them, underscoring the intangible and ultimately indefinable character of the topic. It is notable, apropos the language of spirituality, that the two ordained Christian minsters interviewed both discussed 'hope, meaning and purpose' dimensions of spirituality at length, but did not expand upon the numinous or 'higher power' dimensions of the topic. The search for meaning and purpose was important to several participants' understandings of spirituality.

Questions were the journey: the search for meaning and purpose

Spirituality was typically characterised by interviewees as a personal journey of exploration and inner discovery that mirrors the outward journey of life; a journey characterised both by a curiosity to reach beyond the everyday, and an urge to find meaning within the everyday. Participants characterised such journeying as episodes of introspection and contemplation as well as the impulse to explore outwardly. Edward reflected upon his own inner journey, whereby one question gave rise to another in an endless process of personal discovery:

> *For me, questions were the journey.*

This reflects the idea that seeking becomes more important than arriving and is illustrated by Geraldine who identified the search for hope, meaning and purpose as a central element of the spiritual quest:

> *But people trying to explain it for themselves struggle often to find the right language, or the words they would come back to are hope and meaning and purpose, because they are everyday words. But they actually have great depth.*

In this respect, substance use emerged as an expression of the human spiritual quest for expansion and transcendence; the imperative to reach beyond the everyday in search of meaning, purpose and connection. Such accounts were characterised by experiences of joy, perceptions of beauty and wonder, connection with nature, with others and with the transcendent. For example, Beth vividly described her early experiences with LSD and suggested that drug use may provide access to a more natural and sympathetic way of being; one more in tune with the fundamental humanity of people that reflects an innate spiritual connectedness. By contrast however, the potentially, problematic consequences of using drugs and alcohol as part of the spiritual quest also clearly emerged from the data.

The hungry ghost: the shadow side of the spiritual quest

A picture emerged from the data in which the human spirituality is driven by two objectives: to seek self-fulfilment and self-actualisation, and to survive in the face of challenges such as low self-confidence, poor self-esteem, social awkwardness and depression. While the first objective inspires the kind of psychonautical explorations described above, the second can lead to attempts at 'self-medication' which mask, rather than cure, the underlying vulnerabilities while breeding dependency and addiction. This suggests a form of spiritual depletion that extends beyond the physiological effects of drugs, and which were illustrated by several participants in terms of the Buddhist perspective on addiction. This is epitomised by Vaughn's description of addiction to drugs and alcohol as a graphic manifestation of the Buddhist 'Hungry Ghost' concept:

> *The classic description of a hungry ghost is this creature with an unquenchable thirst ... a thirst or a hunger that can never be satisfied. But also that everything he touches or she touches, turns to shit. And that was exactly what was happening in my life. You know, it was falling apart literally.*

In this description, addiction extends well beyond the physiological effects of drugs, to encompass a spiritual emptiness characterised by a loss of hope meaning and purpose in opposition to the sense of spirituality as connection explored earlier. This was encapsulated in Vaughn's description of the Buddhist concept of addiction as a fundamental and universal human challenge. Indeed, from this spiritual perspective, addiction is not, fundamentally, the result of substance use; rather, addiction is a graphic manifestation of disharmony and disconnection that are common dimensions of all human suffering. Substance use is the result of this addiction. This perspective suggests that, while people who experience drug and alcohol addiction may describe specific elements, fundamentally, their circumstances are not unique to substance use, but reflect common human struggles. Similar ideas were developed by Samantha, who described her understanding of addiction as a spiritual deficit:

> *And so with addictions, when you have somebody who's dealing with addictions, there's been a serious disconnect that been happening for a very long time.*

Samantha's portrayal of addiction as a spiritual deficit is applicable to both substance and behavioural addition. Nevertheless, the accounts of the interviewees describing

personal experience of PSU attest to the severity of the personal, relational and social consequences associated with drug and alcohol addiction.

Addiction Narratives: from initiation to rock bottom

The accounts of drug use and addiction in the data typically took a narrative form which, while differing in terms of the specific details, depicted a progression from early initiation and experimentation, an almost imperceptible shift from pleasure to addiction, and a growing self-awareness of the need for change. The elements described in this section distil this sense of narrative into four categories which encapsulate the essence of participant accounts. *A million and one reasons why* describes participant's understandings about the origins and development of addiction*. The downward spiral* describes the emergence of addiction as an increasingly destructive force influencing all dimensions of a person's life. *Identity and roles in addiction* describes the nuanced way in which the 'addict' identity informs public perception, social roles and self-esteem and the tensions that can develop between apparently conflicting identities. Finally, *Rock bottom* describes the idea that addiction leads towards the point of annihilation, and that continued survival requires a fundamental change in direction towards the possibility of recovery.

The use of the term 'addiction' here reflects the sense in which it was used by participants, who generally used the term to describe severe, lasting, detrimental effects associated with substance use, particularly characterised by compulsive use. Participants reported having used many substances, encompassing depressant drugs including alcohol, heroin, diazepam and morphine sulphate; stimulants such as cocaine, crack cocaine and methamphetamine (crystal meth); and psychedelics such as cannabis, ecstasy and LSD (acid). It is important to note that not all substances were associated with addiction and it was typical for early use to be unproblematic. Against this varied background of substance use, it is particularly informative to develop an understanding of the explanations for addiction that were advanced by participants.

A million and one reasons why

It is natural for individuals with personal experience or professional involvement in this field to seek to understand the origins of addiction, and most of the participants advanced explanations that included one or (more usually) several interconnected factors. It was widely recognised that addiction is a highly individual phenomenon involving unique combinations of factors in each case. As Sebastian succinctly put it,

there are a '*million and one reasons why'* individuals develop addiction. Nevertheless, several categories emerged which combined to suggest an explanatory framework for the development of addiction, and which include the 'disease model', psychological and social explanations, and environmental factors.

The first group of explanations that emerged from the data is the 'disease model', in which addiction is analogous to a physiological disease process, largely beyond the control of the individual. Under this broad category, a genetic basis for addiction was suggested by Sebastian, who expressed this in terms of an 'addiction gene' which creates a predisposition to drug or alcohol addiction. Other participants broadened this idea to include familial patterns of behaviour which, while not necessarily genetic in origin, are expressed as repeated patterns of addiction within families. Criticisms of the disease model also emerged, which centred on the argument that this view of addiction is fatalistic and disempowering to individuals in achieving recovery. Both sides of this debate were evaluated by Benedict, who concluded that the disease model is valuable in eliminating personal blame and stigma, but that it should be reframed to advance a more individualised approach to care and treatment:

> *I like the metaphor of disease – dis-ease - that something needs treating. So I see addiction as far bigger than the substance, so the substance would be the symptom of whatever else is going on. So the treating of the substance, or the relationship with the substance, would be only one part of the work. It's about all the attitudes and behaviours that go along with that.*

Psychological and neurological explanations for addiction were advanced by many participants. The idea that addiction arises from an 'addictive personality' was suggested by several participants, for example, Beth ascribed her own susceptibility to problematic use as arising from her 'addictive personality'.

Wider links between addiction and mental health were suggested by other participants who described a typical negative cycle in which drugs and alcohol are used to manage the symptoms of anxiety, depression and low self-esteem, but ultimately result in exacerbating these problems and creating chemical dependence as well. The idea that addiction negatively alters the brain was reviewed by Sebastian, who described the 'highjacked-brain theory' in which the capacity to make reasoned decisions is reduced through the neurological effects of drug use, leading to distorted priorities and poor decision making:

> *And the high-jack brain theory is simply that our survival instinct is corrupted into believing – not food, sex and job, the work, or whatever, is going to keep us alive, but 'the drug' or 'the alcohol' is going to keep us alive. And that's it, so we're high-jacked. So that's a huge challenge, isn't it?*

Descriptions of drug use as a mechanism to enhance self-confidence in social situations were common in the data, as was the idea that repeated use creates social dependence on the drug, which in turn becomes a causal factor for addiction. For many participants, drug and alcohol use were intrinsically linked to social circumstances and peer relationships. Several accounts described drug use taking place in the company of others as a shared experience and it seems that, for some individuals, collective drug use contributed to a sense of identify and belonging. Peer influence was especially associated with this form of group membership by encouraging and normalising drug use. Additionally, it was noted by several participants that peer-group membership provided availability of and access to illicit drugs, which further increased the risk of addiction. The sense of group belonging associated with drug use caused some participants to distance themselves from particular individuals when pursuing recovery, for fear of being drawn back to substance use.

The effect of external factors in influencing addiction was also discussed by some participants, for example, poor housing and homelessness contributing to a bleak social outlook, prompting individuals to seek solace through drug use. In some cases, this idea was developed to suggest that addiction is the product of a lack of community cohesion. For example, the wide availability of drugs in inner city settings and the perceived social acceptability of drug use compared to the past. Additionally, social isolation was advanced as a causal factor for addiction, which included alcohol problems in isolated rural communities and the separation associated with studying abroad. Inadequate social support and the erosion of community cohesion were cited by several participants as creating the conditions for addiction to develop, which informed the promotion of interventions aimed at strengthening communities as a response to addiction.

The downward spiral

The personal accounts of substance use and addiction typically described an incremental shift from drug use as a positive dimension of the person's life to, sometimes almost imperceptibly, become the focus of growing concern. Often, the risks involved were not fully appreciated until years later. For example, Steve described

the incredulity that felt when recalling the risks he exposed himself to during his drug using years:

> *Initially when you start it you're no thinking you'll get to where you ended up, but taking methadone and cannabis and 'vallies' and the occasional … with me it was the occasional heroin and I had alcohol as well. Right, but ken, it's like for a lot of years – something between 15 and 18 years – I was taking stuff on a daily basis that could potentially kill me.*

Typically, a picture emerged in which drugs begin to dominate the person's life to the exclusions of other concerns. The social circle contracted to exclude most people who were not also involved in drug use, non-drug related activities were discontinued, and self-care was neglected. These changes unfold incrementally and may have gone unnoticed by the individual until the physiological changes associated with drug dependence emerged. Participant accounts of addiction and recovery did not typically suggest a smooth linear journey, but rather described an iterative and punctuated process characterised by periods of stagnation and frustration as well as rapid change. Periods of relapse were also frequently reported, which were often identified as key 'turning points' in the addiction process (Teruya and Hser, 2010). For example, Geraldine identifies prison liberation as a common trigger for returning to former peer associations and substance use:

> *Sometimes when people come out of prison, they don't have a family or a community to welcome them. Or the only community is that of the drug and alcohol community. Or, you know, sometimes they're collected by cars with the dealers, and they're off on that rocky road again.*

Such turning points were often associated with loss and grief, for example, Beth identifies that a return to problematic drug use was triggered by the death of her father:

> *I was hoping that I was just finding myself, but you know, I may go on to Art College, or go on to do something really good with my life. And that was quite a shock to the system because my Dad fell ill and within six months he passed away, so it was quite quick. A rapid deterioration for him, and so just giving up everything and moving to Mum's was a big decision as well. It took some time to make that*

> *decision. And then falling pregnant. It's just the scenario, the way things happened.*

Several participants recalled developing a growing awareness of the problematic dimensions of their substance use, while simultaneously avoiding action to address these issues. In some cases, undertaking a 'DIY detox' was considered, however, negative experiences of withdrawal symptoms deterred further action with the result that substance use became reinforced through its apparent capacity to provide stability:

> *One night without drugs is like a fucking long time, so you ask someone to come aff, rattle, go through all that, because people have experienced wee bits of coming aff, and it's not very nice. (Steve)*

As individuals become increasingly aware of the problems associated with their substance use, so their self-image changes to reflect the complex and sometimes conflicting identities and roles implied by addiction.

Identity and roles in addiction

Addiction was associated with a shift in identify, both in how the person was perceived by society and how they saw themselves. It was common for participants to have experienced stigma because of their substance use. Often this contributed to feelings of low self-worth and processes of self-stigmatisation. Addiction became associated with significant changes in circumstances, most of which were described in negative terms, and which included relationship breakdown, loss of financial security, unemployment and deterioration in physical or mental health. In some cases, changes in living circumstances were significant, for example, returning to live with her parents after living independently marked a significant negative shift for Beth. Despite the negativity associated with addiction, interviewees also described feelings of pride and optimism. Some were able to continue with employment, while for others, parenting remained a source of fulfilment. Individuals who were able to maintain their parental responsibilities during periods of addiction valued this aspect of their lives both in terms of the welfare of children and as evidence that they retained a capacity to look and act beyond the confines of their addiction. For example, Beth described the importance she placed on looking after her young son who *"very much still was a focus"*, even during periods when she found it difficult to look after herself.

Rock bottom

The growing acceptance of the need to initiate significant change was characteristic of the accounts given. In many cases, a point of complete desperation, or 'rock bottom', was reached. The meaning of rock bottom differed. It was generally described as a critical choice point, marking the lowest depths to which the individual sank during their addiction. The term also implies a desperation point, from which continued survival would be impossible without significant changes. Some participants even suggested that reaching rock bottom is necessary if subsequent recovery is to occur, however, Vaughn countered this idea by describing how, although he lost a lot through addiction, he retained important sources of recovery capital:

> *Perhaps there are some individuals that don't have to go. I mean, I didn't go all the way down the line, I mean I was certainly threatened around my job and my marriage was falling to pieces. But I still had a job, and I still had a marriage and I still had a home, but you know, barely. Whereas other people I know lost everything.*

I Have My Life Back: the road to recovery

Despite the despair felt by many individuals during the depths of addiction, it was apparent, both from the experiences of those with a personal addiction story and those who supported people in recovery, that there is light at the end of the addiction tunnel. This section reviews the personal dimensions of the recovery process. *Personal experiences of recovery* describes the characteristic elements of recovery experiences as recalled by participants. *Roles, identities and relationships* describes the complex and nuanced identifies and interpersonal relationships that develop in association with recovery. *Beyond recovery* explores the new and unexpected opportunities that develop in people's lives through the recovery process.

Personal experiences of recovery

Whatever the severity of the addiction problems experienced, the act of first seeking help with addiction was significant and was often recalled as the point at which the trajectory of the individual's life turned in a positive direction:

> *Because I didnae, didnae know what was wrang; I didnae know how to get oot o'it. And I knew I was fucking up; I knew my life was going nowhere. I knew I was quite luck to still be … alive. But … I was searching for people to help.*

Taking the first step to ask for help seems momentous. Not only does it trigger a variety of potential interventions, but it also, by definition, implies a shift in thinking towards accepting the need for change. It is striking that synchronicity played a significant role for several interviewees, who described how, as they saw it, the universe provided exactly the resources required to support them in recovery. In other cases, accessing help required considerable effort, for example, Jon eventually decided to return to home from living abroad in order to access recovery services that were meaningful and culturally relevant for him.

There was considerable variation among participants as to what was meant by recovery. Most of the participants (both those with or without a personal addiction history) initially equated long-term recovery with sustained abstinence and tended to discuss abstinence when recovery topics were raised. In exploring this further, however, the same participants also argued that overall stability and wider positive life changes are also necessary for sustained recovery. A minority of participants suggested that controlled substance use was possible within recovery, however, this was generally discussed with reference to the original problem substance, rather than drug and alcohol use in general. Thus, it was argued, an individual with a history of heroin addiction could be in recovery if they use alcohol in a controlled way, but not if they continue to use heroin.

Roles, identities and relationships

The ways in which individuals saw themselves within this recovery landscape was especially significant. The idea of recovery as a continuing and potentially endless process was advanced by several participants. Sebastian, for example, self-identified as a 'recovering addict', even though it is over a decade since he last used any drugs or alcohol. Similarly, other participants were wary about claiming certainty about their recovery process, often emphasising the possibility of relapse, even when their drug using days seemed behind them.

The overall sense to emerge from the data was of recovery as a journey rather than a destination, characterised by a series of incremental steps which may include setbacks, but that lead forward overall. The significance of achieving recovery (however that was understood by the individual) was expressed by recalling the period of addiction. As Jon said, when reflecting on the positive changes he had made: "*I think I have my life back!*" Comparisons with peers who had not achieved recovery were also used to underscore the positive changes achieved. Equally, several interviewees discussed the mutual support that develops through sharing experiences with others

who have followed the same path, especially in the context of mutual aid organisations such as 12-Step fellowship.

While peers may have found it reality easy to recognise the changes being made, others found it harder to recognise and accept the purported transformation. Several participants discussed at length the difficulties experience by their families in trusting them after, in some cases, years of lies and broken promises. Jon, for example explained the difficulties faced by his parents in accepting his identity as an 'addict' in need of help, while Beth described the awkwardness involved in rebuilding her relationship with her mum, which became characterised by opaque and awkward communication:

> *I mean, my relationship with my family had deteriorated because I would go out sometimes on a Thursday night and then not come home till the Sunday. Maybe just be in to have a shower and then back out again. I was having difficulties at home too. And sort of staying with my partner who was using drugs very regularly too. So, I felt very distant to my family.*

For several people a single individual played a pivotal role in their recovery journey. Although the specific circumstances differ, there is remarkable similarity between the characteristics of these key individuals, who were described as embodying the qualities of unconditional approval and optimism for change, even when things seemed hopeless. For example, Jon described a friend who offered him practical and emotional support at the time that he was trying to address his drug use.

Beyond recovery

The most effective support, it seems, came from those who were prepared to challenge as well as support the person in recovery. Often the focus for this activity lay in learning, or relearning, the essential skills of living that were either never developed or were eroded through the process of addiction. These included the interpersonal skills for creating and sustaining effective relationships, attending to physical wellbeing, and developing fulfilling roles in life. For example, Steve identified the importance of developing effective listening skills as he worked through his early recovery process, and the interplay that developed between him and a key supporter during his early recovery period. Achieving a degree of recovery inevitably led interviewees to look beyond the present to consider the life ahead. Opportunities discussed by participants included volunteering, attending further education courses, and becoming an

addictions worker. Indeed, most of the participants with a personal recovery story either currently worked in an addiction recovery service or had done in the past. Returning to the spiritual focus on meaning and purpose in life, such work was typically described as a way of 'giving back' to society or to others who were currently facing addiction, and as a way of finding meaning within the addiction experience. Becoming an addiction worker brings unique challenges for individuals in recovery, which were described by Steve in terms of dual 'worker' and 'ex-service user' identity. He explained how he felt this duality created a potential conflict of interest which could influence his decision-making as an addiction worker. For some, recovery apparently occurred spontaneously at certain times. For example, Beth described experiencing several periods of 'natural recovery' during which she did not use drugs and functioned very effectively without any external input. However, at some point in the journey many individuals found it necessary to access some form of structured support.

Supporting Recovery and Delivering Treatment

Recovery emerged as a highly personal process, in which the 'inner journey' made by individuals was crucial. These recovery journeys were, nevertheless, typically characterised by external interventions in the form of structured treatment and recovery programmes. Four thematic categories emerged to describe the factors influencing the provision of recovery support and programmes. *A tapestry of recovery* describes the range and combinations of interventions and programmes that are available. *Love is the key to all healing* describes a range of ideas emphasising the therapeutic alliance between 'client' and 'worker'. *Recovery and community* summarises ideas concerned with situating recovery programmes within wider community contexts. *Pass the parcel: the politics of recovery* describes the institutional and political dimensions of delivering recovery interventions. These themes are now explored.

The tapestry of recovery

A rich tapestry of ideas, experiences and aspirations emerged to describe the forms of support available to people in recovery and it was common for participants to have experience of services characterised by markedly different ideologies and structure and which offered radically different interventions. Most participants seemed aware of the ideological divide within the addiction recovery field between abstinence and harm reduction approaches, but few advocated either position unequivocally. Rather, it was more common to hear a nuanced assessment, recognising strengths and weaknesses of both approaches. For example, Benedict described working in a drug rehabilitation

project in which he suggested that service users 'sample abstinence' for a limited time to assess the potential benefits without necessarily committing to it long-term.

Forms of recovery support described by interviewees included: publicly funded programmes such as NHS addiction treatment services; not-for-profit organisations which were partly or wholly funded from public sources; private services where service users pay fees directly; and mutual aid organisations. It is notable that, in general, the descriptions of publicly funded services included few references to spiritual elements, while private services and mutual aid programmes were more commonly portrayed as including spiritual dimensions. A range of specific interventions were described, including: medical and pharmacological approaches such as OST; psychological and counselling interventions; residential rehabilitation; and other psycho-social interventions. Mutual aid programmes were also identified which encompassed both the 12-Step fellowships, such as AA and NA, and evidence-based approaches such as SMART recovery.

Love is the key to all healing

Despite considerable variation between interventions and approaches, the quality of therapeutic engagement within such processes emerged as a common concern. Relationships characterised by a high degree of empathy, the use of positive affirmations and kindness were associated with effective outcomes by many participants. The ability to create and maintain a safe, healing space and to give time to the process was highly regarded and was powerfully encapsulated by Samantha, who stated that "*Love is the key to all healing".* The quality of the interpersonal relationships involved, and the importance of vocation in this field of work, were particularly significant. Many participants described the importance of placing the individual at the centre of the process and used person-centred language in discussing the factors that promote effective engagement and recovery, especially those that arise from the connections that develop between people. Identifying a personal vocation to help others emerged as being of importance to several interviewees, often associated with putting personal interests aside in the service of others:

> *The other quality you have is the ability to be absolutely able to lay yourself aside and focus on the other person while keeping that person safe. (Geraldine)*

This sense of selflessness was expressed particularly by individuals with a personal recovery story who decided to support others to achieve recovery. For some

participants, the ‘supporter’ role brought unexpected challenges concerning how directive to be in recovery-focussed interactions with individuals.

> *If someone is going to step in front of a bus you need to let them know, but you know just to show some kindness and to talk with people. (Benedict)*

Some of the participants went further to discuss how best to respond to apparently destructive or harmful behaviours and to advocate reframing such ‘negative’ behaviours to emphasise the strengths that underlie the individual’s actions.

> *I work with Criminal Justice and people with a long history of crime and prison. But I'd always look, like even if it was drug dealing, it’s like, well what are your strengths? The skills that you could bring into the world now. And with incredible results. Because, those questions actually open up something of, well actually there are skills and maybe you can use those in a way that is not going to cause harm to you or others. (Benedict)*

This reflects the esteem generally given to individuals seeking help with addiction by interviewees, however, it was apparent that there are limits to such acceptance for some, particularly in relation to drug dealing. For example, Geraldine described the difficulty she felt in extending unconditional acceptance to drug dealers:

> *I have spoken about having a very positive place in supporting people who have addictions. My negative side of it is those who supply drugs etc., because they are some of the people I will never understand. Their reasons can only be selfish to me, that I cannot imagine in what they are doing they are bringing hope, meaning and purpose to other people.*

The physical and temporal ‘space’ within which interventions are delivered was a concern for several interviewees. Several participants emphasised the relevance of providing safe, sacred spaces and allowing adequate time to facilitate recovery processes. Geraldine emphasised the importance of creating and maintaining a safe space within which to explore the meaning and purpose of individual lives:

> *What you are doing is creating a space. Now you could call it a ‘safe space’; you could call it a ‘comfortable space’, or you could actually*

call it a 'sacred space', where they feel that they can open up and begin to find themselves and in finding themselves they'll find hope and meaning and purpose.

Many interviewees discussed the importance of creating a physical environment that is inspiring, relaxing and ordered, to promote and encourage recovery, yet it is apparent that often the real-world experience was characterised by cluttered environments that failed to inspire or contribute to the recovery experience. For example, Brenda described the physical environment of one NHS building where service users were assessed and treated:

You will see a room that is poorly organised, untidy, sometimes dirty, certainly not therapeutic – distracting, unpleasant, poorly lit – looks like a mess. And yet, people expect someone to come in and sit down and be able to think about good things – aspirational things.

This perspective reflects wider concepts regarding the application of spiritual interventions: the time and space which typically surround such approaches, which typically contrast with the time pressure that is perceived to characterise mainstream programmes. There is a sense that specificity of interventions is less significant than the fact that time and space is given to them.

Recovery and community

Community was widely identified as playing a valuable role in supporting recovery. This included several forms of community engagement activities aimed at reducing the risk of addiction as well as network-building to support individuals in recovery. Benedict describes a project he was involved in:

And that came from the community reinforcement approach which was about: OK, so that lifestyle isn't serving you anymore; it's time to start something new. And it's about building up links in the community – trying out courses. And it's very activity-based, so we would do drama, we would do therapies, we would go out on activities, just to try different things, new things.

Others emphasised the value of situating recovery activity within the community as a way of countering the social isolation and individualisation that, they argued, leads not only to addiction problems, but to wider forms of prejudice, discrimination and bigotry. This viewpoint emphasises the value of community immersion, of nurturing natural

communities and of effecting social change through community reinforcement. Programmed group activity was identified as a way of benefiting participants and the wider community at many levels. Alex gave the example of a drumming group for people with mental health needs which was ostensibly focussed on learning traditional African drumming techniques, but that at the same time produced an array of 'occupational spin-off' benefits, including elevated mood, improved self-confidence and self-esteem, and group identity, each of which disrupted established ideas about this social group.

Pass the parcel: the politics of recovery

Many participants reflected on the political and organisation dimensions of service delivery, which encompass social attitudes to addiction, conflicting ideologies around treatment and recovery, and the wider political climate surrounding healthcare delivery. Addiction was competing for political attention and finite resources against many other health and social care issues. Interviewees described ideological tensions between conflicting approaches to treatment and competition over financial and other resources, which together created the conditions for fragmented programming delivered in a climate of fear and suspicion. Brenda summarised the situation as a giant game of 'pass the parcel', in which policy-makers, service commissioners and clinicians all attempt to shape services, with the result that progress stagnates to the detriment of service users. It was suggested by several participants that, within this climate, the ideals of the recovery movement have been usurped by advocates of both the harm reduction and abstinence approaches, who each claim 'recovery' for themselves. This, it seems, has led to a form of 'tokenism' in which *claiming* recovery credentials has become more important than the values that underpin the recovery approach. For instance, Benedict reflected upon what he saw as the growing politicisation of recovery which he saw as having become ubiquitous and, in so doing, has rendered recovery meaningless:

> *And then it seemed to get politicised, that you know, in order to compete for funding, you needed to have the word 'recovery', so then it appeared just everywhere … You know and in your literature and your mission statements and all that, the word 'recovery' and 'sustaining recovery' you know, so it almost lost any meaning.*

This description suggests a tokenisation of recovery, at odds with the person-centred ideals underpinning recovery thinking; a tokenism that, for several participants, extended to programme evaluation. Edward, for example, reflects on a duality whereby

ostensibly person-centred interventions are evaluated through 'target-driven' approaches. The need to 'reclaim' recovery is articulated by Benedict wishes to remove confusion and return to a concept based around community and the development of purposeful lives:

> *What I'd like, if I take all that confusion away about recovery, it's about recovering something of who you are: you know, your identity, your community, and your place within that community. Um, self-esteem and recovering hope really, that you might be able to carve out a life that has purpose and meaning for you.*

Other participants echo this analysis and argue for the need to 'reclaim' recovery as a person-centred movement arising from a capacity for understanding and responding to the needs of individuals. The examples given by participants of the most effective application of recovery principles were largely drawn from outside the publicly funded arena. For example, Sebastian contrasted the NHS community addiction service that he previously manged to the private residential rehab facility that he runs in Thailand. He concluded that the publicly funded model leads to inefficiencies, an inability to respond quickly to new evidence and circumstances, and a disillusionment among service users. By contrast, he believed that the private business model created freedom and flexibility in terms of programming, enthusiasm and optimism among service users and gave him freedom to include explicitly spiritual elements in the programme.

The Spiritual Journey of Recovery

The interface between spirituality and recovery gave rise to a complex set of interrelated concepts encompassing both the personal spiritual journey and the use of spiritually informed approaches in support of that journey. This section reviews the spiritual dimensions of the recovery journey. *The inner journey,* describes the personal spiritual exploration that associated with attaining long-term recovery, whilst *Spirituality in recovery programmes* describes the inclusion of spiritual interventions and approaches within addiction recovery programmes.

The inner journey

The participants who gave personal accounts of achieving long-term recovery all suggested that addressing the spiritual dimensions is not only is desirable, but is essential for long-term, sustained change. For example, Sebastian described it as the "*magical component*" that made the difference between struggling to achieve recovery

and living a fulfilled life. For many participants, a personal ‘spiritual awakening’, often traced to a single moment or event, was crucial in triggering a fundamental change. Sebastian described the impact that his own spiritual awakening made for his recovery process:

> *It had taken me a long time to embrace that [spiritual] side of the programme and it was probably not until that time that I got clean, so I tried, and tried, and tried and then never really entertained that part of it. And then finally I believe I had a bit of a spiritual experience, awakening, whatever you want to call it, and I practiced it daily as well – what my sponsor told me to do, pray, da, da, da, you know and so on. And then I got clean.*

Accounts of a significant point of change were typical, however, many participants also emphasised the incremental changes that both preceded and followed the moment of ‘spiritual awakening’. Interviewees described the benefits associated with following a personal spiritual path, which included providing insight into past situations, developing courage and resilience to face life challenges, and enhancing health and wellbeing. It was also evident that, for some participants, spiritual practice led them to develop greater self-compassion, countering the self-stigma associated with addiction. The idea that recovery is essentially a spiritual process led one participant to draw parallels between the spiritual insights achieved through practices such as meditation and the mind-expanding effects of psychedelic drugs, suggesting that psychedelics may have a role to play in supporting recovery from drugs such a heroin by providing access to the deep unconscious.

Spirituality in recovery programmes

None of the participants seemed to advocate using spiritual approaches to the exclusion of other methods; instead, spiritual interventions were located within an overall approach that promotes recovery at three levels of depth. First, at the physical level, interventions such as OST address the physiological dimensions of addiction. Next, psycho-social interventions, such as counselling, Cognitive Behavioural Therapy, or Motivational Interviewing, address the psychological components of the addiction situation. Finally, spiritually informed interventions address the existential dimensions of addiction. The experience of several of participants, however, was that mainstream addiction services, especially publicly funded ones, do not typically encompass spiritual dimensions within their programmes. Furthermore, although there was no consensus among participants about how to define spiritual interventions, which overlapped

significantly in participant accounts with complementary and alternative therapies. Descriptions of spirituality-informed approaches to supporting recovery included: the spiritual elements of the 12-Step approach as practiced within AA and NA; healing interventions such as acupuncture, Reiki and shamanic techniques; Buddhist detox and rehab programmes; and practices such as mindfulness, meditation and Yoga. These spiritually informed approaches were accessed by individuals in a variety of ways. They could be fully integrated into existing 'mainstream' treatment programmes, associated with, or promoted by, such services, or completely independent. The positioning of such interventions within an individual's recovery journey appeared to inform the meaning attached to the intervention. Unsurprisingly, individuals who independently sought out a spiritual intervention were likely to be open to such approaches, even when they involved considerable effort and commitment. For example, some participants undertook inter-continental travel in order to access detoxification or rehabilitation programmes. On the other hand, interventions that were integrated with, or promoted by, mainstream programmes were potentially less acceptable to service users, particularly if the intervention was perceived as including religious elements. For example, while he was working in an NHS addiction recovery programme, Sebastian encouraged service users to access the 12-Step mutual aid fellowship, however, he found that that references to God deterred individuals from engaging:

> *I became really acutely aware that* [references to God are] *really off-putting for a lot of people. Because, for whatever reason, they might feel punished by God, they might feel – might be a recovering Catholic as people say. Or might associate religion to, you know, a bad experience at school, or assembly, or for whatever reason. I don't know, there's a thousand reasons isn't there? It's a powerful factor in putting people off, I can tell you that.*

This reflects a wider concern expressed by several participants to ensure that spiritual approaches are presented in a way that is culturally acceptable to service users. For example, several people described deriving personal insight and guidance from Buddhist practices, but went on to argue that, if such teachings are incorporated into recovery programmes, they should be relevant, accessible and acceptable to service users.

