Fiona Robson *2006*

The Role of Faith, Religion and Spirituality in Overcoming Problematic Substance Use

This Thesis, submitted for the degree of Doctorate in Clinical Psychology, is based upon work conducted by the author in the Department of Clinical Psychology at the University of Leicester mainly during the periods between September 2005 and June 2006. All work recorded in this Thesis is original unless otherwise acknowledged in the text or by references. None of the work has been submitted for another degree in this or any other University.

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With what misgivings we turn our lives over to God, imagining somehow that we are about to lose everything that matters. Our hesitancy is like that of a tiny shell on the sea shore, afraid to give up the teaspoonful of water it holds lest there not be enough in the ocean to fill it up again. Lose your life, said Jesus, and you will find it. Give up, and I will give you ALL. Can the shell imagine the depth and plenitude of the ocean? Can you and I fathom the riches, the fullness of God's love?

Elisabeth Elliot.

- Whatever is of merit here, may it be to the glory of God whom I believe inspired the project and sustained me through the journey, teaching me many valuable, if sometimes painful, lessons in the process.

- Thank-you to those who so generously shared their stories in the interviews. I pray that God may guard and guide you on the road ahead.

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- To my neglected friends, I thank-you for your understanding and I hope for plenty of opportunities in the years ahead to restore lost time.

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THESIS ABSTRACT

Problematic substance use represents a significant issue within the UK in terms of its impact upon the psychological and physical well being of individuals, their families and wider society. The current thesis considered the role of faith, religion and spirituality in overcoming problematic substance use.

Literature review

The current literature review considered the role of meditation, as an example of a spiritual practice, in overcoming problematic substance use. A range of theoretical rationale for the role of meditation are explored and empirical studies considering Transcendental and Mindfulness meditation examined. Some studies indicated an association between meditation and reductions in substance use however, this has not been universal and firm conclusions are limited by methodological weaknesses.

Research report

The current qualitative study sought to explore the role of faith/religion/spirituality in overcoming problematic substance use through semi-structured interviews with eight participants.

A grounded theory approach generated a process model, which conceptualised the development of problematic substance use as a process of restriction and the journey of overcoming this as one of elaboration, including for some, the development of a pre-existing faith. The model appeared to reflect generic models of change, suggesting that there may be common pathways to change independent of the precise elements involved.

Religion, faith and spirituality, including engagement with faith communities, appeared to offer a range of resources and address a number of functions previously served by substance use. Additionally it appeared these factors countered potential vulnerability factors for substance use. A number of elements identified in the study may be more broadly applicable to clients overcoming problematic substance use, such as the development of meaning and purpose in life.

Critical Appraisal

The research process and the author's personal journey were reviewed. A significant issue for consideration was the author's perspective as a person of faith.

(Word count: 299)

Section A). Literature Review

A Consideration of the Role of Meditation in Overcoming Problematic Substance Use.

Target Journal – Addiction Research & Theory
(Please refer to Appendix A for Instructions for Authors).

Literature review search strategy

The literature reviewed was identified through a search of the databases: PsychINFO and MEDLINE, along with the Library Catalogue of Leicester University. A range of search terms were used focusing upon: alcohol/drug/substance abuse/misuse/use, addiction, alcoholism and meditation, Mindfulness meditation, altered states of consciousness and Buddhism. Searches were limited to articles written in the English language. A snowballing technique was used to follow up references and ideas that appeared to be of particular relevance. Where unpublished information was cited attempts were made to contact the authors. Professionals working in the field of problematic substance use were also consulted.

Literature review abstract

Problematic substance use represents a significant issue within the UK in terms of its impact upon the psychological and physical well being of individuals, their families and wider society. The current literature review considers the role of meditation in overcoming problematic substance use. A range of theoretical rationales for the role of meditation are considered, for example the influences on postulated common denominators and potential indirect effects. The current review highlights that studies considering Transcendental meditation and Mindfulness meditation have sometimes indicated an association with reductions in substance use. This has not however, been universal and outcomes have not always been maintained. Even with more rigorous studies there would appear to be a range of methodological issues, limiting the conclusions that can be drawn. These include problems with excluding expectation effects and also motivation as a potential confounding variable.

(Word count: 142)

Keywords: Meditation, Mindfulness, Problematic Substance Use, Spirituality, Treatment.

LITERATURE REVIEW:

A CONSIDERATION OF THE ROLE OF MEDITATION IN OVERCOMING PROBLEMATIC SUBSTANCE USE.

1. Introduction

Problematic substance use represents a significant issue within the United Kingdom in terms of its impact upon the psychological and physical well being of individuals (DoH, 1995; World Health Organisation, 2001; Home Office, 2002) their families (Adfam, 2004) and wider society (Home Office, 2002). It may be defined as any pattern of substance use, that is drug or alcohol use, leading to significant physical, psychological, or social harm. While this definition is tautological, alternative terminologies such as substance abuse/misuse, alcoholism, addiction and recovery can carry connotations not necessarily implied here, such as moral and disease models of substance use. However this terminology will be used where relevant in referring to the existing literature.

Spirituality has sometimes been associated with overcoming problematic substance use for example, in some instances of spontaneous remissions[1] individuals attribute spiritual and religious factors as having been important (Tuchfeld, 1981; Ludwig, 1985). Additionally a range of spiritual and religious intervention approaches to problematic substance use have been developed. For example one international approach, Alcoholics Anonymous (AA), classifies itself as a 'spiritual program and a

[1] Spontaneous remissions refer to the overcoming of problematic substance use without recourse to formal interventions.

spiritual way of life' (AA, 1972). The basic tenets of this approach drew upon religious as well as medical ideas (AA, 1981) and are now referred to as the twelve steps. This 12-step model has also been applied more broadly, for instance to narcotic and cocaine use.

The concept of spirituality has proved difficult to encapsulate within a single agreed definition (Cook, 2004). Cook (2004) proposed a working definition of spirituality as: 'a distinctive, potentially creative and universal dimension of human experience arising both within the inner subjective awareness of individuals and within communities, social groups and traditions. It may be experienced as relationship with that which is intimately 'inner', immanent or personal, within the self and others, and/or as relationship with that which is wholly 'other', transcendent and beyond the self. It is experienced as being of fundamental or ultimate importance and is thus concerned with matters of meaning and purpose in life, truth and values' (p.548-549). Reflecting the notion of universality, Miller and Thoresen (1999) note that spirituality may be regarded as 'multi-dimensional space in which every individual can be located' (p.6). A British survey has revealed an increased acknowledgement of spiritual/religious experiences (Hay & Hunt, 2000). There also appears to be a growing recognition of spiritual dimensions within Health Care, for example the role of spiritual care has been recognised by the current Secretary of State for Health (Waterman, 2005).

Miller (1998) has suggested that spirituality represents a multi-dimensional concept, including the dimension of spiritual practices, such as meditation (Miller, 2002).

Meditation is espoused by the 12-step model, encapsulated within the eleventh step (AA, 1981). It has also been considered as a form of complementary or alternative therapy and was found to represent one of the top three complementary/alternative therapies used in a USA survey of drug users (Manheimer *et al.*, 2003). Considering the research relating to complementary approaches in the problematic substance use field, the Department of Health highlighted that service users often rate complementary therapies positively and this may facilitate client retention, as for example with acupuncture (NTA, 2002). A particular form of meditation, Mindfulness meditation, has been applied in combination with Cognitive Therapy in the field of mental health (Teasdale *et al.*, 1995) and other Mindfulness techniques have been incorporated into the broader treatment approach of Dialectical Behaviour Therapy (DBT), which has been used to address problematic substance use (Linehan *et al.*, 2002).

Meditation may promote physical and mental well-being. For example, the practice of Transcendental Meditation appears to be associated with reductions in heart and respiration rate (West, 1979), and long-term follow up studies have demonstrated a reduction in blood pressure amongst hypertensive patients (Shapiro, 1978). It may also serve to reduce anxiety and promote subjective feelings of relaxation (Shapiro & Gilbert, 1978; West, 1979). Mindfulness-based stress reduction, of which Mindfulness meditation forms a key part, appears to have beneficial effects in terms of addressing physical and mental health difficulties such as chronic pain (Kabat-Zinn, 1982), anxiety disorders and eating disorders (Breslin *et al.*, 2002).

Miller (1997) notes that research into spirituality and addictions represents a relatively new field. However it appears that there is a significant volume of writing around this area and studies in inter-related areas, such as that concerning the 12-step approach. Miller (2002) suggested a number of dimensions to the concept of spirituality. These dimensions (adapted from Miller, 1998, 2002) are given below.

- **Engagement in spiritual practices or behaviours**
  (e.g. meditation, prayer and worship).
- **Spiritual beliefs**
  (e.g. regarding a deity or the interrelatedness of living beings).
- **Spiritual values and motivations**
  (e.g. karma, duty to God).
- **Spiritual experiences**
  (e.g. mystical experiences, a sense of God's presence).

Given the apparent breath of writing relating to spirituality and addictions the current review has selected to focus upon meditation, as one example within a dimension of spirituality, and its role in overcoming problematic substance use. Broad categories of meditation will firstly be outlined before examining the theoretical rationale for a role for meditation in overcoming problematic substance use. Much of the empirical research in this area has been conducted in the USA; one study reviewed using Transcendental Meditation was conducted in Sweden (Bräutigam, 1978), the remainder of studies considered were from the USA. The review focuses upon those studies considering substance use outcomes directly and examines the limitations of the research in this area to date. Broader psychological changes in response to meditation have been indicated (Shapiro & Walsh, 2003) and these may be related to

substance use outcomes, however detailed consideration is beyond the scope of the current review. The relatively well developed literature concerning Transcendental Meditation will firstly be examined before considering more recent studies addressing the role of Mindfulness meditation. Other types of meditation have been applied in the field of problematic substance use (e.g. Niederman, 2003), however studies considering substance use outcomes were not identified. Finally, common methodological limitations and issues relating to the implementation of meditation as an intervention will be explored.

2. Meditation

A variety of forms of meditation practice have emerged (West, 1979). Kus (1995) distinguished 'reflective' and 'centering' forms of meditation. Meditation as reflection may be considered as a form of contemplation, for example mulling over a particular saying or text. This form of meditation has been suggested to be common within the 12-step tradition (Kus, 1995). Studies focusing upon reflective forms of meditation were not identified by the current review. However, this form of meditation could be conceptualised as a form of cognitive restructuring, as has been applied to the use of 12-step slogans (Steigerwald and Stone, 1999). In centering meditation, attention is focused upon a particular event, such as breathing, or an object or sound. Transcendental Meditation (TM) represents an example of this form of meditation. A mantra may be silently repeated as individuals sit with their eyes shut (West, 1979). While the mantra is to be favoured, West (1979) suggested that other thoughts do not need to be prevented. A third form of meditation is Mindfulness meditation (Marlatt & Kristeller, 1999). Also referred to as insight or Vipassana

meditation, sensations, thoughts and emotions are allowed to enter and leave consciousness with awareness but without initiating a psychological reaction (Alterman *et al.*, 2004; Marlatt & Kristeller, 1999). Alterman *et al.* (2004) suggested that in practice, concentrative forms of meditation and Mindfulness meditation may be similar in their effect. Marlatt and Kristeller (1999) also note a number of points of commonality between the two forms. They suggest that both forms of meditation raise awareness of mental content from a detached perspective and both provide experience of the impermanent and ever changing nature of perceived reality. In addition, Transcendental and Mindfulness meditation are both originally derived from religious/spiritual traditions (Marlatt and Kristeller, 1999; Smith, 1994).

3. Theoretical rationale for the role of meditation in overcoming problematic substance use

3.1. Anxiety

One theoretical rationale for proposing that meditation may facilitate the overcoming of problematic substance use lies in the postulated common denominator of anxiety. The tension-reduction hypothesis concerning alcohol use posits that alcohol consumption is reinforced through the tranquilizing effects of alcohol. Consistent with this, negative emotional states such as anxiety have been associated with relapse across a range of addictive behaviours including alcohol use (Marlatt, 1985). Considering other substances, Wong *et al.* (1981) postulated that substance users may be divided into 'hedonistic users' and 'therapeutic users' and cited evidence that the latter appear to use drugs such as barbiturates for tension relief.

Meditation is considered to produce a deep state of relaxation (Atkinson *et al.*, 1993) and has been used to address anxiety disorders (Breslin *et al.*, 2002). Parker *et al.* (1978) suggested two mechanisms by which relaxation techniques, including meditation, may address excessive alcohol use in accordance with the tension-reduction hypothesis. They suggested that relaxation techniques may provide a substitute means of lowering levels of arousal. Alternatively, they considered that relaxation techniques may act to make alcohol use less reinforcing through inducing a generally lowered state of arousal.

While substances such as alcohol may be used in anticipation of tension reduction amongst some groups (Orford *et al.*, 2004) the relationship between alcohol and anxiety appears complex and it has not always been found to have an anxiolytic effect (Wilson, 1988). There is also some variability in findings concerning the relationship between meditation and anxiety (Klajner *et al.*, 1984). Klajner *et al.* (ibid), suggested that evidence relating to anxiety responses to specific stressors has been more consistent and indicates a beneficial effect for meditation. Studies using controlled stressors may however lack ecological validity.

3.2. Managing negative affect

It has been recognised that a broader range of negative affect states, rather than just anxiety, may precipitate substance use (Gorsuch & Butler, 1976) and relapse (Marlatt, 1985). Anecdotally, individuals receiving meditation training have referred to the use of meditation techniques to help them manage negative affect states such as anger and frustration (Niederman, 2003). Marlatt (2002) suggested that

Mindfulness meditation promotes acceptance of the impermanence of all subjective experiences. Given that substance use may represent an attempt to manipulate hedonic tone (Brown, 1997), insight into the ever changing nature of subjective states may, according to Marlatt (2002), relieve the need for such manipulation attempts.

3.3. Increased perceived control

Klajner *et al.* (1984) make reference to an idea posited by Marlatt (1976, cited in Klajner *et al.*, 1984) that, rather than alcohol being consumed for its tranquillizing effects, it may be reinforcing in times of high stress because it induces an increased sense of control over stressors in the absence of alternative coping strategies. Klajner *et al.* (ibid) applied this idea to suggest that relaxation techniques may theoretically reduce substance use through promoting an increased perception of personal control. They indicated that increased perceived control as a reinforcing factor may explain the finding that relapse to substance use is sometimes related to interpersonal conflicts (Marlatt, 1985). Expectancy effects of anxiety reduction would also however be a possible explanatory factor. There is some evidence that meditation is related to an increase in perceived control, but this has not consistently been found (Klajner *et al.*, 1984).

3.4. Altered states of consciousness

Altered states of consciousness (ASC) have been defined as 'any mental state(s) ... which can be recognized ... as representing a sufficient deviation in subjective experience or psychological functioning from certain general norms for that

individual during alert, waking consciousness' (Ludwig, 1966, p.235). According to Weil (1972, cited in McPeake *et al.*, 1991), the desire to experience altered states of consciousness represents a universal human motive.

It may be posited that a similar function/goal attracts individuals to both substance use and meditation. Some studies considering meditation and substance use have found that populations who have independently elected to engage in meditation, or in sects practicing meditation, have a higher than average proportion of individuals with a history of substance use. Shaffi *et al.* (1974) for example found that, amongst the meditators recruited to their study, 69% used marijuana (Cannabis) prior to taking up TM in contrast to only 51% of yoke peer control participants. Shaffi *et al.* (ibid) note that the latter proportion is consistent with general surveys of USA college populations at that time. A common function/goal of achieving an ASC may be common to both substance use (McPeake *et al.*, 1991) and meditation (Marcus, 1974). Participants in some studies of meditation have reported attaining altered states of consciousness (e.g. Murphy *et al.*, 1986). Meditation may then represent an alternative means of achieving an ASC, reducing the need for substance use when it serves this purpose.

3.5. Managing impulses/cravings

Alterman *et al.* (2004) highlighted the role of Mindfulness meditation in promoting a decoupling between impulses and action, so that action is not automatically dictated by impulse. Groves and Farmer (1994) suggested that such mindfulness leaves an individual more able to choose how to respond to impulses, including triggers for

cravings. With a decoupling between impulse and action, impulses may be responded to differently. Groves and Farmer (ibid) argued that a different response may reduce or prevent the craving and weaken the habitual response of craving to such triggers. Marlatt *et al.* (2004) described this as form of counter-conditioning.