Some interviewees argued that including overtly spiritual or religious elements in recovery programmes undermined the secular underpinnings of publicly funded

healthcare delivery. For example, Steve described the response by service managers and commissioners to the (erroneous) belief that the recovery programme he was involved in included dimensions of the 12-Step approach:

> *We have had in the past people from ADPs* [Alcohol and Drug Partnerships] *that sort of report back, saying we're using religious elements within groups and that – only because they've heard misinformation … There was one member of the ADP that actually got in touch with managers here and asked if we were doing the first three steps of the 12-Step programme and why are we doing this religious programme? Which we weren't.*

This reflected a tacit understanding among many of the participants that overtly religious practices challenge the secular principal underpinning publicly funded healthcare. It is notable, for example, that the contributions of the two ordained Christian ministers interviewed included very few unprompted references to faith or religion. Rather, these participants focussed on social and community engagement and the opportunity to help individuals find meaning and purpose in life.

A further effect of including spiritually informed approaches within mainstream recovery programmes was to illuminate the shortcomings of existing programmes. In particular, the 'time' and 'space' associated with spiritually informed approaches was contrasted by several participants with the pace of time-pressured character of mainstream recovery programmes, where there is a perception that staff do not have time to spend with service users, that interventions are delivered according to strictly defined timescales, and that generally there is no 'space' for individuals. By contrast, typical spiritual approaches emphasise giving time and space to the process, often in the context of a ritual approach. Indeed, the 'ritual' dimension of spiritual practice was emphasised by several participants, who drew parallels with the ritual aspects of drug use (such as, for example, the preparation of drugs for injection). This gave rise to the idea of making new rituals aimed at supporting recovery rather than addiction.

Several participants discussed the value of framing interventions within ritual and ceremony to enhance the impact and emphasise a positive turning point in life. For example, shamanic soul retrieval and Reiki healing were both cited as examples of ritual interventions aimed at healing the spiritual deficit associated with addiction by returning the individual to a sense of wholeness. How such ritual interventions were situated within the recovery journey was important. For example, Samantha argued

that the most effective spiritual elements involve two phases; a ritual or ceremonial response to the individual’s immediate situation, followed by a supportive personal spiritual practice aimed at integrating the healing process and sustaining positive personal changes which emphasise reconnection with self, nature, life, community and family:

> *I really believe that it is unrealistic in our culture to think that people who go through shamanic healing work know how to find these tools on their own. So I feel that unless you are willing to give a two-parted intervention, where you're helping people regain skills of how to live life in a healthy way, then I don't think the work is going to be successful.*

Similar ideas were advanced by other participants, who explored the spiritual underpinnings of the 12-Steps including the personal inner exploration, the acceptance of and connection with a higher power, and the emphasis on a ‘spiritual awakening’ implicit to the 12-Step approach.

Some participants emphasised the importance of contextualising spiritual interventions by identifying meaningful and realistic goals for recovery and healing. It was also suggested that, whilst spiritual approaches are helpful in many circumstances in clarifying goals, initiating changes and establishing meaning and purpose, other interventions are necessary to translate these spiritual ideas into reality. The importance of making spirituality relevant to individuals in recovery was emphasised by several participants, for example, here Sebastian describes his approach to introducing a spiritual dimension to his rehab programme:

> *I decided I’m going to explain this thoroughly to them, to give them a better chance to embrace it, which I do. So we explain the psychology of spirituality, the history of spirituality. We explain the different practices and, you know, to just be a bit rational around it. And also, the main group session that people will do about it is where they will explore what their spirituality could be. And we connect spiritual principles and good healthy values with spirituality.*

Chapter Summary

This chapter has described the Phase One findings, illustrated with quotations from the interview data. Participants discussed personal experiences of addiction and recovery, and the relevance of spirituality to those processes. They also addressed the social context within which PSU and treatment is situated and identified linkages to relevant policy and practice issues. The experiences of theses interviewees positioned spirituality as relevant to understanding the origins and emergence of addiction and to informing recovery-based interventions. As described in Chapter Four (Methodology), the findings from this chapter informed both the methodological choices and interview focus during Phase Two.

Chapter Seven: Phase Two Findings

Introduction

This Chapter presents the findings from the IPA analysis of the Phase Two data which, as described in the Methods chapter, consisted of in-depth individual interviews with six men living in Scotland who reported personal experience of drug or alcohol addiction and recovery and who identified spiritual practice as significant to their recovery process.

Categories and themes

The Phase Two interviews yielded especially rich data, characterised by strong narratives and deep personal reflection. Each story was unique, yet the interviews were connected by common threads describing experiences of drug and alcohol addiction and the relevance of spirituality to the recovery process. IPA analysis led to three overarching themes: *Myths and Archetypes*; *Darkness and Light*; and *Lessons for Recovery*. Of these three themes, *Myths and Archetypes* reveals the significance to participants of the 'story telling' process, whereas *Darkness and Light*, which includes several sub-themes, presents the narrative content, and *Lessons for Recovery* encapsulates participant reflections on applying spiritual approaches to facilitate recovery in others. The relationship between the thematic elements is summarised by Figure 7.1. In this idealised model, *Myths and Archetypes* gives narrative form to the expression of the *Darkness and Light* duality which forms a three-level hierarchy of sub-themes. *Lessons for Recovery* emerges from the exploration of *Darkness and Light.* The elements of each half of *The Darkness and Light* duality are introduced and arranged broadly chronologically. Thus, within *Darkness*, *The Spiritual Void* is followed by *The 'Disease' of Addiction* and then *Proximity of Death*, while within *Light*, *The Spiritual Quest* is followed by *Spiritual Awakening* and then *Living Spiritually*. Within this structure, the two elements of *Darkness and Light* are experienced in a sometimes sequential, sometimes overlapping, occasionally synchronous way, whereby *Darkness* is eventually replaced, partially or completely, by *Light*. The thematic categories are now explicated with illustrative quotations from the interviews.

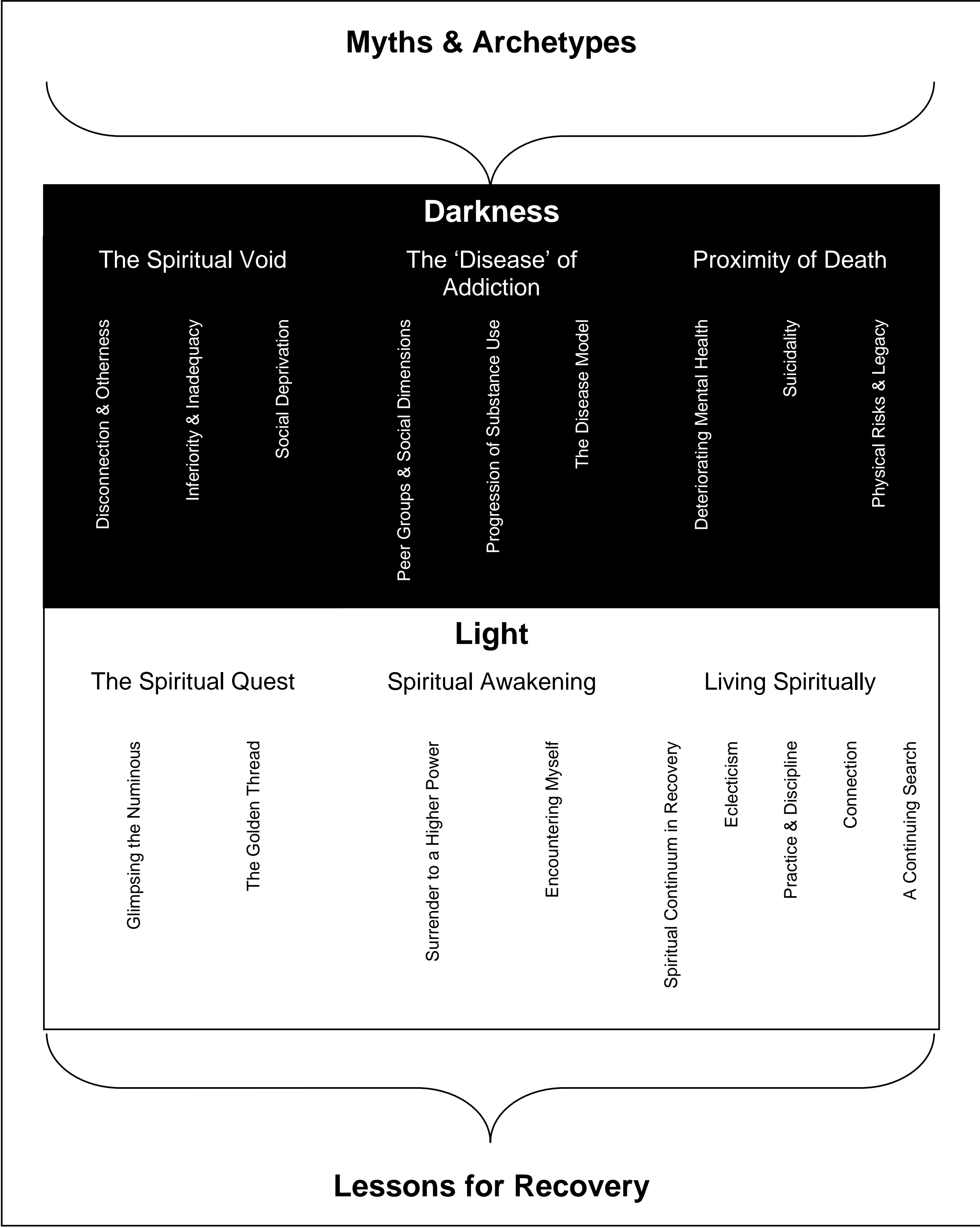

Figure 7.1 Idealised representation of Phase Two thematic elements

Myths and Archetypes

It was apparent that the 'story-telling' act was significant for participants, some of whom referred to the cathartic and therapeutic impact of sharing their experience, both previous and within the current research. Interview narratives characteristically

combined chronological timelines with vivid descriptions of significant episodes which 'stood out' as allegories[2] or 'myths', through which individuals gave meaning to intense experiences of significance to their lives. Such 'myth-making' became significant in developing participant accounts of the journey from addiction to recovery, and the spiritual dimensions of that process. Today, the word 'myth' is commonly used to signal a false or erroneous story or belief, however, here the term is intended in the original sense, describing narratives that present deep truths carrying meaning beyond their immediate significance.[3] Unlike traditional myths, though, which are rooted in ancient cultural roots, the myths presented here are 'personal' myths, which derive from, and are primarily concerned with giving meaning to, the individual's own story. Four sub-themes emerged within the overarching *Myths and Archetypes* theme, which are now described in detail. These are: *The Past is my Teacher*; *Spiritual Guidance*; *Transformational Stories*; and *Archetype*s.

The nature of myth is to recall a past time, significantly different from the present, in such a way as to inform current circumstances. This was reflected in the theme *The Past is my Teacher,* which described how the myth-making participants in this study distinguished between the *then* of their addiction past and the *now* of recovery. Not only did these stories recall a different time, they concerned a different *person*, reflecting the totality of the transformational process described. For the most part, the changes described emerged incrementally (notwithstanding the dramatic 'turning points' described in the *Light* category), however, hindsight enabled participants to look back through decades to reflect the magnitude of the journey they had taken and the transformation they had achieved. It would be understandable if these individuals viewed the choices and values of their younger selves judgmentally, however, the opposite was evident. Participants greatly valued *all* of their experiences for the life lessons they brought, even if objectionable at the time. This reflects the value placed within the myth-making process on bringing meaning and learning to the present. Pete described how he now views past events and experiences as a rich source of learning and personal development:

> *I notice even more looking back on it now, because I feel like my best teacher, now, is my past, and my experience of what happened in the*

[2] Allegory: 'A story, poem, or picture that can be interpreted to reveal a hidden meaning, typically a moral or political one.'(Oxford English Dictionary, 2003)

[3] Myth: 'A traditional story, typically involving supernatural beings or forces, which embodies and provides an explanation, aetiology, or justification for something such as the early history of a society, a religious belief or ritual, or a natural phenomenon.' (Oxford English Dictionary, 2003).

past, and being able to understand it and speak about it, you know. Because I used to react on the way I felt back then. I'd always … If I never got my own way, sort of thing. Or if I went in the huff with you, or fell out with you, I would feel myself going inside myself and practically reach a point where it was impossible for me to come out. It's quite a strange feeling eh. (Pete)

Here, Pete used retrospective phases ("looking back on it now"), the past simple ("I used to react…"), and conditional perfect ("*if* I went in the huff with you…I *would* feel myself going inside") to stress the distance between previous patterns of thought and behaviour and his current life. He also emphasised how the transformation he achieved was informed by his awareness of his past as his "best teacher".

It was apparent that participants were committed to absorbing the deepest lessons from past experiences. The mythical nature of the resulting accounts typically functioned to give meaning to spiritual dimensions of the addiction and recovery process, particularly when life events were apparently guided by spiritual forces, as encapsulated in the *Spiritual Guidance* theme. It was typical for the myths that participants developed to describe the emergence of spiritual processes, either in recounting the intense spiritual deficit associated with addiction or by relating the emergence of spiritual power and guidance. For example, Sean recounted a series of events which led him to separate himself from the drug dealing network, of which he was part, in response to powerful spiritual guidance. He described choosing a seemingly irrational course of action that initiated profound changes for his life. Superficially, this account described a set of dramatic social interactions; however, at a deeper personal mythological level, it signalled the emergence of a spiritual *voice* and spiritual direction in Sean's life. In a later example, Sean described receiving guidance that he should renounce eating meat, whilst working as a butcher:

Then everything was conspiring to make sure I was looking after myself. I would start eating organic food. I even went back to actually working as a butcher. This was the sort of stuff that was happening. Because that was what I done when I left the school, I went and got a job as a butcher. And I was working in the butcher's shop one day and I was actually making haggis and I was in the back shop myself doing this and I heard this voice as clear as day and it's like: 'It's time to be a vegetarian, Sean.' And I was like, 'Who was that?' And I turned round and there was naebody there. It was the first time I had

> *heard the voice of a kind of spirit guide. And I was like, 'What's a vegetarian?' Because I had no reference point for even really what a vegetarian was, because I had eaten meat almost every day of my life and sort of grown up with that, so that was a kind of major culture shock as well. So I guess yes, I was addicted to junk food as well. Not that all meat is junk, but I hadnae any consideration for what I was consuming in any way at all. So that was an important change as well.*

A more mundane setting than the back premises of a butcher's shop could hardly be imagined, yet it was there that Sean had a life-changing spiritual experience. It was apparent that he was unprepared both for the experience itself and the move toward vegetarianism that it inspired, which came as a "major culture shock". The emergence of such spiritual guidance in the lives of participants often heralded significant and often dramatic turning points represented as vivid narrative myths, which as *Transformational Stories* held significance for participants. Recovery generally unfolded gradually over time, however, the process was typically punctuated by *Transformational Stories* which marked significant and often dramatic shifts, delineating the 'before' and 'after' points on the journey. Barry, for example, described a transformational experience in an AA meeting, during which another member's story led him to acknowledge the significance of his alcohol problems and begin to see the world differently:

> *And I went to an AA meeting and I don't know what happened in this meeting, in the sense that there was nothing out of the ordinary, it was a very ordinary meeting. And all I remember was this guy shared his story in a very, very similar way to mine. Almost like the details were like that. And this guy just talked and somehow I listened in some way and then he stopped talking and had come to the end and suddenly I jumped up and said, 'I'm Barry an I'm an alcoholic!' And everything changed from that point for me.*

Like Sean's earlier example, here Barry emphasises the ordinariness of the circumstances, while also hinting at the inexplicability of the experience ("I don't know what happened"). The act of self-identification described by Barry ("I'm an alcoholic") is an example of how participants ascribed meaning to their roles and identities that reach beyond the immediate relevance to assume archetypal significance.

The personal myths developed by participants were characterised by the presence of *Archetypes*: narrative or mythological depictions of recurrent events, figures and motifs conveying symbolic meaning beyond the specific case.[4] Archetypes are a recurrent feature in mythology from all cultures (Hamilton, 1942), carrying particular significance in Jungian psychology as manifestations of the 'collective unconscious' brought into consciousness (Jung, 1991). Such archetypal identities engender connections between the individual, emic, case and the generalised, etic, one, whereby personal narrative is informed by archetypal identify, and the inclusion of archetypal identity applies collective meaning to the specific case. Viewing these narratives from an archetypal standpoint intensifies both the impact of the personal story and its wider relevance to drugs, addiction and spirituality. Many archetypal interpretations surfaced from the data, including *addiction* as a representation of the shadow archetype, *recovery journey* as archetypal quest and *initiation* into drug use as archetypal rite of passage (highlighting the relevance of initiation into recovery as a rite of passage as well). Archetype-based interpretations were especially relevant to understanding the emergence of gender identity in view of the all-male interview sample for this phase of the study. In this respect, three archetypal figures emerged which informed the development of gender identity and roles.

First, *Lost Little Boy* emerged as a figure representing the Jungian *Inner Child* archetype (Jung, 1991), reflecting innocence and vulnerability. The participants all described emerging from working class backgrounds in which traditional notions of masculinity prevailed, characterised by toughness and emotional detachment. Yet these individuals characteristically described experiencing vulnerability and sensitivity at an early age, at odds with the perceived social norm. Lacking supportive role models or effective coping strategies, participants typically concealed and supressed their vulnerabilities, disconnecting them from their authentic identity and foreshadowing the emergence of addiction. This highlights the sense of concealment and duality that characterised many of the stories, whereby the *outer* portrayal masks *inner* vulnerabilities, evoking the *shadow* archetype which represents the hidden or concealed aspects of the self and even the capacity for evil. Descriptions of early drug use described young teenagers becoming immersed in adult realities, requiring them to grow up prematurely, as recounted by Martin:

[4] Archetype: 'A recurrent symbol or motif in literature, art, or mythology. (In Jungian theory) a primitive mental image inherited from the earliest human ancestors, and supposed to be present in the collective unconscious.' (Oxford English Dictionary, 2003)

I think an addict becomes a very lonely individual, becomes a very isolated individual and, you know … I was that kind of lost wee boy that went into drugs, and they [drugs] gave me so much in a certain way from a certain group of individuals using certain drugs but then as that progressed then that came back again [the Lost Little Boy].

The loss of innocence described here hung as a tacit presence within most of the interviews, recalled in accounts of subsequent recovery when, as men in their late twenties or thirties, these individuals were confronted by the 'lost little boy' archetype, abandoned decades previously. This is exemplified by Sam, who recounted his experience of working with a counsellor for the first time during his residential rehab:

There was a lot to cope with. You were getting a counsellor and I was finding that hard to deal with, ken, getting a counsellor and sitting with somebody for like … sitting talking with your counsellor for like an hour and a half. I found that a bitty heavy because it was basically the first time I had talked about my feelings and emotions for ever. Never having experienced any of that apart from with a key worker, but then I was under the influence and on a prescription and it's a different setting.

It is clear from this extract that, not only did Sam find the intensive therapy 'heavy', but also that he developed an awareness of the contrast between this experience and that of his medically focussed drug treatment, where his continued drug use, the effects of the prescribed medication and the different service focus all ensured that he did not explore his inner world so deeply.

Second, *Alpha Male* emerged as an archetypal dominant masculine persona, characterised by risk-taking and extremes of behaviour. In some cases, the men spoke about naturally assuming an *Alpha Male* leadership role within their peer group. However, in other cases, it was clear that the aspiration to assume a position of influence and leadership emerged in response to the unacceptability of the *Lost Little Boy* as an 'act' to conceal inner vulnerabilities. The effect was to drive experimentation with drugs to conform to a tough social image and avert perceptions of weakness, as described by Sean:

Because there was always that, I guess, adolescent guys. There was always the jostling for the Alpha Male position. Because I wasnae … even though there was part of me that was really kind of angry, there

> *was still this part of me that was in touch with my feminine from my primary school days. And it was sometimes if that was kind of recognised then there'd still be that bullying and intimidation within the group and kind of banished so to speak. So, I would just have to come back twice as crazy, in a sense, to get accepted, because I couldnae understand a part of myself at that age, there was no reference point, there were no role models for me.*

This account is underpinned by a sense of isolation and confusion arising from the absence of reference points and role models that Sean identifies. It is apparent that Sean was aware of the nuances of his character, which incorporated a connection with his 'feminine', leading to his poignant realisation that he was not fully accepted within his culture. Within this context, it becomes very understandable that he should "come back twice as crazy!" as a strategy to mask his gentler instincts. This exemplifies a wider sense of 'concealment', apparent in the interviews, whereby the participants described masking aspects of themselves in order to 'fit in' with the norms of their social group. A significant aspect of the recovery journey for all the men became finding acceptance within supportive social groups and learning to live authentically and undisguised.

Common descriptions of male competitiveness encompassed peer pressure to experiment with drugs, vying for the *Alpha Male* position within the tribe-like social group, and seeking sexual connection with women. The social networks emerging from these accounts carried a raw, almost primitive aspect, stripped of the 'niceties' of mainstream society. What emerged were accounts of life lived viscerally and in the raw, in which social relationships were navigated plainly. This was encapsulated by Sean, who identified the absence of rites of passage as contributing to the problematic nature of contemporary masculinity:

> *I mean I cannae generalise, but I just see these patterns being really predominant in our society, at all levels of society actually. There are really kind of immature masculine energies. And it seems to have been accepted as the way it should be and a lot of the time. And I feel that on the journey that I've been, and the journey that I continue to be aware that the entire social structure that I stepped into as an adolescent was set up. There was nae, there was nae rites of passage. So I ken, now, that I was seeking my initiation into manhood in a very perverse way and it could only lead in one way,*

> *just degradation and addiction and dependence. Because there was no real connection as to what it is to be a mature man.*

The retrospective, almost anthropological, insight that Sean brought to his own adolescent culture was very perceptive. He recognised the absence of structure, rites of passage or an embedded sense of “what it is to be a mature man”, as the source of significant individual and societal problems. He identified initiation into manhood is a necessary process that, if not provided a positive framework, inevitably takes a destructive form. In so doing, he seemed to situate his own adolescent experience within wider social and cultural deficits, characterised by the loss of connection with ritual and ceremonial markers.

Not all the participants identified with the *Alpha Male*, but instead found other dominant males intimidating. The stand-out example of this was Sam, who attended an all-male Christian rehab facility and found the intensity of the religiosity and perceived competitiveness extremely challenging:

> *It was a male environment, yeah. There was a different rehab just across the road that was just for females. So, it was just males yeah, it was just males. So just that was pretty intimidating and intense, ken it was big enough, but it wasnae that big, ken. You couldn’t sort of hide unless you were in your room at night, so it was pretty stressful at times as well.*
>
> *Pretty intense and even at the church, the chapel all that doubt would set in as well, because I would be like, ‘They seem to have a big faith,’ or ‘They seem to be walking God’s … Jesus’s way,’ but I’m no.’ All those doubts were setting in, all them thoughts were running riot ken … too many thoughts. You know, some would be closing their eyes and praying out loud and praying in tongues and my mind would be, ‘Oh no’ just too much thoughts, too much thinking, ken … when I was there so all them doubts would just set in and I would go at night, ‘cos you would go to chapel like last at night, ken ten o’clock at night and you’d be back to your room for ten-thirty. So, it would be … I would just end up going to my room and head burst. And I would be like, ‘I’ll just get another day in, another week in.’*

This extract strongly conveys the overwhelming intensity of this Christian residential rehab experience. Sam seems to link the all-male setting with the intensity of the

experience, which he clearly found very demanding. It might be imagined that he did not find anything positive in the experience, however, in the context of his entire recovery journey, he valued his rehab experience as a significant rite of passage, of the kind identified by Sean as being so necessary for embracing manhood effectively.

Finally, for the *Archetypes* theme, several participants explored their evolving relationship with the *anima*: the archetype 'inner feminine' which, in Jungian terms, represents the feminine aspect found within the unconscious of a man (Jung, 1991). This was strongly reflected by the participants who all described developing greater awareness of the feminine, and, in so doing, balanced the masculine and feminine dimensions of their internal world. None of the participants used the terms 'anima' directly and not all referred to the 'feminine', however, they all described developing an awareness and understanding of that aspect of their character, and a willingness to question 'traditional' gender constructs and identities. For example, Sean described how his growing awareness of the feminine aspect of his own character both informed his healing process and transformed his relationship with women:

> *I guess there's a few different layers to look at it through because what seemed to conspire in my life, when I was going through these changes, it was almost like the universe manifested an entire army of women. And that might be mistranslated, but the feminine force really kind of came in. I think it's like the Humpty Dumpty analogy that all the king's horses and all the kings' men couldnae put the broken man back together again. But the sort of women … the kind of feminine came and that's where a lot of my healing came in the nurturing time. And I ken I went through a phase of … I didnae totally deny my masculine, but I guess part of me was maybe embarrassed about how that had been. So, I still suppress, that was the next level of suppression, but I can see the intelligence of that design because I needed to rediscover the feminine part of me and the universe really brought the women sort of in to help. And that continues, I've got a much clearer relationship with what that is now.*

The dynamic balance between masculine and feminine, described by Sean, is one example of *polarity*, which recurred in the data through the emergence of archetypal pairings, such as masculine/feminine, drug-user/non-user, addiction/sobriety, illness/health and life/death. The identification of these and other pairings introduced

tension within participant narratives which pointed towards a fundamental polarity which provided overarching structure to the data: *Darkness and Light*.

Darkness and Light

The cyclical struggle between darkness and light is an archetypal pairing, found in legends, morality tales and folk wisdom from many cultural traditions (Hamilton, 1942; Kalsched, 2013). This polarity creates vivid mythical perspectives through which everyday events become starkly dichotomised. This is also a fundamental polarity that recurs within processes of trauma recovery and depth psychology, as described by Kalsched (2013), who identifies connection with experiences of dark and light as central to the recovery of wholeness following trauma. The language of darkness and light recurs within the data, imparting new meaning to the addiction and recovery experience, whereby darkness represents a descent into disconnection and addiction, while light describes the discovery of spiritually inspiring routes towards recovery. The account that follows employs the darkness-light polarity to explore participant narratives in a way that maintains proximity with the data while introducing interpretive dimensions that accord with IPA principles. *Darkness and Light* did not generally arise as chronologically separate phases of participant lives, rather, they existed as two opposing forces in dynamic interaction, however, in this account, the two elements are explored sequentially.

The Darkness

As a depiction of absence, *Darkness* both describes and explains the journey into addiction. Darkness is not so much a ‘thing’ as ‘nothing’, carrying with it patterns of emptiness. As a space it commands fear, depression, lack, and loss, but also represents a space of potential, ready to be filled with light. The emptiness of *Darkness* creates ‘rock bottom’. This meta theme incorporates three main themes: *The Spiritual Void*; *The ‘Disease’ of Addiction*; and *Proximity of Death*. These three themes present a broadly chronological relationship, whereby *The Spiritual Void* describes the conditions that led to addiction, *The Disease of Addiction* describes progression of drug and alcohol use, and the emergence of addiction and *Proximity of Death* describes the relevance of death, loss and mortality to experiences of addiction. These three themes are now described.

The Spiritual Void

A key motif within the myth-making process is the creation of origin stories which, in the case of the individuals interviewed, focussed on tracing their addiction to source.

Through such myth-making, the *Spiritual Void* emerged as an explanatory framework for addiction. This reaches beyond social and psychological dimensions to encompass a significant spiritual and existential emptiness, characterised by hopelessness, isolation, loneliness and a lack of identity, which creates the conditions for later substance use and addiction. Although originating in childhood, *The Spiritual Void* developed incrementally into adolescence, spanning the transition from primary to secondary education (at around age 12) and subsequent initiation into drug and alcohol use, which for all the participants happened around age 13. It was as if the seeds of addiction were sown in childhood, germinated during adolescence and blossomed in early adulthood. The Spiritual Void incorporates three sub-themes: *Disconnection and Otherness*, *Inferiority and Inadequacy*, and *Social Deprivation*, which collectively provide an interpretive account of the circumstances that led to addiction for the individuals interviewed, and which are now described.

In recalling their younger selves as children and young adolescents, the men interviewed here overwhelmingly described experiences of *Disconnection and Otherness* that emphasised the differences they perceived between themselves and those around them. This difference was reflected in social awkwardness, heightened sensitivity to feelings and emotions, and an overall sense of 'not fitting', represented in depictions of young individuals experiencing strong and often conflicting feelings and who felt unsupported to address a confusing inner world. Although none of the participants reported undergoing formal testing or diagnosis, several suggested that nowadays they probably would have been diagnosed with Attention Deficit Hyperactivity Disorder (ADHD), which certainly reflects the empirical evidence demonstrating association between ADHD and PSU (Maté, 2008; Chen *et al.*, 2015; Kaye *et al.*, 2019). A sense of 'otherness' developed whereby individuals became increasingly conscious of their difference and vulnerability, which led to a form of social disconnection that extended beyond normal teenage rebellion to include isolation and disengagement, even within emerging sub-cultural peer groups. Against this background, participants often cultivated a persona of invincibility which enabled them to function socially while concealing their authentic (but vulnerable) identity through bravado, physical prowess and a willingness to exceed social boundaries, as illustrated by this except from Martin:

> *I think again, when I look back over my drug use, a lot of it was about wanting to escape any kind of responsibility. I could even see that from my school days, like I left school without no qualifications. I just,*

kind of, opted out basically and it was the Seventies and again I got into glue, because again that was big at that time. I was kind of rebelling against society and Punk Rock was there, so I fitted right into that. You know get pissed, destroy, fuck society, you know all of that, all these kind of ideas that were, embedded in myself and that was the whole basis of my kind of philosophy of life I suppose, my way of thinking around things.

Often, the discrepancy between such portrayals of rebellious invincibility and inner vulnerability gave rise to a form of cognitive dissonance, which intensified identity confusion and disconnection. In response to this, drug and alcohol use emerged as a tool to facilitate social functioning, which itself sometimes become the focus for undesirable peer pressure. For example, Pete describes coercion to smoke cannabis, despite experiencing anxiety and paranoia after using the drug.

So I had all this image of myself, so I had to keep this reputation going within myself, so I couldnae be seen to be getting beat by cannabis. So I would consistently try and smoke it, even though it had this effect on me. You know, I would smoke a joint, a few draws of it and I would have to run away home and say, 'Guys, I can't do this anymore.' Even after shelling out some money buying the stuff, I'd run away home and lock myself in the room, go through the whole paranoid thing. Come out the next day and they'd suggest, 'Oh, do you want to get a bit of dope again?' and I'm, 'Oh, for fuck's sake!'