3.6. Global self-development

Gelderloos *et al.* (1991) have suggested that TM may influence a range of factors underlying substance use, rather than solely one area, including psychological distress, limited coping resources and neurotransmitter imbalances. In common with a number of authors they have highlighted that TM primarily represents a tool for personal development. Any benefits in terms of reductions in substance use may therefore represent a significant side-effect (Marcus, 1974). Clements *et al.* (1988) considered that drug abuse occurs due to an inability to address needs and desires in an adaptive manner. They argued that TM promotes an overall and stable state of well-being, removing the need and urge to use drugs.

3.7. Indirect influences of meditation: Revised social norms/identity and time alternate activity.

It has been suggested that meditation groups may offer a new cultural group (Ganguli, 1985). As a cultural group, communities of meditators may provide revised social norms that discourage substance use through social pressure and disapproval (West, 1979). Consistent with this there is some evidence of an anti-substance use culture within TM circles: Benson & Wallace (1978) found that views shifted with TM practice amongst those attending two training centres. While a

majority of the population studied reported condoning or encouraging substance abuse prior to taking up meditation, after beginning to practice meditation, most of these individuals discouraged substance use. Marcus (1974) additionally considered that TM may provide a new *social* role of being a meditator.

Meditation may also represent a time alternative activity to substance use. Long term follow-up studies of individuals with problematic alcohol use have identified the development of substitute dependencies as a factor in continued abstinence (Valliant & Milofsky, 1982). For some, this has included the development of alternative hobbies or work (Valliant & Milofsky, ibid).

3.8. Summary

Meditation has been postulated to address a range of factors that may be related to substance use. It has been suggested that it may have an impact upon levels of substance use when this relates to tension-reduction attempts, through replacing or reducing the arousal lowering effects of some substances. The relationship between anxiety and substance use is however complex and studies considering meditation and anxiety have not always produced consistent findings. Substance use has also been related to a broader range of negative affect states. It has been suggested that meditation may promote tolerance of such affect states through raising awareness of the impermanent nature of all subjective states. Anecdotally individuals have reported a beneficial effect of meditation in managing a range of negative affect states. As an alternative to the tension-reduction hypothesis it has been postulated that alcohol may be reinforcing as a result of increasing a perceived sense of control

at times of high stress. Evidence of increased perceived control with meditation has been found, which according to this hypothesis would suggest it could replace substance use, but not in all studies. Meditation could also be considered to provide a means of attaining an ASC which may previously have been sought through substance use. The desire to experience ASCs has been described as universal and ASCs have been reported by meditators. Meditation may also assist in the management of cravings. Mindfulness meditation has been considered to decouple impulses and actions allowing alternative behaviours to be developed and counter-conditioning to be experienced. Meditation may have a more global development role which impacts upon substance use, influencing a range of underlying factors. Meditation could have a more indirect effect through providing a time alternative activity and, when engaged in on a group basis, a new social community. The development of time alternative activities has been found to be associated with abstinence and there is evidence that TM circles discourage substance use suggesting that these may offer a revised social norm.

4. Research review

4.1. Transcendental Meditation (TM)

There is a relative wealth of research concerning Transcendental Meditation and substance use and a number of reviews, on a range of research studies, were identified by the current author. The most recent review to date explored the effectiveness of TM in criminal behaviour as well as substance abuse recovery (Hawkins, 2003) and included twenty-five studies concerning substance abuse. It was concluded that the TM program was associated with a significant reduction in

substance use, however while some limitations of the studies were noted in tabulated format, these were not discussed in detail nor their implications considered. For instance, it was indicated that some participant groups were highly motivated and already committed to TM and the absence of a control group in some studies was highlighted. The use of already established TM meditators was an issue across many of the studies (e.g. Benson and Wallace, 1978). The substance use of such populations is not necessarily problematic. Additionally the requirement for TM courses that participants abstain from drug use for a period of 15 days prior to commencing meditation, would appear to preclude drug dependent participants (West, 1979). Furthermore West (ibid), argued that those who continue with TM may be a biased population not representative of those who drop out and equally, it may be argued those who never independently select to take up TM (Marcus, 1974). Because of such sample biases, there may be an over-representation of individuals more motivated to reduce substance use, without intervention, amongst those continuing to practice TM, representing a confounding factor. For example, Benson and Wallace (1978) conducted a large survey of participants from two TM training courses, who had been practising for at least three months. While a decline was found in the frequency of use of all substances considered (which included marihuana, narcotics and 'hard liquor'), some participants continued to use substances. Amongst those who continued substance use over half had been irregular meditators and approximately a quarter had stopped meditation practice for a week or more. This would be consistent with TM influencing substance use but also alternatively with levels of motivation determining both the frequency of meditation and substance use. The absence of a control group with random

assignment to conditions limits exclusion of motivation as a confounding factor. A further difficulty with surveys of already established TM meditators arises if they are in contact through attendance at TM groups, as demand characteristics may influence responses (Marcus, 1974). As previously noted, there may be a generally anti-drugs culture within TM circles. A further limitation noted across some studies by Hawkins (2003) was the use of a retrospective design. This sometimes required participants to recall patterns of substance use over a two year period (e.g. Benson and Wallace, 1978). Such assessment of substance use patterns typically relied upon self-report without independent verification.

A review by Clements *et al.* (1988) reached a similar conclusion to Hawkins (2003), namely that TM is associated with a reduction in substance use. Another review by Aron and Aron (1980), included a specific focus on three studies of TM in the treatment of drug abusers rather than already established TM meditators, they concluded that TM may represent a useful adjunct to treatment. However these reviews again gave little or no consideration as to the studies' methodological limitations. Also the reviews considered so far were all associated with organisations advocating the use of TM, the reviewers may therefore be expected to generally be in favour of TM. A number of other reviews of TM studies have given more consideration to methodological limitations; an early review of four TM studies by Marcus (1974) considered that, despite a range of design flaws, the studies indicated positive outcomes on substance use. West (1979), discussing meditation in general, briefly considered meditation and drug abuse. He highlighted a range of flaws concerning retrospective studies of TM practitioners, but suggested that the area

warranted further investigation. Two more recent reviews giving consideration to methodological limitations were conducted by individuals affiliated with the Maharishi International University, an organisation advocating TM. Gelderloos *et al.* (1991) reviewed 24 studies concerning TM and the prevention and treatment of substance misuse. They concluded that the TM program can represent a useful adjunct to addiction treatment. Alexander *et al.* (1994) conducted a qualitative review and statistical meta-analysis of 19 studies on the effects of TM on substance use. Twelve of the studies were common to both of these reviews. Alexander *et al.* (ibid) concluded that substance use was consistently negatively associated with the regularity of TM practice and the time for which it has been practiced. Acknowledging that not all studies reviewed included 'high-users or addicts', Alexander *et al.* (ibid) highlighted that many of the studies included sub-populations of such individuals and concluded that the studies were suggestive of a secondary prevention role for TM. Their meta-analysis revealed equivalent or higher effect sizes for the better designed studies (e.g. random controlled studies) as compared to retrospective surveys or cross-sectional studies. They suggested that this indicated the findings of TM effects on substance use are not due to methodological limitations. A few of the studies reviewed by Alexander *et al.* (ibid) did not however find a significant reduction in substance use with TM. In explaining these inconsistent findings, Alexander *et al.* (ibid) noted that the populations in each of these studies only included a small proportion of substance users prior to the commencement of meditation. One relatively large study (N=115) of drug users, not considered by Alexander *et al.* (ibid), has however found a general pattern of a return to substance use after TM practice as an intervention (Anderson, 1977). The

duration of meditation teaching and practice in this study was however brief (5-7 days) and the majority did not continue to practice meditation after discharge from the hospital in which the intervention took place. Interestingly this study did find a shift in reported drug use away from heroin to other drugs.

It appears that a more limited number of studies have addressed some of the methodological limitations of earlier studies. For instance, both Alexander *et al.* (1994) and Gelderloos *et al.* (1991) commended a Swedish study by Bräutigam (1978) as particularly rigorous. Rather than using already established TM meditators, participants (N=20) had been identified as drug abusers and also treated for hepatitis, suggesting problematic substance use. A prospective experimental design was used, addressing issues regarding recollection of substance use patterns over a long period of time and use of a control group and random assignment[2] aimed to overcome responder/selection bias. Meditation was used as a stand alone treatment. After a three month period of meditation practice the meditation group decreased significantly more in their use of 'hard' drugs (i.e. LSD, amphetamines, and/or opiates) compared to the control group and had a significantly lower average use of hashish. There was however some variability in the pattern of change in drug use, with a sharp decline in the first month of taking up meditation but then some points of increase in the remaining experimental period (3 months) and a further three month period, not however to previous levels of use. It is also noted by the

[2] Participants were randomly assigned to experimental and control conditions but with an element of matching, according to form of drug use. To ensure the groups were matched in terms of the representation of different types of drug use participants were firstly categorised as 'hard' drug users (i.e. using LSD, amphetamines, and/or opiates more than ten times in preceding six months) and those using almost solely hashish (Cannabis). Participants from each of these categories were then randomly assigned to the control and experimental condition in equal numbers.

researchers that over the 24 months following the study 80% of the participants relapsed, although it is not clear how this was defined. Miller and Rollnick (2002) have indicated that relapse may represent a normal part of change. It would be interesting to consider if the practice of TM had any bearing on the duration and frequency of relapses. It is not clear how drug use was measured, it would appear that this was through self-report of frequency. No independent verification measure is reported.

While Bräutigam (1978) used a control group, allowing comparison across conditions, there was some variability within conditions. For example, amongst the meditator group there was variation in the frequency of independent practice which was designed to take place for twenty minutes morning and evening. Additionally the control group was offered group therapy, based upon a client-centred approach, but not all elected to attend. Variables other than the meditation may also have inadvertently been set up between the groups. For instance, the meditator group were required to abstain from drug use for several days prior to receiving TM training. No mention is made of a similar abstinence requirement for the control group. Furthermore participants were recruited by letter which highlighted that TM had had an effect on drug usage in the USA. This information may have generated an expectation of change in the meditation group and no expectation of change in the control group. Miller & Rollnick (2002) highlighted the role of beliefs regarding treatment efficacy in influencing treatment outcomes. After three months the control group requested to receive training in TM, which would appear consistent with expectancy effects.

In contrast to the literature cited earlier, which generally appeared to consider the findings regarding meditation and substance use encouraging, others have been more cautious. Klajner *et al.* (1984) reviewed meditation within the broader classification of relaxation strategies and concluded that the evidence for its use in treating alcohol abuse was equivocal. Similarly, they suggested that the methodological limitations of studies considering relaxation training, including meditation, and drug abuse precluded conclusions regarding its effectiveness in this area. Some have taken this to mean that meditation is ineffective in the treatment of substance abuse and even used this as a placebo control (Rohsenow *et al.*, 2000). Shapiro & Giber (1978) considered the impact of meditation upon substance use within the broader context of psychotherapeutic effects and again concluded that the findings of reduced substance use could not be regarded as definitive due to methodological flaws, such as the issue highlighted earlier of expectancy effects. Similarly Delmonte (1985) raised the issue of expectancy effects and concluded that there is little in the way of direct evidence that meditation per se is responsible for observed reductions in substance use.

One prospective study, not considered by Delmonte (1985) nor by Shapiro & Giber (1978), which may contribute to consideration of expectancy effects was a prospective study conducted by Taub *et al.* (1994)[3]. As with Bräutigam's (1978) study this was again with problematic substance users, in this instance at an alcohol rehabilitation centre. The control group received treatment as usual. A total of 35 participants were assigned to the TM condition, which formed an adjunct to the usual

[3] This study was first reported in 1978 (cited in Gelderloos *et al.*, 1991).

treatment. In addition there were two further treatment conditions; biofeedback and electronic neurotherapy. Unlike Bräutigam's (1978) study, substance use outcome was not only based upon self-report but verified at points with the corroborative evidence of others and where possible, when face-to-face interviews were conducted, with breathalyzer screening. At 18 months they found that there were significantly more non-drinking days and abstinent individuals amongst the meditation group than the control group.

Potential participants in Taub *et al's.* (1994) study were randomly assigned to hear a lecture about the project and one of the three treatment conditions. Consent was then obtained for those who wished to take part. The control group was drawn from each of these three lecture groups in equal proportion, the remainder were provided with the therapy relating to the lecture they had attended. While the process of randomly assigning participants controlled for self-selection biases across conditions, the exposure of the control group to the introductory lectures may again have set up differing expectations between the control and treatment condition groups. Comparison across conditions may however allow some consideration of the potential role of expectancy effects. Schedules across the treatment approaches were designed to reflect each other as closely as possible, for example in terms of therapist contact time, and staff were committed to their particular approach. There was a significant treatment effect across conditions favouring the TM and biofeedback conditions. The difference between the TM condition and the neurotherapy group would appear counter to expectancy effects being the primary influence on substance use outcomes and the neurotherapy was retrospectively considered as a placebo

control. The neurotherapy condition had not however been instigated as a placebo control and differed from the remaining two treatment conditions, including TM, in that it involved a less active role and could not be practiced independently. This may have negatively influenced individuals' sense of self-efficacy, which is related to the likelihood of change (Miller & Rollnick, 2002). In terms of continued practice of TM at six months follow-up it is reported participants meditated on 41% of available occasions (total opportunities considered as twice daily).

While there is a sizable range of research indicating an influence of TM on substance use outcomes, this has not been universal and there would appear to be a number of limitations across many of the studies, for example the use of established TM participants and retrospective designs. More rigorous studies have found a reduction in substance use, however it would appear that there are still methodological difficulties limiting the conclusions that can be drawn. For example, they are relatively small in size and it is hard to definitively exclude expectancy effects. After a flurry of studies, conducted particularly in the 1970's, the published research contains a relative paucity of studies from more recent decades. While this may reflect shifting research interests it would be expected that studies would have addressed the limitations highlighted and it could represent the tendency for the publishing of positive rather than negative findings.

4.2. Mindfulness meditation

The literature relating to Mindfulness meditation and substance use was found in the current review to be less well developed than that concerning TM. In terms of studies considering substance use outcomes directly one pilot study was identified, along with one larger study. Alterman *et al.* (2004) conducted a pilot study with 31 participants from a substance abuse recovery house with a 12-step focus. Most participants had been using a combination of substances, including alcohol. Eighteen participants were randomly assigned to the experimental condition and 13 to the control condition, which represented treatment as usual. Subsequent analysis however revealed that the experimental groups' problematic substance use was more severe in terms of indices such as average (mean) frequency of recent heroin use. Overcoming the limitations of varying levels of independent meditation practice in some studies, participants engaged in daily group based practice between training sessions. Audiocassette based instruction and reading material were used. Practice was monitored by a staff member from the recovery house.

A repeated measures design was used by Alterman *et al.* (ibid) with measures at base-line and at eight weeks post intervention. Additionally there was a follow up period after five months. Outcome data were available for over 75% of each group. It is not discussed if there were any systematic difference between those for whom outcome data was and was not available. Substance use was assessed through self-report but also through urinalysis, screening for heroin and cocaine use. A Timeline follow-back technique using mnemonic aids was used to facilitate recall for the self-report. A semi-structured interview (ASI) was also used. This focused upon a range

of life problem areas including drug and alcohol issues, it considers a time period of 30 days and therefore relies upon accurate recall across this time period.

Both the control and meditation groups in the Alterman *et al.* (2004) study demonstrated a significant decrease in alcohol and drug problems, however there was no significant difference between the meditation group and the control group. Self-report assessment suggested that approximately half of the experimental group had continued with meditation, but this was not necessarily as frequent as during the intervention period.

Marlatt *et al.* (2004) described a larger study focusing upon the use of Vispassana meditation as a stand-alone treatment for substance use problems. The study considered the use of this form of meditation in a minimum security prison population. The population was described as, many having been 'heavy substance users' prior to admission and having used a variety of substances including alcohol, opiates and cocaine. A quasi-experimental design was used. There were 306 participants in total, 88 of whom were included in a three month follow-up period (Control condition N=29, Meditation treatment condition N=59). The control group was case matched to the meditation participants and received treatment as usual within the prison. Pre-, post- and follow up measures, three months after release from prison, were made. Measures included alcohol and drug questionnaires considering frequency and quantity of consumption, as well as scales relating to a range of psychological variables. The psychometric properties are not stated and it appears no corroborative evidence was sought regarding substance use. Preliminary

findings included a significant time by condition effect, considering the period to three month follow-up, favouring the meditation group for a number of measures including average weekly drug use.

Participants were not randomly assigned to groups and those in the meditation condition had volunteered to take part and received a four day orientation course. Participants for the control group on the other hand had not volunteered to take part in the meditation course, meaning that there may be a selection bias. It is unclear if the pre-measures were conducted prior to the meditation orientation course which would have introduced a pre-existing variable between the groups at base-line and may have set up expectations regarding meditation. It appears there was some variability in the control condition as, whilst most engaged with at least one intervention, the nature of the rehabilitation programmes in which they participated varied.

Mindfulness techniques have also been incorporated into the broader treatment approach of Dialectical Behaviour Therapy (DBT). While trials demonstrate a beneficial effect of DBT in terms of reduced substance use and improved psychological functioning (Linehan *et al.*, 2002), Mindfulness represents only a partial component and meditation techniques per se are not necessarily used.

The literature relating to Mindfulness meditation and substance use would appear to be at an earlier stage than that concerning TM. As an adjunct to standard treatment, Mindfulness meditation did not appear to confer any additional benefit in the pilot

study conducted. In contrast, as a stand alone treatment in a larger study it appeared significantly more effective, in terms of reduced substance use compared to a control group. Methodological issues however, such as variation in the interventions engaged in by the control group, lack of random assignment to conditions and the possibility of expectancy limits the conclusions that can be drawn.

4.3. Methodological and other issues

It would appear that there are some common methodological limitations spanning many of the studies considered. Considering the therapeutic effects of meditation Smith (1975) highlighted two common difficulties in attributing significant findings to meditation per se. Studies have often not controlled for expectancy effects nor for the effects of simply sitting quietly. In terms of expectancy effects, some consideration has been given to the impact of indications given to participants. In a relatively small study (N=40), Malec and Sipprelle (1977) considered three experimental conditions and a control condition. In the experimental conditions, a video tape introduced a Zen[4] meditation exercise followed by one of three conditions:

1. Modelling and suggestion of a relaxation outcome of meditation.
2. Modelling and suggestion of no specific outcome.
3. Modelling and suggestion of arousal as an outcome of meditation.

[4] Zen meditation is a form of Buddhist meditation (Hinnels, 1984) and would appear to overlap with Mindfulness approaches / Vipassana meditation (Heath, 1997).

In the control condition, participants were asked simply to remain seated. Malec and Sipprelle (ibid) did not find differences in terms of physiological measures (e.g. rate of respiration) nor self-report (verbal description given by participants as to how they felt following meditation) between the different experimental conditions, suggesting that the way in which the meditation had been presented did not significantly influence the outcome. As noted by Malec and Sipprelle (ibid), the expectations participants brought with them to the study were not however considered. Relevant to Smith's (1975) critique regarding the effect of sitting quietly a difference was found between sitting quietly and the meditation conditions, in terms of lowered muscle tension and respiration rate, favouring the meditation conditions. It could still be argued however that meditation is simply a form of relaxation and it was considered within this context in the review by Klajner *et al.* (1984). Studies considering different forms of relaxation have however indicated differential effects for different types of relaxation including meditation. For example, Wong *et al.* (1981) found differences between groups exposed to meditation and deep muscle relaxation training. Throll (1981), found more significant decreases in state and trait anxiety at post-test in a meditation condition as compared to a progressive muscular relaxation condition. Differences have not however been universally found. Reviewing the literature in this area, Shapiro (1982) concluded that studies have generally indicated a difference between meditation and placebo controls but not between meditation and what he refers to as other self-regulation strategies, such as progressive relaxation. Even studies finding some differences indicate similarities on other measures, for example Parker *et al.*, (1978) found a significant difference in changes in blood pressure between meditation, progressive relaxation and a quiet rest

control group but there were no significant differences between the three conditions in self-reported anxiety. One difficulty in comparing the different findings across studies may be variance in the frequency and duration of practice of meditation/progressive relaxation.

Alexander *et al.* (1994) concluded from their review that there is a consistent relationship between level of substance use and regularity and total duration of meditation practice. During experimental periods, group practice may overcome difficulties of monitoring independent practice; however, whether and how frequently individuals continue past experimental phases and into follow periods is likely to vary. Anderson (1977) has concluded that meditation may be of benefit only to those committed to regular practice. Negative findings concerning meditation and substance use at follow-up may be related to the lack of continued independent practice. For example the approximately two percent of Anderson's (ibid) sample who did continue with meditation reported refraining from substance use. Similarly a study by Wong *et al.* (1981), using an unspecified form of meditation, found that at six month follow-up most participants had discontinued practice but, amongst those continuing with meditation, lower levels of drug and alcohol use were reported. Motivation may however represent a confounding factor. The use of group-based meditation may help sustain motivation to engage in meditation and also relate to the provision of a new social culture potentially with social norms related to the non-use of substances. Some have suggested that meditation may be favoured by those more highly educated; and use of complementary approaches by those with substance use problems has been

associated with higher levels of education (Manheimer *et al.*, 2003). However Wong *et al.* (1981) found that amongst a population, at a chemical dependency treatment facility, individuals with lower levels of education were more likely to consider meditation positively. Additionally Wong *et al.* (ibid), found that those rating meditation training positively were more likely to have drug rather than alcohol problems, and tended to be younger. It was also found that they tended to have more personality problems and a greater need for social closeness but a higher level of self-acceptance. Meditation may sometimes be contra-indicated and a number of studies excluded participants with a history of psychosis (e.g. Taub *et al.*, 1994).

5. Conclusion and future research

The current review considered the role of meditation in overcoming problematic substance use and a range of underlying theoretical rationale. Meditation has been postulated to address a range of factors that may be related to substance use. Such factors include: anxiety; other negative affect states; perceived levels of control; and altered states of consciousness. In terms of anxiety, it has been postulated that meditation may replace or reduce the arousal lowering effects of some substances, when substance use relates to tension-reduction attempts. The relationship between anxiety and substance use is however complex and studies considering meditation and anxiety have not always produced consistent findings. Considering a broader range of negative affect states, meditation may promote tolerance of such states through raising awareness of their impermanent nature. Anecdotally individuals have reported a beneficial effect of meditation in managing a range of negative affect states. It has been argued that, in contrast to the tension-reduction hypothesis,

alcohol may be reinforcing as a result of increasing a perceived sense of control at times of high stress. Evidence of increased perceived control with meditation has been found but not in all studies. Meditation may also represent an alternative means of attaining an ASC, previously generated through substance use. The desire to experience ASCs has been described as universal and ASCs have been reported by meditators. A role for meditation has also been suggested in managing cravings. Mindfulness meditation has been considered to decouple impulses and actions allowing alternative behaviours to be developed and counter-conditioning to be experienced. Meditation may have a more global development role which impacts upon substance use, influencing a range of underlying factors. It could also have an indirect effect though offering a time alternate activity and, when associated with group membership, a new cultural community with revised social norms and an alternative social role as a meditator. The development of time alternative activities has been found to be associated with abstinence and there is evidence that TM circles discourage substance use suggesting that these may offer a revised social norm.

A number of studies have indicated an association between reductions in substance use and meditation, including Transcendental Meditation and Mindfulness meditation and, in the case of TM, both as a stand-alone approach and in addition to standard treatment. This has not however been universal and outcomes have not always been maintained. It would be interesting to consider if the practice of meditation had any bearing on the duration and frequency of relapses using long term follow-up studies and also on any changes in the substances used. Even with more rigorous studies, focusing upon problematic substance users, there are a range of

methodological limitations. One issue is the variation in the continued practice of meditation over time and it may be that this technique is only suitable for particular populations who favour this approach. Motivation may represent a confounder influencing both reduced substance use and continued meditation practice. The use of group-based meditation may help sustain motivation and also itself affect substance use through the provision of a new social culture. It would appear that meditation has differential effects to simply sitting quietly however there are conflicting findings concerning the differences between meditation and other relaxation strategies. Future studies need to control for expectancy effects and measure the expectations that participants bring to studies. Expectancy of effect may represent a fruitful area of research in its own right given that this may influence outcome. Additionally, it is important that similar abstinence requirements are made of control and experimental groups and that conditions for control groups are standardized. It may also be of benefit to consider use of different substances separately, for example those with stimulant versus those with depressant effects.

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Section B). Research Report

The Role of Faith, Religion and Spirituality in Overcoming Problematic Substance Use:

"From Restriction to Elaboration"

And the day came when the risk to remain tight in a bud was more painful than the risk it took to blossom.

Anais Nin

Research report abstract

Aims

The current study sought to explore the role of faith, religion and spirituality in overcoming problematic substance use and considered how findings may be more broadly applicable.

Method

A grounded theory approach was adopted using semi-structured interviews with eight participants who attributed to faith/religion/spirituality, an important role in overcoming problematic substance use.

Results and Conclusion

A process model of overcoming problematic substance use and the role of faith/religion/spirituality was generated. The model conceptualised the development of problematic substance use as a process of restriction, and the journey of overcoming this as one of elaboration, including for some the evolution of a pre-existing faith. Participants developed an openness to novel paths, including spiritual ones. The model appeared to reflect generic models of change, suggesting that there may be common pathways to change independent of the precise elements involved.

Religion, faith and spirituality, including engagement with faith communities, appeared to:

- Offer a range of resources, for example providing alternative cognitions and coping resources.
- Address a range of potential vulnerability factors for substance use, such as low self-esteem.
- Address a variety of functions served by substance use, for instance facilitating social engagement, thereby superseding substance use.

A number of elements identified in the current study may be more broadly applicable to clients overcoming problematic substance use for example, the development of meaning and purpose in life.

(Word count: 230)

1). INTRODUCTION

1.1. Religion and spirituality in the UK and in healthcare

While in England participation in organized religion, certainly in terms of Church attendance amongst some denominations, appears to be falling (Jackson, 2005), there is an increased acknowledgement of spiritual/religious experiences (Hay and Hunt, 2000). There also appears to be a growing recognition of spiritual and religious dimensions within Health Care. The role of spiritual care has been recognised by the current Secretary of State for Health (Waterman, 2005) and it has been reported that access to information on religious and spiritual issues will be provided to mental health nurses (Nurses, 2006). Within some National Health Service (NHS) Trusts there is a department of Spiritual and Pastoral Care for internal client referral and spiritual health care has recently formed a topic considered as an issue for Clinical Governance.

1.2. Defining faith, religion and spirituality

In the current study, religion referred to sets 'of recognizable systems of belief and practice having a family resemblance' (Hinnells, 1984 p.270), generally encompassing a 'belief in, worship of, or obedience to a supernatural power or powers considered to be divine or to have control of human destiny' (Collins, 2004). Religions may have Holy Books or scriptures, often regarded as divinely revealed or inspired. Faith, in the current context, indicated a personal belief in a religion/God(s). Considering spirituality, it would appear that the relationship with religion is complex, with spirituality sometimes being defined in contrast to religion (Cook, 2004). Marlatt *et al.* (2004) however, suggested that while not completely synonymous, spirituality can be conceived as sharing commonalities with religious orientations and value systems. Cook (2004) proposed a working definition of spirituality as: 'a distinctive, potentially creative and universal dimension of human experience arising both

within the inner subjective awareness of individuals and within communities, social groups and traditions. It may be experienced as relationship with that which is intimately 'inner', immanent or personal, within the self and others, and/or as relationship with that which is wholly 'other', transcendent and beyond the self. It is experienced as being of fundamental or ultimate importance and is thus concerned with matters of meaning and purpose in life, truth and values' (p.548-549). Resounding with the notion of universality, Miller and Thoresen (1999) note that spirituality may be regarded as 'multi-dimensional space in which every individual can be located' (p.6).

Miller (2002) suggested a number of dimensions to the concept of spirituality. These dimensions (adapted from Miller, 1998, 2002) are given below. They would seem to be equally applicable to religion; the term religion has therefore been added.

- **Spiritual/religious beliefs**
  (e.g. regarding a deity or the interrelatedness of living beings).
- **Spiritual/religious values and motivations**
  (e.g. karma, duty to God).
- **Spiritual/religious experiences**
  (e.g. mystical experiences, a sense of God's presence).
- **Engagement in spiritual/religious practices or behaviours**
  (e.g. prayer, worship and meditation).

Considering the examples of spiritual/religious practices, prayer may be broadly defined as 'every kind of inward communion or conversation with the power recognized as divine' (James, 1945, p.454). Worship represents 'homage or reverence paid to a deity' (Thompson, 1996) and meditation 'can be defined as a family of practices that train attention and awareness, usually with the aim of fostering psychological and spiritual wellbeing and maturity' (Shapiro & Walsh, 2003 p.88).

1.3. Religion, spirituality and substance use

1.3.1. Introduction

The national service framework, Models of Care, provides guidance that substance misusers should have access to specialist drug and alcohol residential rehabilitation programmes, including programmes based upon spiritual and religious approaches[1] (NTA, 2002). There is also a range of informal care for substance users provided by religious organisations (Drugscope, 2002). In the current study the term problematic substance use is preferred to substance misusers, as such terms can carry connotations not necessary implied here, such as moral models of substance use. Alternative terms are however used where relevant in referring to the existing literature. Problematic substance use may be defined as any pattern of substance use, that is drug or alcohol use, leading to significant physical, psychological, or social harm. Problematic substance use has a significant impact in terms of the psychological and physical well being of individuals (DoH, 1995; Home Office, 2002; WHO, 2001), their families (Adfam, 2004) and wider society (Home Office, 2002).

1.3.2. A role for spiritual and religious factors in overcoming problematic substance use

Religiosity, that is the condition of being religious (Thompson, 1996), has been found to be a protective factor inhibiting initial substance use (Brown *et al.*, 2001, Gorsuch 1995). This effect appears to occur independently of the presence of moral community support (Richard *et al*, 2000). A number of authors have posited that as well as having protective effects, such factors may play a role in overcoming problematic substance use (Marlatt, 1985; Orford, 2001). Religious practices and affiliations have sometimes been found to be associated with improved psychological functioning generally (Gartner, 1996) and evidence from

[1] These currently represent a small element of a spectrum of otherwise largely secular services, please refer to NTA (2002) for details of these other services.

spontaneous remissions/recoveries[2] is consistent with spiritual and religious factors sometimes playing a role in overcoming problematic substance use specifically. For example, some respondents in interview studies looking at spontaneous recovery from alcoholism, explicitly excluding those receiving assistance from Alcoholics Anonymous[3], have attributed religious and spiritual factors as being important (Tuchfeld, 1981; Ludwig, 1985). Some respondents in Tuchfeld's (1981) study, appeared to have had dramatic religious conversion experiences while others gradually developed a religious commitment. Considering spiritual experiences, Ludwig (1985) encompassed mystical and transcendental experiences within this. Such experiences appeared to be associated with a greater ability to resist the desire to drink or loss of cravings for alcohol.

1.3.3. Spiritual/religious intervention programmes for problematic substance use

As stated earlier, the current national service framework includes a role for residential services based upon spiritual and religious approaches (NTA, 2002). Specifically this refers to 12-step and faith-based approaches, each of which will now be considered in turn.

1.3.3.1. 12-step approaches

12-step approaches originated with Alcoholics Anonymous (AA); this is an international self-help approach co-founded by Bill Wilson and 'Dr Bob' in 1935 (Swora, 2004). Bill Wilson, initially resistant to the concept of a personal God, considered that his own problematic alcohol use was resolved through a religious/spiritual experience (AA, 2001). AA does not consider itself a religious organisation (AA, 1972), but classifies itself as a 'spiritual program and a spiritual way of life' (AA, 1973). The basic principles of AA's approach were however derived from the field of religion, as well as medicine (AA, 1981); it is these that are now

[2] Spontaneous remissions/recoveries refer to the overcoming of problematic substance use without recourse to formal interventions.
[3] Alcoholics Anonymous is a spiritually based program.

referred to as the twelve steps. They include some principles which are of an explicitly spiritual nature, for example 'Sought through prayer and meditation to improve our conscious contact with God, as we understood Him, praying only for knowledge of His will for us and the power to carry that out' (Step eleven - AA, 1972). AA has provided a model which has been extended to create a range of organisations, for example Narcotics Anonymous and Cocaine Anonymous. Residential rehabilitation centres founded on the same principles as the self-help groups have been developed (Preston & Malinkwski, 2002).

Twelve-step Facilitation Therapy, a twelve step approach 'that encourages AA attendance and the working of the twelve steps' (Project MATCH research group, 1996, p.24) has been demonstrated in a large randomized controlled trial to be equally effective as other psychological treatment models, namely Cognitive Behavioural Therapy (CBT) and Motivational Enhancement Therapy (MET), for 'alcohol dependent' clients (Project MATCH research group, 1996). A small survey (N=60) amongst members of UK Narcotics Anonymous groups revealed that 50% engaged in at least daily spiritual practices. This represented a significant predictor of abstinence (Day *et al.*, 2003).