That eventually Pete learned to enjoy cannabis, emphasises the role of social networks in initiating and sustaining substance use. Pete described a similar process with his first use of heroin, which led to a disturbing 'whitey' experience, despite which he eventually conceptualised heroin as a pleasant drug. By contrast, there were also examples of participants defying peer pressure in specific contexts. For example, Pete described an overwhelming phobia of needles and obsession with hygiene which led him to resist injecting drugs even when it was the norm:

I was sitting around in a room, and I was terrified of needles and I was probably one of the only ones who never used needles out of thirty guys. But I'd sit in the room and lots of friends, at quite a young age, they all had needles, and blood, and spurting blood about

> *everywhere and I was shitting myself in case I got jagged by one of these things.*

These examples from Pete typify the way in which the men interviewed for this study identify themselves as different from their peers and from the wider society: a sense of difference associated with feelings of *Inferiority and Inadequacy.*

Several accounts of participants' early experiences described feelings of *Inferiority and Inadequacy* associated with low-self-confidence and low self-esteem. Such feelings contributed to the emergence of PSU, as illustrated by Keith, whose lack of confidence and self-esteem meant he was "scared to do a lot of things" until he discovered that drugs and alcohol gave him the confidence that he lacked. In some cases, such experiences were linked to the individual's perceived social status or academic attainment. For example, Martin described the feelings of inadequacy that he experienced whilst at primary school, arising from his awareness that other children were 'better off' and 'cleverer' than he. The latter portrayal was certainly unfounded given that Martin eventually progressed to complete an MA degree in philosophy. In other cases, the actions of close relatives undermined self-confidence and wellbeing. For example, Pete described how his parents consistently discouraged and belittled him by comparing him unfavourably with others:

> *There was times when, quite innocently, mother, father would say remarks. Quite powerful statements without realising the damage they were making at that age. Like I'd be sitting watching, like, snooker on the TV. Snooker was a big thing at that time. And my mother would turn around to me and say, 'How could you not be like him on the TV?' You know, that sort of thing is like saying, I am no good enough. So their beliefs … I would carry their beliefs with me, feeling like, feeling like a disappointment, feeling like a failure. This is all building up to a certain age where I couldn't handle it anymore. These feelings, all this stuff.*

There was bitterness in Pete's voice as he spoke these words, underscoring the corrosive effect of numerous apparently insignificant comments, no doubt intended to encourage positive action, but which served only to reinforce a sense of worthlessness. It was clear that, despite his extensive personal growth and recovery, Pete still carries strong feelings of anger, resentment and disappointment towards his parents, who he partially blames for his later substance use problems. This experience was reflected by

that of the other participants, who described dysfunctional and sometimes abusive relationships with parents and other close relatives, the impact of which was often exacerbated by the social and environmental context in which they were situated.

The feelings of inferiority and inadequacy associated with the *Spiritual Void* did not arise solely from the inner world of the participants and the actions of those immediately around them but, instead, reflects the social setting from which they emerged. The *inner* hopelessness and negativity that characterised participants' formative years typically arose within a similarly demoralising *external* societal context, characterised by deprivation, collective depression and lack of opportunity, encapsulated in the *Social Deprivation theme.* Sean, for example, described the prevalent hopelessness he experienced growing up in a deprived village during the 1980s.

> *I guess the culture round about here, 1980s, it was the tail end of the punk sort of movement, Thatcher's Britain. There was no real opportunity. There was nothing. These places became like ghost towns overnight, and the sense of self-worth, self-esteem, all that went down. There was just that general cloud hanging over the place.*

Here Sean succinctly encapsulates collective depression and oppression that characterised the social circumstance of his youth. He continues to live in the same village and later described often seeing his contemporaries who, unlike him, remain caught in the destructive cycle of deprivation and addiction that he has left behind. This extract is typical of participant accounts and provide personal testimony to the evidence linking social deprivation and PSU (Daniel *et al.*, 2009). The sense of hopelessness associated with these circumstances, encapsulated by the *Spiritual Void*, informs an impulse to escape through altered states of consciousness. In the absence of other opportunities, substance use provides a dependable method to fill the void by providing access to inspiring perceptions and experiences. Indeed, in some cases, early drug use was described in spiritual terms as mediating inspirational, psychedelic and revelatory experiences, leading several participants to draw parallels between these experiences and the effects of later spiritual practices such as meditation and mindfulness.

The 'Disease' of Addiction

Developing coherent understandings of the nature of addiction was clearly important to all the participants. In doing so, they were consistent in 'pathologizing' the processes

they described in a way that emphasised the difference between others and themselves. The explanatory frameworks developed by participants coalesced into three themes: *Peer Groups and Social Dimensions; Progression of Substance Use; and The 'Disease' Model,* which are now described.

If the *Spiritual Void* created the *need* for substance use, *Peer Groups and Social Networks* created the *opportunity* to pursue it. Substance use provided a means to facilitate belonging and identity through shared peer group experiences and to self-medicate the symptoms of isolation, anxiety and social awkwardness felt by individuals. The combination of social identity, personal empowerment, and spiritual expansion offered by drugs and alcohol proved a powerful recipe that enabled individuals to function effectively within their peer group and glimpse alternative, attractive states of mind. It was common for participants to describe initial substance use as 'finding what I had been looking for', suggesting a solution to their complex difficulties that stretched beyond the physiological effects of the substances in question. This developing belief in the faciliatory potential of substances seems to foreshadow later addiction, underpinning a belief in the 'disease model' that most of the participants appeared to share.

It was evident that substance use became normalised within participants' social networks, and that this led to continued drug using behaviour, even when this conflicted with the individual's instincts. Despite establishing the acceptability of substances within specific peer contexts, participants identified two differences between their own pattern of use compared with their peers. First, several participants believed that their substance use was largely driven by an intention to 'self-medicate' unpleasant feelings of anxiety, fear and poor self-esteem in order to feel 'normal', whereas their peers primarily used substances hedonistically. Secondly, participants evaluated themselves as possessing poor impulse-control compared to other people who exhibited more moderate approaches to drug and alcohol use, as in this example from Sam, who contrasts his own 'addict traits', which he partially ascribes to genetic predetermination, with the approach of non-addicted 'normal' people, who appear to exhibit controlled substance use:

> *I used to believe, ken, I used to think that it was genetic. Stuff I've watched and read and learnt over the years I've heard that it partly could be genetic. Ken, the genetic makeup of addict traits. And that addict trait, even just the … I cannae pick up a drug. One or two times is never enough. If I pick up, my mind sort of alters chemically*

> *and I get sort of greedy, ken what I mean? But a normal person, a non-addict, could pick up a drink or a drug maybe once or twice and maybe just put it down, but maybe not suffer the allergy that I would have, like the obsession, the craving. It would return.*

The perceived need for self-medication and poor impulse control combined in the minds of several participants with the availability and normality of substance use within peer groups, to ensure the progressive development of PSU among participants. The *Progression of Substance Use* within such social groups took a characteristic form, through which initial experimentation led to more sustained use and a widening repertoire of drugs. The participants had each used a different range of drugs, however, the overall process of progression was similar in each case. Early use typically included alcohol, tobacco and solvents, with other substances such as benzodiazepines, stimulants and a range of pharmaceuticals added later. Although the 'menu' of substances varied between individuals, it seemed to be taken for granted that individuals progressed through several drugs and drug types, with the associated risk increasing as more 'serious' substances were introduced.

It was apparent, however, that even within drug using peer groups, notions of risk and acceptability of drugs varied, whereby while some drugs were deemed 'acceptable' (typically alcohol, cannabis, tobacco, cocaine and speed), others were taboo. The participants in this study did not limit their drug use to 'acceptable' substances but described making choices that they knew were disapproved of within their wider peer group. In this respect, using opiate drugs, especially heroin, represented a serious and risky choice which set the individual apart from the wider peer group. Participants described the move towards opiate use as unacceptable to themselves as well as to their peers. The sense of self-stigma this engendered was vividly described by several participants who clearly felt the devastating impact of repeatedly making choices (drug taking, injecting, acquisitive crime, lying) that undermined their self-image and perpetuated a self-destructive cycle. Indeed, several participants described how the move into opiate use separated them from their friends, contracted their life interests and led to addiction. This perspective emphasises the pharmacological effects of drugs, evoking equivalence between addiction and physical dependence to substances such as alcohol, benzodiazepines and opiates. All of the participants except Sean reported dependent opiate use, which they identified as defining their addiction experience, however, paradoxically, the same individuals all concluded that addiction is not chiefly the result of drug effects, but results from individual character traits and

behavioural choices. Disentangling and understanding their own addiction became a significant focus for most of the men interviewed who grappled with multiple and conflicting explanatory frameworks, before settling albeit sometimes uncomfortably, with the *'Disease' model*.

Developing coherent explanatory frameworks for their addiction seemed important to all participants, who displayed remarkable frankness in pathologizing addiction as a mental health 'condition'. By accepting the disease model as an explanation for addiction, participants self-identified, at least partially, with 'mental fragility' or defect, characterised by weakness of will, impulsivity and reduced capacity for rational action, in contrast to their non-drug-using counterparts, and in comparison to their later 'recovery' selves. Indeed, participants identified all these traits as symptomatic of their addiction condition. This stance was perhaps best summarised by Sam, who cited his experience of attending residential Christian rehab as being instrumental in raising his awareness of addiction as the result of a 'defect of character' and that, furthermore, he remains vulnerable to this 'weakness':

> *But when I've came back from Teen Challenge I got involved and got on the programme of being able to work on all my emotions. I went through the steps and worked on all my shame and all my guilt, all my fears, all my insecurities, all my defects of character and realising some of them are going to be there for the rest of my life. Accept they're still going to be there, ken, all my stuff's still going to be there.*

Indeed, all of the participants described a continuing susceptibility to addiction and associated risk of relapse, even when they had been abstinent of all drugs and alcohol for decades. For some, who were solidly established in their recovery, the risk was not so much of returning to substance use, but rather that they would revert to a less integrated or spiritual way of living. However, for others, there seemed to exist a genuine fear of relapse to substance use, as in this example provided by Sam:

> *I've been four year clean and sober, but I believe that if I was to pick up a drink or a drug right now that that allergy or craving would return. Not like magic, not, 'Oh that's it, it's back, it's returned!' Not like that, it's just if I picked up now, ken the craving would slowly return. You'd maybe get away with it for a day or two, or a week. And I'd be, 'See, I told you, I'm not an addict, I'm fine!' And that would be*

> *my disease telling us I'm no an addict, but it's that progression, I believe, ken the progression of an addict.*

Here Sam clearly established the differences he identifies between himself and others with no history of addiction. Sam's use of the term 'allergy' here emphasises his understanding that as a disease, addiction has the potential to re-emerge after a period of remission in response to the wrong stimuli. The philosophy of the 12-Step fellowship, which stresses the addict's lifelong vulnerability to relapse, is clearly emerging here, and it is notable that Sam, in common with all the other participants except Sean, identified engaging with the 12-Step fellowship as a central plank of his recovery process.

Most participants seemed to reflect uncritical acceptance of the disease model, however, two of them (Martin and Barry) clearly found the disease approach troubling. Applying the disease 'label' to themselves appeared to resonate with their own addiction experience but highlighted wider controversy associated with this viewpoint. For example, Martin reflects the ambivalence he felt in identifying appropriate terminology to describe his own experiences with addiction:

> *I can certainly see that progression of what I understand* [addiction] *to be an illness or a disease. And I know that many people don't like that term and sometimes I don't feel that comfortable with it myself, because it's got certain connotations … And so often I just say a 'condition' you know, because it's like … it certainly was a condition because I became pretty much addicted to drugs and whether it was cannabis, whether it was, whatever I was using.*

None of the participants used their alignment with the disease model to divest themselves of responsibility for their addiction; rather, they emphasised its significance in providing an explanatory framework for their addiction based on the differences that they identified between themselves and other non-addicted individuals. Although the participants tended to identify a progression in substance use, it was clear that, for most of the participants, 'addiction' had less to do with the specific drugs used and more to do with the individual's response to life. In different ways, participants developed the idea that addiction is 'not about the drugs'. Barry, for example, recounts an early NA meeting that he attended during which another member shared the devastating effect on his life of his drug use. The drug that the individual had used was cannabis (often regarded as trivial in comparison with other drugs such as opiates).

Barry drew comparisons between this man's experience with cannabis and his own use of pharmaceutical opiates and injecting drug use, identifying equivalence between these experiences and some underpinning commonalities for addiction, separate from the substances used. Other participants developed similar ideas by identifying addiction as, primarily, a psychological condition characterised by a limited capacity to moderate behaviour. Keith illustrates this by describing how, despite maintaining abstinence from drugs and alcohol, he engages in shopping binges, which mirror the loss of control associated with drug addiction:

> *I like buying things. Now if I do that in moderation, that's fine, that's OK, we all do it, but it's like when I'm doing it to the point where it's having a detrimental effect on my life and then repeatedly doing that. Like last year I think I bought, in the space of a week, four coats. They were all in the sale … but it's like I don't need them, do you know what I mean, then at the end of the month it's like, wait a minute, where's my money? Oh I bought the four coats … If I were more at peace with myself I wouldn't need to do that.*

Here Keith seems to tacitly identify his recovery as a 'work in progress', underpinned by some vision of how being "more at peace with myself" might look. This reflects the view of most of the participants that some individuals (among whom they include themselves) are predisposed towards addiction, which may manifest in varied and changeable forms. Underpinning the 'Disease' model lay awareness of the potentially fatal consequences associated with addiction.

Proximity of Death

As substance use developed, the problematic and destructive consequences began to displace the beneficial effects. Proximity to death and loss was a recurring theme in participant accounts and served to underpin the precariousness of life and emphasise appreciation for the 'second chance' that recovery offers. At one level, this related to events and situations that could have led to the participant's own death, such as accidental drug overdoses, suicide attempts, risk of blood-borne virus infection and assaults. However, at the metaphysical level, 'death' in the sense of loss of vitality and spirit or 'soul loss' was a constant presence. Participants commonly described reaching a point of 'rock bottom' as the closest to death without physically dying, from which point the urge to transform arose. This theme includes three sub-themes: *Deteriorating Mental Health*; *Suicidality*; and *Physical Risks and Legacy*, which are explicated now.

The psychological challenges faced by participants during their early life has already been described within the *Spiritual Void* section, often characterised by low self-confidence and anxiety. As PSU progressed, mental health typically deteriorated, with anxiety, depression and paranoia all identified as increasingly problematic. For example, Keith described the extremes he went to isolate himself from other people in response to the paranoia he experienced:

> *I say things deteriorated, mental health deteriorated. Like I'd sit in my house. So, this is the couch [indicates seat] the TV's there [in front] my windows are here [to the left]. I'd have the TV on and I'd have a blanket over my telly and over me, just so no one would know there's someone in the house.*

The sense that emerged from this account was of an individual becoming increasingly separate from reality and experiencing paranoia to the point at which the very will to live seemed at risk. Similar descriptions of disconnection were offered by other participants, with some clearly reaching the ultimate point of despair. Perhaps the most vivid examples of the proximity of death arose from accounts of suicide attempts, which reflect the depth of despair experienced by individuals during these darkest moments. Some of the participants described attempting suicide, the most graphic of which was Martin, who constructed a noose to hang himself.

> *I actually tried to take my own life quite seriously, I actually hung myself … you can maybe just see the mark there* [points to neck]*, yeah a just round there. And it was actually my wife that cut me down … and I think even my daughter witnessed that as well. … I had weapons around the house because you're getting all that paranoid way as well and I built a noose in my attic and just all that kind of crazy way of thinking. You didn't really think about that, you just thought it was normal behaviour, but of course it's not, but that was my mind-set and that was kind of my way of viewing myself and viewing the world … that I had a noose already in my attic just ready to use it, and that time I did use it.*

The graphic nature of this account underscores the anguish and turbulence that was, in different ways, so typical of the narratives and yet serves also as a resurrection story of a man who, figuratively and literally, returned from the dead. The physical scar on

Martin's neck is physical reminder of that episode. Indeed, several of the participants reported physical legacies of health risks faced during the addiction period.

The physical health risks associated with drug use (especially opiates) and injecting were a significant feature of several accounts. It was common for the period of drug use to have led to significant health consequences both at the time and as a legacy. Most immediately, it was often the experience of having survived an accidental drug overdose that led individuals to take stock of their lifestyle and associated risks as they became conscious of the 'everyday' exposure to potentially fatal risks that most people would find unacceptable. Several participants described a history of injecting drug use and the associated physical health risks, particularly the risk of blood-borne virus infection. This risk became a reality for Barry, who became Hepatitis C positive due to his drug injecting and who went on to complete a pegylated interferon treatment programme. Other participants identified a range of physical health consequences resulting from their drug use, including Pete, who reported the jaw condition temporomandibular joint syndrome and Sam, who believed for many years that his drug use had left him unable to father children:

> *I've discovered that I didn't have to believe what I think, ken. I used to believe I couldn't have kids. I've sat in meetings, NA meetings, and shared that I didn't believe I could have kids and I'm going to go to my GP, my doctor, and find out what's wrong with us. I used to think there was loads of things wrong with us, ken. I thought there was stuff wrong with my sperm or something. Months later my fiancé fell pregnant, she had a wee girl. She had my first daughter, then three month later she fell pregnant again and now I've got two beautiful daughters, they're three and four. But five year ago I was like, 'Ah, I cannae, I can never have kids, I don't think I could be a father.' Just crazy thoughts, crazy thoughts about myself, just self-doubt.*

Sam spoke vividly about the effect that the disappointment caused by this 'diagnosis' had on him, which excluded (as he thought) opportunity to have children. In fact, this information proved to be erroneous, as Sam went on to have two daughters; an example of hope and *Light* triumphing over despair and *Darkness*.

The Light

As a depiction of hope, *The Light* both describes and explains the journey towards fulfilment. *Light* fills the void of *Darkness* with hope, potential, optimism and connection.

It is through discovering and connecting with the light that recovery develops. This overarching theme incorporates three themes: *The Spiritual Quest*; *Spiritual Awakening*; and *Living Spiritually*: As with *Darkness*, these three themes broadly follow a chronological progression, whereby *The Spiritual Quest* describes initial awareness of and searching for spiritual understanding and experience, *Spiritual Awakening* describes key spiritual 'turning points' and *Living Spiritually* describes post-recovery integration of spiritual framework and practices to support self-actualised living. These three themes are now explicated.

The Spiritual Quest

The *Spiritual Void* created conditions for spiritual enquiry and discovery, identified as *The Spiritual Quest.* This describes a process of discovery that includes several elements and stages, but one that, typically, initially emerged prior to the commencement of drug and alcohol use, included aspects of substance use, and extended through the addiction stage into recovery. The concept of a *Quest* recalls an archetypal process of discovery with no certainty of outcome; indeed, participant narratives typically described 'journeys into the unknown' which for many individuals became a spiritual process. Often the *Spiritual Quest* receded during the addiction phase, but it never disappeared completely and continued as a *Golden Thread* through recovery and into the pose-recovery life, establishing the idea that within D*arkness, Light* emerges. This section explores *The Spiritual Quest* through two sub-themes, *Glimpsing the Numinous, and The Golden Thread.*

The Spiritual Void engendered both a need and a curiosity for spiritual experiences, which typically led to tantalising episodes of spiritual connection that were often not fully understood at the time. Such episodes emerged as *Glimpsing the Numinous*, which describes the first stage of the *Spiritual Quest* and is summarised as discovering previously unknown aspects of the Self through spiritual experiences. These experiences often initially arose spontaneously, although, later, drugs and alcohol were used to pursue further episodes. Finally, other sources of inspiration, such as music and nature, became important in inspiring spiritual curiosity.

It was common for participants to recall becoming increasingly aware of their intrinsic spirituality through the emergence of both an impulse and a capacity to experience reality differently. The insight that spirituality is essentially an *inner* dimension of experience, characterised by cultivating deep awareness of, and connection with, the Self, was typical of these accounts. As Sean recalls, however, such self-encounters

were often undertaken in the absence of meaningful cultural references or spiritual guidance:

> *At that time, I didn't ken it, but I had experiences within that that were oot of my ordinary everyday perception. I had nae idea what they were, but the memory, the experiences there was a thread that went all the way through my life. And I recognised that there was that unconscious yearning to be oot of the reality that I felt trapped in, sort of round about this wee village. But I had nae idea what that was for ... There was just this desperate craving for something else, some kind of release, some kind of altered state.*

The 'thread' that Sean identified provided a glimpse of the guidance he sought to escape the unpleasant realities of his life at the time. The desire to seek spiritual experiences (even if not recognised as such at the time) led naturally to drugs and alcohol. Initial experimentation typically emerged both as an attempt at self-medicating the isolation, anxiety and social awkwardness described within *The Spiritual Void* and in the pursuit of existential and spiritual experiences. Many of the participants described inspirational and revelatory encounters mediated through early experiences with drug and alcohol which offered glimpses of spirituality by enabling them to connect more deeply with themselves. Several participants identified parallels between the effects of this early substance use and later spiritual practices, whereby substance use emulated the effects of spiritual practices such as meditation, shamanic journeying and yoga. This perspective powerfully reinforces the idea that spirituality centres upon the inner self, as described by Barry:

> *I can remember the first time I ever took opiates and just feeling a sense of completeness and wholeness and completely safe and protected, and I think in some way that's what spirituality has brought in a very different way, but it's the same experience and, you know, and a healing path within, to heal those traumas, to be at peace with those pains and to come into that sense of wholeness again.*

This quote illustrates a recurring motif concerning the positive dimensions of substance use, which participants, at least initially, experienced as functional, enjoyable and, indeed, therapeutic. It is as if substance use and spirituality exist as two closely related, sometimes interconnected realms of experience. As Keith recalls:

I can remember … it was like '97, one of the best experiences of my life, just being on two ecstasy tablets and just feeling awesome. Do you know, like that word's used all the time now, but actually feeling not a care in the world. I can talk to girls, I can talk to mates, I can be this confident teenager and Jack the Lad and … yeah, and back then it was really good, I'm not going to lie, I really, really enjoyed it.

The experience Keith describes here doubtless arises, in part, from the physiological effects of the substances involved, however, it was also clear that drug use served an important social function in creating and facilitating identity within peer groups. Indeed, peer identity played a significant role in shaping the path toward substance use. The difficulties experienced by many of the participants in establishing their authentic identify was explored in the *Spiritual Void* section. In the absence of such *individual* identities, peer groups became a significant focus for 'adopting' identity. This was often described in quite 'tribal' terms, whereby small, tight-knit social groups became the focus for experimentation, not just with drugs, but with roles and identity. In this context, it was notable that many of the participants established personal and cultural connections through music, which were significant in first reflecting the social context within which they lived and later in reflecting an emerging recovery process. In this way, music became the literal soundtrack to the journey from addiction to recovery that simultaneously reflected the process and provided a source of solace, inspiration and meaning. For at least two of the participants, music became inextricably enmeshed with their journey, with Martin playing in and organising several bands, and Sean working as a DJ. Having glimpsed aspects of the spiritual, whether through inner reflexive processes, chemically induced experiences, or collective processes, the door had opened to following the *Golden Thread.*

The narrative myths developed by participants to make meaning from their addiction and recovery experiences all followed a broadly similar three-act structure, spanning the time prior to initiation into substance use, through the progression of substance use and addiction before achieving recovery. Finding cohesion between these three stages was an important aspect of the narrative process, one that was enabled by identifying connection with spirituality as a *golden thread* running through the narrative structure. The term *golden thread* was used by Sean to describe how spirituality permeates his life story, even when he was "*predominantly within this kind of maelstrom of terror*".

It was like following the golden thread, the kind of trail so to speak, it just happened. Because I was still … I mean predominantly within

> *this kind of maelstrom of terror. But I had stopped, I stopped drinking a long time ago, I had stopped smoking weed, I had stopped everything I had started. Then everything was conspiring to make sure I was looking after myself.*

The golden thread described here by Sean adds directionality to the concept of light emerging from darkness and links to Ariadne's Thread and the labyrinth that inform the conceptual underpinnings of this thesis. The golden thread provides a path to follow, a way out of the 'maelstrom'. Other participants developed similar points, emphasising the continuity of some form of spiritual connection (even if highly attenuated) during the addiction phase, bridging the pre-addiction and post-recovery periods. Several participants describe following the *Golden Thread* during the most intense and chaotic periods of substance use, in a way that suggests an active process of searching. Although early spiritual experiences became overshadowed by later addiction, the *Spiritual Quest* was not abandoned (indeed in some cases it intensified) through the period of addiction. Barry, for example, described how he continued to pursue a variety of spiritual experiences throughout the period that he was using drugs and alcohol. The idea that a spiritually determined path, led out of the *Darkness* toward the *Light*, was common to these accounts. The *Golden Thread* also served a powerful function by retrospectively mapping the journey of recovery that had been made, providing a reminder of the obstacles they had overcome and the achievements they had made. It was clear that the questing process required persistence and belief in the possibility of change. It was often in the depths of *Darkness* that the 'breakthrough' came in the form of a *Spiritual Awakening*, the reward for following the *Quest.*

Spiritual Awakening

The *Spiritual Awakening* concept is as fascinating as it is elusive, yet it emerged as a recurring theme, with several participants describing a 'turning point' which marked the emergence of new spiritual perspectives. The essence of the A*wakening* experience, as described by these individuals, was a dramatic awareness of a source of spiritual guidance or power, which was not part of the individual's previous experience. This turning point signalled the start of the recovery journey, through which the participants discovered new life. Indeed, one interviewee described joining a 'born-again' Christian church, however, the sense of having been given a second chance at life was common to all participants. Barry, for example, uses the term '*Spiritual Awakening'* to describe his response to a significant NA meeting he attended during which he listened to another member sharing the impact of his cannabis use:

> *And that made me realise actually this isn't about the drug, this is about the person and the behaviour. Because everything he shared, I could really relate to, you know, because he just talked about his internal world … I realised it wasn't about the drugs, you know, that addiction was something far bigger and it was about something within you, and also my sense of isolation had gone. Because I realised I wasn't the only person who had that experience. And, you know I would talk about those things: that was my spiritual awakening.*

The instantaneous change that Barry describes here is remarkable and it is clear that this moment had great impact through personal insights that led to significant life changes. Although *Spiritual Awakening* is typically described as a single revelatory event, it is perhaps better conceptualised as a process comprising several stages. The initial revelatory stage has already been described however this was usually associated with two further stages, *Surrender to a Higher Power;* and *Encountering myself*.

A common aspect of the *Spiritual Awakening* process was the acceptance of the need to '*surrende*r' responsibility to a '*higher power'* which within the 12-step tradition is understood as a result of working all the steps (Dosset, 2015). This profound step became fundamental to the process of navigating away from *Darkness* towards *Light*. Experiences of 'surrender' reached beyond simply acknowledging or connecting with the higher power, but implied 'letting go' of the desire to retain control of the process of transformation. This point was characteristically associated with an overwhelming sense of relief, as if a burden had been lifted from the shoulders, as in this example from Pete, who reached a point of total surrender, beyond which fundamental change began to unfold:

> *I've had a few experiences. I mean, lying on the bed totally, totally, beaten. I don't know what it was, but there was a part of me totally surrendered. I was just … something changed within me, something gave up. Because I called to it again, 'Just take me,' I remember they words 'Just take me.' I think it was an acceptance of my own death or whatever. And then, from that moment things changed. I suddenly got enough strength or power to get up and carry on with, with doing the right thing in recovery. Whereas I was totally beaten before then.*

Responding to a spiritual spark and surrendering to a higher power marked the 'turn' of the addiction process and the beginning of the recovery journey, whereby the *Light*

begins to shine within the archetypal *Darkness*. Sean recalled how responding to the spiritual 'call' meant that he needed to surrender aspects of his established male identify:

> *There's a traditional hard Scottish sort of male attitude that's been so prevalent I see. So that was it, that was the beginning of surrendering that way. And I didn't really have any idea of what was calling, because it was a call that came deeper from beyond my mind, I guess. From where I'm sitting now, I see it really was my soul screaming for some kind of help. And I soon noticed that kind of cry was heard. Over the next few years, that's when some just pretty remarkable episodes unfolded and started connecting with people who were most definitely on a spiritual path with healing, and that world started to open up to me gradually.*

Such surrender speaks of a failure of previous will-based attempts at recovery and accords with the 12-Step principle of abandoning personal willpower and seeking a power beyond the self (Dossett, 2013). Responding to the spiritual spark could take individuals in unpredictable and sometimes alarming directions as they surrendered control to unseen spiritual forces. For example, Sean recounted his experience of spiritual guidance leading him to make apparently irrational decisions that culminated in his ostracization by the local drug using community and eventually led him towards a tumultuous road to recovery.

The process of surrender was often characterised by trialling a variety of spiritual practices, and a process of connection with, acceptance of, and surrender to, a higher power or source. Often there was an indiscriminate character to this activity, for example Barry described how, at the height of his drug using, he sought solace in churches and Hare Krishna temples. Several of the participants also cited Buddhist ideas and practice as influential to their recovery journey and seemed to particularly relate to the aspects of Buddhism emphasising openness, tolerance, self-exploration and compassion. Indeed, such self-exploratory processes emerged as a significant dimension of the recovery journey.

One aspect to emerge strongly from all the accounts was the necessity of self-analysis and introspection as part of the recovery process, which is represented through the *Encountering Myself* theme. Several methods were described to achieve this, including gardening, music, connecting with nature, meditation and prayer. Whichever the

method, it was apparent that, for all participants, the act of looking deeply, honestly and unflinchingly into their own inner world became the essential transformational process that drove recovery, as described by Pete:

> *It's something I've always believed in my recovery. The talking. The value of talking and sharing and being honest and open and getting that stuff out. And recovery has been a really hard thing because of having to experience all those emotions and feelings that I was denying and running away from all those years. Instead of trying to bury them, speaking them out.*

It was as if the connection and support that were formed through the 12-Step fellowship and other settings became the container within which this self-analysis work took place. It was clear that this introspective process was far from comfortable. For many participants, recovering from drug and alcohol addiction was marked by the return of early fears and vulnerabilities which had lain concealed and repressed during the years of addiction. Descriptions of a 'lost little boy' were common, as was the notion that as adult men, these individuals suddenly found themselves confronting this inner turmoil without familiar (chemically based) coping mechanisms, or indeed the psychological skills to process the emergent emotions.

The enhanced self-awareness that participants developed through the spiritual aspects of their recovery journey led some to re-evaluate aspect of their personalities that they had previously considered problematic. For example, Martin and Barry both emphasised the positive dimensions of their capacity for 'obsessiveness', which in the past had contributed to their addiction experiences. Martin described the single-mindedness he had required to complete a Master's degree and train as a yoga teacher, while Barry highlighted the personal discipline that he brought to his spiritual practice.

Several of the participants attended residential rehabilitation of some form which became the focus for such self-examination through a range of approaches including group work, individual counselling and in some cases prayer and other spiritual practices. Indeed, it was apparent that many of the participants were poorly prepared for the process of recovery, particularly residential rehabilitation. Certainly, several participants identified the need for much better preparation for anyone planning to attend residential rehab programmes, and Pete suggested that had he known how tough the process was, he might not have signed up. However, despite (or perhaps

because of) such challenges, the spiritual questing described by participants led to transformational personal growth that in many cases became the starting point for fundamental lifestyle change.

Living Spiritually

The participants all discussed spirituality and their own spiritual practice at length and in depth. It was apparent that they all regarded spirituality as playing a central role in their recovery process, which was hardly surprising given that they had been recruited to the study for this reason. Nevertheless, the degree of importance attached to the spiritual aspects of recovery was remarkable. The depth of the integration of spiritual practice and belief in the lives of the participants informed the *Living Spiritually* theme, comprising five themes: *Spiritual Continuum; Practice and Discipline; Eclecticism; Connection;* and *A Continuing Search,* which are now described.

It was apparent from all the participants that recovery requires time and cannot be rushed. Furthermore, there was some evidence that the depth and extent of recovery achieved depended, at least in part, on the amount of time spent in recovery. A recovery continuum emerged, reflecting the degree to which spirituality was embedded in the recovery process; itself a function of time in recovery. At one end of the continuum, spiritual practices supported continued abstinence. This exemplifies the experience of the two individuals who reported the least-established recovery (Sam and Keith), who at times depicted spiritual practice almost as a substitute for substance use. By contrast, individuals at the other end of the continuum described commitment to a spiritual life encompassing all aspects of living and reaching well beyond the initial abstinence goal. For these individuals, spirituality become not merely the means to achieving and maintaining abstinence from drug and alcohol use but provided a complete framework for living an inspired and fulfilled life. Significantly, although participants acknowledged the potential for relapse, they explored this in relation to ‘relapse’ to lower, less spiritual or inspired ways of living rather than returning to substance use. In this context, several participants borrowed Buddhist thinking to reframe addiction beyond simply using drugs to encompass behaviours and cravings associated with harmful patterns of living that are symptomatic of the human condition. They also typically reflected commitment and discipline in their spiritual practices.

A feature of the accounts by those participants who seemed further developed in their recovery journey was the extent to which the practice and discipline of their chosen spiritual path had become an embedded element of their lives. Those at an earlier stage of recovery described a more functional attitude to engaging in spiritual practice,

whereas those further along the process described a serious approach to maintaining a spiritual engagement through practice and discipline. This is well illustrated in this excerpt from Barry, who described the form and flow of spirituality in his daily life:

> *My morning starts with prayer. So normally when I wake up I connect with myself, you know, where I am, the body, connect with the environment, the house, the garden, and then prayer and then I do yoga. My yoga practice is I suppose very physical because part of that is doing Alexander Technique and then doing Yoga practice, simply because I'm very active physically, do lots of cycling, running, walking and also I've got a spine that is painful, so it's for stretching and to look after that pain. To manage that pain. Which on good days is barely there now. And then do meditation which – I do transcendental meditation – and so I do that twice a day. And then after that its very much getting on with the stuff you need to do in day-to-day life.*

Barry's account of the ritual nature of his spiritual practice echoes the 'daily programme' concept, which Dossett (2017) identifies as being central to the 12-Step recovery approach. This example also illustrates a feature common to all the accounts: the eclectic nature of the spirituality practised. Significant differences existed between participants in terms of spiritual approaches and practices, however they all described an eclectic form of spirituality drawing upon several sources simultaneously. All participants described religious components to their spirituality, however, it was clear that none of them identified completely with any single religious approach. Rather, eclectic forms of spirituality were typical, informed by several traditions which included religious and non-religious elements. Participants described engaging with a range of spiritual *approaches* or *disciplines*, which included 12-Step fellowship, shamanism, evangelical Christianity and Buddhism. They also identified a range of spiritual *practices*, which included meditation, prayer, shamanic journeying, music and connecting with nature. For several participants, contemporary spiritual authors and broadcasters, typically espousing a spirituality rooted in self-awareness and becoming present 'in the moment', were an important influence. The eclectic approach to spirituality is typified by Sean, who describes his enthusiasm to draw from multiple traditions as well as the limitations he identifies with following a single approach:

> *There are various teachers and masters and traditions that have come my way, and I've learned a lot through them all, but I dinnae*

feel particularly identified just with any sort of one, because I always find that's maybe a bit of limitation so I just want to be open, because I just want to be open to everything and everybody to the best of my ability and able to feel whatever life's inviting me to feel right now.

The fact of drawing on multiple traditions means that there is no single doctrine or explanatory framework underpinning the spiritual positions adopted by participants. Instead, individuals sought to develop such understandings for themselves. Perhaps for this reason the individuals in this study said comparatively little about their spiritual *beliefs,* which are characteristically harder to articulate than approaches and practices. Nonetheless, for many of the individuals interviewed, developing and maintaining connection with spiritual forces became a cornerstone of their spiritual life. Connection formed an important part of the spiritual life for many of the participants and reflects ideas advanced by Hari (2015a, 2015b), that the opposite of addiction is not abstinence, but rather is connection, as reflected by Keith:

Sobriety is not the opposite of addiction, connection is the opposite of addiction … Well for me I only got connected when I got sobriety, do you know what I mean, I never felt connected to anything and now I feel more connected to my colleagues, to my friends, to my family, but that's just my journey. But the whole aspect of meaningful activities, having a life, having connections with other people, recovery capital. That's what I saw in NA.

Participants described significant connections and relationships with 'Spirit' (or higher power), with nature, with themselves and with others. All participants identified connection with a higher power as fundamental to their spirituality and the focus for spiritual comfort and solace, guidance, hope and direction. These accounts also illustrate the ambivalence felt by some of participants over terminology for the higher power and the relevance and legitimacy of religion, whereby a freer, individual version of a higher power contrasted with concepts of a religious God. Indeed, participants typically drew sharp distinctions between religion and spirituality and several of them developed critiques of religion, focussed both on childhood experiences of authoritarian and judgmental religious attitudes, particularly based upon formative experiences of Roman Catholicism and later involvement with evangelical Christianity. This contrasted with notions of spirituality, as distinct from religion, which was associated with acceptance and individual self-expression. This 'anti-religious' stance was not adopted in relation to all faiths, and several of the participants cited Buddhist ideas and practice

as influential in their recovery journey, indeed, it was apparent that Buddhism was not subject to the same critical standpoint that Christianity was. This accords with a view of spirituality that emphasises presence in the moment, the cultivation of which is a central tenet of the Buddhist approach (Harvey, 2006).

One recurring motif was connecting with a higher power through nature, whereby the beauty and inspiration associated with the natural world becomes reflective of the higher power and provides an inspiring spiritual touch point. This took different forms, including gardening and aspects of shamanic practice. Sean's account of gardening as a dimension of his recovery process presented a fascinating allegory for his life. Initially, the garden was choked with weeds and rubbish, but through hard labour he cleared the debris and created a space in which flowers and vegetables flourished. He readily saw the parallels with his wider life and recalled how he consciously worked through his own inner 'rubbish', bringing order and productivity to the garden of his life:

> *A lot of my therapy was in the gairden. When I came up here it was a perfect metaphor because I went into my gairden when it was … it was chest high in like creeping thistles. And that was … my mind was just 'Fwoar' And I just had to get out in … I was determined I would create a gairden and bit by bit I dug and I dug and all these things and every single bit of root had to be out with these thistles, or they grow back. So, for months and months and months I would be out there like hammering and hammering and getting all these roots out and then I started sort of growing vegetables and flowers and all this, and that was the mirror for what was going on in my mind.*

In this example, the process of connecting with nature through gardening becomes profoundly therapeutic, illustrating a deeper task of connection that participants identified: cultivating a relationship with themselves. It was typical for the individuals I spoke with to describe emerging into recovery with no real idea about their own identify. It was as if the identity of a vulnerable child, a 'lost little boy', had become frozen at the point of initiation into drug use and then reanimated decades later as recovery unfolded. Developing a deep awareness of themselves and their needs and desires became crucial to the process of developing meaning and purpose in life for the participants. As part of this 'self-discovery' process, developing and maintaining authentic connections with others became essential, especially through the 12-Step fellowship.

For most participants, connecting with mutual aid through the 12-Step fellowship via AA or NA was pivotal. Many participants contrasted their experience of drug-using peer groups, characterised by deceit and selfishness, with the warmth, authenticity and acceptance experienced in 12-Step meetings. It was clear that the shared nature of these processes was significant for many participants. Interestingly, little mention was made of the fact that 12-Step engagement centres on forming connections with others who also have experiences of addiction and recovery, implying that it was the experience of acceptance, rather than the commonalities between each individual's substance using experiences that was transformational. Indeed, the one participant who had not engaged with 12-Step organisations (Sean) described finding acceptance and personal transformation through engaging with individuals in a variety of contexts, who had experienced other forms of personal difficulties in life:

> *And just begin to meet more and more people who were dealing with the same stuff in their own way. Maybe not the chronic addictions, but meeting life with a different attitude and actually beginning to embrace that gnawing hole for what it was, that craving for what it kind of was, so it would all come into alignment.*

A similar valuing of genuine human connection was developed by Sam in his account of attending an evangelical Christian church, although, in this case, the experience also carried a manipulative undercurrent, as if the church in question were seeking to draw in vulnerable people to evangelise. This led Sam to develop a nuanced position in which, while valuing the genuine care and warmth received, he also recognised a degree of manipulation exerted by the church as an organisation, distinct from its individual members.

Developing and maintain authentic connections at a variety of levels formed a central element of *Living Spiritually*, however, it was clear that continuing the *Spiritual Quest* was equally as important. None of the participants suggested that they had reached the 'end' of their spiritual quest. And all emphasised the continuing nature of the spiritual journey, as Sam described:

> *Being honest, I'm still searching, I'm still looking for my own Higher Power. I think that's a good thing … I'm still open-minded, I'm still looking, I've still not gave up.*

For several the participants, this continuing search led them into facilitating recovery and bringing spirituality to others in a variety of ways, including teaching meditation,

teaching yoga, working as a shamanic practitioner and working in an addiction recovery support service. The participants' views on the relevance of spiritualty in supporting recovery among other people facing addiction were, therefore, especially relevant.

Lessons for recovery

Several participants reported that they were in contact with former peers who remain trapped in the cycle of social deprivation and negativity that characterised the working-class communities of their youth. It is interesting, therefore, to consider why and how the individuals interviewed within this study managed to 'escape' that cycle while others remain 'trapped'. The participants all described the centrality of spirituality to their personal recovery journey, which was hardly surprising given that they had been recruited for this reason. However, they were divided on the relevance of spiritual approaches to recovery more widely. Sam, for example, was certain that many individuals achieve recovery from addiction without engaging at the spiritual level, or indeed without necessarily undertaking a personal process of introspection. Barry and Pete, by contrast, both argued that some form of spiritual process is essential to transcend addiction and attain meaningful and lasting recovery. These participants did, however, identify significant challenges and barriers to applying spiritual practices and approaches more widely within addiction recovery programmes.

The need for time and space in recovery was emphasised by several participants, who suggested that the demands on statutory services to provide basic treatment to large numbers means that addressing spiritual dimensions of recovery becomes challenging. Furthermore, Pete cautions that the commitment and capacity to explore the inner world, implicit to the spiritual approach, should be understood both by people in recovery and those that commission and deliver support services.

> *People need to learn, need to be taught that spirituality isn't the airy-fairy thing, that it is quite a tough discipline. If people can get an understanding of that … and this is not just the addicts, this is the people in charge of funding and stuff like that.*

Several participants also emphasised the importance of making spirituality relevant to people in recovery and that it is common for individuals to be suspicious of religion but accepting of non-religious spirituality. In this respect, the use of appropriate and acceptable language, measures to present spiritual approaches in socially and culturally appropriate ways, and adopting a gradual, non-threatening approach to

introducing spiritual ideas to individuals in recovery were all seen as important. Furthermore, Martin identified the challenge presented by the secularity of statutory health and social work services, in engendering an organisational suspicion of spiritual approaches and interventions, highlighting the need for further development in this area. Several participants identified the alienating effect of some spiritual approaches for many individuals, especially when spirituality and religion are conflated. Identifying effective ways of engaging individuals in recovery in spiritually meaningful processes that are, nevertheless, accessible and culturally relevant, was an important aim for several participants. Sean developed this idea by discussing the importance of rites of passage for young people and the absence of such formal ways of marking key transitions within contemporary culture:

> *There are a few projects happening these days. Maybe not enough, I feel it should be part of the school curriculum for guys. Especially the kind of males, but obviously for women as well. But getting out and actually getting away, being out in the wilds for three or four days back-to-back and learning to survive oot there with people, like a few times throughout the course of the year. I think that would really help a lot of people because I feel that the disconnection with nature and natural cycles has a really negative impact on the psyche.*

It is interesting that Sean chose to focus on interventions for boys and young men, particularly given his personal experience of discovering his own sense of masculine identity. He clearly places importance on connection with nature, and in so doing broadens the canvas beyond substance use towards finding approaches to address deep-seated social problems. Sean's position is underpinned by a sense of intrinsic authenticity of 'being out in the wilds' combined with an implied suspicion of the disconnecting effects of contemporary society. Indeed, most of the participants were reluctant to offer detailed examples of how best to use spirituality to support recovery in others, tending instead to stress the individual quality of addiction and recovery. In discussing potential approaches to supporting change and recovery in others, the men interviewed for this study reflected their own understandings of the eclectic nature of spirituality. This led them to advocate for a plurality of spiritual opportunity made available in response to a desire from individuals to pursue a spiritual path of recovery.

Chapter Summary

This chapter has presented the results of IPA analysis of the Phase Two data. Participant accounts were explored as examples of personal myth-making, characterised by the inclusion of archetypal events, figures and motifs, thus locating contemporary stories of drug and alcohol addiction recovery within a much older narrative tradition. The mytho-archetypal approach created a framework within which to locate participant narrative accounts, which centred on the dynamic interplay between the Darkness/Light polarity. From this perspective, spirituality emerged as a constant theme that both shaped, and gave meaning to, participant experiences of addiction and recovery, with relevance to the provision of recovery-focussed interventions.

Part III: *Emerging from the Labyrinth*

There are no wrong turns in a labyrinth; pilgrims always get home. Likewise, there are no wrong uses of the labyrinth: people in all times in all ways have made their own use of its geometry. History itself is a permission to use the labyrinth in one's own way. The labyrinth has only one path, so there are no tricks to it and no dead ends. It confirms our faith that hope exists in the universe. (Schaper and Camp, 2013, p12)

Chapter Eight: Discussion: the labyrinth as an emerging model for recovery

Introduction

The central thesis proposed at the start of this work was that spirituality has relevance to experiences of problem substance use, addiction and processes of recovery, and that improving awareness of spirituality among service providers and access to spiritually informed interventions might enhance recovery and wellbeing among those with experience of problem substance use. This proposition is especially important considering recent dramatic increases in DRDs in Scotland, particularly among middle-aged men (National Records of Scotland, 2019). The men interviewed during Phase Two of this study largely fit the profile of those identified at highest risk of death; men who grew up during the 'Thatcher years' and, more generally, between 1960 and 1980. In view of the relevance of the DRD risk within Scotland currently, and the profile of the participants in this study, it is important to consider why and how the individuals interviewed managed to survive, unlike many of their counterparts, and, furthermore, were able to develop rich and fulfilling lives. Might the spiritual journeys of recovery they have recounted in these study data be part of this complex picture?

This chapter attempts to explore questions such as this by framing the findings of the two phases of this study within the literature linking spirituality, addiction, stigma and masculinity in the context of a novel 'labyrinth' model of addiction recovery. The study did not use a design where it is possible to conclude that spirituality was a protective factor. All that is possible with this qualitative exploratory design is to suggest possible connections that can be investigated further using other approaches. That said, the purpose of this chapter is to draw connections between the study findings and processes of wellness, holism and recovery, and to outline the wider implications of the findings for theory, policy and practice. Wider research implications are also noted. In this chapter, I will demonstrate the ways in which the background literature on spirituality and addiction, described in Chapters Two and Three, is extended or challenged by the findings of the research, and will discuss the potential benefits associated with enhancing spiritual awareness among service providers and service users in addiction treatment and recovery programmes. The chapter begins by describing the labyrinth model in the context of myth as a spiritual lens through which

to understand experiences of addiction. The chapter concludes by summarising the main original contributions arising from the model and its relevance to theory and practice, especially pertaining to DRD, masculinity and spiritual questing. The labyrinth model is informed by the findings of both phases of this study, but is primarily positioned as a theoretical response to the male accounts of addiction, recovery and spirituality described in the preceding chapter. The model's relevance to women in recovery is discussed in the context of recommendations for further research in the final chapter.

A labyrinth model of addiction recovery

The connection between addiction recovery and the labyrinth may not be immediately obvious. However, as this section will demonstrate, the labyrinth models the personal exploration and transformation implicit to processes of recovery and provides a framework for understanding recovery as a fundamentally spiritual process. The model that is presented has emerged iteratively from the findings of this study as a framework for understanding processes of addiction and recovery. Furthermore, the labyrinth has proved to be relevant in understanding men's experiences, which are a focus for this study. In the myth, Theseus represents maleness and the masculine, while Ariadne's thread represents a source of feminine spiritual guidance (Higgins, 2018). The interplay between these two aspects emerged from the data as a rich source of analysis and theory development concerning men's experiences of addiction, recovery and contemporary spiritualty. This section begins with a discussion of the relevance of myth-making and understanding experiences of addiction and processes of recovery through a spiritual lens, particularly as informed by Jungian theory. This is followed by an overview of the emerging three-stage labyrinth model. Finally, the three stages of the labyrinth model are explicated, drawing upon study findings and the wider literature.

Myth-making and the spiritual lens

Attending to the spiritual dimensions of substance addiction and recovery brings unique perspectives which reach beyond the bio/psycho/social framing of much research and practice. The personal accounts within this study revealed the relevance of myth-making in understanding recovery as a spiritual journey characterised by key turning points and transformational stories which both give meaning to past experiences and inform current living. The mythic archetypal perspective offers a framework for locating such stories within which individuals develop understandings of their experiences of addiction and recovery. Beyond this, though, the inclusion of archetypal figures and

objects, and the journey from darkness to light, resonates with wider collective understandings of the recovery process. The themes of light and darkness emerged in this study as a framework to conceptualise personal experiences and theoretical interpretations in which addiction is understood as a progressive life phenomenon with significant spiritual components. Such experiences were characterised by transitions from the 'darkness' of substance use, addiction and 'rock bottom' towards the 'light' of recovery. Jungian psychology and analytic psychotherapy are especially relevant to understanding archetypal processes of the types described in Chapter Seven, leading several authors to explore dimensions of addiction and recovery from this perspective. Addenbrooke (2011), for example, notes that, although Jung himself wrote relatively little about addiction, several post-Jungian writers have addressed the subject in Jungian archetypal terms. Addenbrooke cites Schoen (2009), Naifeh (1995), Zoja (1989) and Redfearn (1985), each of whom develop different Jungian perspectives on addiction and recovery which are now briefly reviewed.

Schoen (2009) applies Jungian analytical concepts to develop a framework for understanding the spiritual dimensions of addiction and recovery informed by an account of the Jungian influence on the emergence and development of AA and the 12-Step approach. He traces addiction to the archetypal 'Shadow' (the 'hidden' aspect of the psyche), which he considers to be synonymous with the concept of 'Archetypal Evil', through a five-stage framework describing the significance of the 'Shadow' on the development of addiction. According to Schoen, the Ego/Persona becomes aligned with a 'False Self', which leads to the development of a 'Personal Shadow' which, in combination with the introduction of the 'Potentially Addictive Behaviour', leads to the creation of the 'Addiction-Shadow-Complex', which eventually usurps the psyche. In Schoen's view, the Archetypal Shadow/Evil associated with addiction opposes the self-awareness which he identifies as a necessary condition for recovery. This reflects the darkness and light polarity which emerged as a significant theme in the current study and resonates with the narrative accounts of the participants, who described the necessity of deep self-awareness in resolving addiction and achieving recovery. In contrast to Schoen's 'Archetypal Evil' concept, Naifeh (1995) argues that addiction is best understood as the expression of a normal human drive towards wholeness. In Naifeh's view, recovery from addiction manifests through the spiritual path and necessarily occurs at an archetypal level.

In comparison, Zoja (1989) argues that the urge to excess, which typically characterises addiction, arises from a collective need for initiation and ritual which is

not met by contemporary consumerist society, and the search for inner, mystical experiences, rather than hedonism. Redfearn (1985) conceptualises addiction in terms of 'parts' of the self, within the psyche. During addiction, only the 'addict self' finds expression: recovery entails retrieving lost parts of the personality through a process of regaining wholeness. This is developed by Addenbrooke (2011), who references the archetype of the wounded healer as a dimension of the addiction and recovery experience which is typically expressed through the 12-Step tradition of mutual aid and mentorship and the wider trend for people in recovery, to support others in recovery (Dossett, 2018).

The concept of the recovery journey as movement from darkness to light, which emerged so strongly from participant accounts, is explored by Southern (2004) who also writes from a Jungian perspective to identify linkages between personal accounts of spirituality and theoretical constructs surrounding recovery. For example, Southern identifies hidden dimensions of the self that inform the progression of addiction, while Addenbrooke (2011) applies a Jungian-archetypal perspective to process of recovery among trauma survivors with experiences of addiction through dream journals as a process of spiritual growth. Overall, the Jungian theorists and practitioners cited here approach addiction as a dimension of the deep psyche, arising from a failure to connect with the 'Shadow' (or hidden) archetype, and emphasise the necessity of personal spiritual exploration to recovery, as described by several of the participants in both phases of this study. This Jungian perspective thereby provides a theoretical framework within which to situate the archetypal concepts, and the *Darkness* and *Light* polarity, that emerged from the data.

For participants in this study, spirituality proved to be a necessary part of the recovery journey. Spirituality emerged from the Phase Two data as a 'golden thread', providing guidance out of chaos and confusion towards order and clarity. This 'guiding thread' concept kindled parallels with Ariadne's thread, from the Greek myth featuring Theseus and the Minotaur, inspiring the title of this thesis and informing a conceptual model for understanding experiences of addiction and processes of recovery based upon the labyrinth. The labyrinth model emerged as the product of the process of synthesising Phase One and Phase Two data, described in Chapter Five, and is potentially relevant to both theory and practice. The emerging model is underpinned by Ullyatt's (2010) dual conception of the labyrinth as both structure and design, and is informed by the findings of this research and the wider literature on addiction, recovery and spirituality.

So as to explicate this further, the emerging model will now be situated within the mythology, symbolism, history and spiritual practice associated with the labyrinth.

Labyrinth as a model

The spiritual quest inherent to the journey from addiction to recovery is to seek, find and follow Ariadne's thread as the source of spiritual guidance, direction and connection. This informs a novel interpretation of the labyrinth as a model to understand processes of recovery from addiction which mirrors the process of growing self-awareness, transcendence, and transformation associated with the addiction–recovery arc, and which is now presented.

Ullyatt's (2010) dual definition of labyrinth as both structure and design underpins an interpretation within which the unconscious is 'projected' at increasing levels of abstraction by the two forms of labyrinth. In this view, the structural form of labyrinth described by Ullyatt is read as a projection of the unconscious. It is dark, full of hidden passages within which to become disoriented, and contains the shadow, the hidden and perhaps shameful aspect of the self, represented by the Minotaur and which is echoed in addiction narratives. By contrast, labyrinth as design is read as a 'projection of the projection'; a representation of the deep unconscious at a further level of abstraction, whereby the apparent simplicity of the unicursal labyrinth conceals the complexity of the maze, which itself represents the unconscious mind. This proposed relationship between the unconscious self, labyrinth as structure and labyrinth as design, is illustrated in Figure 8.1 below.

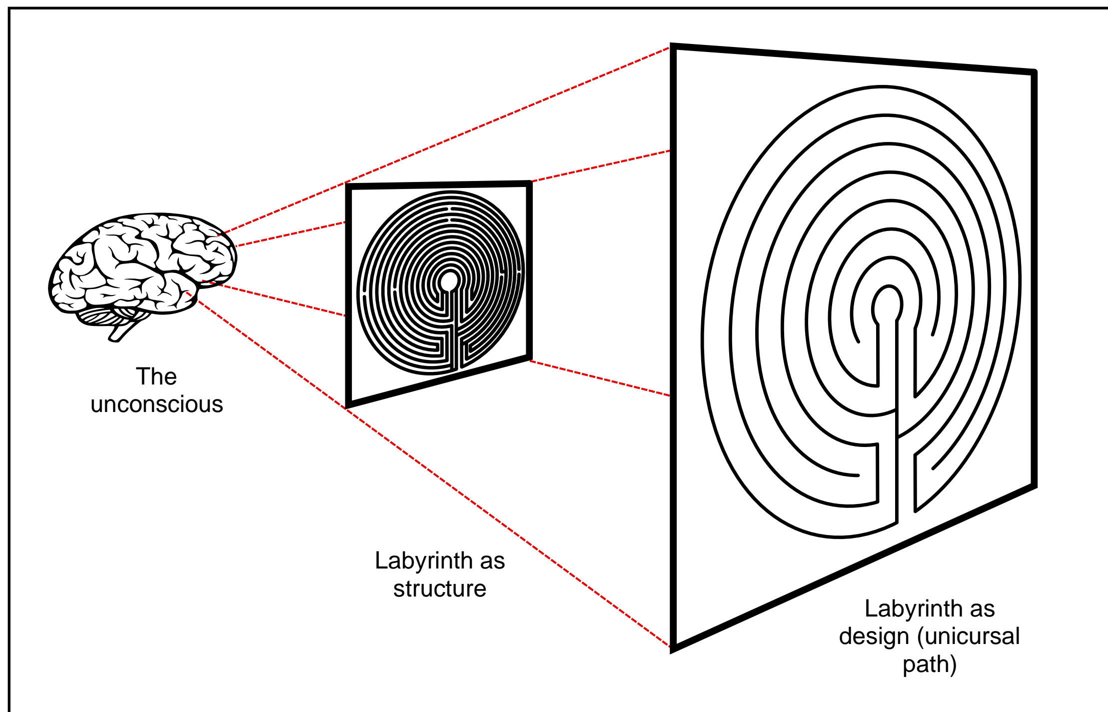

Figure 8.1 Labyrinth as projection of the Unconscious at two levels of abstraction

The interconnectedness between the unconscious self and the two forms of labyrinth bring multiple layers of meaning to the act of tracing a labyrinth design (for example, by walking a physical labyrinth), which becomes both a literal journey along the unicursal path, and the representational depiction of a structural labyrinth, which is itself the projection of the psyche. In the myth, Theseus is assisted in his quest by Ariadne, who gifts him a ball of thread to guide his return to the entrance of the labyrinth after slaying the Minotaur (Higgins, 2018). In the unicursal labyrinth (labyrinth as design), Ariadne's Thread is intrinsic to the path (the path *is* the thread); by contrast, the complexity of the labyrinth as puzzle (labyrinth as structure) requires Ariadne's Thread to be revealed or discovered. By revealing the unicursal path to the centre goal, Ariadne's Thread converts labyrinth as structure to labyrinth as design. Likewise, tracing the unicursal labyrinth as design (which necessarily follows Ariadne's Thread) provides access to the deeper structural labyrinth and unconscious self. The persistence of the labyrinth design as a tool for spiritual practice and awareness conceivably lies with this capacity to connect the seeker, via Ariadne's Thread, to the deep unconscious. The linkage between the two labyrinth forms, embodied via Ariadne's Thread, is illustrated at Figure 8.2 below. The emerging labyrinth model which, at this point, may seem troublingly conceptual, is grounded in the narratives of the research participants, as will be established.

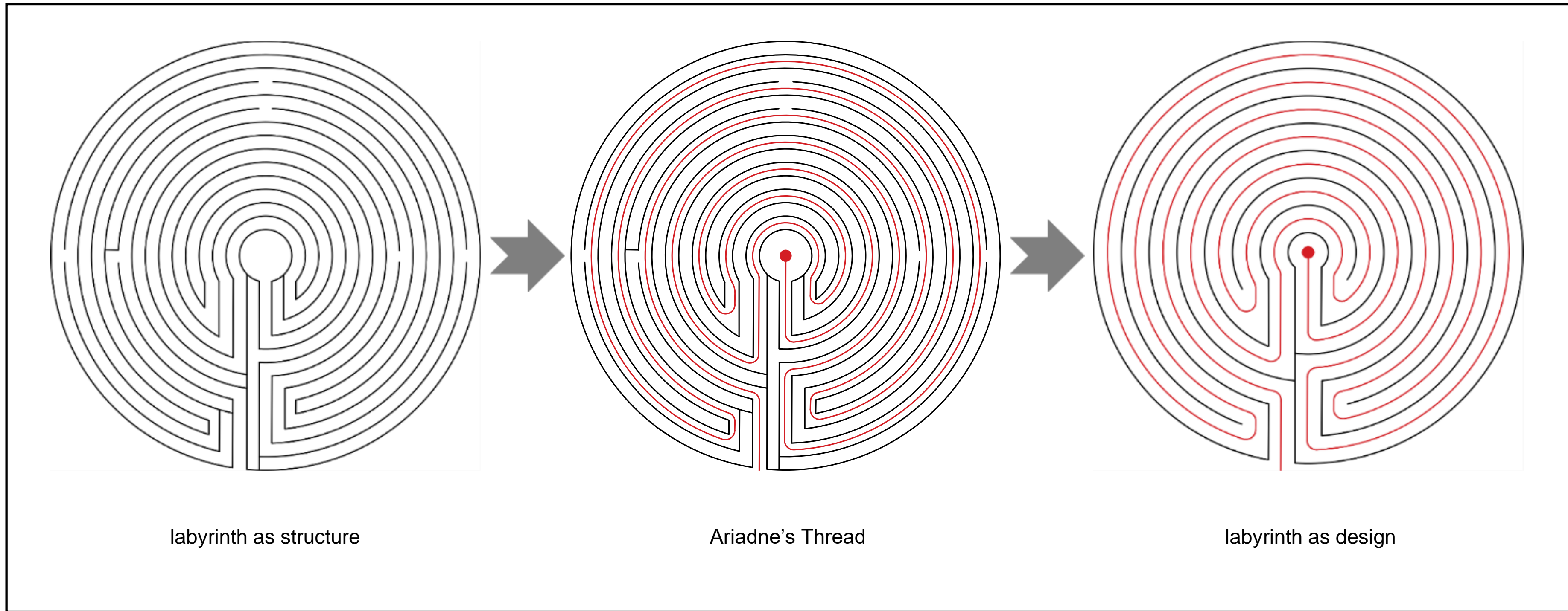

Figure 8.2 Ariadne’s thread converts labyrinth as structure to labyrinth as design

The Theseus myth functions, as all myths do, at many levels. Superficially a tale of a heroic protagonist overcoming a formidable foe, it can also be read as a symbolic representation of the psyche and, in the context of this thesis, as a symbolic depiction of processes of addiction, recovery and spirituality. This symbolic depiction of the labyrinth and Ariadne's Thread is developed here as a model to understand experiences of addiction and processes of recovery from a spirituality perspective. Within this reading, the labyrinth, a confusion of passages, capable of trapping the unwary explorer, becomes the unconscious self, while Theseus, heroic and yet fallible, represents the conscious self, seeking understanding and alignment. The Minotaur represents the Shadow, the hidden and perhaps shameful aspect of the self, which in this model manifests as addiction. The centre of the labyrinth is a liminal space for potential transcendence; a transcendence meditated through Ariadne's Thread, which is symbolic of spiritual guidance and transformation associated with the recovery journey.