1.3.3.2. Faith Based Approaches

Faith-based approaches to problematic substance use have arisen from a variety of religious traditions. Within the UK, it would appear that these are currently from a predominantly Christian perspective. Consolidating a number of sources (e.g. Hinnells, 1984; Thomas, 2000; Walshe & Warrier, 1993), Christianity may be described as a religion centred on Jesus Christ, who is believed to be the Son of God and Saviour of the world through his death and resurrection. A central tenet of Christianity is the doctrine of the Trinity. This holds that there is one God but three persons: God the Father, God the Son (Jesus Christ) and God the

Holy Spirit. Followers are believed to be endowed with the Holy Spirit, bringing empowerment for Christian living. Christian teachings are recorded in the Holy Book, the Bible. Considering perspectives on substance use, Abrahamic faith traditions, that is either Judeo-Christian or Islamic, prohibit or discourage the use of psychoactive substances or their excessive use (Christian Education Movement, 1993; Cave, 1993).

One example of a Christian-based programme addressing problematic substance use is Teen Challenge. Founded by David Wilkerson in 1958, this is now an international organisation with residential rehabilitation centres in the United Kingdom. Change is considered to be effected through spiritual transformations. The residential programmes are typically of a one year duration and include participation in Christian practices, such as prayer and worship, as well as a structured routine of daily activities (Peterson, 2001). It appears that at least seven research studies have been conducted looking at the Teen Challenge program (Muffler *et al.*, 1992; Petersen, 2001). The most recent of these, an independent survey, focused upon graduates of an induction programme from one site. A success rate in maintaining abstinence of 67% was found (Teen Challenge, 1994). Although it is not clear over what spread of duration abstinence was maintained, alumni from a thirteen year time period were included in the study. The majority of the sample (80 %) indicated that the development of a personal relationship with Jesus Christ represented a significant influence in maintaining abstinence.

Responding to the ethnic diversity of our UK population, a culturally and religiously sensitive drug service, called Nafas, has been developed in London (Nafas, 2006). A value espoused by Nafas is that in considering the whole person, the spiritual dimension must be taken into account. One objective of Nafas is to provide training and guidance to existing service providers and commissioners on the needs of, amongst other groups, drug misusers from the

Muslim tradition. As described by Walshe and Warrier (1993), Muslims are followers of the religion Islam and submit to the will of God (Allah). They believe that the message of God (Allah) was revealed to the Prophet Mohammed and this is recorded in the Holy Qu'ran. There are five central Islamic practices, referred to as the five Pillars of Faith, for example worship (Salat) with ritual prayer times (Walshe & Warrier, ibid).

Choudhury and Hussain (2002) have considered the role of Islamic worship in overcoming problematic substance use. They suggest that verses from the Qu'ran may help reinforce the idea that forgiveness is possible, providing a way forward. Islamic intervention approaches for problematic substance use have been developed in various parts of the world; regular prayer forms an essential component and a religious leader provides instruction regarding Islam (Suliman, 1983).

Other religions have also been applied to understandings of addiction and recovery. Groves and Farmer (1994) have expounded Buddhist doctrine in relation to addictions. Buddhism is a non-theistic faith (Groves & Farmer, 1994), founded in India by Siddharta Gautama, known as the Buddha (Walshe & Warrier, 1993). Its doctrine suggests four noble truths centring on the concept of suffering and the cessation of this, which is Nirvana. The Noble Eightfold Path, encompassing for example, right thought and right action, is considered as the path to Nirvana (Walshe & Warrier, ibid). A precept of Buddhism is to refrain from use of intoxicants (Christian Education Movement, 1993). Groves and Farmer (1994) indicated that substance use has been treated in an explicitly Buddhist context within countries in which this represents an indigenous religion. Poshyachinda (1992 cited in Groves and Farmer, 1994) described the role of Buddhist Temples in offering detoxification treatments for opiate abusers. This involved the use of herbal medication and religious rites over a period of one

month. It is reported that that 20-30% of the opiate users were abstinent after six months. Meditation, which is linked to components of the Noble Eightfold Path, represents a primary mechanism of change within Buddhism (Groves & Farmer, ibid) and has sometimes been associated with a reduction in substance use (e.g. Marlatt, 2004).

1.4. Rationale for the current study

In summary, some individuals attribute religion and spirituality as being significant in the process of overcoming problematic substance use. This is true both for those engaging in spiritual and religious based programmes and for 'spontaneous' remitters. Religious factors also appear to be protective against initial substance use. A range of spiritual and religious approaches has been developed to address problematic substance use.

While for some, religious elements may represent a prohibitive factor to engagement (Day *et al.*, 2003; Ellis & Schoenfeld, 1990), for others religious/spiritual approaches may be the treatment of choice (Muffler *et al.*, 1992). The UK Government's Drug Strategy (Home Office, 2002) highlighted the need for treatment services to be appropriate to individuals' needs. In adopting a holistic health care approach, it would seem important to take account of the role that religion/spirituality may play in facilitating the overcoming of problematic substance use for some individuals. Additionally, considering the overcoming of addictions or excessive appetites, Orford, (1985) argued that the process of change is most readily understood 'by an appreciation of the factors that are common to a variety of forms, whether religious, medical or 'spontaneous'' (p.301).

Miller (1997) suggested that research into spirituality and addictions represents a relatively new field. The research conducted to date has predominantly been conducted in the USA and

focused mainly upon the 12-step tradition, although Native American spirituality has been considered (Cook, 2004). The current study aims to explore the role of faith, religion and spirituality in overcoming problematic substance use, drawing principally from a UK population and including participants from outside of the 12-step tradition. To gain insights into the depth of relevant spiritual and religious experiences, individuals' subjective experiences, and their relationship to overcoming problematic substance use, a qualitative approach will be adopted.

Aims and Objectives

The study aims to explore:

- Individuals' experience of the process of overcoming problematic substance use or working towards this.
- Individual's experience of spirituality, religion and faith.
- The relationship between the above two domains.

The study also considers ways in which the understandings generated may be more broadly applicable in terms of adopting holistic health care approaches.

2). METHOD

2.1. Design

The current study used a qualitative design to explore the role of faith, religion and spirituality in overcoming problematic substance use. A Grounded Theory approach, drawing upon Pidgeon and Henwood (1996) and Strauss and Corbin (1998), was adopted with semi-structured interviews.

2.2. Rationale for study design and researcher's position

Research into spirituality and addictions represents a relatively new field (Miller, 1997). The current study sought to generate theory through applying a grounded theory approach with participants attributing faith, religion and/or spirituality as important in the process of overcoming problematic substance use. Theory emerging through the application of this methodology is grounded in the textual material of participants' accounts. It was considered important that individuals were able to share their subjective stories and meanings rather than imposing pre-selected criteria, which could oversimplify potentially complex experiences and limit the understandings gained. Grounded theory additionally offers the novice qualitative researcher a systematic framework for the research process.

The epistemological stance adopted by the researcher was broadly considered to represent a critical realist epistemology as referred to by Madill *et al.* (2000). This perspective assumes a reality but one which is experienced only through the 'lens' of beliefs and expectations. Considering the potential influence of such a lens it is also important to acknowledge the author's position as a Christian and as someone raised within a Christian faith tradition.

2.3. Participants

2.3.1. Inclusion and Exclusion Criteria

To participate in the study individuals had to have a history of substance use with at least one of the following substances: alcohol, heroin or crack/cocaine. These substances reflect those typically targeted by treatment services. They had to either no longer be using the substance(s) or have made significant progress away from problematic use and attribute faith/religious/spiritual factors as having been important in this process. Participants were required to be over 18 years of age. Exclusion criteria included any difficulties with consenting, in the view of any of the parties involved and also with engaging in the interview process, in the view of the researcher, for example due to intoxication with substances. The resource limitations meant that participants also had to be fluent in spoken English.

2.3.2. Description of participants

There were a total of eight participants, three female and five male, ranging in age from 24 to 62 years. Three were currently married. (One further participant had been interviewed, allowing practice for the author as a novice qualitative research interviewer. This interview informed the topic guide but was excluded from the analysis due to concerns that the interviewee's relationship, to an earlier participant, may have allowed discussion prior to the interview which could potentially influence responses). In terms of ethnic origin participants were predominantly White British except for one White American and one classified as Black – Other (see Appendix B). Participants were recruited through a range of organisations: the NHS, 12-step groups/rehabilitation centres, faith-based rehabilitation centres and religious organisations. Four participants were currently in rehabilitation centres (time-span: 7 weeks – 6 years), two from a rehabilitation centre with a 12-step based approach and two from a Christian faith-based rehabilitation centre. The other four participants were living in the

community, of these one was engaged with a community 12-step programme, one with an NHS based treatment service, the remaining two were recruited through Churches and had not received any formal treatment directly relating to substance use.

Participants had previously used a range of substances but all had experienced problematic substance use with at least one of the following substances: alcohol, heroin or crack/cocaine. All were currently either substance free or in some instances, when alcohol did not represent the problematic substance, using this socially. Across participants this status had been maintained for between seven weeks and over nineteen years. All were currently affiliated with religious organisations and/or identified with a particular religious faith, this was predominantly the Christian faith but the Islamic faith was also represented and two participants had an additional interest in Buddhist traditions. Three of the participants had a history of a clear pre-existing faith, the remainder had had some exposure to religious ideas either through Sunday School or general culture including school education. Considering the more general pattern of peoples' lives, all participants had participated in education and employment and for many, this continued for at least part of their substance-use-career.

2.4. Procedure

Ethical approval for the study was gained from the Leicestershire, Northamptonshire and Rutland Research Ethics Committee 1, on the 4th August 2005, and for a substantial amendment to allow the use of telephone interviews on the 7th November, 2005 (please refer to Appendix C).

2.4.1. Recruitment

Directories were referred to for relevant contacts of faith-based groups and drug treatment services, and professionals working within the field were consulted. Managers/leaders of potential organisations were approached for agreement to participate in the study. Sampling was purposive in the sense that diversity was actively sought. Copies of the Letter of Invitation and Participant Information Leaflet (see Appendix D & E) were distributed by consenting organisations to relevant individuals identified by staff. Where applicable a request was also made for these organisations to display an advertisement for participants (see Appendix F). Interested participants returned a response slip to the Researcher who duly contacted them by telephone to provide further information and agree an interview for consenting participants.

Strauss and Corbin (1998) indicate that data gathering proceeds until theoretical saturation is reached, that is the point at which no new substantive material emerges. They recognize however that this will be constrained by resource limitations. In the current study time limitations meant that recruitment had to end prior to theoretical saturation being reached.

2.4.2. Interviews

Semi-structured interviews were conducted at the organisation site, at the Researcher's University Site or in one instance, by telephone. A topic guide was devised for the initial interview and then revised for each subsequent interview (see Initial and Final Topic Guides, Appendix G), to allow theoretical sampling. Theoretical sampling is an approach within grounded theory designed to sample material relating to theoretically relevant concepts emerging through the analysis. For example, a number of participants referred to a sense that life was 'just existing' prior to making a change away from substance use. To further explore

this idea and allow comparison across a range of participants a question was added regarding the nature of life prior to individuals making a change away from problematic substance use. The interview guide was not designed to be prescriptive but to be used flexibly and with allowance for following up alternative lines of enquiry raised during the interview, as appropriate. Given the Researcher's lack of experience, the items were posited as questions rather than general topic areas to facilitate the interview process, as recommended by Maykut and Morehouse (1994). Following the initial interviews, it was decided that the background information would be collected at the start of the interview to facilitate engagement and allow testing of the recording equipment during natural conversation.

Interviews were audio-recorded, with a back-up recording made. They were then transcribed by the researcher according to the conventions laid out in Appendix H. Participants were each assigned a code for the purposes of anonymity and in the transcribing process all identifying information was removed and personal names within the text were replaced with pseudonyms.

2.4.3. Analysis

In accordance with the grounded theory approach (Strauss and Corbin, 1998), analysis proceeded concurrently with data collection. Analysis sensitized the researcher to the data, allowing relevant issues raised in interviews to be followed up in vivo and also enabling the generation of specific areas for theoretical sampling. There was also fluid movement back and forth across different levels of analysis.

Levels of data analysis:

- **Open coding** – Assigning verbal labels to small segments of data.
- **Category formation** - Comparing segments of data and grouping conceptually similar segments to form categories which were assigned working titles e.g. Meditation/Spiritual Practices.
- **Organization and integration of categories;**
    - Sub-dividing categories, for example items within the category finally entitled Spiritual practices (originally Meditation/Spiritual practices mentioned above) were sub-divided according to conceptual similarity, for instance items relating to prayer formed a sub-division. Through this process the dimensions and properties of categories emerged.
    - Working out the relationships between categories (axial coding). The working titles of categories were reviewed and flow diagrams used to explore the relationships between categories.
        - Categories which appeared to be a more specific example of another category were merged and less homogenous categories divided.
        - Categories which appeared related together were subsumed into main categories, for example those categories which appeared to represent a barrier to change.

Each interview was open coded, as illustrated in Appendix I. This represents a phase of detailed scrutiny of the data, small segments of text, often a line or so, were each assigned codes. Codes aimed to capture the meaning of each segment, providing a 'recognizable description' (Pidgeon and Henwood, 1996 p. 92) fitting the data; they varied in their level of conceptual abstraction. Items were compared and grouped into categories on the basis of conceptual similarity. The properties and dimensions of categories were further developed through theoretical sampling. As the study progressed and new concepts and categories emerged previous interview data were reviewed, in accordance with the constant comparative method of grounded theory. Categories were organized and integrated, establishing the relationships between them and developing main and sub-categories, an aspect of axial

coding. The use of diagramming in the form of flow charts helped with this process. Integration and refinement of the categories led to the final model (see Results) and the development of an overarching core category. Memos (for example see Appendix J) were used throughout to record, emerging ideas and their evolution, links between concepts and ideas, and data management, for example the merging or splitting of categories and the rationale for this.

2.4.4. Validation Issues

A number of measures were taken to enhance the validity of the findings. In addition to the memos, documenting the flow of ideas emerging though the analytical process, a reflexive research journal was maintained. This recorded the researcher's reflections regarding the research process and emerging ideas, for example, impressions were noted following each interview. This journal helped to make explicit the lens through which the researcher viewed the data. Regular meetings with both research supervisors and a qualitative support group offered multiple-perspectives on the data and emerging ideas. For instance, transcripts were reviewed and understandings of the data explored. In considering the emerging findings the constant comparative method ensured that these were supported by, or grounded in, the data.

3). RESULTS

3.1 Introduction

The analysis of the current data generated a process model of overcoming problematic substance use and the role of factors relating to faith, religion and spirituality (see Figure 1, pg. 61). This model was characterised by an overarching core category entitled: ***FROM RESTRICTION TO ELABORATION***. Each component of the model subsumed under this core category corresponds to a main category, typed in bold in Figure 1 (e.g. ***Gateway to Change***), of which there are nine in total, and subsumes a range of sub-categories (listed under the main categories in Figure 1, e.g. *State of Psychological Readiness*). Although the model is divided into separate components, the clear divisions between these are to some extent artificial, for example some of the factors classified as sub-categories within the ***Gateway to Change*** may continue through into ***Facilitating / Maintaining Factors***.

Consideration of each category (shown in Figure 1) is woven into a narrative or story-line (Strauss and Corbin, 1998) expounding the core category. The results focus upon those elements of most relevance to the research area, and are substantiated by exemplar quotes[4]. Reference to the pertinent transcript segment is provided for additional supporting quotes and those relating to areas of lesser relevance. To set the context, the core category is initially outlined. The development of ***Problematic Substance Use*** is then considered, as the first stage in the story, reviewing the factors which appear to confer a ***Vulnerability***. The notion of the development of problematic substance use as a process of ***RESTRICTION*** is introduced. Following this consideration is given to the ***Factors Promoting Change*** and the

[4] Quotes are written in italics and followed by a reference to their transcript location (Transcripts are provided as an addendum). Transcript references are given in the following format: P(participant number):Line number(s), e.g. P3:407 refers to a quote taken from the transcript of the interview with participant three, starting at line 407. The transcript conventions used are provided in Appendix H and at the start of the Transcript Addendum, please note all names have been changed to protect anonymity and identifying information removed.

Barriers to this, along with the intervening concept of ***Ambivalence.*** Moving onto the journey of ***ELABORATION***, and for some development of a pre-existing faith *(Return of the Prodigal)*, the elements forming a ***Gateway to Change*** are explored, opening up to a discussion of those factors ***Facilitating*** and ***Maintaining*** Change and an examination of what has changed (***Wide Ranging Changes)***. Penultimately, some consideration is given to elements posing a potential ***Risk*** of a return to problematic substance use and means of overcoming some of these. Finally a summary of the model is provided.