The labyrinth journey characteristically encompasses three-stages, identified by Sandor (2005) as *release* (the journey inward and 'letting go' of the everyday), *receive* (within the still space at the centre of the labyrinth), and *return* (the outward journey whereby the experience is integrated and applied to life). I have reinterpreted this three-stage labyrinth process to develop a model of the addiction-recovery arc. This model is informed by labyrinth theory explicated, for example, by Sandor (2005) and Ullyatt (2010), and the work of Flaherty *et al.* (2014) who, in an IPA study of secular, spiritual and religious recovery, describe recovery as typically a three-stage pattern. However, the specific application of labyrinth theory to addiction recovery is, I believe, unique and, as such, represents a novel contribution to the field. The model uses the labyrinth to reflect the archetypal journey from disengagement and despair, through inner examination and transcendence, to re-engagement and recovery. Each stage is associated with a specific recovery 'task', identified as 'Awareness' during the inward journey, 'Transcending Rock Bottom' in the centre of the labyrinth, and 'Transformation' within the outward journey. Additionally, the three stages are linked to aspects of the Theseus myth through the themes *Questing in the dark*, C*onfronting the Minotaur*, and *Following Ariadne's Thread.* The model is illustrated at Figure 8.3 below.

In this labyrinth model, the first stage, the journey inward, involves questing into the passages of the unconscious and thereby developing awareness of the obstacles to a fulfilling life, which fall into three categories: *wounds*, which may arise from adverse

childhood experiences, abuse, trauma and other negative experiences; *masks*, which conceal the authentic identity and often arise from immature versions of masculinity; and *spiritual void*, through which the individual experiences disconnection and isolation from self, others, nature and spirit. The contention of this model is that developing awareness of these obstacles (which may lead toward 'rock bottom') creates potential for transcendence towards greater integrity.

The second stage occurs within the liminal space of the centre of the labyrinth which, in this model, is the forum for two linked processes: confronting the Minotaur and discovering Ariadne's Thread. The Minotaur is conceived as the shadow aspect of the self, closely associated with addiction: indeed, 'Transcending Rock Bottom' was considered as an alternative title for this thesis. The Minotaur is overcome (transcended) through spiritual direction provided by Ariadne's Thread. Here the model departs from the Theseus myth, in that the thread is discovered, or revealed, through the struggle with the Minotaur whereas, in the myth, Theseus deploys the thread at the entrance to the labyrinth. This portrayal seems to fit better with the addiction–recovery arc, whereby key turning points signal a change in spiritual direction. In this interpretation, Ariadne's Thread is revealed through the self-awareness process inherent to the first stage of the model.

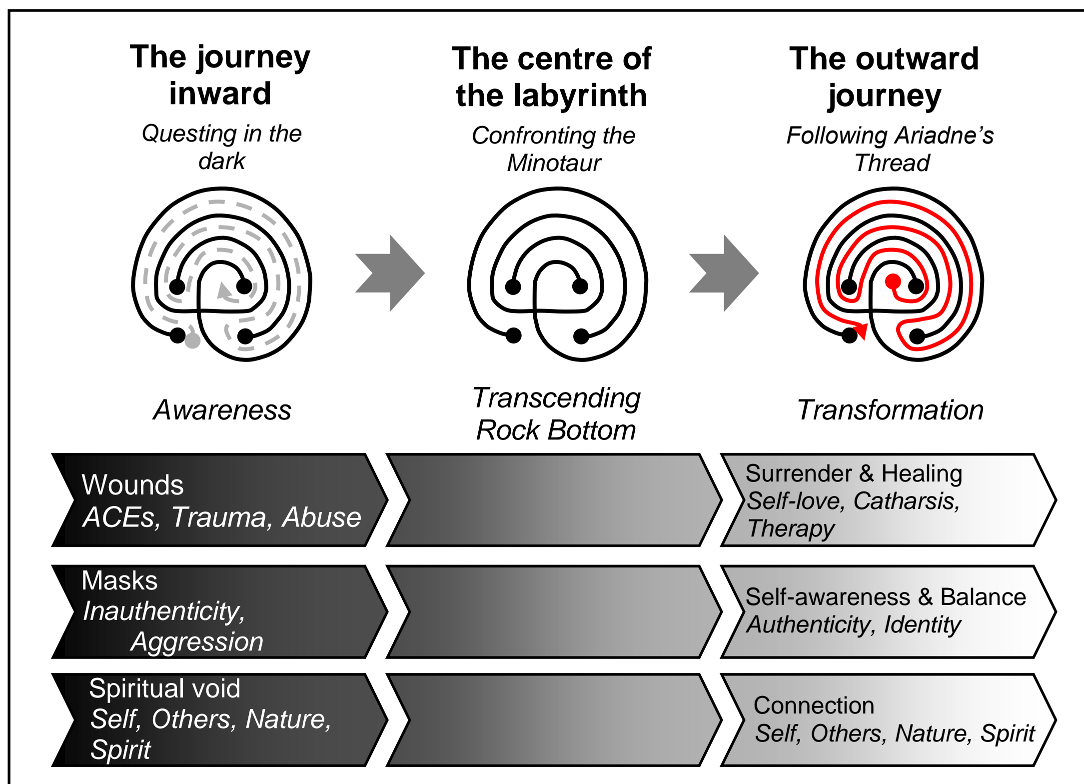

Figure 8.3 Labyrinth model of addiction, transcendence and recovery

Finally, during the third stage, Ariadne's Thread is followed on the outward journey that involves transforming the obstacles identified during the first stage to re-establish positive ways of living. This transcendence process involves *self-love and healing*, *identity and balance,* and *connection*, which link closely to steps four to nine in the 12-step process (Dosset, 2015). Although the specific features of this spiritual direction differ between individuals, I would argue that recovery as a spiritual process includes these common elements. This model is now explicated through reference to the findings of this thesis and the relevant literature relating to addiction, spirituality and recovery.

The journey inward: questing in the dark

Theseus, in the myth, ventures unseeingly into the labyrinth, just as recovery, as conceived in this model, begins with a step in the dark. Recovery, as described by the participants in this study, and reiterated within wider literature, is not characterised by a distinct start and end, but rather emerges as a process of developing awareness, focus and transformation that unfolds over time, identified by a growing dissatisfaction with the current situation, and emerging impulse for things to be different (Kougiali *et al.*, 2017). This section maps the findings of this study concerning the early phases of the recovery journey onto the emerging labyrinth model, centred on growing awareness of *wounds*, *masks* and *spiritual void*.

The men interviewed here linked their addictions to earlier adverse experiences, especially those from childhood, which included accounts of abuse and trauma, loss, low self-esteem, social anxiety, and lack of identity during childhood and early adolescence. This provided a deeply moving and graphic illustration of the growing evidence linking adverse childhood experiences (ACEs) with later PSU. For example, in a systematic review of studies on ACEs, Hughes *et al.* (2017) report that individuals who experienced at least four ACEs were six times as likely to consume alcohol problematically than were those who had no ACEs, and were also at increased risk of problem drug use.

As participants in this study attest, ACEs have long-lasting consequences. In the labyrinth model the traces of such experiences are revealed as wounds. The men interviewed in this study typically identified as themselves psychologically susceptible, informed by a conviction that some individuals are predisposed to addiction through a 'weakness of character'. Informed by 12-Step thinking, such participant understandings of addiction broadly accord with popular viewpoints linking addiction with lack of free will, and reveal contradictions between 12-Step ethos and contemporary theory.

Vonasch *et al.* (2017) demonstrate that this 'loss of free will' explanation contrasts with scholarship in the area and argue that this belief can be used in self-serving ways that may undermine people's efforts to achieve recovery. The assumptions underpinning the 'lack of free will' view are challenged by Cox, Klinger and Fadardi (2017), who assert that the common understanding of 'free will' is, more accurately, the capacity to choose between a set of choices. They suggest that those individuals facing the most restricted choices are most susceptible to addiction and, furthermore, that the conditions of addiction place additional limitations on choice. Cox, Klinger and Fadardi argue that, although the choices available to individuals may be limited, it does not follow that choice is totally absent, rather, recovery is best facilitated by enhancing individuals' capacity to make choices. The 'fatalistic' view is further challenged by Heather (2017), who questions the relevance of 'compulsion' as an explanatory term for addiction. Other authors go further to question the relevance of biologically based models of addiction entirely. For example, Adams (2016) argues for a social model of addiction which takes account of the complexity of relationships that individuals encounter in their lives, to sit alongside so-called 'particle' explanations. Finally, some participants in both phases of this study sought to separate addiction from substance use, which reflects emerging theory around models of non-substance addiction, for example, as advanced by Zou *et al.* (2017), who suggest diagnostic criteria for pathological gambling, food addiction, internet addiction, and mobile phone addiction. These authors consider behavioural addiction and drug addiction to be alike, but with important specific differences. The absence of free will and personal agency, characterising the addiction experience, informs a fatalism and powerlessness over the inexorable progression of a disruptive and destructive process. The wounds described by the men interviewed in this study, which accord with wider descriptions and causal factors for addiction, were accompanied by defensive responses, identified in this model as masks.

The men interviewed in this study typically discriminated between their identity prior to and during their addiction, compared to their 'recovery' identify. The unifying factor was the notion of recovery identity as 'authentic', compared with the inauthenticity of the addiction phase. It was as if the process of recovery involved the removal of masks to reveal the authentic self. The masks involved were typically associated with male identify and masculinity which, prior to the recovery phase, were characterised by portrayals of invincibility and fearlessness, aggression and risk-taking. Many of the men interviewed described membership of all-male peer groups (identified as 'tribe', 'group' or 'gang') as the context for initiation into substance use and the development of their

male identity. This reflects the findings of several authors who describe the effect of social identities in creating pathways into and out of addiction. Su, Supple and Kuo (2017) demonstrate that, although social anxiety is associated with avoiding substance use, peer pressure encourages use. Similarly, Otten, Mun and Dishion (2017) found that, among adolescents, deviant peer clustering informs progression of substance use, while Dingle, Cruwys and Frings, (2015) identified peer effects as creating a social gateway to substance use progression from adolescence into adulthood. Participant accounts in this study matched these findings, describing a form of social anxiety driven by isolation within the peer group whereby difficulty 'fitting in' became, in part, the reason for continued substance use. This emphasises linkages between psychological and social dimensions of adolescent substance use. Indeed, the substance using experiences described by participants in the current study were characterised as much by their social context as they were by internal and psychological dimensions. Participants described developing distinct social identifies during early adolescence which facilitated initiation into and continuing of substance use.

The mask of the person using substances plays a significant social function by signalling a range of behaviours and attitudes (generally pejorative) to describe and denote the wearer as belonging to an identifiable social grouping. Often this reflected different degrees of acceptability associated with various categories of substance use (with opiates generally identified as the most stigmatising). It was apparent that individuals did not simply become aware of such masks once they were in recovery but were conscious of their existence *at the time* of their substance use. They also absorbed many of the wider social attitudes and values aimed at people who use substances which informed a form of self-stigma, whereby individuals were simultaneously aware of, and repulsed by, the masks they wore. Awareness of these masks increased as individuals journeyed through the recovery labyrinth. Indeed, increasing self-awareness and authenticity is the central feature of the recovery process, which may be conceptualised as a 'demasking' processes.

The masks worn by the seeker entering the labyrinth highlight layers of disconnection which manifest as the spiritual void. The spiritual void concept describes the multiple degrees of isolation and disconnection associated with addiction. During the journey inward, the seeker becomes aware of the ways in which they are disconnected from themselves, others, nature and spirit. The spiritual void emerges from self-destructive behaviours, dysfunctional relationships, isolation from the environment, and

disconnection from spiritual meaning and direction. The concept that spiritual 'absence' creates the conditions for addiction emerged in both phases as the *Spiritual Void* and in Phase One as *The Hungry Ghost*, inviting comparison with the Jungian shadow archetype. Several authors identify the spiritual void as creating the conditions for addiction, including Hagedorn and Moorhead (2010), who describe the experience of individuals with addiction and perfectionism as a 'God-shaped hole'. McCoy *et al.* (2004) identify spiritual void as the dominant explanation within evangelical Christian substance rehabilitation programmes, where addiction is understood as an attempt to fill a spiritual void, the remedy for which is fostering a relationship with God. Both phases of this study described the spiritual absence that leads to addiction as arising from multiple factors with far-reaching consequences, encompassing inner pain, social identity and deprivation. The interrelationships between spirituality, religiosity, depression, anxiety, and drug-use consequences were examined by Piacentine (2013), who demonstrated that spiritual wellbeing among individuals receiving methadone maintenance was lower than for the general population, and that higher anxiety was predictive of negative drug-use consequences.

The spiritual void described by participants included obvious psychological aspects but was also located within a societal context. Participants often identified linkages between their emerging addiction and the societal context of their formative years whereby their inner experience of isolation was echoed by their external experience of social deprivation. Typically, participants described social deprivation which reflected the impact of inequality among those born in the 1960s through to the late 1970s, who grew up in 'Thatcher's Britain' during the 1980s. It is worth recalling that his period, associated with the rise of neoliberalism and a shift towards authoritarian-right political attitudes, was characterised by widening social and health inequalities (Gray *et al.*, 2015; Grasso *et al.*, 2019), which have largely persisted for those most affected, evidenced, for example, by the rapid rise in the provision and use of food banks in the UK since 2010 (Loopstra, 2018). In the view of Labonté and Stuckler (2016), the austerity policies implemented in response to the 2008 global financial crisis are the legacy of a 40-year experiment with neoliberal social and economic policies which had the effect of embedding health and social inequalities and, furthermore, according to Fox Piven (2015), supressing dissent. It was apparent that the men interviewed in the current study situated their inner personal struggles within these wider social and political realities that were instrumental in both forming them as individuals alongside shaping the communities within which they grew up. This perspective reminds us that the challenges faced by those experiencing addiction have as much to do with societal

context as individual experience and that recovery processes require societal and community responses as well as individual interventions.

The centre of the labyrinth: confronting the Minotaur

The centre of the labyrinth is the focus for two tasks. First, to confront the Minotaur; the wounds, masks and spiritual void that collectively impede a fulfilling life. And second, to discover Ariadne's Thread; the spiritual guidance that will lead towards a spiritually rewarding way of living. Characteristically, these tasks overlap, as evidenced by the participants in this study who recalled connecting with significant spiritual practices and processes during the period of their heaviest substance use, supporting the concept of 'rock bottom' as a liminal space of transcendence. The rock bottom concept (Kemp, 2013) is developed now as a framework for understanding the progressive and destructive aspects of addiction, encompassing suicidality and the proximity of death, and including discussion of the current challenges associated with the DRD epidemic in Scotland.

Participant accounts typically described an insidious progression of addiction, characterised by worsening consequences associated with increased substance use. These accounts reflect the notion of substance use as a progressive and multi-factorial problem. For example, Darke (2011) describes the progression of heroin use as following recognisable pathways. However, these characteristics also create opportunities for positive change, as described by Darker *et al.* (2015), who demonstrate that, as adolescent substance use progresses, several types of intervention are possible to delay and minimise associated harms. Similar ideas are developed by Yates and Malloch (2012), who argue that the uniqueness of each person's pathway into addiction mean that different approaches to supporting recovery are relevant and necessary. Despite opportunities for early intervention, many of the participants in this study described situations where they or others reached 'rock bottom'; a point of total desperation, beyond which complete collapse is inevitable if change is not made. The notion of rock-bottom is widely used within concepts of addiction and recovery and has received attention among addiction theorists. Kemp (2013), for example, argues that rock bottom is understandable in existential terms as an 'event of truth' separating addiction from recovery and providing authentic guidance on the path to recovery. In this respect, rock bottom resonates with the religious and spiritual concept of 'the dark night of the soul', whereby, in several religious traditions, intense episodes of introspection and despair lead to spiritual awakening or transcendence (Durà-Vilà and Dein, 2009). Dossett (2013) draws parallels between the

dark night of the soul concept and processes of powerlessness and surrender fundamental to the 12-Step tradition. From this perspective, ‘rock bottom’ presents a point of opportunity at the interface between addiction and recovery from which both continued despair and the potential for positive change become possible.

The ultimate manifestation of ‘rock bottom’ is surely the decision to die, which emerged in several participant accounts within this study and reflects established linkages between PSU and suicide risk. For example, Simoneau, Ménard and Blanchette-Martin (2017) demonstrate that greater severity of addiction is associated with increased suicide risk, while Schneider (2009) identifies substance use disorders, particularly alcohol, as a significant risk factor for suicide, concluding that further research is needed to identify the exact relationship between suicide and substance use. Furthermore, many cases of DRD are characterised by undetermined intent, meaning that the drug-related suicide rate is undoubtedly higher than the recorded statistics suggest (Olsson *et al.*, 2016). Similarly, in a review of the literature, Darke and Ross (2002) conclude that heroin users are 14 times more likely than peers to die from suicide, and that deaths among heroin users attributed to suicide range from 3–35%. An explanatory framework is advanced by Capron *et al.* (2016), who tested the salience of the ‘depression-distress amplification model’ in explaining suicide among people with PSU. This model posits that suicide risk may increase through the intensification of depressive symptoms by anxiety sensitivity cognitive concerns. Having concluded that such a pathway does operate, Capron and colleagues emphasise the relevance of assessing anxiety sensitivity cognitive concerns among those at risk.

The concept that addiction arises, or intensifies, in response to an absence of spiritual direction is a recurring motif. Indeed, too often, the progressive decline associated with PSU leads to death, situating this study within the current public health challenge relating to DRDs in Scotland, reflected by the current ‘Rights, Respect and Recovery’ strategy to tackle drug and alcohol deaths, the associated formation of drug deaths task force and a current inquiry into problem drug use in Scotland led by the Scottish Affairs committee of the Westminster parliament (Scottish Government, 2018, 2019a; House of Commons Scottish Affairs Committee, 2019). Several of the participants from both phases of the study described experiences that brought them close to death, whether the result of accidental overdose, attempted suicide, or mid/long-term health problems, such as hepatitis C. The risks associated with the addiction lifestyle were explored by the Phase Two participants, encapsulated in the theme *The Proximity of*

Death, which described not only the risk of physical death associated with problem drug and alcohol use but also the loss of 'spirit'. These dual threats (to physical health and spiritual wellbeing) are reflected in the experiences of individuals who inject drugs in public spaces and who face the risk of hepatitis C and other blood-borne viruses, as well as of the stigma and shaming they experience in association with these activities (Rhodes *et al.*, 2007).

The health and social inequalities associated with deprivation are especially relevant to people who use drugs, as they are disproportionality exposed to the long-term consequences of the political and social conditions described above (Atkinson, 2016; Parkinson *et al.*, 2018). Men over the age of 35 from the most deprived backgrounds carry a significantly elevated risk of DRD as a consequence of the compounding impact of deprivation, addiction and a range of other health and social conditions, including those arising from systematic discrimination and stigma in services (Scottish Drugs Forum, 2016; Parkinson *et al.*, 2018). DRD among those in middle age is observed throughout the UK (Pierce *et al.*, 2018), however, the problem is more acute in Scotland (National Records of Scotland, 2019; Office for National Statistics, 2019). In 2018, the Scottish Government reported that Scotland's DRD rate of 218.3 per million for 2018 is now the highest in Europe, and three times the UK average (National Records of Scotland, 2019). This rate also exceeds the figure for opioid-related deaths in the US, which is facing its own crisis with fentanyl deaths (Gomes *et al.*, 2018). These are the worst ever Scottish DRD statistics, confirming that the country is facing a growing crisis (SDF, 2016; McAuley, Robertson and Parkes, 2017). As a further example, methadone-specific DRD in Scotland is highest in the 35+ age-group, despite the protective effect that OST is known to confer (Gao et al., 2016). The increases in DRD currently observed in Scotland are contributing to a more general trend whereby recent life expectancy gains in the UK have stalled (Fenton *et al.*, 2019; Leon, Jdanov and Shkolnikov, 2019), which Ramsay *et al.* (2019) have linked in part to drug deaths, highlighting the wider relevance of joined up policies to reverse this.

It is evident that complex social and psychological barriers, including stigma and service thresholds/inaccessibility, must be overcome to keep people safe. This is prompting policy-makers, service providers and researchers to develop solutions to support the needs of people over the age of 35 who use drugs (SDF, 2017a, 2017b). Relevant approaches include ensuring services are accessible and welcoming to older (over 35) people who use drugs, providing a range of treatment modalities including the use of heroin-assisted interventions where previous treatment has been unsuccessful,

and supporting medical treatment with psychosocial interventions (Dickie, Arnot and Reid, 2017).

The personal accounts in this study were characterised by emerging spiritual connections and critical turning points in the transition from addiction to recovery. Such accounts typify recovery stories (Sremac, 2018; Vandivier, 2019), often forming 'redemption narratives' which, according to Dunlop and Tracy (2013), occur more frequently the longer the individual has been in recovery and are associated with positive behavioural change. Redemption narratives of this type typically incorporate a spiritual awakening process, often associated with surrender to a higher power, especially within the 12-Step approach to recovery (Dossett, 2013). Indeed, such surrender is a central element of the spiritual quest for many individuals, illustrated, for example, by Strobbe *et al.* (2013), who found that self-reports of spiritual awakening predicted improved drinking outcomes, while Florentine and Hillhouse (2000) highlighted the significance of surrender to a higher power in the process of addiction. Medina (2012), in the findings of an IPA study, explored the 'Paradox of self-surrender' and addressed criticisms of 'surrender' as antithetical to psychotherapy. Medina finds that, far from exerting the disempowering effects claimed by critics, 'self-surrender' to a higher power was associated with feeling more responsible, empowered, connected and free. The distinctions between surrender and compliance are developed by Brooks, Arminio and Caballero-Dennis (2013) who adopt a narrative inquiry approach to defining the essential qualities of surrender (as opposed to compliance) as arising from the inner voice, mapped by the individual, and spoken in the first person. These authors also identify the paradox of surrender, whereby control over potential triggers for relapse is exerted by 'giving up control'. Examples of this were common among the current study's participants, who typically recalled key turning points and a process of surrender, drawing upon an eclectic spirituality, as central to recovery. Transcending rock bottom, by discovering the spiritual guidance represented by Ariadne's Thread, opens the potential for positive change on the outward phase of the labyrinth journey.

The outward journey: following Ariadne's Thread

The findings of this study imply a natural link between spiritual engagement within the recovery journey and an increased sense of personal agency as participants sought to take control of their lives. This suggests that spiritual engagement among individuals in recovery has utility in enhancing personal locus of control and thus the ability of individuals to execute positive life changes. The process of following Ariadne's Thread, which inspires the title of this thesis, refers to Theseus's return from the centre of the

labyrinth following his defeat of the Minotaur, guided by the thread given to him by Ariadne (Higgins, 2018). This mythic quest also represents the 'defeat' of addiction and subsequent discovery of the path to recovery, guided by the 'thread' of spirituality, described by participants in this study. The journey out of the labyrinth is guided by Ariadne's Thread, which provides direction to transform the obstacles to a fulfilling life identified during the inward phase. This is a process of establishing new, positive patterns of living, particularly characterised by healing the wounds of the past by developing self-love and engaging in therapy, removing the masks associated with addiction by cultivating balanced, authentic identity, and developing authentic connections with self, others, nature and spirit. In this section, the forms and meanings of these transformations are described, illustrated with reference to the type of spiritual guidance described by participants in this study.

A key feature of the recovery journey described by the men interviewed in this study, and mirrored in the wider literature, is the idea that initiating action promotes healing. This typically took the form of accessing therapeutic interventions and was underpinned by a shift toward embracing self-care and self-love that countered the self-stigmatising processes associated with addiction described earlier. Therapy variously entailed counselling, alternative forms of healing or 'mainstream' treatment, such as OST or detoxification, or, typically, a combination of such elements. Considering addiction as a holistic experience encompassing physiological, psychosocial, social and spiritual dimensions, it follows that recovery works at these same levels of depth, whereby the personal transformation required mirrors the depth of the addiction process. For several study participants, recovery became an emerging process which deepened with time and engagement. While initial goals were focussed on abstinence and effective day-to-day living, later aspirations encompassed wellbeing and self-actualisation. From this perspective, establishing abstinence is foundational but not definitive of recovery. Nevertheless, achieving and maintaining abstinence is a central feature of the recovery journey for many individuals (including many of the participants in this study), especially within 12-Step fellowship contexts (Dossett, 2018). However, as Hickman *et al.* (2011) argue, current conceptions of 'recovery' fail to adequately distinguish between abstinence from dependence-causing substances and achieving recovery. Using treatment mortality data, Hickman and colleagues suggest that additional time receiving OST is associated with lower mortality, and improved long-term abstinence, establishing abstinence as a necessary foundation for long-term recovery. Length of time in recovery therefore became critical in determining the extent and depth of the process. This accords with the findings of Laudet, Morgen and White

(2006), who demonstrate that longer recovery time is significantly associated with lower stress and with higher quality of life.

The men interviewed in this study described myth-making, often undertaken in the context of 12-Step fellowship or similar contexts, as being fundamental to their recovery process. Being witnessed in sharing personal stories became a cathartic and cleansing act, signalling a shift away from addiction towards recovery. Personal myth-making also supports self-knowledge and growth towards a more authentic identity. For the men interviewed for this study, cultivating a balance of masculine and feminine qualities became a significant part of their inner journey towards wholeness. To study men's experiences of substance use and addiction is, in some senses, to explore masculinity. To explore their experiences of recovery is, arguably, to observe the tempering of this innate masculinity with the archetypal (divine) feminine, represented by Ariadne's Thread. It is notable that several participants cited the guidance and influence of spiritual women during the recovery process, emphasising the significance of the feminine, particularly in the context of contemporary spiritualty, in contrast to the masculine alignment of traditional monotheistic religions (Longman, 2018). This links to the work of several authors who extend Jungian constructs within the addiction context, for example, Cichon (2012) considers addiction in relation the archetypal Feminine, represented by Ariadne, whereby the winding of Ariadne's thread into the labyrinth represents the depth associated with the archetypal feminine. Addiction, in this reading, arises from incomplete connection between inner Masculine and Feminine which seems to resonate with the development of gender identity among the male participants in this study. This speaks directly to two themes to have emerged within this thesis; first, that contemporary eclectic spirituality carries a feminine dimension which serves to balance intensely expressed forms of masculinity, and second, that substance use and addiction represents a projection of the masculine instinct towards risk-taking and experimentation, which has significance for aligning spiritually informed interventions to meet the needs of men in recovery. The men interviewed in this study described meaningful personal processes through which their experiences of drug use and recovery were intrinsically connected to the development of their identities as men, typically characterised by an existential struggle to emerge from the darkness and despair of addiction. This is closely associated with the need for authentic rites of passage to counter the earlier initiation into substance use. Indeed, creating and facilitating authentic and culturally acceptable forms of initiation represents a meaningful aspiration for making addiction recovery spiritually meaningful, especially

for young men. In this context, Theseus's heroic quest into the labyrinth provides a template for male initiation.

The final dimension of transformation to emerge from following Ariadne's thread is the transformation of the spiritual void of addiction through developing connection with self, others, nature and spirit. This aspect of the labyrinth model is now discussed within the context of the literature on recovery. First, the transformation of relationships with others is discussed within the context of male peer groups. Next, the relevance of eclectic forms of spirituality, both to those in recovery as well as in society more widely, is examined. Third, the relevance of Buddhism as a spiritual practice in support of recovery is reviewed. Finally, the implications for applying spiritual interventions to facilitate recovery within addiction treatment and recovery programmes are discussed.

Developing authentic connections with others is a significant element of the labyrinth recovery journey. The process of transitioning from substance-using peer groups towards abstinence within alternative social networks echoes processes of transition from gang membership and criminality towards spiritual awareness and self-identify among men in prison, as identified by Deuchar (2018). Deuchar argues that spiritualty is significant to the development of mature masculine identity separate from the gang, suggesting parallels with the experiences of the participants in the current study, whereby spiritual engagement replaced gang membership and offending (in Deuchar's work) and substance use (in this study). Greater awareness of the salience of 'gang' membership to the development of masculine identify and process of substance use is needed to inform recovery programmes targeting the needs of men. Such responses to the specific needs of men in recovery are largely situated within the wider, emerging, men's movement. For example, Griffin (2009) specifically addresses the experiences of men accessing 12-Step recovery programmes and identifies needs that are particular to men in that situation. This informs further work (Covington, Griffin and Dauer, 2011), which describes a structured programme to support men in recovery by addressing Self, Relationships, Sexuality and Spirituality, in which developing a clear masculine identity is regarded as essential to the recovery process. The work described by Covington and colleagues advances a balanced understanding of masculinity, characterised by masculine and feminine aspects, of the type described by some of the participants in this study.

A further significant element of the labyrinth recovery process is connection with spirit or higher power, often expressed through engagement with a range of spiritual and religious practices and traditions. It was typical for participants to identify clear

distinctions between religion and spirituality and, although some reported having engaged with faith groups, it was more common for participants to express critical or sceptical views about organised religion, while describing eclectic forms of spirituality, informed by various traditions. Such a stance is not unique to individuals in recovery, but rather reflects wider changes in attitudes towards religion and spirituality, characterised by a questioning and rejection of religious orthodoxies in favour of non-religious spiritual concepts, but which, nevertheless, draw upon both religious and non-religious spiritual ideas. For example, McCoy *et al.* (2004) identify a developing trend for young Americans to distinguish between spirituality and religion, not as mutually exclusive, but rather as interconnected concepts. Kurtz and White (2015) identify the concept of 'secular spirituality' which, they suggest, encompasses the experience of beyond (horizontal and vertical transcendence) and between (connection and mutuality) and in six facets of spirituality (Release, Gratitude, Humility, Tolerance, Forgiveness, and a Sense of Being-at-home) shared across religious, spiritual, and secular pathways of addiction recovery. Both the 'beyond' and 'between' dimensions of spirituality identified by Kurtz and White are relevant to the spiritualty of addiction recovery in a variety of ways. Indeed, promoting connection with self, higher power, nature and others, is a feature common to many spiritual disciplines and thus to spiritually informed approaches to recovery, such as theories situating connection, rather than sobriety, as the counter to addiction (Hari, 2015a, 2015b).

Kurtz and White's (2015) 'between' dimensions of secular spirituality reflect the relevance of social networks and community engagement as part of a spiritually informed response to addiction. For example, community engagement was found by Redman (2012) to protect against addiction and to facilitate recovery among people with a history of substance use and incarceration. Redman found that community engagement assists the identification of positive goals and life purpose, but was more evident among those with greater social capital. Bathish *et al.* (2017) argue that addiction recovery can be understood as a socially mediated transition, characterised by changes in social networks and social identity, which inform broader improvements in quality of life. Practical examples of projects aimed at improving the social capital and recovery prospects of individuals facing addiction include the Carlton Athletic Recovery Group, a recovery group based in the Glasgow East End (Malloch and McIvor, 2013). Travis *et al*, (2012) observe that Christian faith groups are a significant provider of rehab and other recovery-focussed interventions, which is notable given the current shift towards non-religious eclectic spiritualty and highlights the need to ensure the cultural and social acceptability of spiritually informed recovery programmes. That

said, Pardini *et al*. (2000) demonstrate that, among recovering individuals, higher levels of religious faith and spirituality were associated with a more optimistic life orientation, greater perceived social support, higher resilience to stress, and lower levels of anxiety.