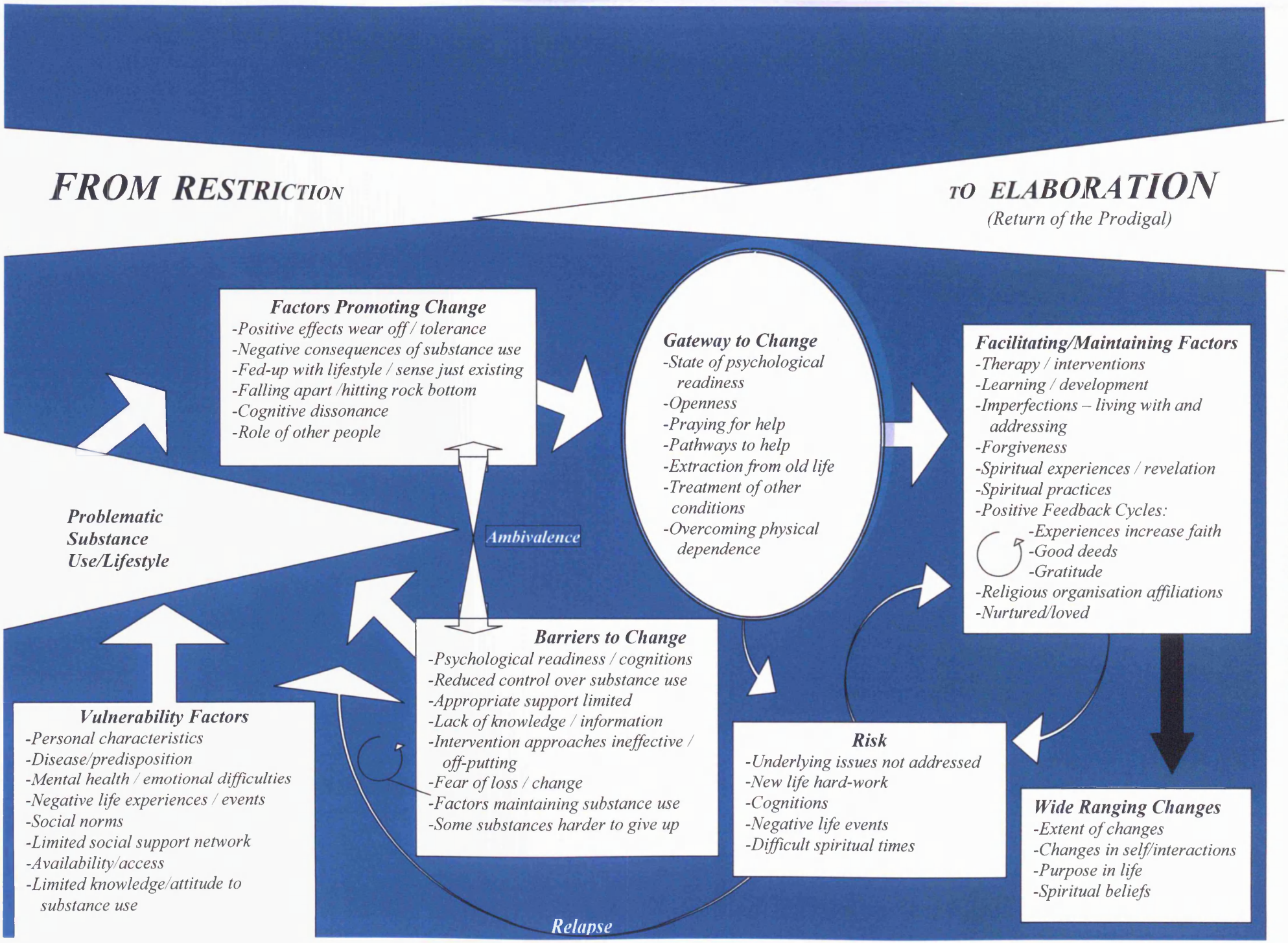


Figure 1. Model of the process of overcoming problematic substance use From *RESTRICTION to ELABORATION*:

3.2. Core Category: From restriction to elaboration

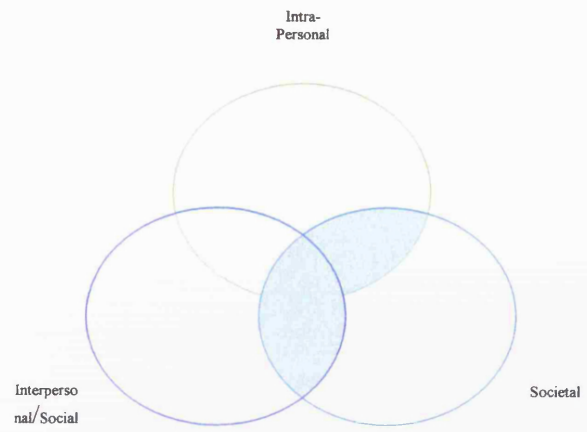
The core category: ***FROM RESTRICTION TO ELABORATION***, conceptualized the development of problematic substance use as a narrowing of priorities and interests and the journey away from this as one of ***ELABORATION***, incorporating for some, development of a pre-existing faith – *Return of the Prodigal*.

3.3. A process of restriction - Development of problematic substance use

3.3.1. Vulnerability factors

Factors conferring a potential ***Vulnerability*** to substance use (refer to Figure 1) operated on a number of levels: the individual level, intra-individual or social and a societal level with interactions between these, as portrayed in Figure 2.

Figure 2. Vulnerability Factors



At the individual level, a number of *personal characteristics* were identified by participants, including having an 'extreme nature' *(P6:27)*. This may relate, for some, to a tendency to be very driven in their approach to life or to perfectionism *(P5:42-47)*.

I was an addict because I overdosed sport, I overdosed studies, I over done anything, you know. I thought because I was really well structured (I was being) perfectionist. (P4:818)

There was a sense of dissatisfaction that may relate to having unrealistic goals. Some disliked themselves or never felt good enough, a sense of low self-esteem *(P1:739, P7:111-112)*

I never felt good enough, I never know, never knew where my place was um, I had an older sister who was very clever and my Dad was a teacher um in [Educational Establishment Name] and (that), and I just felt that I could never live up to their standards so I felt, you know, that I was never good enough and um, I felt like drugs was my place... (P6:42)

For some, the concept of an extreme nature was consistent with a genetic *pre-disposition* to problematic substance use and a *disease* model *(P5:987-990)*. One individual holding the disease model considered that their addiction had been pre-determined by God.

The disease was in me before I use and I know God choose for me to have it, I didn't ask for it. (P4:794)

A genetic tendency may alternatively be mediated through the differential effect of substances on different individuals *(P5:172-174)*. This may interact with *social norms*, for example individuals able to 'hold their drink' may be well adapted to cultural environments encouraging substance use (*P5:171-176)*.

Substances also seemed to be used to help overcome shyness and social anxiety, at least amongst some male participants *(P7:74-78)*.

I found it hard to sit with other people, because I was shy, really shy [PAUSE]. That's one of the things drugs took away from me ... was the shyness. (P3:234)

However, it sometimes seemed hard to regulate the dose response.

I wa..., was the life of the party, loved by everyone once, once I had the right amount of alcohol and drugs inside me. If I went overboard I became very, very nasty, if I kept / went / didn't have enough I was [PAUSE] just me which isn't very interesting, you know a, a sober me... (P7:79)

There was reference to a variety of *mental health* or *emotional difficulties*, particularly depression or low mood *(P7:25-26, P6:71-72)*. Participants suggested that substances were used to help to regulate their emotions, related to a range of situations *(P3:216-220)*.

Well because he [ex-husband] was abusive err, I had to drink to / because the pain was so intense. (P1:290)

This was dependent upon *access* to substances *(P9:14-19)* and may have related to an absence of alternative coping strategies *(Limited social support network)*.

...when it came to [PAUSE] talking about problems there was just no-one around... (P6:636)

A positive perception of substance use *(positive attitude to substance use)* and *limited knowledge* about potential negative effects *(P6:571-575, P1:38-39)* may also have increased ***Vulnerability***. For the individuals in this study, these ***Vulnerability Factors*** appeared to

confer a risk not only for substance use but also for problematic substance use which will be considered next.

3.3.2. Problematic Substance Use/Lifestyle

Over time there was an escalation in the level of substance use *(P4:98-99, P7:85)*, and this became an increasing priority in participants' lives *(P3:358-359)*, with other interests and responsibilities being pushed out:

That's [drug use and not being able to stop] what affected all the rest of my life. Stopped me from having interests, doing normal things you see. (P4:313)

I would wake up with a lot of remorse and guilt especially after I had a son. I didn't know, you know, who put him to bed at night... (P1:104)

There was often however continued material provision for children *(P8:751-753)*. The negative consequences accumulated *(P3:31-36)* but individuals felt unable to control their use *(P7:239)* and felt trapped in this *(P4:99-103)*, and some experienced withdrawal effects[5] *(P5:265-267)*. Although there were sometimes periods of abstinence during participants' substance use careers, for example in association with restricted access to substances *(P6:106)*.

[5] Withdrawal effects are the rebound effect of psychological and/or physical symptoms 'caused by abrupt cessation of a *substance* in an habituated individual' (Felscher, 1993 p.382).

3.4. The complex journey towards elaboration

Factors relating to movement away from the pattern of ***Problematic Substance Use***, described above, that is ***Factors Promoting Change***, existed in complex relation with factors in the category ***Barriers to Change,*** therein creating ***Ambivalence***. Each of these categories will now be considered in turn.

3.4.1. *Factors Promoting Change*

While substance use became of increasing salience, a recognition seemed to develop that the desired effects of substance use were only temporary and over time substances became less effective *(Positive effects wear off)*.

...I did feel quite happy because I was using the drugs, it was a false happiness. [PAUSE] But that didn't last for long with the drugs... (P3:247)

...they didn't even take any pain away anymore, they used to, they used to numb the pain ... (P6:152)

This development of *tolerance*[6] to a substance seemed to promote a change in substance use, either away from substance use or to alternative substances *(P3:271-277)*. In conjunction with the diminishing positive effects were an accumulating range of *negative consequences of substance use (P6:109-111)*. This included actual health consequences or concerns about potential future health implications.

[6] Tolerance is the phenomena of a substance decreasing in effectiveness over repeated administrations as the brain gradually adapts to compensate for the substance's effects.

I caught a virus, a blood borne virus and that's what really jarred it in my head, to think I've got to do, really, really do something about this. (P3:13)

I just saw my long-term [PAUSE] well body's, (you know), organs failing, I was intelligent enough, I knew physically what was going to happen to me. (P5:583)

There was also recognition of the impact of the individual's substance use upon others *(P5:464-471).* A point seemed to be reached when individuals felt they had had enough of the whole life-style associated with their problematic substance use *(Fed-up with lifestyle, e.g. P6:244).* The restricted pattern of life focused upon substance use was associated with a sense that life had become *just existing*, creating a desire for change *(P4:236).*

Um, and I was just getting enough of it, I just was existing, I had just got fed-up. (P5:523)

There was a concept that things had to reach a certain low point before effective change could take place *(Falling apart).*

I think I needed to get as low as I got um, for it to of worked in the way it has worked, to be that desperate, to be able to just say to God; 'Look just take it away I, I'm sick and tired of having' (you know)... (P5:62)

Consistent with the twelve step tradition, this was also referred to as *hitting rock-bottom (P4:155).*

For some, substance use did not fit with pre-existing religious beliefs and values, thereby creating *cognitive dissonance* that is a state of 'conflict between belief and overt behaviour' (Reber, 1995).

The whole time I drank there was just something inside of me that just wasn't / just what I was doing wasn't acceptable. Getting drunk wasn't the right thing to do. (P1: 41)

This had a religious/spiritual impact, although there was continued involvement with religious organisations.

I was playing drums in my, in my [Relative's] Church...and I was desperately trying to get that relationship [with God] back but when you've, you've got two litres of Vodka in your system, you've got a water bottle on the bike which has got Vodka in it, or going into Tescos on the way back, you, you can't say to God you're not going to go and have a drink and so there was this barrier. (P5:375)

Some individuals had not previously tended to be involved with religious organisations but encountered religious people who offered support and stimulated new ideas and reflection. Some mentioned that others had been praying for them *(Role of other people)*.

...one of the [Salvation Army] ladies particularly she was just really encouraging and said that there's more to life than this (you know if you) ever need any help I'm always here and um they gave me a leaflet of [Christian rehabilitation organisation]. (P6:119)

I used to work with a Christian ... I remember we were going to the bus one night and she says to me "Edith, why do you drink such a lot?, Why do you do these things? Is it because you('ve) trying to find Jesus?" ... after I'd had the baby and I was pretty low and things weren't going right, her words used to come to me (and) I found myself picking up me kids, you know the Gideon's [BRIEF PAUSE] bible, reading them ... (P8:69)

...when I got baptised people come to me and said "Oh I've praying for you for ages" so I do feel that their prayers worked and were answered. (P8:446)

3.4.2. Barriers to change

Despite the difficulties associated with problematic substance use, described above, there were a range of factors that appeared to inhibit change (***Barriers to Change***). It was suggested that a stage of *psychological readiness* had to be reached.

... if you come off heroin or anything [BRIEF PAUSE] if you're not ready [BRIEF PAUSE], up here [POINTS TO HEAD] you ain't going to do it ... it's a mental thing ... (P9:325).

Prior to this, problematic substance use may be conceived of as a stage that will be grown out of *(P5:279-282)* or people may not recognise a need to deal with underlying issues *(P4:159-160).* Substances themselves appeared to influence individual's perceptions and may have affected whether or not any need to change was perceived *(P6:614-616).* Some did go through the motions of making changes prior to a state of psychological readiness to please others but this did not lead to lasting change *(P3:309-314).*

There was a belief that substance use could no longer be controlled *(Reduced control over substance use, e.g. P3:516-520),* but once a state of psychological readiness was achieved, a lack of available and appropriate support, information and interventions could still represent ***Barriers to Change*** *(Appropriate support limited).*

I would pray and ask God to help me, obviously I mean it.... When I take it out there [secular world], it doesn't stop me from using because there was no kind of structured way of how to, do you know what I mean. It's more deeper than deciding. It's not a decision, it's a programme. (P4:55)

Substance use was often not disclosed, for example to relatives, work colleagues and sometimes religious representatives, or was actively hidden.

...because people that are from the [Religious Institution], there was no opening up from me to them. Even if I did they wouldn't have been in the right position to give me the right feedback (P4:35).

A high level of functioning sometimes meant that others did not recognise that there were any difficulties *(P5:539-541).* These factors therefore also limited support. Even when interventions were readily available, the form of these could be off-putting to individuals or perceived as ineffective *(Intervention approaches ineffective/off-putting).*

...the day sessions were a waste of time I have to say, these were ones where you went to, you were breathalysed and you were taught about the physical signs of alcohol and / but you

didn't get counselling there, (we used to sit in) group work and that was just [PAUSE] not / almost like an insult of intelligence. (P5:307)

There was also a fear of change and what this would mean *(Fear of loss/change).*

... I had loads of excuses which seemed reasonable to me, for reasons why I couldn't do that [stop drinking]...Like I could lose my job, I, I had to provide, I had to be someone at / what would I be if I stopped drinking, (was it my life), you know take away the comfort zone, the security blanket, you know um I had the fear of change ... (P5:326)

Substance use appeared to be maintained by the functions it served, for example, regulating emotions and offering an altered state of consciousness.

I used the drugs then to fix myself, to just get totally out of it so I wouldn't know, anymore. So, you know, so I'd be that buzzed up all the time I was in another world, reality was a long, long way away... (P3:218).

A vicious cycle could develop, for instance, negative emotions such as guilt could be a by-product of substance use, promoting further use *(Factors maintaining substance use, e.g. P5:257).* It appeared that the function served by substance use needed to be replaced with an alternative, as directly reflected upon by one participant.

I know to get off drugs you need to replace it with something else... (P6:321)

Some substances were also perceived as *harder to give up* than others *(P7:166-169)*, this may have been due to the intrinsic properties of substances or individual's perceptions but this seemed to mean that some substances were more likely to be continued with.

A range of factors then seemed to represent ***Barriers to Change***, including psychological and social factors.

3.4.3. Ambivalence

There sometimes seemed to be a dynamic tension in the form of ***Ambivalence*** between ***Factors Promoting Change*** and ***Barriers to Change***.