Buddhism was especially significant among the religious and spiritual traditions to surface as being relevant to participants in this study. Groves (2014) argues that the Buddhist 'hungry ghost' idea, which emerged as a Phase One theme, can be viewed as an early description of the state of addiction. Perry (2017) describes hungry ghosts as inhabiting one of the 'Six Worlds' of the Buddhist cosmos, representing a destructive aspect of the self, consuming the positive energy of the individual and creating a form of spiritual malnutrition, constantly seeking but never satisfied. Perry goes on to draw close parallels between the hungry ghost and people experiencing drug or alcohol addiction, suggesting that addiction persists until the individual is ready to change. Writing from a Buddhist perspective, he argues that the suffering associated with addiction is capable of transformation into compassion when the individual finally accepts the need to change. A similar view is advanced by Dunbar (2017), who suggests that, from the Buddhist perspective, transformation of addiction requires deep self-understanding and acceptance. The importance of acceptance (and self-acceptance) is developed by Gabor Maté, who takes the 'Hungry Ghost Realm' concept as the basis for a descriptive and explanatory framework for drug and alcohol addiction, as well as a guide to supporting recovery (Maté, 2008). Maté's analysis of the personal desperation of addiction, and its societal underpinnings, is enhanced by the unique perspective afforded by his personal experience of addiction and ADHD and his role as an addictions doctor, which informs his call for greater compassion and self-acceptance as a necessary condition for recovery:

> *No matter how hard I try, I have found out that I may never fully defeat my addiction-prone tendencies. And I've also learned that this is all right. Triumph and defeat: these are still metaphors of war. If, as the research shows, addictions arise near our emotional core, to defeat them we would have to wage a war against ourselves. And a war against parts of the self—even against nonadaptive, dysfunctional parts, can lead only to inner discord and more distress.*
> (Maté, 2008, p334)

The idea that acceptance and self-acceptance hold the key to recovery clearly resonates with the Buddhist perspective which offers a framework for understanding

addiction and recovery as a spiritual process in which recovery denotes a journey towards authentic living, and which reflects wider concepts of 'holism', which increasingly inform health and social care (Aghadiuno, 2010).

This reflects Buddhism's wider relevance to concepts of addiction and processes of recovery reflected in the literature. Groves and Farmer (1994) present an explanatory framework for addiction informed by Buddhism's Four Noble Truths as a framework for understanding the origins, form, results and management of craving and attachment. This view, and the Buddhist emphasis on non-permanence, informs the causation of addiction and possible responses to it. Groves and Farmer argue that Buddhism presents a spiritual but non-theistic alternative to the theistic underpinnings of 12-Step philosophy and, as such, is relevant to Buddhist clients as well as those who reject the theism implicit in the 12-Step approach. By contrast, Chen (2010), views Buddhism and the 12-Step approach as complementary, whereby Buddhism provides an explanation for the suffering that causes addiction (primary suffering) and the suffering resulting from it (secondary suffering), while the 12-Step approach presents a practical, spiritually informed response to such suffering. In this respect, the case of Buddhism reflects a wider observation about the evolution of 12-Step culture from a predominantly Christian-based, white, male, middle class endeavour to a spiritually, socially and culturally diverse movement which aspires to be inclusive of those of all spiritual, theistic and non-theistic orientations (Dossett, 2013, 2015, 2018).

Finally, perhaps the most fundamental perspective offered by Buddhist thought on addiction is the idea that addiction is not unique to a dysfunctional subset of the population but, rather, is a near-universal human experience (Groves and Farmer, 1994; Zou et al., 2017). That we all potentially suffer 'addictions' which are only resolved through self-acceptance and surrender is, arguably, a powerful leveller against the stigmatising and 'othering' of people experiencing problems with substances. The spiritual journey of recovery described by participants often began with a specific substance use focus, such as the 12-Step fellowship, but typically diverged to include (for example) Christian groups, Buddhism classes, and yoga training. These experiences brought participants in contact with many individuals whose life challenges did not arise from substance use, but which accorded with Buddhist concepts of the universality of human addiction. In this respect, the findings of this study resonate with those of the Higher Power Project, which described a plurality of spiritual orientations among people in recovery (Dossett, 2013, 2015, 2017, 2018).

Spiritually informed responses are typically mediated through a combination of self-directed spiritual discoveries (including accessing established faith groups and other spiritual networks) and interventions and programmes specifically aimed at supporting recovery. Participants in this study reported both routes in support of their spiritual recovery journey. The longest established and most widespread addiction-specific spiritual approach is the 12-Step, which combines mutual support with a spiritual framework for connecting with a 'higher power'. The 12-Step approach formed the core form of recovery support for several study participants, either through membership of NA or AA. Dossett (2013, 2015) describes the spiritual underpinnings of the 12-Step approach and its evolution from Christian-based origins in the US to its global reach as a spiritual programme open to people of all theistic, spiritual and non-theistic orientations. This distinction is developed by Kurtz and White (2015), who describe the evolution of spirituality within the 12-Step movement and identify divergence between 'Christianizers', who emphasise the Christian origins of 12-Step spirituality and 'Seculizers', who seek to define the movement in non-religious spiritual terms. This divergence, Kurtz and White suggest, reflects the diversification of religious experience and the growing secularization of spirituality across the cultural contexts within which the 12-Step fellowship is situated. Similar points are developed by Walker, Godlaski and Staton-Tindall (2013) who identify significant problems associated with the Christian underpinnings of the 12-Step approach that, they argue, should preclude 12-Step spiritual practices becoming the backbone of addiction treatment or recovery. Dossett (2013) identifies four main criticisms of the 12-Step approach. First, that 12-Step spirituality masks the religious underpinnings of the approach. Second, that 12-Step spirituality is inherently disempowering for women. Third, that 12-Step spirituality privileges a Judeo-Christian or post-Christian outlook, to the exclusion of alternative viewpoint, especially those of First Nations peoples. And, finally, that by framing addiction as a 'spiritual illness', the 12-Step approach perpetuates judgment, stigma and disempowerment among people experiencing addiction. Despite these potential criticisms, the 12-Step approach continues to underpin the addiction recovery processes of millions of people globally (Dossett, 2013), and has been shown to be effective in facilitating adaptive change among people experiencing addiction (Kelly and Yeterian, 2012). However, despite the strong spiritual underpinnings to the approach, the greatest evidence of effect arises from the adaptive social network changes associated with membership and participation, rather that spiritual processes directly (Kelly, 2017).

The 12-Step fellowship has evolved as a unique spiritual path to recovery with a global reach, however, it is not the only spiritually informed approach to recovery, and increasingly linkages between spirituality and the broader concept of 'holism' are emerging. Holism, and the parallel concept of person-centred care, may be understood as a bio/psycho/social/spiritual framework with relevance to health care more widely, not just to addictions (Michaelson, Pickett and Davison, 2019). Indeed, holism presents an important potential element in treatment, within which spirituality is central, although, as Adedoyin *et al.* (2014) show, this is neglected in substance use. Nixon (2012) conceptualises recovery as a therapeutically-mediated 'quest for wholeness', which supplants the addiction "short cut" counterfeit, transpersonal spectrum of development model (Wilber, 1977) as providing a three-stage model of recovery. Sussman *et al.* (2013) develop a framework for defining and understanding spirituality and religion in substance use programmes in which spirituality is conceptualised as a search for the 'sacred' and as connection with a higher power. They caution that spiritual and secular concepts are often conflated within substance use recovery programmes, leading to confusion over what is in fact spiritual. Examples of the use of spiritually informed approaches in recovery programmes include mindfulness-based meditation, which Black (2014) argues has merit either as a stand-alone therapeutic modality, or as a complement to ongoing treatment.

For several of the men interviewed as part of this study, their recovery journey began as bid to address a problematic pattern of substance use but evolved into a lifelong quest for self-knowledge and spiritual depth, highlighting the relevance of adopting a life-course approach to understanding drug use trajectories and turning points leading to recovery (Hser, Longshore and Anglin, 2007). This finding is supported by the 'better than well' concept that developed in response to the associated between long-term recovery and improvements in wellbeing that exceed pre-addiction levels and, in some dimensions, exceed the population 'average' (Hibbert and Best, 2011; Valentine, 2011; Best, 2012; Collins and McCamley, 2018). For example, Hibbert and Best (2011) assert that individuals in recovery express a higher quality of social life and higher levels of satisfaction with the lived environment.

Not all studies report positive results in evaluating spiritual interventions in addiction recovery. In one study, comparing treatment as usual with or without a spiritual guidance intervention group, spiritual guidance did not have any impact on substance use and was associated with less improvement in depression and anxiety symptoms, compared with the treatment-as-usual-only group (Miller et al., 2008). Miller and

colleagues advanced several explanations for the failure of this intervention to yield any benefit, including that the intervention was of insufficient intensity to produce effects and that the intervention took place too early in the recovery process when other practical challenges took precedence. They also suggest that spiritual transformation may not be responsive to interventions, but is more likely to occur spontaneously, underscoring, perhaps, the essential mystical character of spiritualty (Miller et al., 2008).

Looking back

The theoretical positioning of this study was informed by several key ideas about spiritualty, which are now reviewed in light of the study findings, especially the labyrinth model. In Chapter Two, Stoll's (1989) multidimensional model of spirituality was used to map the concepts of spirituality advanced by several theorists, namely Meraviglia (1999), Koenig (2012a), O'Murchu (1997), Delgado (2005) and Paley (2008). In Stoll’s view, spirituality encompasses a vertical transcendent connection with higher power and a horizontal connection with self, others, nature, meaning and purpose, and the social dimensions of spirituality. The data in the current study reflected both vertical and horizontal dimensions of Stoll’s model, consolidating its relevance to qualitative research on spirituality. The definition of spirituality developed for this study incorporated Stoll’s vertical higher power connection as a necessary condition, and the horizontal dimension as a common, but non-essential, element. Overall, this definition performed well in light of the study data and findings. Participants generally identified spirituality as combining higher power with connections to self, others, nature, and meaning and purpose. The definition proved capable of encompassing the experiences, beliefs and spiritual practices described by participants, while also reflecting the centrality of transcendence to spiritualty. The definition also performed effectively alongside the labyrinth model, which incorporates higher power connection at the ‘centre’ phase and wider connection in the ‘outward’ phase.

A further influence on the initial positioning of this study emerged in response to Carrington’s (2010a) Integrated Spiritual Theory. Carrington combines masculine-feminine and spiritual-physical dualities and was influential in informing this study by advancing spiritual epistemologies which later informed the shamanic analytic process. Although Carrington’s ideas, and aspects of my own research praxis, lie towards the edge of academic convention, these positions are underpinned by the tenets of theobiology developed by Gorsuch (1984) and later theorists, discussed in Chapter Four, which seek to reconcile scientific and spiritual epistemologies. Although the

shamanic analysis process was conceived chiefly as a reflective tool, it proved of greatest value as an adjunct to analysis by facilitating deep embeddedness with the data. This is not to privilege the shamanic approach above other techniques; it is merely an example of one way to embed spirituality informed epistemologies in academic research, as discussed by Carrington (2010b), and therefore warrants further investigation.

Chapter summary

This chapter focussed on a labyrinth model, informed by the findings of this study, as a framework for understanding addiction recovery as a spiritual process. I have argued that the three-stage reflexive character of the labyrinth closely parallels the addiction-recovery arc in a reading enhanced by the mythic symbolism of Theseus, the Minotaur, and especially Ariadne’s Thread, as a representation of the spiritual path to recovery. Like the recovery journey, the labyrinth is fundamentally a process of self-discovery which, for the men involved in this study, meant examining and rebalancing their masculine identity, and cultivating significant connections to self, others, nature and spirit, through eclectic spirituality. The labyrinth model also provides a framework for addressing the multi-dimensional character of addiction and recovery, especially in view of the significant risk of DRD for people currently using drugs in Scotland. The potential relevance to theory and practice and for future avenues of research arising from the model are addressed in the next, and final, chapter.

Chapter Nine: Conclusions

The findings of this study have potential to inform theory, policy and practice pertaining to addiction, spirituality and qualitative research methodology. In this final chapter, I restate the processes and findings, highlight their implications for practice and policy, make recommendations for action, and identify areas for future research. I also assess both the strengths and limitations of the study design, methods and implementation.

This thesis has explored the relevance of spirituality to processes of addiction and recovery, focussing on the experiences of men living in Scotland. An initial review of the literature on spirituality and PSU informed the development of a two-phase qualitative research design, combining framework analysis in the first phase and IPA in the second, which featured accounts from men living in Scotland with personal experiences of PSU and recovery. IPA analysis in Phase Two was augmented by a novel shamanic analysis process. Synthesis of both data sets informed development of a labyrinth model of addiction recovery which emphasises the role of personal myth-making and transcendence.

The findings of this study confirm the relevance of spirituality to processes of drug and alcohol addiction, and recovery from such addictions. Concepts of spiritual health and wellbeing were especially relevant to participants with personal experience of PSU and recovery by illuminating both the antecedence of their addiction and subsequent recovery journeys. The spiritual void emerged as an explanatory construct within which to position underlying factors such as ACEs and the personal transformation associated with recovery. The study data illustrated how the spiritual void may be sublimated through spiritual questing and spiritual engagement. It was apparent that, for study participants, such questing was characterised by individual eclectic concepts of spirituality. Furthermore, this study sought to specifically understand male experiences of addiction and recovery. For the men who were interviewed, the evolution of their male identity paralleled their journey from addiction to recovery and was associated with balancing ‘traditional’ male characteristics with female ones and connecting with forms of spirituality that emphasise the feminine.

Although this study has demonstrated that concepts of spirituality have relevance for people using drug and alcohol addiction services in Scotland, the data were less clear that such concepts have relevance for those providing such services. Attitudes among

treatment and recovery workers were not specifically investigated, nevertheless, the findings tentatively suggest that initiatives to make treatment and recovery services spiritually relevant should reflect the social and cultural context within which they are located. This is especially pertinent considering participant opinion that the perception of religiosity deters engagement, especially in the early stages of recovery. Furthermore, applying spiritually informed interventions is currently unusual within publicly funded treatment services, meaning that proposals aimed at introducing such activity should consider organisational culture and context.

Implications and recommendations for policy and practice

Scotland currently faces a worsening crisis of DRD, especially among middle-aged men who use drugs (Parkinson *et al.*, 2018; Scottish Government, 2018). Furthermore, those who continue to use substances face significant morbidity associated with a range of physical and mental health conditions (Atkinson, 2016). Yet, the participants in this study, particularly in Phase Two, who largely match the demographic profile of those at highest risk, have succeeded in living fulfilled and successful lives. In view of the importance of the DRD risk within Scotland currently, it is particularly relevant to consider why and how the individuals interviewed managed to survive, unlike many of their counterparts and, furthermore, were able to develop rich, fulfilling lives. Might the spiritual journeys of recovery they have recounted in these study data be part of this picture?

Recommendations

The growing crisis of DRD in Scotland suggests that current policies aimed at prevention and treatment are inadequate. This study has demonstrated the relevance of spirituality within person-centred responses alongside physical, psychological and social responses. However, the study data suggest that spirituality is inconsistently addressed in practice, especially within publicly funded treatment services, thus validating the development of spiritually relevant responses aimed at supporting people in recovery. Accordingly, this section draws on the study findings to develop four key recommendations aimed at policy-makers, service organisations and the addiction recovery movement. These four recommendations are to:

- Raise awareness among policy makers of the relevance of spirituality to drug and alcohol recovery;
- Embed spirituality into drug and alcohol services;

- Remove barriers to people in recovery from accessing spiritually informed interventions; and
- Develop resources and training to apply labyrinth-based interventions to promote recovery.

These recommendations are discussed next.

Raise awareness among policy makers of the relevance of spirituality to drug and alcohol recovery

At the policy level, there is a need to embed spirituality within person-centred responses to PSU that address physical, psychological and social aspects. Although small in scale, this study adds to the evidence on spirituality and addiction with potential to increase awareness among policy makers and policy influencers of the relevance of spirituality as a core element of assessment, treatment and care. The NHS in Scotland developed a strategy to promote spiritual care in all settings (NES, 2009b), however in the decade since its launch, few changes have been seen in practice. Furthermore, since starting this study in 2012, I have observed little change in practice concerning spiritual care, either in general or in PSU contexts in the NHS. The moving accounts of desperation, transcendence and recovery provided by the participants of this study demonstrate the impact that such stories have. Such narratives have potential to inform and influence policy-makers with the aim of influencing drug and alcohol policy to recognise the relevance of spirituality at the policy and service level.

Embed spirituality into drug and alcohol services

Spiritualty is often viewed sceptically in addiction treatment and recovery services. Similar to wider health and social care contexts, service users may sometimes be signposted to 12-Step meetings, but addressing spiritual dimensions within treatment programmes is typically not done. In part, this may arise from the limited time available to address the 'basics' of treatment, leaving spiritual dimensions of care as a peripheral side issue. The study findings demonstrated the importance of time and space in processes of recovery. There is a need, therefore, to ensure that service resourcing accords with the aspiration to deliver person-centred, spiritually informed models of care.

Furthermore, the study findings emphasised the relevance of setting and place in process of recovery. Regrettably, drug and alcohol treatment services often inhabit old, dirty, uninspiring buildings which in addition to being unfit for their intended purpose,

serve to add to the stigma experienced by services users (Dundee Drugs Commission, 2019). Action is needed to ensure that such services are delivered in pleasant, inspiring premises that enhance the experience of service users and workers, and are conducive to delivering person-centred, spiritually relevant interventions. The Maggie's Centres in Scotland and elsewhere, for example, provide exemplars of inspirational care facilities that could inform this thinking (Van der Linden, Annemans and Heylighen, 2016).

Third, the findings of this study suggest that the legitimacy and relevance of spirituality is disputed within addiction treatment services. A need exists, therefore, to confirm the legitimacy of attending to the spiritual needs of all people, including those using services within treatment and recovery programmes, and to enhance confidence among workers in addressing it. This should be taken forward by developing resources confirming spiritualty as a central element of treatment and recovery and developing training aimed at enhancing staff knowledge, skills and confidence in addressing spiritual dimensions of recovery.

Remove barriers to people in recovery from accessing spiritually informed interventions

Person-centred models of care are assuming greater significance and spiritually is increasingly relevant to many health and social care contexts. The current challenge, then, becomes introducing spiritually informed interventions to those accessing treatment and recovery services in acceptable and culturally relevant ways. The eclectic forms of spirituality described in this study inform the recommendation that the widest possible range of spiritually informed processes and practices should be accessible to people in recovery, whether available through organised religion, mainstream spiritual practices, or interventions tailored to the addiction recovery context. Resources should made available to map existing provision of spiritually informed interventions, identify gaps in provision, and develop strategies to ensure widespread access to relevant opportunities.

Develop resources and training to apply labyrinth-based interventions to promote recovery

The labyrinth model of recovery described earlier suggests several linked actions aimed at enhancing recovery. First, it is recommended that the model described in this thesis is developed as a practical tool aimed at facilitating self-awareness, recovery capital, and recovery planning among people accessing services. Second, labyrinth walking should be promoted as a practice for contemplation, connection and

transformation among people in recovery. Several publicly accessible outdoor labyrinths are available in Scotland, and resources should be developed highlighting the relevance of labyrinth walking to people in recovery and providing guidance to these existing facilities. Furthermore, guidance and resources should be developed to introduce facilitated labyrinth walking within recovery services and programmes. Facilitated labyrinth walks using temporary canvas labyrinths are often used in religious and secular settings (Hopthrow, 2010), providing a model for adaptation to the recovery context. Moreover, miniature 'finger labyrinths' provide accessible access to the labyrinth experience, and are readily incorporated into other facilitated or self-directed therapeutic activity (Hong and Jacinto, 2012).

The actions recommended here are aimed at applying spiritual understandings to support wider activity to reduce risk, improve outcomes, and enhance health and wellbeing within at-risk groups, especially in the context of the current DRD crisis. Although these recommendations were developed from findings that largely focussed on the experiences of men, they are aimed at enhancing the lives of all people in recovery. The small-scale exploratory nature of this study means that further evidence is needed to establish the wider relevance, feasibility and acceptability of these proposed actions.

Recommendations for further research

Research should be undertaken to further understand the relevance of gender as a dimension of spiritualty among people in recovery, especially by exploring women's experiences. For example, in view of the finding that men's recovery experiences are characterised by balancing masculine with feminine aspects, it is relevant to explore how recovery processes inform gender identify among women. Furthermore, the focus on male identify, especially in substance use 'gang' contexts, reveals a need for further research to inform the development of culturally relevant, positive, initiation process for young people of all genders.

The participants in this study attributed their survival and success, largely, to their spirituality. However, what relevance does this finding have for other people who experience addiction? Further research is needed to identify long-term risk factors for DRD, and the potential relevance of spirituality in countering those risks, especially studies taking a life-course approach to understanding risks of death and protective factors.

Research should be undertaken to further understand addiction as a spiritual phenomenon. Such research might focus on the experiences of people who continue substance use, those who do not include spiritualty within their recovery process, and those who report negative experiences with spirituality. Studies of this kind will help understand the experience of individuals who achieve recovery using spiritual means, compared to those who do so without spiritual practices.

Several studies have addressed the potential benefits of labyrinth walking to support health and wellbeing (Schaper and Camp, 2013; McGettigan, 2016; Lizier *et al.*, 2018) and its application in specific settings, including prisons (Zucker and Sharma, 2012), education (Zucker *et al.*, 2016), forensic mental health (Heard, Scott and Yeo, 2015), paediatric palliative and critical care (Weaver *et al.*, 2019), and one focussing on substance use recovery (Rice, 2004). Further research is required to evaluate the relevance of labyrinths to addiction recovery, and the potential value of facilitating labyrinth walking within recovery programmes.

The use of shamanic processes to facilitate data analysis was distinctive to this study. This experience yielded positive results as an example of the application of spiritual epistemologies as discussed by Carrington (2010b), albeit undertaken on a small scale, suggesting wider application within qualitative research. Further research is required to assess the wider value of this technique, especially among researchers without prior experience of shamanic processes.

Strengths and limitations of the study

In this section, the strengths and limitations of the epistemological position, study design, methodology, data sources, analytic methods, and findings are evaluated. The greatest strength in this study is, I believe, the richness of data collected. I was fortunate to recruit participants who generously shared their compelling personal stories, as presented within these pages. A further strength proved to be the two-phase research design, envisaged as a solution to the methodological tensions such as the challenge of spiritual epistemologies and the complexity of spirituality identified as implicit to the study. The idea of developing an initial overview of the topics, followed by a narrowly focussed idiographic process, translated well to the needs of this small exploratory study. Finally, selecting IPA for Phase Two produced a nuanced understanding of the participants’ experiences and was a clear strength in developing original findings.

All research involves some degree of compromise, and the decision to situate this study within the qualitative paradigm limits the relevance of the findings beyond the study settings. This orientation shaped the participant recruitment strategy, sample size, data collection and analysis, which informed an idiographic study that produced non-generalisible findings. This approach yielded rich data of potential relevance to policy and practice but, in doing so, highlighted the drawbacks associated with such highly interpretive approaches. Alternative viewpoints on the topics could be generated through, for example, sequential explanatory mixed methods research (Ivankova, Creswell and Stick, 2006), or nomothetic forms of qualitative research such as Grounded Theory (Charmaz, 2014).

A second consequence of the Phase Two idiographic stance was that, by focussing on the experiences of one group (men with experience of addiction, recovery and spiritualty), the experiences of other relevant groups were excluded. These groups include women, recovery service workers, people who achieved recovery without spiritual assistance, and those whose recovery was hindered by spiritual practices. Further research should investigate these perspectives.

One effect of the purposive networked aspect of the selection process was to bias recruitment towards a relatively narrow range of spiritual orientations and experiences. For example, Phase One participants did not include several important religious perspectives, including Islam, Hindu or Sikhism, all of which have relevant viewpoints on addiction and recovery. Furthermore, most Phase Two participants cited the 12-Step fellowship as a major source of spiritual inspiration and guidance, which is undoubtedly an important perspective for spiritually informed recovery (Dossett, 2013, 2015, 2017, 2018). In retrospect, however it would have been preferable to purposively select individuals who represented greater diversity in spiritual orientation.

The international component of the study warrants further scrutiny. The fieldwork in Thailand took place sometime after the UK-based activity, which led to it being somewhat disconnected from the earlier Phase One data. Furthermore, Phase One analysis failed to develop effective linkages between the research undertaken in Thailand and the rest of the Phase One data, limiting the relevance of this international activity to the overall findings.

A further feature of this study was the novel use of shamanic processes adjunctive to IPA analysis. For some, the inclusion of this untested method may undermine the credibility of the findings. From this critical perspective the subjectivity of the shamanic

process carries an unjustifiable risk of bias. In this study the shamanic process was only used to support conventional analysis, rather than as an analytic method in its own right; thus, considerable further testing is required before this approach is afforded wider credibility. Furthermore, in retrospect, it would have been preferable to fully inform the participants of the intended analysis process. It would also be advisable for any future research using this novel method to provide potential participants with full details of the intended methods to be used.

Finally, the core motif to emerge from the findings invites scrutiny. The labyrinth model emerged directly from participant narratives, which reflected dislocation, desperation, and the guidance of the 'golden thread'. Yet, the conceptual leap that resulted in the labyrinth model was undoubtedly informed by my personal perspective. The resulting tentative model is credible within the context of this study yet requires further refinement and testing to determine any wider relevance and applicability.

Final word

The labyrinth emerged from this thesis as a unifying theme linking the research process, the remarkable accounts of the participants, and my personal journey. This has been an exploration of deep personal experiences, the search for myth and meaning, and the quest for spiritual guidance. It also informed an intriguing potential contribution to qualitative analysis. More than anything else, though, this work brings awareness to the relevance of spirituality to experiences of addiction and processes of recovery, with potential to impact practice and inform policy. This journey has also addressed the realities of the human toll of drug and alcohol use. What emerged is hope: hope that the path of addiction does not inevitably lead towards self-destruction and death; hope that deeply fulfilling ways of living are within the grasp of those in the depths of despair; hope for the possibility of transcendence. The labyrinth returns the seeker to their point of departure with renewed awareness, fresh insight, and deeper wisdom. I will conclude with the words of Barry who, along with others, so generously shared his story with me.

> *"I think, that the search for God… the search for a Higher Power outside, is actually within here [points to heart area of chest]. And what that is, is that connection to the potential within me that I looked at when I was in addiction and could see and couldn't understand why my life wasn't working in that way. And what the spirituality has brought me to is to connect to that potential within me. Whether you*

call it 'God', 'Higher Power', 'The Universe', you know, whatever, but I think it's the potential within me that's been illuminated in some way."

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Appendices

Appendix A: Glossary of Scottish dialect and substance use phraseology

Term	Meaning
aff	off
cannae	can not
couldnae	could not
didnae	did not
gairden	garden
hadnae	had not
jagged	injected, pricked with a needle
ken, kent	know, known
nae	no
naebody	nobody
no	not
oot	out
they	those
rattle	drug withdrawal (usually opiates)
vallies	valium (diazepam)
wasnae	was not
wee	small
whitey	feeling faint following drug use (usually cannabis, but ascribed to heroin use by a participant in this study)
wrang	wrong

Appendix B: Summary of shamanic reflexive analytic process

Interview	Summary of journey	Assumptions	Values, beliefs and life story	Emotional connection with the participant(s)
		What assumptions did I make about the participant or their responses to my questions? *How did these assumptions affect or shape my interventions and behaviour during the interview?*	*How did my personal values, beliefs and life story affect or shape my interventions and behaviour during the interview?*	*To what degree did my emotions or feelings for the participant affect or shape my interventions and behaviour during the interview?*
1	I was riding in a red Cadillac across the American Desert, with Participant 1 at the wheel. Felt like I was being taken along as witness to a journey. I had a reporter's notebook, glasses and a tweed jacket. Next I saw Participant 1 riding across the desert on a horse, dressed all in black. A sinister figure, a dark presence, quite intimidating. Participant 1 rode to a high plateau, where he stopped for a long time by a placid lake: a place of reflection and contemplation. Finally, I saw Participant 1 dressed in a business suit carrying a briefcase, which represented the wisdom and insight he had attained through his recovery journey.	I was aware of making assumptions about Participant 1 as quite a scary figure – someone who lived at the centre of an illicit world of drugs, music and violence. I also perceived him as someone who had learnt to master his anger and who had experienced periods of mental instability, which I found unsettling.	I was aware that Participant 1's description of his life – his childhood, adolescence and adulthood were very different from my own experience – I encountered him as 'other', as someone with difference values and experiences from my own.	In my journey, I took the role of 'witness', to Participant 1's account. I felt Participant 1 as very self-assured and powerful, who was choosing to show me aspects of his vulnerability because he was assured in his capacity to have worked through that inner material.
2	A beech forest in Autumn, lots of fallen leaves. Reds, Golds, Oranges. A small moss-covered cave with a small table with draw. Inside the draw 4 manila files with information on each of the four questions. A circuitous path through the forest to an outcrop, coved in moss. At the top an open-sided hut – oriental in appearance, with a wizard like hermit. Informed that this was the route to Participant 2's true self, which I had been led to. Two squirrels playing (him and me) and an inquisitive fox cub (my researcher self).	I see Participant 2 as a 'hippy' with flared jeans and long hair (which he actually does have in reality).I am aware of the conventional nature of much of my own life course and career, as if I stand 'on the edge' of the 'alternative' lifestyle as an observer.	I am aware of the value I place on order and completeness in life and enjoy the 'complete' feel to Participant 2's narrative. I felt comfortable pursuing the interview, which took various turns as I had a sense of 'direction'. It was parent that Participant 2 had thought through his narrative and what he wanted to say.	I saw two squirrels playing, symbolizing the natural closeness that developed between us during the interview and the sense of trust that existed. I also saw myself as a fox cub, look in representing the inquisitiveness of my researcher self.
3	I saw Participant 3 emerge from a chaotic and fearful scene, where drug-crazed beings danced around a blazing fire. Before him lay	I saw Participant 3 as someone with in an evolving recovery		I felt more of a distance between me and Participant 3, compared with

	a deep, dark forest and although his inner path led there, he chose to take a route that skirted the edge of the forest, avoiding the darkest parts. I interpreted this as representing Participant 3's spiritual and recovery journey, which seemed to go 'so far and no more' into the spiritual inner landscape. Around his route Participant 3 was confronted by food stalls, clothes shops and gadget shops, drawing him into an external, material life. Eventually he exits, leaving the forest behind. I appear as a wizard with a telescope, able to scan the entire landscape. I see the depths of the forest which represent Participant 3's inner life which he could gain much from if he chose to explore it.	journey, who so far developed a restricted view of spirituality. By his own admission he continues to be drawn by addiction-like traits, which attract him to material things such as clothes and food.		the other participants, perhaps in view of the sense of 'incompleteness' of his recovery story – the feeling that it is an active and unresolved process and the uncertainly about spiritually that results.
4	A deep, black shaft leads to a night-time underworld. Under a black sky tribal dancers cavort around a fire, sparks flying into the inky air. Cups of fresh blood are passed between the revellers and drunk. Next, a low narrow tunnel leads to a desert, I see Participant 4 as a pantomime dame – wig, lipstick, fake breasts and a dress. This is all striped away by the winds, then his skin, then flesh and finally his bones dry up and crumble to dust. The dust is carried by the desert winds to an oasis where a magnificent temple is seen. Participant 4 emerges as his true self.	The main assumption I became aware of was the sense that the story Participant 4 was telling was 'rehearsed', that he had thought about and reflected upon his recovery journey at great depth over a period of some years that the narrative he presented was in that sense 'polished.	I was aware of the contrast between Participant 4's working class Scottish background, and my own middle class English upbringing.	I was very aware of the parallels between Participant 4's experiences in childhood and my own – not direct incidents, but the more general sense of a vulnerable boy who was unsure of his place in the world.
5	A winding path leads invitingly through a sun-dappled forest, filled with the intoxicating scent of strange flowers. Suddenly the forest becomes a dark, foreboding, frightening place filled with disturbing sounds and half-seen shadows, Within the dark forest an inky pool is filled with snapping crocodiles that inflict terrible injuries upon Participant 5. The pool must be crossed to reach the far shore, from which a golden path leads to a circle of tree-stump seats in a forest glade – a place of ancient wisdom and fellowship.	I saw Participant 5 as a highly evolved person, deeply committed to his path of spiritual exploration. I was aware of being personally very inspired by his life story.	It felt to me that despite having very different origins, Participant 5 and share many beliefs and values. I noticed the great warmth and respect for him that I feel.	I experienced awe and immense respect in witnessing the path of transformation and transcendence described by Participant 5's journey. Could I have survived such an ordeal?