...I just thought I was trying to get as high as I could, have as much fun as I could [PAUSE] but I wasn't stupid either, you know what I mean, I knew that £30 pounds worth of gear is not a good idea, 'cos there's a good chance you could go over. (P3:337)

If the ***Ambivalence*** was resolved in favour of ***Factors Promoting Change,*** then change may be initiated. As previously mentioned, this pattern of change appeared to represent a journey of ***ELABORATION***. A variety of elements appeared to form a portal through which there could be elaboration from the narrowed state of life that accompanied extreme stages of problematic substance use, as discussed below.

3.5. Journey of elaboration (return of the prodigal).

3.5.1. Gateway to change

As previously introduced, there was a concept that a *state of psychological readiness to change (P9:450-454)* must be achieved. It would appear that the ***Factors Promoting Change*** can sometimes cause a shift to this state of psychological readiness to change, for example recognising the impact of the *negative consequences of substance use (P7:150-154).* Some attributed God as having a role in the development of a state of readiness to change.

...the click...that light, that light that God really sent in the heart you know...it's what I was saying it's when you are ready to hear, and that's when God decides... (P4:958)

A component of a state of psychological readiness to change appeared to include a belief that change was possible, on occasion prompted by the responses of others to disclosure of substance use.

Right, um [PAUSE], so I'm still on heroin but [PAUSE] (I) I've got it now that I, I can do it, you know (P9:387)

As people became ready to make changes, there appeared to be an *Openness* to novel paths *(P7:531-533)*, perhaps cultivated by a sense of desperation at the prospect of a continued life of problematic substance use and associated difficulties.

I was just going to be open to whatever, was going to happen 'cos I just wanted to change...I just always knew that, it was either life or death, I was either going to sort myself here or I'm

going to go back (and die really) 'cos I just thought there was / there wasn't much (left really). (P6:277)

Some reached out to 'God' for help *(Praying for help).* This was true of people both with and without a strong pre-existing faith *(P6:112-114).*

...I'd...just pray and ask God to help. Um, finally one day I just said: "I don't know if I have a drinking problem but if I do please give me some help" and everything kind of fell in place after that. (P1:141)

An openness to religious concepts may have been influenced by previous exposure. For some this included direct contact with religious organisations.

I was in a family that had a house group going on in it's own Church / err in it's own house as well as the Church, I was involved with Sunday schools and everything really and it was, it was normal to me... (P5:80)

Even without strong religious affiliations, a pre-existing interest in spiritual or religious ideas was sometimes expressed *(P7:276-281).*

...I sit here sometimes I think, I don't know if I ever did believe in him [God], but there has been times in my life that I've really prayed and I've always been [PAUSE] spiritual, do you know what I mean I've always found that side of life comforting, appealing, and something I've been interested in. (P3:601)

The role of pervasive cultural narratives was acknowledged.

I think I always believed in Jesus ... but I think that's (it's) harder not to believe in him because you're force fed this stuff in, in the media, in schools... (P7:647)

Opening up to 'God' was seen as initiating a chain of events, ultimately offering avenues away from problematic substance use *(Pathways to help).* For some, access to such avenues occurred directly or indirectly through religious organisations or contacts (*P1:164, P6:115-122).*

... I spoke to my Vicar but I did ask him and two other people, one person knew someone who knew someone else that did a rehab and actually got one of these leaflets [Shows leaflet of Christian Rehabilitation Centre] sent to me and another guy said he'd look on the internet... (P5:545)

As previously mentioned however, there were sometimes barriers to gaining help through others, including religious networks.

Even when there was an initial reluctance to engage with spiritual/religious ideas states of apparent desperation appeared to create an openness to such notions.

When I came in here someone said try praying, [MOCK EXPRESSION OF SHOCK – BOTH LAUGH] (Fucking Hell) "You're mad ain't ya, what possible good is that going to do me?" but then I was in that much pain I thought I would give anything a go, you know, anything... (P3:710)

Encountering something in others may have served to increase openness to novel concepts *(P9:364-366).*

I remember going to the Church and everyone was singing 'nd seemed really happy 'nd, and I really wanted that and I wanted, um to be happy... (P6:291)

A common theme was the development of the idea that God can speak through others.

...when you realise that you can't do it alone and God speaks through other people then, um, I don't know it's definitely changed my attitude and my ego. (P1:708)

This may have helped to cultivate a willingness to consider the ideas and advice of others.

...this time around I, I believe that [PAUSE] God speaks in everyone else mouth, mouth, you know, even if you are atheist ...That's what now happening to, pay attention to whoever says whatever he says and I try and look at it from [PAUSE] sometimes many different areas. (P4:689)

The suggestion of others was sometimes directly responsible for the experimentation with spirituality.

Yeah I don't think it would have been possible without being shown, well without it being suggested to me that I try, a spiritual path. (P3:953)

In order to make way for a new life free from problematic substance use, there is also an element of people having to extract themselves from their old lives *(Extraction from old life, e.g. P6:180)*. For some, this meant considerable sacrifice *(P1:478-483)*. Additionally people had to *overcome* their *physical dependence* upon substances and some required the treatment of co-existing mental health problems *(Treatment of other conditions)*. Once the ***Gateway to Change*** had opened up, a variety of factors appeared to facilitate change and contribute to its maintenance.

3.5.2. Facilitating/maintaining factors

There was a spectrum of involvement with formal and voluntary intervention services/organisations amongst the participants *(Therapy/Interventions)*. Views regarding pharmacological approaches varied: sometimes this appeared helpful whilst one participant in particular felt they could never be free using medication.

Um, alcohol was more of a problem, um I found that harder so I went on disulfiram [PAUSE] um, which is the drug that makes you throw up if you have [BRIEF PAUSE] a drink... And I take that everyday so I haven't had a drink in four months and twenty seven days. (P7:10)

I haven't met anyone who stayed clean with methadone or subutex. How can you? You are replacing something with something. It's a total abstinence thing, because I would not feel happy that I stopped heroin while I have some kind of thing I need to take everyday. I'm still weak, am I? You tell me I'm not totally free, totally, like (before), if I had my meth or I had this or I had that, the spiritually malady is still there. (P4:549)

Interventions sometimes seemed to offer new insights, for example generating understandings of the past *(P3:74-95)* and offering the possibility of developing alternative ways of being for the future. There was reference to a gradual process of learning through every-day life situations and from the experience of others *(Learning/development)*, as illustrated by the following quote from 'Doug':

... here [Faith Based Rehab] I found that people were real, um, they were consistent, errr you were there 24 hours with them so you saw them when they were tired, they were grumpy or whatever and you saw yeah they were grumpy and they might (snatch) at you or something but (at least they're sorry) and they meant it and it was over time that you realized if you could [BRIEF PAUSE] (... act) you could perhaps give some of Doug rather than you know the guy who sort of like always putting on the act or (what he can only show you sort of thing) (P5:670).

A range of phrases and sayings were used by individuals to help reinforce new ideas and alternative ways of being, drawing on religious or 12-step themes *(P9:997-998, P1:737-741)*.

...they said to me at anger management you should do this count to 10 business, I don't do that [PAUSE] I just do this, 'No, that's not Christian' I tell myself... (P7:611)

Beliefs about substance use often seemed to change, sometimes in line with religious frameworks.

...I don't agree with getting drunk but um I know that it's okay to have a glass of wine with your meal or something like that...that's okay but not, not getting drunk 'cos you don't know what you're doing and drugs is just totally wrong, you know. (P6:590)

An important area of development seemed to be the emergence of an understanding of the imperfect nature of life and people *(Imperfections)*. There was recognition that suffering was unavoidable, but also a sense in which positives could be drawn from suffering. *(P1:536-537)*

That's how you grow spiritually, through suffering. (P4:241)

People came to recognise that making mistakes was part of human nature but also there was a feeling that these need to be addressed, for example through dialogue and *forgiveness*.

If it happens [making a mistake] then I bring it out. I don't keep it in (my head) ... Talking about it and also, talking about it to the right person... (P4:594)

I'm not a perfect person, I've still got my faults 'nd wort but at the end of the day I can say sorry can't I to somebody... I think he [God/Jesus] forgives me, tells me not to do it again but we all fall don't we. (P8:764)

Forgiveness for some also appeared to offer a means of coming to terms with the past, both their own behaviour and hurts inflicted by the actions of others.

Um, just knowing that I have God that's forgiven me...you know Jesus was born to take all our sins and forgive us and for me that just blew me away because (I) was always carrying

stuff that I did you know and um, [PAUSE] and because I'd been forgiven, being able to forgive [PAUSE] that guy that I was with, everything that he did to me and other stuff that happened to me. You know that whole line of forgiveness is just, really spoke to me because um, I've been able to / I think only through that I've been able to let, let things go you know and then you realize when you let that go you're able to, be so much happier (...) you know live, live better as well. (P6:352)

The implementation of *spiritual practices* seemed to offer alternative coping strategies that were readily available.

...if I feel things are getting tough in home, 'cos it can be sometime, I'll put on (a) praise tape yeah... (P8:359)

...prayers a thing I use all day, all day long sort of thing... (P5:815)

Spirituality was also described as a resource to deal with cravings.

...I was having thoughts of drinking, (made me) have a craving...[Thought] I've got to take this / take the power away from this. One of the ways of doing it was using you know / reminding myself of how bad it is when I do drink. Err, and I mean that for me is a spiritual thing to do now because the steps are all about healing the spirit. So I connected with my spirituality straight away. I mean I / when I got into the toilet had a quick prayer as well...But, um, that helped, that helped me to get through that craving. (P3:781)

Another participant attributed spiritual forces as having removed cravings.

My cravings had gone... I've never got through that craving before. So it was I think the spirit stopped me from craving 'em. (P9:843)

Spiritual practices also seemed to generate an altered state of consciousness on occasion *(P3:728-758).*

...I can be in the, in the middle of a meeting um, I play congas and I can get into a rhythm and people are praying or whatever and I'm playing this rhythm and that for me is sort of my quiet time, yes, I'm physically doing something but I'm somewhere else and switched off as well. (P5:876)

Not everyone however, endorsed all spiritual practices or particular elements.

I don't believe you should pray for specifics (P7:743)

For those willing to try different spiritual practices the consequent experiences *(Spiritual experiences)* appeared to amplify their openness to such approaches *(P6:301-305)* setting up a *positive feedback cycle.*

...the first time I did it [prayed], it just helped that little bit. It sort of organizes my head (a bit) and I thought this is worth keeping up this is. It snowballed from there. (3:968).

Similar cycles appeared to exist with other actions, for example, through helping others self-esteem appeared enhanced, potentially serving to maintain and develop changes *(Good-deeds e.g. P1:785-786).* Sometimes this involved helping others with problematic substance use.

I help people now...Get 'em to a rehab in [City], got two, three off / well not g..., got 'em off heroin but I've got 'em there and err...I just think it is that he's turned my weakness into my strengths and err I just get called from all over...it's encouraged me that [BRIEF PAUSE], you know, a loser, well not a loser but a person that was been in that area can now help people, you know, kick that habit. I s'pose it makes me think 'Yippee' you know like I am, I am, I have turned out to be something that [PAUSE] that can be useful for people. (P9:904)

Individuals also seemed to cultivate a sense of *gratitude*, often extended to God *(P9:967-970),* which served to remind them of the positive results of the changes they had made in their lives, again potentially maintaining these changes.

...I keep a grateful heart... (P1:776)

Affiliations with religious organisations provided a network of individuals to offer support and guidance.

...you know for me Polly and Ricardo, they're the pastors here, and they've been great for me, they've been / one of them's just totally encouraging and I don't think I ever had that in my life, you know um, 'nd Polly's just been a friend and a mother all in one [LAUGH]. She's there when I have problems and just really, she's always really comforting and she always just has an answer to everything... (P6:499)

A sense of being *loved* and *nurtured* by God or others seemed to have a profound effect *(P8:102-110, P7:449-454).*

...everyone was just really loving, yeah and that really touched me 'cos I felt, I felt like a reject before, 'cos you are treated like that, I mean on the street you, you get people that spit at you 'nd, [BRIEF PAUSE] and just, you know (that you, just call /) you're just like an outcast really. (P6:249)

In the journey of ***ELABORATION***, in addition to changes around substance use there was a far broader spectrum of changes ***(Wide Ranging Changes)***, these are reviewed below.

3.5.3. Wide ranging changes

The broader changes in individuals were noticed by others as well as the individuals themselves *(P6:661-662, P8:826-832).* Further to the changes already mentioned, there were suggestions of individuals feeling more secure and less anxious *(Changes in self, e.g. P5:701-702).*

More secure in myself, and that's taken time... (P6:347)

There were also changes in interactions with others, for example a new found confidence in this *(Changes in interactions).*

...I've found I've been really, really nice to people, chatting to people about you know, in shops and stuff about 'Hi, how you doing', being a lot more confident, soberly confident um and talking to people ... (P7:576)

There appeared to be a shift in priorities from substance use to other priorities, with a renewed sense of *purpose in life*. For some this meant 'living for God'.

I knew that God had touched my life because I began to see more of a purpose to live and enjoy life which, I missed from the age of 11 or 12...I believe God give me the answers to that, you know, to live for him 'nd purpose of living... (P6:314)

For many, this purpose seemed to include the already mentioned feature of helping others, including those with problematic substance use.

In terms of individuals' *spiritual beliefs*, a belief often seemed to develop that God would help individuals and that ultimately things would be alright because of this *(P8:605-607, P9:1192-1193)*, fostering a sense of hope.

...I couldn't do this without my faith. I'm developing a faith. I have faith it's going to be alright 'nd, in that / I sort of had a little bit of faith when I got here but (you know like, it was in the) rehab (...), they would help me give me the tools I need to start getting myself better. Since I've been here it's now created that faith that it's going to be alright, because God's in there for me. (P3:690)

In the journey of ***ELABORATION*** a previous concept of a punitive God was sometimes replaced by a perception of a more loving God with whom a personal relationship could be established *(P6:143-145, 332-333)*.

I had to try and get rid of the punishing God that the Catholic Church had (...) and err [BRIEF PAUSE] get a loving and forgiving God. (P1:650).

A number of people incorporated ideas from a variety of sources into their spiritual belief framework *(P7:414-422, P3:730-733).*

3.6. Risk

While not a focus of the research, indications relating to relapse and **Risk** were present in the accounts. Across the process of ***ELABORATION*** there were points of potential risk. Within the **Gateway to Change**, while people may *overcome physical dependence*, if underlying issues are not addressed *(Underlying issues not addressed)*, then there may be a return to ***Problematic Substance Use*** *(P3:309-314).* In the early stages change appeared *hard work* as new pathways were furrowed *(P7:356-358).* Later in the journey of ***ELABORATION*** however, these pathways seemed more established and a return to previous ways less likely *(P8:763-764).* As at the point of initial **Vulnerability**, *negative life events* again appeared to represent a point of risk *(P7:247-250),* unless alternative coping strategies were established. Thinking patterns appeared to represent a risk, for example the idea that substance use could be managed without it becoming problematic once again *(Cognitions, e.g. P4:383-385).* In people's spiritual lives there were sometimes difficult spells, which may represent a potential risk *(Difficult spiritual times, e.g. P1:638).* At such times people sometimes employed spiritual practices, on occasion acting on the advice of others *(P3:698-706, P1:644-647).*

3.7 Summary

The current model suggested a range of ***Vulnerability*** factors for ***Problematic Substance Use.*** The development of ***Problematic Substance Use*** was characterised as a process of ***RESTRICTION*** with other interests and responsibilities being pushed out. In terms of change away from this the model conceived of a dynamic tension between ***Factors Promoting Change*** and ***Barriers*** to this, generating ***Ambivalence.*** The journey of change was characterised as one of ***ELABORATION***, as individuals became open to new ideas and practices, including spiritual or religious ones, which then served to ***Facilitate and Maintain*** change. Changes extended beyond alterations in substance use, encompassing new beliefs, patterns of interaction and ways of being ***(Wide Ranging Changes)***. The change process included, for some, the evolution of a pre-existing faith, referred to as the *Return of the Prodigal*. Although not a particular focus of this study, a range of potential areas of ***Risk*** for relapse were also indicated. Spiritual and religious factors appeared to operate at different phases of the model, as will be discussed in detail in the next chapter, for example religious and spiritual factors contributed to cognitive dissonance that promoted change and they later provided a purpose in life.

4). DISCUSSION

4.1. From restriction to elaboration

4.1.1. Introduction

Emerging from the current study was a conceptualization of the development of problematic substance use as a process of ***RESTRICTION.*** Substance use increased in salience and came to be a central focus overshadowing other interests and responsibilities. The journey of overcoming problematic substance use was captured within the counter-concept of ***ELABORATION.*** Participants described a developing openness to novel paths, including spiritual ones. Exploring new avenues opened the way to alternative ideas and experiences, these sometimes amplified individuals' openness to continue with new pathways. For some the journey of ***ELABORATION*** incorporated the evolution of a pre-existing faith *(Return of the Prodigal).* For others this was a new experience, although there had sometimes been a previous interest in spiritual and religious ideas.

The notion of problematic substance use as a process of ***RESTRICTION*** is consistent with current diagnostic categories of substance use disorders, which refer to substance use displacing other activities and social role obligations (APA, 1994). Similarly Brown (1997) proposed a theoretical model of addiction in which an individual's repertoire of rewarding activities narrows as the object of the addiction becomes increasingly salient and takes precedence over all else. Brown's (ibid) model also suggested that recovery from addiction involves the development and regeneration of a broad repertoire of reinforcing activities. This would appear to reflect the notion of ***ELABORATION*** in the current model, suggesting that there may be a generic process of elaboration in overcoming problematic substance use common to spiritual/religious means as well as other approaches.

4.1.2. From restriction to elaboration: An example concerning meaning/purpose in life

The ***RESTRICTED*** pattern of life associated with problematic substance use in the current study was characterised by a sense of *just existing*, suggesting a lack of meaning. As noted by Stevens (1996), 'A life which is deficient in meaningfulness is one which is experienced as lacking in point, purpose and vitality; living is merely 'going through the motions" (p.202). Consistent with this empirical studies have suggested a lower level of meaning in life amongst individuals with problematic substance use compared to other groups (e.g. Nicholson *et al.*, 1994), this may however be confounded by the use of inpatient population samples. The sense of *just existing*, in the current study, appeared to represent a ***Factor Promoting Change*** and the journey of ***ELABORATION*** could be regarded as a quest for meaning. Spirituality would seem to offer a source of meaning. Reviewing definitions of spirituality Cook (2004) noted that meaning/purpose represented a relatively common theme. For the participants in the current study this spirituality was contained within a religious framework. Religious faith often afforded participants a sense of *purpose in life,* sometimes described as 'living for God'. One common way in which a sense of purpose was expressed was through helping others *(Good deeds)*, including helping others with substance use problems. Reviewing the literature relating to spirituality and addiction, Morgan (2002) referred to 'service to others, particularly those still caught in the mire of addiction' (p.74), as becoming a vocation for those in recovery. Morgan's review focused predominantly upon literature pertaining to 12-step traditions however, the current study included a broader spectrum of participants. Helping others *(Good deeds)* was conceptualized in the current study as part of a positive feed back cycle in the process of change, potentially enhancing factors such as self-esteem and thereby serving to maintain and develop changes. Consistent with this helping others has been found to be associated with higher levels of mental health in a large sample of

Church members (Schwartz *et al.*, 2003). The enhancement of self-esteem would appear to address one of the ***Vulnerability Factors*** identified in the current study.

In the sometimes narrow, problem focused, approach of current statutory service provision it would seem that meaning and purpose of life issues may be neglected. It would appear however, from the current study that they can represent an important aspect of change. Concurring with this, Nicholson *et al.* (1994) suggested that 'life meaning issues' ought to be considered by treatment providers. One approach that could be regarded as addressing sources of meaning in individuals' lives is the Community Reinforcement Approaches (CRA) (Miller *et al.* 1999). This seeks to 'make the client's alcohol [or drug]-free life more rewarding and affirming' (p.118). Miller *et al.* (ibid) noted that this approach is however not widely known. Meaning issues may be more pertinent to some groups than others and interestingly Project MATCH, a large randomized clinical trial, found that the effectiveness of a 12-step approach to aftercare, as compared to Cognitive Behavioural Approaches, may be of reduced effectiveness for clients with low meaning-seeking (Project MATCH research group, 1996).

4.2. The complex journey towards elaboration

4.2.1. Reflections of a generic model of change

The journey towards overcoming problematic substance use was complex. Factors operated to inhibit or reverse movement away from problematic substance use, as well as to promote or facilitate this and there was sometimes a dynamic tension between these bidirectional forces in the form of ambivalence. This would appear to reflect aspects of a generic model of change which has been influential in the addictions field, namely Prochaska and DiClementes' Stages of Change or Transtheoretical Model (DiClemente, 2003). The Transtheoretical

Model proposed a variety of stages involved in change and consistent with the current study highlighted the role of ambivalence. One ***Barrier to Change*** in the current study's model was the absence of a *state of psychological readiness*. Aspects of this would appear to resonate with an initial phase proposed by Prochaska and DiClemente of Pre-contemplation. Pre-contemplation represents a stage during which individuals do not perceive their substance use as problematic and see no need for change. One ***Factor Promoting Change*** in the current study was words shared by concerned religious individuals (*Role of Other People*). This appeared to stimulate reflection and could be considered as potentially promoting a shift to the next stage of change suggested by Prochaska and DiClemente, namely that of Contemplation, during which the possibility of change is considered and its costs and benefits weighed. The current model's sub-categories, within ***Barriers to Change*** and ***Factors Promoting Change,*** would appear to represent costs and benefits to be considered, for example the *negative consequences of continued substance use* versus the *fear of change* and what change would mean.

One criticism of Prochaska and DiClementes' cycle of change model is that the stages are arbitrary divisions assuming coherent and stable plans for change (West, 2005). DiClemente (2005) however, argued that the stages represent identifiable tasks conceptualising states through which an individual may shift rapidly back and for, rather than traits. DiClemente (2003) suggested that interventions need to be orchestrated to 'mirror the process of change' (p.249). This may have been a factor explaining why some interventions were off-putting (*Intervention approaches off-putting*) to participants in the current study, for example tasks aimed at promoting contemplation presented at a point of readiness for action. This highlights the need to tailor approaches to the individual and to adjust this over time to fit their state of flux. It would also seem important that interventions are consonant with

individuals' belief systems. For example the current study revealed that substitute medication was not always acceptable to participants.

4.2.2. Cognitive dissonance and faith communities *(Return of the Prodigal)*

One ***Factor Promoting Change*** in the current model was *cognitive dissonance*. A number of participants had a clear pre-existing religious belief system which was at odds with substance use, creating cognitive dissonance that is a state of 'conflict between belief and overt behaviour' (Reber, 1995). In contrast to the general finding that problematic substance use tends to be associated with a lack of religious involvement/affiliation (Miller, 1998) those in the current study with a clear pre-existing faith continued their involvement with faith communities. This may have served to maintain and promote the cognitive dissonance experienced. Generating and amplifying cognitive dissonance or, discrepancies between an individual's current behaviour and broader goals and values, represents an aim of the therapeutic approach of Motivational Interviewing, (MI), (Miller & Rollnick, 2002). An important point made by Miller and Rollnick (ibid), is that the process of amplifying dissonance should not be experienced as coercion as 'the discrepancy is between current behavior [*sic*] and goals or values that are important to the person' (p.39), it is not trying to impose another's goals or values. In the current study it was noted that there could sometimes be an apparent reluctance to disclose substance use, for example to religious representatives. This may be due to a fear of judgement and stigma. This may represent an area for liaison and dialogue between health professionals and faith communities, sharing understandings about substance use and helping to facilitate effective responses to disclosures. Individuals able to disclose their problematic substance use to others within their faith community often found this represented a *pathway to help*, highlighting the importance of religious having information made available regarding sources of assistance. Social Behaviour and Network

Therapy (SBNT) (Copello *et al.*, 2002) aims to activate/develop social networks who will represent a constructive support for changes in drinking behaviour in instances of problematic alcohol use. It may be equally applicable to drug use. Faith communities and religious leaders might represent an appropriate resource for social networks for people of faith.

4.2.3. Optimistic beliefs

One foundation for the journey of ***ELABORATION*** appeared to be developing a *state of psychological readiness.* It was suggested that this included a shift to believing that change was possible; this is consistent with the MI concepts of fostering hope and enhancing self-efficacy (Miller & Rollnick, 2002). For participants in the current study it appeared that a belief in the possibility of change may be generated directly through the responses of others and indirectly through encountering different ways of being in others *(Role of other people).* Additionally hope may be supported by an individual's faith, as referred to by the current participants. Consistent with this higher levels of religious faith and spirituality amongst recovering individuals have been found to be associated with an optimistic life orientation (Pardini *et al.*, 2000). Feeling *nurtured/loved* may have served to facilitate a sense of self-efficacy. A range of therapeutic approaches highlights the paradox that acceptance of the client as they are facilitates change (e.g. Linehan, 1993; Rogers, 1961).

4.2.4. Open minded

Central to the journey of ***ELABORATION*** was the development of an openness to new concepts and novel practices. Personal Construct Psychology describes a 'Creativity Cycle' through which change may occur (Fransella and Dalton, 2000). This perspective proposes that individuals have construct systems through which they understand and make sense of the world. People are conceived of as behaving like scientists testing out their constructs or

theories. With a loosening of an individual's construct system alternatives may be explored and tested out. This appeared to reflect the process of participants becoming *open minded*, for example trying out new ideas such as prayer which they then continued if found helpful. Participants' exposure to spirituality or spiritual and religious practices in others may have introduced novel constructs, for example the belief that people could be happy without drugs, or led to the revision of pre-existing concepts for example beliefs about prayer or God.

4.3. Superseding substance use

Substance use appeared to serve a variety of functions in participants' lives, such as regulating affective states and facilitating social engagement *(Factors maintaining substance use/**Vulnerability Factors**)*. This is consistent with functionalist approaches to understanding substance use which emphasize the role of underlying functions served by substance use (Orford, 1985). Alexander and Hadaway (1982) conceive of substance use as an adaptive response but note that such adaptation attempts are not necessarily successful. In the current study substance use did not appear to offer the ideal solution to the needs being addressed. There were for example, difficulties in ensuring that the level consumed gave the desired effect but not unwanted effects. In addition *tolerance* to substances developed over time and positive feedback cycles were sometimes set up with substances being consumed to try and alleviate negative emotional states generated through substance use, such as guilt *(Factors maintaining substance use)*. These limitations may in themselves promote the seeking of alternative ways of addressing the needs for which substances were used. A theory of substance use being replaced or superseded by alternative strategies was generated and explored in the current study. Long-term follow up studies have identified the development of substitute dependencies as a factor in continued abstinence (Valliant, 1988). In the current study spiritual and religious resources appeared to offer an alternative means of addressing a

number of functions potentially served by substance use; namely providing coping resources, facilitating social engagement; and achieving altered states of consciousness, as considered below.

4.3.1. Alternative coping resources

In the current study, *negative life experiences* and *mental health* or *emotional difficulties* were posited as ***Vulnerability Factors*** for substance use, when these co-occurred with *access*ibility, and it was considered that this may link to a lack of available alternative coping mechanisms *(Limited social support network)*. Additionally negative emotional states appeared to be a *factor maintaining substance use*. These ideas would appear consistent with functional models of substance use and empirical evidence that psychological distress and mental health difficulties are related to substance use (Gorsuch & Butler, 1976; NTA, 2002). Religion and spirituality appeared to offer participants in the current study a range of alternative coping resources including, *spiritual practices*, such as prayer and worship. These appeared to be readily available and accessible coping resources, independent of the presence of other people. Additionally, religious communities often offered a source of support (*Religious organisation affiliations)*. Harrison *et al.* (2001), in a review of the literature on religious coping, concluded that positive religious coping strategies such as seeking spiritual support, collaborative partnerships with God (ego-religion) and receiving congregational support, were generally associated with lower rates of depressive symptoms. Obtaining new social support has been found to be a factor associated with abstinence in outcome studies (Valliant, 1988).

4.3.2. Social engagement

The current study conceptualized shyness as a ***Vulnerability Factor*** *(Personal characteristics)* for substance use. Similarly, quantitative research has found that shyness, in conjunction with other factors rather than alone, represented a risk factor for substance use, at least amongst males (Ensminger *et al.*, 2002). Interestingly it was males in the current study, who had previously been shy or anxious about social situations, who suggested that substance use facilitated social engagement. Consistent with this, previous research has indicated that an expectation of increased self-confidence represents a motivation for alcohol consumption (Orford *et al.*, 2004). McMurran (1994) has suggested that, 'learning to socialize confidently without the aid of alcohol or drugs ' (p.111) may represent an obstacle to be overcome in addressing problematic substance use. In the journey of ***ELABORATION*** there was a suggestion that participants generally felt more secure and less anxious, with mention of a new found confidence in social interactions. Attachment theory suggested that secure attachments or 'a secure base' facilitates exploration including social interactions (Holmes, 2001). Holmes (ibid) refers to a secure base in adults as 'a representation of security within the individual psyche' (p.7). Feeling loved by other people within a religious community, and/or God, was a common theme and may have provided a sense of a secure base, fostering confidence and facilitating social interactions.

4.3.3. Altered states of consciousness

A description within the current study suggested a sense of altered states of consciousness occurring with substance use. Altered states of consciousness (ASC) have been defined as 'any mental state(s) ... which can be recognized ... as representing a sufficient deviation in subjective experience or psychological functioning from certain general norms for that individual during alert, waking consciousness' (Ludwig, 1966, p.235). Marlatt (2004), suggested that 'Addictive behaviors, [*sic*] ... might be understood as misguided attempts to

solve the problems of human existence by artificially altering one's state of consciousness with psychoactive substances that temporarily mimic authentic spiritual transformation' (p.263).

It has been suggested that the desire to experience ASC represents a universal human motive (Weil, 1972, cited in McPeake *et al.*, 1991) and McPeake *et al.* (ibid) argued that the promotion of alternative means of inducing altered states of consciousness ought to be part of intervention approaches addressing problematic substance use. ASC may relate to the concept of peak experiences. According to Maslow (1971) a key feature of peak experiences is ' ...this total fascination with the matter-in-hand, this getting lost in the present, this detachment from time and place' (p.60). In the current study, *spiritual practices* such as meditation, worship and drumming appeared to offer a means of experiencing an ASC or peak experience on occasion. A variety of activities may and have been employed as a means of promoting ASC, in programmes addressing problematic substance use, including; drumming (Winkelman, 2003), meditation, physical and artistic activities (McPeake *et al.*, 1991)

4.4. The old has gone the new has come

The journey of ***ELABORATION*** involved and generated a variety of changes for individuals in terms of themselves, their interactions, their life-styles and their spiritual beliefs and practices.

4.4.1. Learning through others

Interaction with other people, including people of faith, provided participants with opportunities for learning from the experience of others and through everyday situations. Social learning theory (Bandura, 1977) highlighted the role of imitating the behaviours modelled by others within an individual's social group and according to McMurran (1994), this is an efficient means of learning about complex social behaviour and cultural norms. One area in the current study in which cultural norms sometimes appeared to shift related directly to substance use. Participants' attitudes towards substance use often seemed to change, sometimes in line with religious frameworks, developing a more negative perception. This shift in attitudes would appear to counter the ***Vulnerability Factor*** of a *positive attitude to substance use* suggested in the current study.

4.4.2. Cognitions

Phrases or sayings appeared to be used by participants in the current study to reinforce new ideas and alternative ways of being *(Learning/Development)*. This may be understood within the context of cognitive behaviour models. Cognitive models suggest that early experiences lead to the development of schemas or core beliefs used to understand the self and the world, developing through a variety of experiences including interactions with others (Beck, 1995). Cognitive Behavioural Therapy (CBT) approaches seek to facilitate a process of cognitive restructuring whereby problematic thoughts and beliefs are modified and replaced with alternatives that enhance functioning. The use of phrases and sayings by the current participants could then be regarded as generating and reinforcing new schemas and thought patterns. Similarly Steigerwald and Stone (1999) suggested that the use and adoption of slogans within the Alcoholics Anonymous tradition may be understood as a form of cognitive restructuring. Within the current study sayings often drew upon religious or 12-step themes. For clients for whom these traditions represent a meaningful paradigm they may offer a rich

source of alternative cognitions and training in spiritual competencies may be of relevance for therapists and healthcare professionals.

Furthermore, development of the belief that *imperfections* are part of the human condition may have increased the current participants' ability to tolerate failures, negative circumstances and emotional states. This would appear to contrast to the apparent *personal characteristic* of being a perfectionist, identified as a ***Vulnerability Factor*** in the current model. Cultivating understandings about imperfections may represent a useful therapeutic avenue, perhaps overlapping with addressing all-or-nothing type thinking as within CBT approaches (Beck, 1995).