	Participant 5 crawls, half dead to the centre of this circle and receives healing energy from the earth, from companions sitting on the seats and from the heavens. A powerful, inexorable force draws Participant 5 upwards, gifting him wings. He soars through the air, high above the forest towards lofty mountain peaks.			
6	I saw Participant 6 as a lost little boy on a desert island. In the middle of the island was a lagoon and Participant 6 was swimming in its sheltered waters. He had a map that showed him the way around the island, but could not find a way off, as the waters beyond were rough and shark infested. He is kneeling on the ground sobbing, with his hands to his face. I see myself as a soaring bird, able to see the whole island and the sea beyond, and can see that Participant 6 has all the information necessary to escape the island and that only fear is holding him back	I see Participant 6 as still in a process of searching and feeling his way through his own inner territory; uncertain of himself at times.	I became aware that my own experience of growing up in an ecclesiastical family played into my understanding of Participant 6's experiences with Christianity, particularly evangelical Christianity. As I leant to be suspicious of the evangelical approach.	I became very aware of the vulnerable and suggestable aspects of Participant 6's constitution. Rather like a lost little boy, searching for his true path.

Appendix C: Artwork created via shamanic reflexive analytic process

Participant 1

Participant 2

Participant 3

Participant 4

Participant 5

Participant 6

Appendix D: Phase One service users' information sheet

Version 3: 04/09/2013

Participant information sheet (interview): service users and relatives

UNIVERSITY OF STIRLING

SCHOOL OF NURSING, MIDWIFERY AND HEALTH

Study title
The relevance and significance of spirituality in drug and alcohol addictions and recovery from addiction: an exploratory qualitative study.

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Participant information sheet (interview):
service users and relatives

Invitation:

My name is Nick Fuller and I am required to undertake a project as part of my PhD programme and invite you to take part in the following study. However, before you decide to do so, I need to be sure that you understand firstly why I am doing it, and secondly what it would involve if you agreed. I am therefore providing you with the following information. Please read it carefully and be sure to ask any questions you might have and, if you want, discuss it with others including your friends and family. I will do my best to explain the project to you and provide you with any further information you may ask for now or later.

What is the purpose of the study?

I am interested in understanding the relevance of spirituality in drug and alcohol addictions, and recovery from such addiction. I need to collect information from individuals

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and their relatives who currently use drug and alcohol addiction services, or who have used such services in the past. I will use this information to better understand the links between spirituality and addictions, and to suggest how services can use this information to meet the needs of their clients.

The term 'spirituality' can mean different things to different people. For some it is about God or organised religion, however for many others spirituality has to do with aspects of life that can be difficult to define in words, but that connect in some way with experiences beyond everyday reality. In this study, part of my aim is to learn more about the different ideas people have about spirituality and how this may help us to understand health, particularly around drug and alcohol addictions and recovery from addictions.

Why have I been chosen?
You have been chosen because you have been identified as someone who may have an interesting and relevant personal story to tell about drug or alcohol use or recovery, which would be valuable to this study.

Do I have to take part?
No. Taking part in the study is voluntary and it is up to you to decide whether or not to take part. If you do, you will be given this information sheet to keep and you will be asked for your contact details, to arrange the next step. You will be asked to sign a consent form at a later date. You are still free to withdraw at any time and without giving a reason. A decision to withdraw at any time, or a decision not to take part, will not affect the standard of care you receive now or in the future.

What will happen to me if I do take part?
If you choose to take part in the study I will contact you to make arrangements to attend a an individual interview, which will take around 90 minutes and will take place at a time and place that is convenient for you. During the interview you will be asked questions about your experiences of drug and alcohol use, your ideas about recovery, and the factors that help your (or your relative's) recovery journey. Your conversation will be audio recorded

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with your permission.

What will happen after the interview?

At the end of the interview you will be asked if you agree to be contacted again to check and clarify details or to add further information once the audio-recording has been transcribed and analysed for meaning. It is up to you whether you wish to be contacted again.

Consent

You will be asked to consent to taking part in an interview with a researcher and to your conversation being audio recorded.

If I agree to take part can I withdraw later from the study?

Yes, you can withdraw from the study up to two weeks after the interview, by either telephoning or writing to the research team. Contact details are given at the end of this sheet. Any data collected up to that point (audio recordings or written versions of your discussion) will be destroyed in a safe and secure manner. If you decide that you wish to withdraw from the study more than two weeks after the interview, every practical effort will be made to identify and remove your information, however as your anonymous information will be merged with information from other participants as part of the data analysis process, it may become impractical to identify and remove everything relating to you.

Are there any disadvantages to taking part?

There are no risks to you taking part in this research. The only disadvantage is that you will need to give up some of your time to attend the interview, which will last about 90 minutes.

What are the possible benefits of taking part?

There is no immediate health benefit involved in taking part in the study, but the information gained may influence care and treatment for people recovering from drug and alcohol problems in future. You will be reimbursed for any travel expenses and refreshments will be provided.

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Will my taking part in this study be kept confidential?

Yes. All the information collected (audio recordings and written transcripts) will be treated as strictly confidential in accordance with the Data Protection Act 1998. No identifiable details will be included in any research reports and all names of people and work places will be removed and substituted with a pseudonym to maintain anonymity. The data will only be seen by the research team directly involved in the data analysis and will be stored in a locked office and on a password protected computer. All audio-recorded data will be destroyed following data analysis. All other data will be destroyed 10 years after the completion of the research. The researchers will take all reasonable steps to protect your privacy.

What will happen to the results of the research study?

Once the study has been completed the information will be used to help improve understanding of care and treatment for people recovering from drug and alcohol addiction. A research report will be written, and the study will be reported in academic journals and may also be presented at conferences for substance misuse professionals and researchers. Your own personal information will not be identified in any reports written. In no way will anyone ever be able to identify you through our reporting of the findings. If you wish to receive a copy of the research report, you should contact the researcher using the contact details given below.

Who is organising the research?

The research is being carried out by

Nick Fuller
Research Student
School of Nursing, Midwifery and Health
University of Stirling
Stirling
FK9 4LA

Who has reviewed the study?

The East of Scotland Research Ethics Committee REC 1, which has responsibility for

scrutinising all proposals for medical research on humans in Tayside, has examined the proposal and has raised no objections from the point of view of medical ethics. It is a requirement that your records in this research, together with any relevant records, be made available for scrutiny by monitors from the University of Stirling and NHS Tayside, whose role is to check that research is properly conducted and the interests of those taking part are adequately protected.

Who can I speak to about this research?

If you have any further questions about the research, please contact the researcher:

Nick Fuller
Research Student
School of Nursing, Midwifery and Health
University of Stirling
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FK9 4LA
Tel: 07740937316
email: n.w.fuller@stir.ac.uk

If you have further questions, you may contact the research supervisor:

Dr Tessa Parkes
Senior Lecturer
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University of Stirling
Stirling
FK9 4LA
email:t.s.parkes@stir.ac.uk

If you would like to speak to an independent person who knows about the research, you may contact:

Professor William Lauder
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FK9 4LA
Tel: 01786 466345
Fax: 01786 466333
Email: William.lauder@stir.ac.uk

Help and support

Finally, if after taking part in the research you feel you would like to talk to someone about

the issues raised, or your involvement with the research, you may contact:

Gillian Munro
Department of Spiritual Care
Wellbeing Centre
East Lodge
RVH
Dundee
DD2 1SP
Tel: 01382 423116 x 40805
email: gillian.munro@nhs.net

Thank you for taking the time to read this Information Sheet and for considering taking part

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Appendix E: Phase One professionals' information sheet

Version 3: 04/09/2013

Participant information sheet (interview): professionals

UNIVERSITY OF STIRLING

SCHOOL OF NURSING, MIDWIFERY AND HEALTH

Study title

The relevance and significance of spirituality in drug and alcohol addictions and recovery from addiction: an exploratory qualitative study.

Nick Fuller
Research Student
School of Nursing & Midwifery
University of Stirling
Stirling FK9 4LA

Telephone: 07740937316
Email: n.w.fuller@stir.ac.uk

Participant information sheet (interview): *professionals*

Invitation:

My name is Nick Fuller and I am required to undertake a project as part of my PhD programme and invite you to take part in the following study. However, before you decide to do so, I need to be sure that you understand firstly why I am doing it, and secondly what it would involve if you agreed. I am therefore providing you with the following information. Please read it carefully and be sure to ask any questions you might have and, if you want, discuss it with others including your friends and family. I will do my best to explain the project to you and provide you with any further information you may ask for now or later.

What is the purpose of the study?

I am interested in understanding the relevance of spirituality in drug and alcohol addictions and recovery. I need to collect information from professionals with knowledge and

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experience in drug and alcohol addictions practice, or who manage, commission or form policy in this area, or who have experience in the application of spirituality-oriented interventions within the field of drug and alcohol addictions. I will use this information to better understand the links between spirituality and addictions, and to suggest how this information can inform future service development.

The term 'spirituality' can mean different things to different people. For some it is about God or organised religion, however for many others spirituality has to do with aspects of life that can be difficult to define in words, but that connect in some way with experiences beyond everyday reality. In this study, part of my aim is to learn more about the different ideas people have about spirituality and how this may help us to understand health, particularly around drug and alcohol addictions and recovery from addictions.

Why have I been chosen?

You have been chosen because you have been identified as someone who has relevant knowledge and experience to the field of spirituality and drug and alcohol addictions, and whose ideas and experience will make a valuable contribution to the study.

Do I have to take part?

No. Taking part in the study is voluntary and it is up to you to decide whether or not to take part. If you do, you will be given this information sheet to keep and you will be asked for a contact phone number so that we can arrange a suitable time to talk to you. You will be asked to sign a consent form at a later date. You are still free to withdraw at any time and without giving a reason.

What will happen to me if I do take part?

If you choose to take part in the study, I will contact you to arrange an interview. The interview will take about 90 minutes and will take place at a time and place convenient with you. If you are based overseas, this interview may be undertaken on the telephone or using Skype. During the interview you will be asked questions about your professional experiences, your ideas about the factors that promote recovery among from addictions

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and the relevance of a spiritual perspective to such work. Your conversation will be audio recorded with your permission.

What will happen after the interview?

At the end of the interview you will be asked if you agree to be contacted again to check and clarify details or to add further information once the audio-recording has been transcribed and analysed for meaning. It is up to you whether you wish to be contacted again.

Consent

You will be asked to consent to taking part in an interview with a researcher and to your conversation being audio recorded.

If I agree to take part can I withdraw later from the study?

Yes, you can withdraw from the study up to two weeks after the interview, by either telephoning or writing to the research team. Contact details are given at the end of this sheet. Any data collected up to that point (audio recordings or written versions of your discussion) will be destroyed in a safe and secure manner. If you decide that you wish to withdraw from the study more than two weeks after the interview, every practical effort will be made to identify and remove your information, however as your anonymous information will be merged with information from other participants as part of the data analysis process, it may become impractical to identify and remove everything relating to you.

Are there any disadvantages to taking part?

There are no risks to you taking part in this research. The only disadvantage is that you will need to give up some of your time for the interview which will last about 90 minutes.

What are the possible benefits of taking part?

There is no immediate benefit to yourself from taking part, however you will be contributing to research to enhance recovery for future service users within addiction services.

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What will happen to the results of the research study?

Once the study has been completed the information will be used to help improve understanding of care and treatment for people recovering from drug and alcohol addiction. A research report will be written, and the study will be reported in academic journals and may also be presented at conferences for substance misuse professionals and researchers. Your own personal information will not be identified in any reports written. In no way will anyone ever be able to identify you through our reporting of the findings. If you wish to receive a copy of the research report, you should contact the researcher using the contact details given below.

Who is organising the research?

The research is being carried out by

Nick Fuller
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Who can I speak to about this research?

If you have any further questions about the research, please contact the researcher:

Nick Fuller
Research Student
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Tel: 07740937316
email: n.w.fuller@stir.ac.uk

If you have further questions, you may contact the research supervisor:

Dr Tessa Parkes
Senior Lecturer
School of Nursing, Midwifery and Health
University of Stirling
Stirling
FK9 4LA
email: t.s.parkes@stir.ac.uk

If you would like to speak to an independent person who knows about the research, you may contact:

Professor William Lauder
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Help and support

Finally, if after taking part in the research you feel you would like to talk to someone about the issues raised, or your involvement with the research, you may contact:

Gillian Munro
Department of Spiritual Care
Wellbeing Centre
East Lodge
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DD2 1SP
Tel: 01382 423116 x 40805
email: gillian.munro@nhs.net

Thank you for taking the time to read this Information Sheet and for considering taking part in this study.

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Appendix F: Consent form

Version 2: 27/03/0213

Consent form for all participants

Participant Identification Number for this study:

UNIVERSITY OF STIRLING

SCHOOL OF NURSING, MIDWIFERY AND HEALTH

Nick Fuller
Research Student
School of Nursing & Midwifery
University of Stirling
Stirling FK9 4LA

Telephone: 07740937316
Email: n.w.fuller@stir.ac.uk

CONSENT FORM

Title of Project:

The Relevance and Significance of Spirituality in Addictions Recovery

This is the standard consent form that the Health Authority Ethics Committee asks people to sign when they take part in a research project. Please sign both copies and keep one for your own records. The other copy will be kept for our records.

Name of Researcher:

Please initial box:

1. **I confirm that I have read and understand the information sheet dated 27/03/2013 (Version 2) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.** ☐

2. **I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my medical care or legal rights being affected.** ☐

3. **I agree to consent to my conversation being audio recorded** ☐

4. **I understand that any part of my audio recorded conversation can be withdrawn from the study if I request it.** ☐

5. **I agree to consent to anonymised quotes of my interview being used in any publication or presentation of the research** ☐

6. **I agree to take part in the above study.** ☐

Name of Participant	Date	Signature
Name of Researcher	Date	Signature

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Appendix G: Phase One professionals interview schedule

Version 2 27/03/0213

Interview/discussion schedule: professionals

UNIVERSITY OF STIRLING

SCHOOL OF NURSING, MIDWIFERY AND HEALTH

Study title
The relevance and significance of spirituality in drug and alcohol addictions and recovery from addiction: an exploratory qualitative study.

Nick Fuller
Research Student
School of Nursing & Midwifery
University of Stirling
Stirling FK9 4LA

Telephone: 07740937316
Email: n.w.fuller@stir.ac.uk

Interview/discussion schedule: *professionals*

Note: This is a semi-structured interview/discussion format which provides overall guidance on the topics to be covered. The exact focus for each interview/discussion will be informed by the information provided during the interview by the participant(s). Language and terminology used will reflect that used by participants and therefore may differ from the terms used in this schedule. This schedule may be used for face to face interviews or focus groups and for telephone or videoconference interviews with participants.

Introduction

Introduce researcher and provide contact details – leave business card

Ensuring Consent

- Give participant copy of the participant consent form. Talk through each point. Ask if there are any questions
- Remind the participant that they can verify the ethical approval of the study.
- If consent confirmed then ask the participant to sigh both copies of the consent form and give one to them to keep and retain the other copy for the project files.

Thank the participant for their involvement and check how much time the participant has to conduct the interview/discussion.

Questions

Background

1. Please tell me about your professional background and practice:
(Prompt: qualifications, theoretical orientation, philosophical positioning, skills and approach to practice)

Practice focus

2. What is the main focus of your practice/work?
(Prompt: client population, case-load, interventions used, role and remit)

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Drug and alcohol addiction

3. What is your experience with working with people experiencing problems with drug and alcohol?
(prompt: definition of addiction/substance misuse; physical, psychological and social impacts)

4. What do you think are the causes of drug and alcohol problems/addiction?
(*prompt: social factors, genetics, health inequalities, education, psychological factors)*

Drug and alcohol addiction recovery

5. The concept of recovery is very prominent within the substance use/misuse field currently – what does recovery mean for you?
(prompt: definitions and evidence of recovery; helping and hindering factors in recovery; relevance of your practice to promoting recovery)

6. What factors are most supportive of recovery in the drug and alcohol problems/addictions field?
(prompt: motivation, family support, resources, services, culture, background, spirituality)

Relevance of spirituality to addictions recovery

7. What relevance, if any, does spirituality have in processes of drug and alcohol addiction?
(prompt: clarify spirituality – what term(s) does participant use?)

8. What relevance, if any, does spirituality have in recovery from drug and alcohol problems/addiction?

9. What approaches/interventions in drug and alcohol problems/addiction are you aware of that are informed by a spiritual understanding of health and wellbeing? (*locally, nationally and globally*). What evidence supports these practices?

10. What is the relevance of the concept of spirituality for those using and providing drug and alcohol problems/addictions services?

11. How might drug and alcohol addiction services take account of the spiritual dimensions of a person's life and recovery journey?

12. What social, cultural and organisational factors need to be taken into account in the development of service approaches and interventions that take account of the spiritual dimensions of a person's life and recovery journey?
(prompt: practical, social, cultural and organisational factors)

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Closing comments

Is there anything further you would like to add that we have not covered already?

You will have opportunity to review add to or amend anything that you have said today: would you be interested and available to help with this?

Would you also be interested and available to take part in the next phase of the study, which will involve reviewing the findings from this phase of work?

Other informants

Are there other people you know who I should definitely try to talk to as part of this study?
(provide information sheet and covering letter to pass on if appropriate)

Thank you

Thank you for your participation in this study. Please contact me if you have any question arising from our conversation together. See contact details on card and consent form.

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Appendix H: Phase One service users interview schedule

Version 2 27/03/0213

Interview/discussion schedule: service users and relatives

UNIVERSITY OF STIRLING

SCHOOL OF NURSING, MIDWIFERY AND HEALTH

Study title
The relevance and significance of spirituality in drug and alcohol addictions and recovery from addiction: an exploratory qualitative study.

Nick Fuller
Research Student
School of Nursing & Midwifery
University of Stirling
Stirling FK9 4LA

Telephone: 07740937316
Email: n.w.fuller@stir.ac.uk

Interview/discussion schedule: service users and relatives

Note: This is a semi-structured interview/discussion format which provides overall guidance on the topics to be covered. The exact focus for each interview/discussion will be informed by the information provided during the interview by the participant(s). Language and terminology used will reflect that used by participants and therefore may differ from the terms used in this schedule. This schedule may be used for face to face interviews or focus groups and for telephone or videoconference interviews with participants.

Introduction

Introduce researcher and provide contact details – leave business card

Ensuring Consent

- Give participant copy of the participant consent form. Talk through each point. Ask if there are any questions
- Remind the participant that they can verify the ethical approval of the study.
- If consent confirmed then ask the participant to sign both copies of the consent form and give one to them to keep and retain the other copy for the project files.

Thank the participant for their involvement and check how much time the participant has to conduct the interview/discussion.

<u>Questions</u>

Background

1. Please tell me about your interest/involvement in drug and alcohol substance use /addictions and recovery services.
(Prompt: personal lived experience, relative etc)

Contact with services and agencies

2. What services and agencies have you been in contact with to help with drug and alcohol substance use/addiction problems?
(Prompt: interventions, client experience, when and where)

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3. What is your experience of problems with drug and alcohol?
(prompt: definition of addiction/substance misuse; physical, psychological and social impacts)

4. What, for you, have been the causes of drug and alcohol problems in your life or family?
(*prompt: social factors, genetics, health inequalities, education, psychological factors)*

Drug and alcohol addiction recovery

5. The concept of recovery is very prominent within the substance use field currently – what does recovery mean for you?
(prompt: definitions and evidence of recovery; helping and hindering factors in recovery)

6. What factors are most supportive of recovery in the drug and alcohol problems field?
(prompt: motivation, family support, resources, services, culture, background, spirituality)

Relevance of spirituality to addictions recovery

6. In what ways do you see the world differently as a result of your experience of drug and alcohol problems? Have there been positive as well as the negative consequences of your experiences? If so please say more.

7. Are there any ways in which drug and alcohol problems can be associated with spiritual experiences?
(prompt: clarify spirituality – what term(s) does participant use? e.g. religion, wellbeing)

8. What relevance, if any, does spirituality have in recovery from drug and alcohol problems or addiction?

9. What has been your experience (if any) of approaches/interventions in drug and alcohol addiction that are informed by a spiritual understanding of health and wellbeing?
(*e.g. meditation, mindfulness, yoga, auricular acupuncture, etc)*

10. Do you think drug and alcohol problem services take account of the spiritual dimensions of a person's life and recovery journey? If not, how could this be better addressed? Is this important to you or not?
(practical, social, cultural and organisational factors

Closing comments

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Is there anything further you would like to add that we have not covered already?

I would like to provide you the opportunity to review, add to or amend anything that you have said today: would you be interested and available to help with this?

Would you also be interested and available to take part in the next phase of the study, which will involve reviewing the findings from this phase of work?

Other informants

Are there other people you know who I should definitely try to talk to as part of this study?
(provide information sheet and covering letter to pass on if appropriate)

Thank you

Thank you for your participation in this study. Please contact me if you have any question arising from our conversation together. See contact details on card and consent form.

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Appendix I: Images from Thamkrabok Monastery, Thailand

Programme participants drinking detoxifying herbal tea

Shrine room

Appendix J: Phase Two information sheet

Version 4: 04/10/2015

Participant information sheet

UNIVERSITY OF STIRLING

SCHOOL OF NURSING, MIDWIFERY AND HEALTH

Study title
The relevance and significance of spirituality in drug and alcohol addictions and recovery from addiction: an exploratory qualitative study.

Nick Fuller
Research Student
School of Nursing & Midwifery
University of Stirling
Stirling FK9 4LA

Telephone: 07740937316
Email: n.w.fuller@stir.ac.uk

Participant information sheet

Invitation:

My name is Nick Fuller, as part of my doctoral studies, I am currently undertaking a project exploring the relevant of spirituality in understanding experiences of drug and alcohol addiction and recovery. I would like to invite you to take part in this study, however, before you decide to do so, I need to be sure that you understand firstly why I am doing it, and secondly what it would involve if you agreed. I am therefore providing you with the following information. Please read it carefully and be sure to ask any questions you might have and, if you want, discuss it with others including your friends and family. I will answer any questions you have and will provide you with any further information that will help you decide whether or not to participate.

What is the purpose of the study?

Highland Campus:
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I am interested in understanding the relevance of spirituality in recovery from drug and alcohol addiction. I want to collect information from individuals who have a personal experience of recovery from drug or alcohol addiction, who considers some form of spiritual practice to have contributed to their recovery process. I will use this information to better understand the links between spirituality and addictions, and to suggest how this knowledge can help develop drug and alcohol recovery programmes in the future.

The term 'spirituality' can mean different things to different people. For some it is about God or organised religion, however for many others spirituality has to do with aspects of life that can be difficult to define in words, but that connect in some way with experiences beyond everyday reality. In this study, I am interested in spirituality as you understand it in the context of your recovery journey.

Why have I been chosen?

You have been chosen because you have been identified as someone with a personal experience of drug or alcohol addiction and because some form of spiritual practice played a significant role in your recovery journey.

Do I have to take part?

No. Taking part in the study is voluntary and it is up to you to decide whether or not to participate. If you do, you will be given this information sheet to keep and you will be asked for your contact details, to arrange the next step. You will be asked to sign a consent form at a later date. You are still free to withdraw at any time and without giving a reason. A decision to withdraw at any time, or a decision not to take part, will not affect your involvement with any form of support of treatment that you may be receiving.

What will happen to me if I do take part?

If you choose to take part in the study I will contact you to make arrangements to attend a an individual interview, which will take around 90 minutes and will take place at a time and place that is convenient for you. During the interview you will be asked questions about your experiences of drug and alcohol use and the factors that helped your recovery

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journey including your engagement in any forms of spiritual practice. Your conversation will be audio recorded with your permission.

Consent

You will be asked to consent to taking part in an interview with a researcher and to your conversation being audio recorded.

If I agree to take part can I withdraw later from the study?

Yes, you can withdraw from the study up to one month after the interview, by either telephoning, emailing or writing to the research team. Contact details are given at the end of this sheet. Any data collected up to that point (audio recordings or written versions of your discussion) will be destroyed in a safe and secure manner. If you decide that you wish to withdraw from the study more than one month after the interview, every practical effort will be made to identify and remove your information, however as your anonymous information may be merged with information from other participants as part of the data analysis process, it may become impractical to identify and remove everything relating to you.

Are there any disadvantages to taking part?

If you decide to participate you will need to give up some of your time to attend the interview, which will last about 90 minutes. Additionally, you should be aware that you will be asked to discuss aspects of your own addiction and recovery experience. The interview will be conducted sensitively, nevertheless talking about these personal experiences may touch on emotionally significant topics. If you find the interview in any way distressing you can ask for the interview to pause, or stop completely, at any time. If you feel you would like to talk to someone about this experience at the time, the researcher will be happy to spend some time with you immediately after the interview. If after taking part in the research you feel you would like to talk to someone about the issues raised, or your involvement with the research, you may contact:

Gillian Munro
Department of Spiritual Care
Wellbeing Centre

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East Lodge
RVH
Dundee
DD2 1SP
Tel: 01382 423116 x 40805
email: gillian.munro@nhs.net

What are the possible benefits of taking part?

There is no immediate benefit to you associated with participating in the study. Taking part will help us better understand the experience of addiction recovery and, thereby, to potentially improve support services for people recovering from drug and alcohol problems in future. You will be reimbursed for any travel expenses and refreshments will be provided.

Will my taking part in this study be kept confidential?

Yes. All the information collected (audio recordings and written transcripts) will be treated as strictly confidential in accordance with the Data Protection Act 1998. No identifiable details will be included in any research reports and all names of people and work places will be removed and substituted with a pseudonym to maintain anonymity. The data will only be seen by the research team directly involved in the data analysis and will be stored in a locked office and on a password protected computer. All audio-recorded data will be destroyed following data analysis. All other data will be destroyed 10 years after the completion of the research. The researchers will take all reasonable steps to protect your privacy.

What will happen to the results of the research study?

Once the study has been completed the information will be used to help improve understanding of care and treatment for people recovering from drug and alcohol addiction. A research dissertation will be written, and the study will be reported in academic journals and will be presented at conferences for substance misuse professionals and researchers. Your own personal information will not be identified in any reports written. In no way will anyone ever be able to identify you through our reporting of the findings. If you participate in the study, a summary of the findings will be made

available to you for your information.

Who is organising the research?

The research is being carried out by a team from the School of Health Sciences, University of Stirling comprising research student Nick Fuller and two academic supervisors, Dr Tessa Parkes and Dr Nicola Cunningham.

Who has reviewed the study?

The Research Ethics Committee, School of Health Sciences, University of Stirling, has examined the proposal and has raised no objections from the point of view of research ethics. Any records concerning your participation in this study may be examined by monitors from the University of Stirling, in order to check that research is properly conducted and that the interests of participants are adequately protected.

Who can I speak to about this research?

If you have any further questions about the research, please contact the researcher:

Nick Fuller
Research Student
School of Health Sciences
University of Stirling
Stirling
FK9 4LA
Tel: 07740937316
email: n.w.fuller@stir.ac.uk

If you have further questions, you may contact the research supervisor:

Dr Tessa Parkes
Senior Lecturer
School of Health Sciences
University of Stirling
Stirling
FK9 4LA
Tel: 01786 466357
email:t.s.parkes@stir.ac.uk

If you would like to speak to an independent person who knows about the research, you may contact:

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Professor Jayne Donaldson
School of Health Sciences
University of Stirling
Stirling
FK9 4LA
Tel: 01786 466345
Fax: 01786 466333
Email: jayne.donaldson@stir.ac.uk

Thank you for taking the time to read this Information Sheet and for considering taking part in this study.

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Appendix K: Covering letter

Version 2 27/03/0213

Participant covering letter

UNIVERSITY OF
STIRLING

SCHOOL OF
NURSING, MIDWIFERY
AND HEALTH

Nick Fuller
Research Student
School of Nursing & Midwifery
University of Stirling
Stirling FK9 4LA

Telephone: 07740937316
Email: n.w.fuller@stir.ac.uk

To whom it may concern,

I would like to invite you to take part in a research study. Before you decide it is important for you to understand why the research is being done and what it will involve. You should have been given a Participant Information Sheet, explaining the research. Please take time to read that carefully before deciding whether to take part.

If you decide that you would like to take part in the research, please contact me, either by email: **n.w.fuller@stir.ac.uk** or by telephone on **07740937316**

Many thanks for considering participation in this research.

Best wishes,

Nick Fuller
Research Student

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Appendix L: Phase Two interview schedule

Version 4 04/10/2015

Interview/discussion schedule

UNIVERSITY OF STIRLING

SCHOOL OF NURSING, MIDWIFERY AND HEALTH

Study title

The relevance and significance of spirituality in drug and alcohol addictions and recovery from addiction: an exploratory qualitative study.

Nick Fuller
Research Student
School of Nursing & Midwifery
University of Stirling
Stirling FK9 4LA

Telephone: 07740937316
Email: n.w.fuller@stir.ac.uk

Research interview schedule

Note: This is a semi-structured interview/discussion format which provides overall guidance on the topics to be covered. The exact focus for each interview/discussion will be informed by the information provided during the interview by the participant. Language and terminology used will reflect that used by participants and therefore may differ from the terms used in this schedule.

Introduction

Introduce researcher and provide contact details – leave business card

Ensuring Consent

- Give participant copy of the participant consent form. Talk through each point. Ask if there are any questions
- Remind the participant that they can verify the ethical approval of the study.
- If consent confirmed then ask the participant to sigh both copies of the consent form and give one to them to keep and retain the other copy for the project files.

Thank the participant for their involvement and check how much time the participant has to conduct the interview/discussion.

Questions

1. How would you describe your personal experience of drug and alcohol addiction?

(prompt: definition of addiction/substance misuse; physical, psychological, social and spiritual impacts)

2. How would you describe your journey of recovery from addiction?

(prompt: timeframe, treatment programmes, the role of key individuals, approaches and practices)

3. What does spirituality mean to you in the context of your own life?

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(prompt: origins, significant people, meaning of spirituality)

4. In what ways has spirituality contributed to your addiction recovery journey?

(prompt: who has assisted with this process? What practices used?)

5. In what ways does your spiritual perspective help you understand your experiences with drugs or alcohol?

(prompt: Are there any ways in which drug and alcohol addiction can be associated with spiritual experiences?)

6. What are your thoughts about the relevance of spirituality in promoting addiction recovery?

(prompt: relevance to recovery treatment programmes, how to make accessible, practical, social, cultural and organisational factors)

Closing comments

- Is there anything further you would like to add that we have not covered already?

Other informants

- Are there other people you know who I should definitely try to talk to as part of this study?

Thank you

- Thank you for your participation in this study. Please contact me if you have any question arising form our conversation together. See contact details on card and consent form.

- Please let me know if you would like to add to or amend anything that you have said today and I shall be happy to do this

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Appendix M: Example NVivo IPA process: free coding using annotate

phase 2 analysis Nov 2017.nvp - NVivo Pro

FILE HOME CREATE DATA ANALYZE QUERY EXPLORE LAYOUT VIEW

Navigation View, Find, Quick Coding, Detail View (Workspace) · Dock All, Undock All, Close All, Docked, Bookmarks, Close, Zoom, Layout (Window) · List View (List View) · Coding Stripes, Highlight (Coding) · Annotations, See Also Links, Relationships (Links) · Node Matrix, Classification, Report (Detail View) · Previous, Next (Reference) · Color Scheme (Visualization)

Internals

Name	Nodes	Reference
2.1 Barry	90	176
2.2 Pete	85	129
2.3 Sean	75	135
2.4 Sam	87	150
2.5 Marti	43	63
2.6 Keith	76	161

2.1 Barry

Click to edit

Barry: Yeah, it wasn't like 'Right come on we're going.' it was like 'I want to go to, and can you put in the arrangements necessary' and staffing and it's all those things to weigh up staffing and de de de de de. And, but I went to many, many, and often with the students that were on the ward that I used to like talking to because they were very interested in everything and, you know, what was going on, so they would often be the people that would go. And I went to – it was in an AA meeting and I don't know what happened in this meeting, in the sense that there was nothing out of the ordinary, it was a very ordinary meeting. And all I remember was this guy shared his story in a very, very similar way to mine. Almost like the details were like that. And I don't know if you've ever been to 12-step meetings, but there's a very clear format. And this guy just talked and somehow I listened in some way and then he stopped talking and had come to the end and suddenly I jumped up and said 'I'm Barry and I'm and alcoholic!'. And everything changed from that point for me. Because I knew, I knew my problems with opiates, I knew that very well, but alcohol I had never quite accepted my, my problem with. And I said that in that meeting and everything changed for me, the next day. My mind-set, the way I thought, I used to listen to songs differently. I remember *I can't live without you*, Harry Neilson song: I would say I *can* live without you. I was doing things like this. I became very aware of nature. Very aware, we would go for walks and I'd be really aware of everything around me and in a kind of way of projecting that out onto other people, I became very challenging to people on the ward about their

Annotations

Item	Content
45	identifying a key moment of change - what s the relevance and significance of this?
46	change, when it comes affects all levels
47	the 'core' of addication beyond specific substances
48	shared identity through shared expereinces

NWF 87 Items Nodes: 90 References: 176 Read-Only Line: 245 Column: 47 100%

Appendix N: Example NVivo IPA process: initial coding using nodes

phase 2 analysis Nov 2017.nvp - NVivo Pro

Internals

Name	Nodes	Reference
2.1 Barry	90	176
2.2 Pete	85	129
2.3 Sean	75	135
2.4 Sam	87	150
2.5 Marti	43	63
2.6 Keith	76	161

2.1 Barry

Barry: Yeah, it wasn't like 'Right come on we're going.' it was like 'I want to go to, and can you put in the arrangements necessary' and staffing and it's all those things to weigh up staffing and de de de de de. And, but I went to many, many, and often with the students that were on the ward that I used to like talking to because they were very interested in everything and, you know, what was going on, so they would often be the people that would go. And I went to – it was in an AA meeting and I don't know what happened in this meeting, in the sense that there was nothing out of the ordinary, it was a very ordinary meeting. And all I remember was this guy shared his story in a very, very similar way to mine. Almost like the details were like that. And I don't know if you've ever been to 12-step meetings, but there's a very clear format. And this guy just talked and somehow I listened in some way and then he stopped talking and had come to the end and suddenly I jumped up and said 'I'm Barry and I'm and alcoholic!'. And everything changed from that point for me. Because I knew, I knew my problems with opiates, I knew that very well, but alcohol I had never quite accepted my, my problem with. And I said that in that meeting and everything changed for me, the next day. My mind-set, the way I thought, I used to listen to songs differently. I remember *I can't live without you*, Harry Neilson song: I would say I *can* live without you. I was doing things like this. I became very aware of nature. Very aware, we would go for walks and I'd be really aware of everything around me and in a kind of way of projecting that out onto other people, I became very challenging to people on the ward about their behaviour and what they were doing as well. So everything just seemed to change, but then there seemed to be something important that happened is that I went to an NA meeting on the Saturday morning and this guy shared this amazing share and he never once mentioned what drugs he used. He just talked about the impact and then about his recovery. And because it was very important at that time, I went up to him and said 'You never mentioned what drug you used, can you tell me what it was?' And he said, 'Yeah, it was Cannabis.' And that made me realise actually this isn't about the drug, this is about the person and the behaviour. Because everything he shared, I could really relate to, you know, because he just talked about his internal world. Now, I think what happened to me is two things in both of those experiences is I realised it wasn't about the drugs, you know, that addiction was something far bigger and it was about something within you, and also my sense of isolation had gone. Because I realised I wasn't the only person who had that experience. And, you know I would talk about those things, that was my spiritual awakening. I opened up to something, and I remember thinking, either I die at this point, because I was physically very unwell, or I give this a go. And I decided to give it a go. And I did, I went to a 12-step treatment centre away from London in Western Super Mare, Broadway Lodge, and that was the start, the start of it really that was the start. In that process, I was there six months and in that process you go through the 12-steps. And I just

Coding Density

change within the ordinary

Hierarchy of drug use

Nature

Addiction not about the drugs

12 step introduction in hospital

centrality of 12-step process

fellowship - shared expe

spiritual experiences i

transformative moments

NWF 87 Items Nodes: 90 References: 176 Read-Only Line: 245 Column: 47 100%

Appendix O: Example NVivo IPA process: three-stage linguistic, descriptive and interpretive coding process

Name	Sources	References	Created On	Created By	Modified On	Modified By
Barry - descriptive coding	0	0	6/6/2017 4:31 PM	NWF	6/6/2017 4:32 PM	NWF
Addiciton not about the drugs	1	4	6/9/2017 3:19 PM	NWF	6/13/2017 12:39 PM	NWF
addiction as disconnection	1	1	6/9/2017 3:17 PM	NWF	6/9/2017 3:17 PM	NWF
critique of maintream treatment	1	2	6/13/2017 1:00 PM	NWF	6/13/2017 6:49 PM	NWF
Drug use medicating pain	1	3	6/9/2017 2:44 PM	NWF	6/13/2017 12:58 PM	NWF
emotional and physical pain	1	4	6/13/2017 10:05 AM	NWF	6/13/2017 12:47 PM	NWF
explanatory framework	1	1	11/8/2016 2:25 PM	NWF	11/8/2016 2:25 PM	NWF
Hep C	1	4	6/13/2017 10:04 AM	NWF	6/13/2017 12:55 PM	NWF
Hierarchy of drug use	1	1	6/9/2017 2:43 PM	NWF	6/9/2017 2:45 PM	NWF
initiation to injecting drug use	1	2	6/9/2017 2:26 PM	NWF	6/13/2017 1:06 PM	NWF
lessons for treatment programmes	1	2	6/13/2017 1:05 PM	NWF	6/13/2017 1:06 PM	NWF
Opiates another way	1	2	6/9/2017 2:29 PM	NWF	6/13/2017 12:57 PM	NWF
Recovery	0	0	6/13/2017 9:37 AM	NWF	6/13/2017 9:37 AM	NWF
rejecting absolving of responsiblity fo	1	1	6/13/2017 12:40 PM	NWF	6/13/2017 12:40 PM	NWF
sub culture	0	0	6/13/2017 9:35 AM	NWF	6/13/2017 9:35 AM	NWF
substance use meets a spiritual need	1	1	6/9/2017 2:28 PM	NWF	6/9/2017 2:28 PM	NWF
twin themes - belonging and self-me	1	1	6/9/2017 2:47 PM	NWF	6/9/2017 3:18 PM	NWF
Working class roots	1	1	6/9/2017 2:39 PM	NWF	6/9/2017 2:39 PM	NWF
Barry - interpretive coding	0	0	11/8/2016 2:18 PM	NWF	6/6/2017 4:31 PM	NWF
isolation and identity	1	1	6/27/2017 10:49 AM	NWF	6/27/2017 10:50 AM	NWF
rebelion & self medication	1	2	6/27/2017 11:00 AM	NWF	6/27/2017 12:53 PM	NWF
Recovery	0	0	6/27/2017 11:07 AM	NWF	6/27/2017 11:07 AM	NWF
Spirituality and addiction	0	0	6/27/2017 10:27 AM	NWF	6/27/2017 10:27 AM	NWF
the seeds of addiction	0	0	6/20/2017 4:59 PM	NWF	6/20/2017 4:59 PM	NWF
Barry - linguistic coding	0	0	11/8/2016 2:17 PM	NWF	6/6/2017 4:30 PM	NWF

Appendix P: Example NVivo IPA process: initial coding using nodes

phase 2 analysis Oct 2017 - Copy.nvp - NVivo Pro

Nodes

Name	Sources	References	Created On	Created By	Modified On	Modified By
Spiritual dimensions of addiction	0	0	10/16/2017 8:07 AM	NWF	10/16/2017 8:07 AM	NWF
Spiritual quest	0	0	10/16/2017 7:48 AM	NWF	10/16/2017 7:48 AM	NWF
A healing path within	1	4	10/17/2017 12:37 PM	NWF	10/17/2017 1:01 PM	NWF
at peace with the past	1	1	6/13/2017 10:28 AM	NWF	10/17/2017 10:49 AM	NWF
drugs meet a spiritual need	1	2	6/27/2017 10:31 AM	NWF	6/27/2017 12:57 PM	NWF
finding fulfillment	1	3	6/13/2017 10:14 AM	NWF	10/17/2017 12:58 PM	NWF
Living recovery	0	0	10/17/2017 10:53 AM	NWF	10/17/2017 10:53 AM	NWF
Living well	1	4	10/16/2017 7:47 AM	NWF	10/17/2017 12:58 PM	NWF
mutual aid	1	1	6/13/2017 9:49 AM	NWF	10/17/2017 10:58 AM	NWF
12 step introduction in hospital	1	1	6/27/2017 1:17 PM	NWF	6/27/2017 1:18 PM	NWF
12-step residental rehab	1	1	6/13/2017 9:57 AM	NWF	6/13/2017 9:57 AM	NWF
centrality of 12-step process	1	1	6/13/2017 6:08 PM	NWF	6/13/2017 6:08 PM	NWF
effort to attend	1	2	6/13/2017 9:50 AM	NWF	6/13/2017 9:50 AM	NWF
fellowhsip - shared experience and	1	1	6/13/2017 9:55 AM	NWF	6/13/2017 9:55 AM	NWF
NA vs AA	1	1	6/13/2017 12:38 PM	NWF	6/13/2017 12:38 PM	NWF
shifting relationship with 12-step f	1	3	6/13/2017 12:35 PM	NWF	6/13/2017 12:36 PM	NWF
working the 12-steps	1	1	6/13/2017 12:27 PM	NWF	6/13/2017 12:27 PM	NWF
spiritual draw to recovery	1	3	6/27/2017 12:56 PM	NWF	6/27/2017 12:57 PM	NWF
Terms for God	1	3	6/13/2017 12:45 PM	NWF	6/13/2017 12:46 PM	NWF
transformative moments	1	3	6/13/2017 9:53 AM	NWF	10/17/2017 12:57 PM	NWF
Keith	0	0	6/6/2017 4:27 PM	NWF	6/6/2017 4:27 PM	NWF
Martin	0	0	6/6/2017 4:26 PM	NWF	6/6/2017 4:26 PM	NWF
Pete	0	0	11/8/2016 2:04 PM	NWF	11/8/2016 2:05 PM	NWF
Reflexive comments	0	0	11/8/2016 2:13 PM	NWF	11/8/2016 2:13 PM	NWF

NWF 8 items selected

Appendix Q: Example NVivo IPA process: three-stage linguistic, descriptive and interpretive coding process

phase 2 analysis Nov 2017.nvp - NVivo Pro

Nodes

Name	Sources	References	Created On	Created By	Modified On	Modified By
Drug stories	0	0	10/27/2017 10:59 AM	NWF	10/27/2017 10:59 AM	NWF
Embodiment of addiction	0	0	10/27/2017 9:48 AM	NWF	10/27/2017 10:07 PM	NWF
Emerging recovery	0	0	10/20/2017 11:09 AM	NWF	10/20/2017 11:09 AM	NWF
Mutual aid	1	3	9/5/2017 12:16 PM	NWF	9/5/2017 12:19 PM	NWF
12-step	0	0	10/13/2017 2:16 PM	NWF	10/13/2017 2:16 PM	NWF
12 step arose at the right time	1	1	10/10/2017 5:01 PM	NWF	10/10/2017 5:20 PM	NWF
genuine warmth of 12-step welcome	1	3	10/10/2017 5:20 PM	NWF	10/13/2017 3:16 PM	NWF
making amends	1	1	10/13/2017 2:27 PM	NWF	10/13/2017 2:28 PM	NWF
other 12-stepers inspirational	1	3	10/13/2017 2:17 PM	NWF	10/13/2017 2:50 PM	NWF
spiritual dimesions	0	0	10/13/2017 3:20 PM	NWF	10/13/2017 3:20 PM	NWF
growing spiritual practice	1	2	10/13/2017 3:27 PM	NWF	10/13/2017 3:40 PM	NWF
initial rejection of spiritual element	1	5	10/13/2017 2:20 PM	NWF	10/13/2017 2:26 PM	NWF
more comfortable with spirituality	1	2	10/13/2017 3:21 PM	NWF	10/13/2017 3:25 PM	NWF
spirituality essential for recovery	1	2	10/13/2017 3:30 PM	NWF	10/13/2017 3:32 PM	NWF
abstinence	1	5	9/5/2017 2:32 PM	NWF	9/5/2017 2:46 PM	NWF
continuing to use whilst attending NA	1	1	9/5/2017 12:20 PM	NWF	9/5/2017 12:20 PM	NWF
encouraging others to join	1	2	9/5/2017 3:08 PM	NWF	9/5/2017 3:23 PM	NWF
fellowship	1	3	9/5/2017 12:28 PM	NWF	9/5/2017 3:50 PM	NWF
God and spirituality	1	6	9/5/2017 12:26 PM	NWF	9/5/2017 2:49 PM	NWF
initial reluctance to accept abstinence	1	1	9/5/2017 12:17 PM	NWF	9/5/2017 12:18 PM	NWF
my drug use wasn't so bad	1	2	9/5/2017 12:25 PM	NWF	9/5/2017 3:20 PM	NWF
NA's not for everyone	1	1	9/5/2017 3:24 PM	NWF	9/5/2017 3:25 PM	NWF
social network through NA	1	3	9/5/2017 12:21 PM	NWF	9/5/2017 3:32 PM	NWF
there's hope	1	4	9/5/2017 2:17 PM	NWF	9/5/2017 3:20 PM	NWF
need to change	1	2	9/5/2017 12:13 PM	NWF	9/5/2017 2:36 PM	NWF
ORT	0	0	10/20/2017 11:13 AM	NWF	10/20/2017 11:13 AM	NWF

NWF 5 items selected

Appendix R: Example NVivo IPA process: emergent themes

phase 2 analysis Nov 2017.nvp - NVivo Pro

FILE | HOME | CREATE | DATA | ANALYZE | QUERY | EXPLORE | LAYOUT | VIEW

Workspace: Go, Refresh · Item: Open, Properties, Edit · Clipboard: Paste, Cut, Copy, Merge · Format · Paragraph · Styles: Reset Settings · Editing: Select, PDF Selection, Text, Region, Find, Insert, Replace, Delete · Proofing: Spelling

Nodes

- Nodes
- Cases
- Relationships
- Node Matrices

- Sources
- **Nodes**
- Classifications
- Collections
- Queries
- Reports
- Maps
- Folders

Nodes

Name	Sources	References	Created On	Created By	Modified On	Modified By
Emerging themes	0	0	10/31/2017 1:15 PM	NWF	10/31/2017 1:15 PM	NWF
cravings and recovery	1	1	7/25/2017 2:43 PM	NWF	7/25/2017 2:45 PM	NWF
Death & Resurrection	0	0	10/31/2017 1:15 PM	NWF	10/13/2017 5:22 PM	NWF
Drug stories	0	0	10/27/2017 10:59 AM	NWF	10/27/2017 10:59 AM	NWF
Embodiment of addiction	0	0	10/27/2017 9:48 AM	NWF	10/27/2017 10:07 PM	NWF
Emerging recovery	0	0	10/20/2017 11:09 AM	NWF	10/20/2017 11:09 AM	NWF
escapism, experimentation & drugs	0	0	10/27/2017 12:03 PM	NWF	10/27/2017 12:03 PM	NWF
Identify & peers	0	0	10/24/2017 12:00 PM	NWF	10/24/2017 12:00 PM	NWF
Identity & purpose	0	0	10/20/2017 3:35 PM	NWF	10/24/2017 11:07 AM	NWF
lessons for Recovery	1	2	10/31/2017 1:15 PM	NWF	10/17/2017 1:02 PM	NWF
Origins	0	0	10/20/2017 3:39 PM	NWF	10/20/2017 3:39 PM	NWF
Pain shame & anguish	0	0	10/31/2017 1:15 PM	NWF	10/31/2017 1:21 PM	NWF
personal transformation	0	0	10/27/2017 11:02 AM	NWF	10/27/2017 11:02 AM	NWF
polarities	0	0	10/27/2017 11:55 AM	NWF	10/27/2017 11:55 AM	NWF
Recovery tales	0	0	10/20/2017 3:36 PM	NWF	10/20/2017 3:36 PM	NWF
Social contexts	0	0	10/31/2017 1:15 PM	NWF	10/16/2017 7:52 AM	NWF
Spiritual dimensions of addiction	0	0	10/31/2017 1:15 PM	NWF	10/16/2017 8:07 AM	NWF
Spiritual perspectives	0	0	10/27/2017 11:01 AM	NWF	10/27/2017 11:01 AM	NWF
Spiritual quest	0	0	10/31/2017 1:15 PM	NWF	10/16/2017 7:48 AM	NWF
Spirituality	0	0	10/24/2017 11:57 AM	NWF	10/24/2017 11:57 AM	NWF
The grip of addiction	1	1	10/3/2017 11:10 AM	NWF	10/3/2017 11:11 AM	NWF
the past is my teacher	1	1	7/17/2017 7:54 AM	NWF	10/27/2017 10:06 PM	NWF
the spiritual life	1	3	10/27/2017 12:00 PM	NWF	10/27/2017 12:00 PM	NWF
Understanding addiction	0	0	10/17/2017 4:39 PM	NWF	10/20/2017 11:12 AM	NWF
Weakness & vulnerability	0	0	10/27/2017 10:58 AM	NWF	10/27/2017 10:58 AM	NWF
Reflexive comments	0	0	11/8/2016 2:13 PM	NWF	11/8/2016 2:13 PM	NWF
tentative cross-case themes	0	0	3/29/2017 3:28 PM	NWF	3/29/2017 3:28 PM	NWF

NWF 24 items selected

Appendix S: Matrix of themes, Phase One

Phase One themes	
Superordinate themes	**Themes**
The Spiritual Quest	We're spiritual because we're human
	Connection with a source of power
	Questions were the journey: the search for meaning & purpose
	The hungry ghost: the shadow side of the spiritual quest
Addiction Narratives: from initiation to rock bottom	A million and one reasons why
	The downward spiral
	Identity and roles in addiction
	Rock bottom
I Have My Life Back: the road to recovery	Personal experiences of recovery
	Roles, identities and relationships
	Beyond recovery
Supporting Recovery and Delivering Treatment	The tapestry of recovery
	Love is the key to all healing
	Recovery & community
	Pass the parcel: the politics of recovery
The Spiritual Journey of Recovery	The inner journey
	Spirituality in recovery programmes

Appendix T: Matrix of themes, Phase Two

Phase2 themes		
Superordinate themes	**Themes**	**Sub-themes**
Myths and Archetypes	The Past is my Teacher	
	Spiritual Guidance	
	Transformational Stories	
	Archetypes	
Darkness and Light		
The Darkness	The Spiritual Void	Disconnection and Otherness
		Inferiority and Inadequacy
		Social Deprivation
	The 'Disease' of Addiction	Peer Groups and Social Dimensions
		Progression of Substance Use
		The 'Disease' Model
	Proximity of Death	Deteriorating Mental Health
		Suicidality
		Physical Risks and Legacy
The Light	The Spiritual Quest	Glimpsing the Numinous
		The Golden Thread
	Spiritual Awakening	Spiritual Awakening
		Surrender to a Higher Power
		Encountering myself
	Living Spiritually	Spiritual Continuum
		Practice and Discipline
		Eclecticism
		Connection
		A Continuing Search
Lessons for recovery		

Appendix U: Matrix of themes, combined phases

Combined themes (numbers in parenthesis indicate relevant study phase)		
Superordinate themes	**Themes**	**Sub-themes**
Myths and Archetypes (2)	The Past is my Teacher (2)	
	Spiritual Guidance (2)	
	Transformational Stories (2)	
	Archetypes (2)	
	Darkness and Light (2)	
The Darkness (2)	The Hungry Ghost: The Shadow Side of the Spiritual Quest (1) The Spiritual Void (2)	Disconnection and Otherness (2)
		Inferiority and Inadequacy (2)
		Social Deprivation (2)
	The ‘Disease’ of Addiction (2) A Million and One Reasons Why (1) The Downward Spiral (1) Rock Bottom (1)	Identity and Roles in Addiction (1) Peer Groups and Social Dimensions (2)
		Progression of Substance Use (2) Addiction Narratives: From Initiation to Rock Bottom (1)
		The ‘Disease’ Model (2)
	Proximity of Death (2)	Deteriorating Mental Health (2)
		Suicidality (2)
		Physical Risks and Legacy (2)
The Light (2)	The Spiritual Quest (1) The Spiritual Quest (2)	We're Spiritual Because We’re Human (1)
		Connection with a Source of Power (1) Glimpsing the Numinous (2)
		The Golden Thread (2) Questions Were the Journey: The Search for Meaning & Purpose (1)
	Spiritual Awakening (2) The Spiritual Journey of Recovery (1)	Spiritual Awakening (2)
		Surrender to a Higher Power (2)
		Encountering Myself (2) The Inner Journey (1)
	I Have My Life Back: The Road to Recovery (1)	Personal Experiences of Recovery (1)
		Roles, Identities and Relationships (1)
	Beyond Recovery (1) Living Spiritually (2)	Spiritual Continuum (2)
		Practice and Discipline (2)
		Eclecticism (2) The Tapestry of Recovery (1)
		Connection (2)
		A Continuing Search (2)
Lessons for recovery (2) Supporting Recovery and Delivering Treatment (1)	Love Is the Key to All Healing (1)	
	Recovery & Community (1)	
	Pass the Parcel: The Politics of Recovery (1)	
	Spirituality in Recovery Programmes (1)	

Appendix V: Ethics approval letter, SREC

JP/SG

04 April 2013

UNIVERSITY OF STIRLING

SCHOOL OF
NURSING, MIDWIFERY
AND HEALTH

Email: nursingmidwifery@stir.ac.uk
Web: www.nm.stir.ac.uk

John Paley
Chair
School Research Ethics Committee

School of Nursing, Midwifery and Health
University of Stirling
Stirling FK9 4LA

Tel: +44 (0) 1786 466399
Fax: +44 (0) 1786 466333
Email: john.paley@stir.ac.uk

Nicholas Fuller
PhD Student
School of Nursing, Midwifery and Health
University of Stirling
Stirling
FK9 4LA

Dear Nicholas

The relevance and significance of spirituality in drug and alcohol addictions and recovery from addiction: an exploratory qualitative study

Thank you for submitting your proposal to SREC and responding to queries and clarifications.

I can now confirm the study has now been approved.

May I take this opportunity to remind you that a site-file of *all* documents related to the research should be maintained throughout the life of the project, and kept up to date at all times. The site file template can be found on the SREC page of the School's website. Please bear in mind that your study could be audited for adherence to research governance and research ethics protocols.

Yours sincerely

John Paley
(Chair)
School of Nursing, Midwifery and Health Research Ethics Committee

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The University of Stirling is recognised as a Scottish Charity with number SC 011159

Appendix W: Ethics approval letter, NHS

Amended 23/09/2013

EoSRES

Research Ethics Service

East of Scotland Research Ethics Service (EoSRES) REC 1
Tayside Medical Sciences Centre (TASC)
Residency Block C, Level 3
Ninewells Hospital & Medical School
George Pirie Way
Dundee DD1 9SY

Mr Nicholas Fuller
Research Student/Alcohol Primary Care Facilitator
NHS Tayside
The Wishart
50 Constable Street
Dundee DD4 6AD

Date:	18 September 2013
Your Ref:	
Our Ref:	LR/**13/ES/0083**
Enquiries to:	Mrs Lorraine Reilly
Direct Line:	01382 383878
Email:	eosres.tayside@nhs.net

Dear Mr Fuller

Study Title:	**The relevance and significance of spirituality in drug and alcohol addictions and recovery from addiction: an exploratory qualitative study.**
REC reference:	**13/ES/0083**
IRAS project ID:	**119176**

Thank you for your letter of 06 September 2013, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

We plan to publish your research summary wording for the above study on the NRES website, together with your contact details, unless you expressly withhold permission to do so. Publication will be no earlier than three months from the date of this favourable opinion letter. Should you wish to provide a substitute contact point, require further information, or wish to withhold permission to publish, please contact the Co-ordinator Mrs Lorraine Reilly, lorraine.reilly@nhs.net.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Ethical review of research sites

Non-NHS sites

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission ("R&D approval") should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements.

Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at http://www.rdforum.nhs.uk.

Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of approvals from host organisations

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	Version	Date
Evidence of insurance or indemnity		05 September 2013
Interview Schedules/Topic Guides	2	27 March 2013
Interview Schedules/Topic Guides	2	27 March 2013
Investigator CV		
Investigator CV		
Letter from Sponsor		12 June 2013
Letter of invitation to participant	2	27 March 2013
Other: UREC Approval		04 April 2013
Other: Non NHS SSI Form - Cair Scotland		03 July 2013
Other: Non NHS SSI - Wishart Centre		03 July 2013
Participant Consent Form: with highlighted changes	3	04 September 2013
Participant Information Sheet: interview - professionals - addictions & spirituality with highlighted changes	3	04 September 2013
Participant Information Sheet: interview - service users & relatives with highlighted changes	3	04 September 2013
Participant Information Sheet: service users with highlighted changes	3	04 September 2013
Participant Information Sheet: focus group - Professionals with highlighted changes	3	04 September 2013
Protocol		27 February 2013
REC application		25 June 2013
Response to Request for Further Information		06 September 2013

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Reporting requirements

The attached document *"After ethical review – guidance for researchers"* gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

Feedback

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

Further information is available at National Research Ethics Service website > After Review

13/ES/0083:	***Please quote this number on all correspondence***

We are pleased to welcome researchers and R & D staff at our NRES committee members' training days – see details at http://www.hra.nhs.uk/hra-training/

Yours sincerely

pp
Dr Carol Macmillan
Chair

eosres.tayside@nhs.net

Enclosures: "After ethical review – guidance for researchers"

Copy to: Carol Johnstone, University of Stirling
Ms Liz Coote, NHS Tayside

Appendix X: University sponsor letter

UNIVERSITY OF STIRLING

STIRLING FK9 4LA SCOTLAND

Carol Johnstone
Research Development Manager
RESEARCH & ENTERPRISE OFFICE
Tel: 01786 466690
Fax: 01786 466688
E-mail: carol.johnstone@stir.ac.uk

12 June 2013

To Whom It May Concern:

Research Study: The relevance and significance of spirituality in drug and alcohol addictions and recovery from addiction: an exploratory qualitative study

I am pleased to confirm that the University of Stirling will undertake the role of sponsor as outlined in the Research Governance Framework for Health and Community Care for the project entitled "The relevance and significance of spirituality in drug and alcohol addictions and recovery from addiction: an exploratory qualitative study", Chief Investigator Nicholas Fuller, School of Nursing, Midwifery and Health, University of Stirling.

Yours sincerely

Carol Johnstone
Research Development Manager

Appendix Y: University indemnity letter

STIRLING FK9 4LA SCOTLAND

Carol Johnstone
Business Development Manager
RESEARCH & ENTERPRISE OFFICE
Tel: (01786) 466690
Fax: (01786) 466688
E-mail: carol.johnstone@stir.ac.uk

12 June 2013

To whom it may concern

Research Study: The relevance and significance of spirituality in drug and alcohol addictions and recovery from addiction: an exploratory qualitative study

This study is included in the following cover put in place by Aon Ltd. These policies are renewed annually and the current period of insurance is 1 August 2012 – 31 July 2013.

I confirm that the following cover is in place under the Professional Indemnity policy of the University of Stirling. This policy provides indemnity to University of Stirling for legal liability to third parties arising from breach of professional duty due to neglect, error or omission in the course of the business of the University of Stirling.

The limit of the Professional Indemnity cover is £5,000,000 for any one event and in aggregate in any one period of insurance.

In addition the University carries Public Liability cover in respect of its Legal Liability for accidental loss of or damage to Third Party property or for death, injury, illness or disease arising out of the business of the University of Stirling, including liability arising from goods sold or supplied.

The limit of the Public Liability cover is £20,000,000 any one incident and in the aggregate of Products.

I trust that this is sufficient for your requirements. Please however do not hesitate to get in touch with me should you have any queries.

Yours sincerely

Carol Johnstone
Research Development Manager

The University of Stirling is a charity registered in Scotland, number SC 011159