4.4.3. Forgiveness

In addition to learning to accept imperfections as part of life, participants in the current study had learnt new means of addressing such issues, this included by means of *forgiveness*. Forgiveness of others sometimes offered a means of addressing *negative life experiences* from the past, which were considered as a ***Vulnerability Factor*** for substance use. Participants' receipt of forgiveness, believed to come from God as well as others, may have relieved negative emotions such as guilt, which were previously associated with substance use *(Factors maintaining substance use)*. A recognition that future mistakes would be made, was balanced by the concept that when these occurred they could be dealt with through forgiveness, perhaps providing an ongoing means of addressing negative emotions such as guilt. Murray (2002) has suggested that forgiveness can be useful therapeutically in addressing client issues such as chemical dependence. For those open to this paradigm the current study would appear to suggest that it can offer a means of addressing difficult events from the past and relieve a sense of burden. While highlighting that forgiveness has been

regarded as a 'promising therapeutic tool for repairing emotional hurts and discordant relationships with religious and non-religious individuals' McCullough and Worthington (1994, p.4) exert a note of caution suggesting that it may not always be appropriate to advocate forgiveness, for example it may be misunderstood as minimizing the hurt experienced.

4.4.4. Gratitude

A number of participants in the current study cultivated a sense of *gratitude*, reminding themselves of the positives in their lives, often extending this gratitude to God. Graham *et al.* (2004) highlighted the role of cognitions in substance use and suggested that cognitions promoting use will minimise the negative consequences of substance use and focus upon the positives of substance use. For individuals who have stopped using substances, over a period of time awareness of the negative consequences of substance use may fade, with remembrance only of the positive elements of substance use (Cummings *et al.*, 1980). Additionally the positive gains of not using substances may fade as illustrated in Figure 3.

Figure 3. Changing awareness of the negative consequences and positive gains associated with using and not using substances, over time.

	Short-term	**Long-term**
Not Using Substance(s)	Positives gains apparent	Awareness of positive gains fade
Using Substance(s)	Negative consequences apparent	Awareness of negative consequences fade

Cultivating a sense of gratitude and reminding themselves of the positives they have gained, through not using substances, may have facilitated the current participants' continued abstinence. Studies of urge coping strategies have found abstinence, amongst previous cocaine users, to be positively associated with reflecting upon the positive consequences of remaining abstinent (Rohsenow *et al.*, 2005). Additionally, the active involvement of some

participants in the current study in helping others overcome substance use may have facilitated the retention of the negative consequences of substance use in conscious awareness. Blomqvist (2002) reported that individuals maintaining abstinence sometimes recall the past negative consequences of substance use to manage urges to use substances. An avenue for relapse prevention work would therefore appear to be developing strategies for promoting continued awareness of the gains of non-substance use and the costs of substance use.

4.4.5. Shifting conceptualizations of God

For some participants in the current study, their previous conceptualization of God had been of a punitive being. Gorsuch (1995) and Sessions (1958) have suggested that this might pose a vulnerability towards substance use. Sessions (ibid) made a distinction between 'super-ego religion' and 'ego religion'. He defined superego religion as 'that religion in which tradition and authority blindly dominate the field and in which the concepts of guilt and retribution prevail. It is the religion in which the unworthiness of the individual is emphasized...' (p.121). It is interesting in this regard that there was a theme of 'never feeling good enough' within the ***Vulnerability Factors***. Sessions (ibid) suggested in contrast that ego religion 'emphasizes the individual's personal relationship with God...love, faith and optimism are pronounced, contrasting sharply with the pessimism and the air of impending calamity which characterize super-ego religion' (p.122). Participants' later conceptualizations of God seem to reflect these ego-religion themes. Sessions (ibid) argues that ego religion may offer a potential pathway for recovery from problematic substance use. He suggests that the degree to which religion is identified with the ego[3], 'it inspires security, confidence and sanity' (p.122). A theme in terms of changes recognized by participants in the current study was feeling more confident and

[3] The ego is that component of the self according to Freudian theory that maintains the individual as a whole and learns to negotiate between external reality, primitive instinctual demands and the internalized demands from the socio-cultural environment.

more secure in themselves (*Changes in self/interactions).* Conceptions of God as a punitive being have been successfully challenged within the therapeutic setting (Gutsche, 1994). As discussed in the Introduction, there does appear to be an increasing recognition within the National Health Service of the spiritual dimension of individuals' lives and it appears that standard therapy approaches such as Cognitive Behaviour Therapy (CBT) can be enhanced through reference to individuals' religious belief systems (Propst, 1996). However, a distinction has been made between the role of therapists and spiritual directors (Rizzuto, 1996). Co-operation between treatment providers and religious leaders may offer another approach, and certainly within the NHS there is provision for spiritual care.

4.5. Limitations and future research

While diversity was actively sought in the current study participants were principally affiliated with Abrahamic faiths, predominantly the Christian faith. The small sample size meant that theoretical saturation, that is the point at which no more salient material emerges, was not fully reached. The resource limitations and time constraints however meant it was not feasible to conduct a larger study.

The researcher's own belief framework and professional background may have influenced how the data were viewed, as explored in more detail in the Critical Appraisal. However reflexivity was encouraged through the use of a research journal, regular supervision and peer support meetings. The latter two forums offered opportunities to discuss data and provided interpretations from a range of perspectives. Unfortunately time limitations precluded participant verification.

The current findings were grounded in the accounts of the individuals participating in this study and are not necessarily representative of all attributing faith, religion and/or spirituality as important in the process of overcoming problematic substance use. However, many of the findings appeared to resonate with other research and theoretical perspectives. A number of ideas emerged which may warrant further exploration, for example considering the development of an openness to new ideas, shifting conceptualisations of God and the potentially therapeutic role of forgiveness. It would also be interesting to consider in which other populations meaning and purpose in life may represent an important issue in overcoming problematic substance use and also other difficulties. Additionally it may be of relevance to consider if the process of restriction and elaboration is more generally applicable for example, to other conditions associated with a restricted pattern of life such as depression.

5). CONCLUSION

The current study focused upon the overcoming of problematic substance use in instances when faith, religion and spirituality were attributed as playing an important role. The development of problematic substance use was conceptualized as a process of ***RESTRICTION*** and the journey of overcoming this as one of ***ELABORATION.*** In the development of problematic substance use, substances become of increasing salience displacing other interests and responsibilities. In the journey of ***ELABORATION***, an openness to novel ideas and practices developed. Resulting experiences sometimes amplified participants' openness to continue with new avenues. For some the journey of ***ELABORATION*** incorporated the evolution of a pre-existing faith *(Return of the Prodigal).* For others this was a new experience, although there had sometimes been a previous interest in spiritual and religious ideas.

The study found similarities with generic theories and models relating to substance use and change. For example, the complex journey of ***ELABORATION*** in which problematic substance use was overcome reflected aspects of the Transtheoretical Model of change. This may suggest that there are common pathways to change, independent of the precise elements involved. Factors noted as important in overcoming problematic substance use generally, such as developing a sense of hope and learning alternative coping strategies, emerged in the journey of elaboration partly through developing religious faith, contact with individuals from faith communities and the development of spiritual practices.

Religion and spirituality, including engagement in faith communities, appeared to offer a range of resources. For example, providing a renewed sense of meaning and purpose, revised cultural norms, alternative cognitions and coping resources. For clients for whom spirituality

and/or religion is important this resource may therefore be usefully exploited in the process of overcoming problematic substance use. These findings may also however have broader implications. For instance meaning may be an issue to be considered more generally with clients. Some participants also described cultivating a sense of gratitude which may have served to remind them of the positive gains of abstinence and inhibit relapse, again this may be more generally applied.

Religion and spirituality also seemed to provide a potential means of addressing a number of posited ***Vulnerability Factors*** for substance use. These included: *personal characteristics* such as low self esteem, a tendency towards perfectionism and difficulties with social engagement; past *negative life events,* through the process of *forgiveness* and *positive attitudes towards substance use*. The development of religious beliefs, engagement in faith communities and spiritual practices appeared to supersede a range of functions served by substance use; namely providing coping resources, facilitating social engagement; and achieving altered states of consciousness.

Involvement with faith communities during periods of problematic substance use may have maintained the cognitive dissonance described by individuals with a clear pre-existing faith and facilitated change. For a number of participants faith communities offered a pathway to help, although reluctance to disclose substance use was also noted. It would seem important that there is a dialogue between health care professionals and faith communities and training in both directions. The current study sometimes found a shift in conceptualisations of God, potentially facilitating change, this may represent a further area for liaison between healthcare and faith communities. Faith communities may additionally represent a resource for treatment services in providing support for individuals overcoming problematic substance

use, for example being employed in Social Behaviour Network Therapy. Secular approaches also need to be sensitive to the needs of people of faith, respecting values for example regarding the use of substitute medication.

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Section C). Critical Appraisal

We shall not cease from exploration, And at the end of all our exploring, Will be to arrive where we started, And know the place for the first time. T.S. Eliot (1944) Four Quartets.

CRITICAL APPRAISAL

1. Introduction

It is not possible to document the entirety of every twist and turn of my research journey, but rather it is hoped to give a flavour of the research experience and to highlight some of the issues raised through the endeavour. Consideration will firstly be given to reasons for selection of the research topic and its relationship to my personal interests and beliefs, that is the researcher's position, followed by a discussion of the issue of 'bias'. The processes of recruitment, interviewing, transcribing and analysis are then each addressed in turn. While the Grounded Theory research process is a cyclical one, with phases of analysis and data collection interspersed in dynamic interaction (Strauss & Corbin, 1998), the components are addressed separately here for the purpose of clarity.

2. Research and researcher's position

2.1. Selection of research area and researcher's position

I have a long standing interest in the field of 'addictions', stemming from a concern regarding the sometimes related issue of homelessness. It is my belief that the 'invisible' people living and working on our streets, so many of whom are apparently trapped in the mire of 'addictions' (Willis, 1999, Fountain *et al.*, 2003), are all individuals with great untapped potential. I consider this a compassionate stance; it could alternatively be regarded as a patronising moralistic stance, assuming a particular ideal for life, even suggesting an evaluative judgement about substance use. My focus on an extreme end of a continuum of patterns of substance use would appear to ignore the testimony of, for example, 'chippers', that is non-dependent, intermittent users of heroin (Robson, 1999). Strauss and Corbin (1998)

argued that 'persons are the products of their cultures, the times in which they live, their genders, their experiences, and their training' (p.97). Within the context of my own history, a relatively traditional upbringing with promotion of conservative values within a Judeo-Christian framework, drug use and excessive alcohol use were outside the social norm. Experience of different cultures and sub-cultures has provided exposure to alternative social norms. My psychology training has instigated a further socialization process, giving rise to the experience of holding in tension a multiplicity of sometimes paradoxical ideas. I regard drug and excessive alcohol use, at one and the same time, with suspicion, even fear, but also from a position of intense curiosity as to the subjective experience of, for example, the rush of cocaine or the warm cocoon of heroin.

My interest in the issue of problematic substance use has led to engagement in a variety of related reading and work opportunities, including from my own Christian perspective, for example voluntary work within a Christian Drug Rehabilitation Centre. It is interesting then, given a longstanding interest in religion/spirituality and problematic substance use, that I would not originally have conceived of a research project relating these. Somewhat arrogantly, in retrospect, I considered the selection of topics in the realm of spirituality by those with a religious background rather cliché. There is a question in my mind as to whether I was failing to transcend the culture of psychology I am partly a product of. Miller and Delaney (2005) refer to an antipathy towards religion within the discipline of clinical psychology, which it has been suggested may have a silencing effect (M. Baker, NeCIP Conference, 2005). I became aware that, certainly for me, there was an unwritten sense that religion was not an appropriate topic for consideration within clinical study and practice, despite a recognition that this represents an important and relevant aspect of life for many within the general population (e.g. Brierley, 1999) and therefore potential clients. While this

'unwritten rule' had previously been outside of conscious awareness, I was familiar with suspicions running in the counter direction: that within some religious circles psychology was viewed with distrust (Mental Health, 2005).

There was then, no intention of selecting a topic area relating to the realm of spirituality. I did however wish to exploit my interest in the field of addictions and consulted professionals working in this area. A quantitative project in a different vein within the addictions field was thus selected and the background work commenced. I struggled with the literature in the selected area, trying to stimulate the interest that would sustain a long-term research project. The questionnaires being developed appeared reductionist, forcing simplified responses. Meanwhile peers contemplating qualitative projects were discussing the other side of the coin, the richness but complexity of qualitative data. My project appeared to pale in comparison and I longed to 'get lost' in such rich data rather than tussle with Likert scales on this occasion. Grounded theory represented an approach novel to me but teaching stirred my interest. While previous training in quantitative approaches had been appreciated, I longed to venture into this new land and add it to my repertoire of experience.

Some time later I attended a conference held by the British Association of Christians in Psychology. Looked to with anticipation, the key note speaker was William Miller, internationally renowned for his work in the addictions field. He shared that he himself had a religious background and had also conducted research in the area of religion and spirituality, albeit taking the pragmatic decision to wait until his University tenure had been secured. During one presentation he mentioned that the area of spirituality/religion and addiction was under-researched. Slowly an idea developed in my mind. Spurred by frustration with the original research project, inspiration struck. Legitimised by an eminent Professor of

Psychology and Psychiatry in the form of William Miller I was awakened to the idea that a key personal interest, problematic substance use and the role of spirituality/religion in overcoming this, could represent an appropriate area for scientific enquiry. With some trepidation research supervisors were approached, concurrently with frantic work on a new research proposal and a scouring of the scientific literature on the topic. The research was approved, and at what felt like the very last hour, the research topic was changed. This represented a fantastic opportunity to conduct research in an area that held genuine fascination and to gain experience in a new methodology. Exhausted but exhilarated my research journey had begun and ethics approval was duly sought and gained.

2.2. Researcher 'bias'

From the beginning I was concerned about bias stemming from my Christian beliefs. I reflected on the differences that might exist if an atheist or agnostic conducted the research, however an atheist conducting the research could hardly be considered neutral. My interest was precisely because of my religious beliefs and it is perhaps a challenge to the notion of objectivity that research tends to be conducted within a researcher's area of interest. I realized that my psychological perspective would also exert an influence, psychological theories concerning the nature of addiction and human behaviour were all likely to affect the understandings of the data. Critical realist paradigms suggest that 'the way we perceive facts, particularly in the social realm, depends partly upon our beliefs and expectations' (Bunge, 1993, p.231 cited in Madill *et al.*, 2000). The conclusion was reached that rather than aiming for a neutral interpretation of the data, divorced from the researcher, the ideal needed to be one of openness, seeking to understand the participants' accounts but recognizing the role of the researcher's 'values, culture, training, and experiences' (Strauss & Corbin, 1998 p.43). This made it important to document my flow of ideas, generated by conducting the research

and engaging with the data. Equally it was important to open the data and my ideas to others, with potentially differing perspectives, engaging in reflective dialogue.

3. The research process

3.1. Recruitment

From the conception of the current project the totality of me shaped how it was conducted. In terms of recruiting participants, local NHS services and a range of treatment and religious organisations were approached. The latter included Sikh, Hindu, Muslim, Jewish and Christian organisations. Despite some initially promising responses from a variety of organisations, ultimately participants were successfully recruited only through the NHS, Christian and 12-step organisations. While diversity was explicitly sought, my pre-existing interest meant that I was aware of more Christian organisations, particularly those working with individuals aiming to overcome their problematic substance use. Additionally there may be a bias in service provision towards those within a Christian context (Preston & Malinowski, 2002). Additionally my cultural frame of reference may have influenced how well the approach to each organisation fitted with their own cultural frame of reference, potentially influencing subsequent responses. I became aware that my introductory spiel varied according to the nature of the organisation being recruited, for example emphasizing the concept of spirituality to 12-step organisations and that of religion to religious associations. Unconscious factors may also sometimes have been at work, suggestion of a particular denomination to include was met with some resistance in my mind; the façade of openness did not appear to run as deep as I had previously imagined.

Some organisations suggested that they did not have any individuals meeting the inclusion criteria within their membership. This may have been an accurate reflection; however, I

wondered if cultural factors may sometimes inhibit disclosure of past or current problematic substance use, for example the shame sometimes associated with substance use (Cameron *et al.*, 2002). In the current research data, there certainly appeared to be a suggestion that there could sometimes be a reluctance to disclose substance use to religious leaders. Some organisations, including faith-based 'treatment' services, did not return messages as promised. I reflected that this might sometimes be a manifestation of a suspicion regarding psychology and scientific research in the realm of the sacred. Upon receipt of favourable responses from known contacts, I wondered if the old adage 'it's who you know that counts', might be at work. I wondered how this may shape the advancement of knowledge, facilitating only those already established within particular networks, excluding outsiders. There may however have been a more benevolent motive at work, seeking to protect potentially vulnerable individuals from the unknown.

3.2. Interviews and Transcribing

3.2.1. Interviews

Contemplating the dynamic between interviewee and interviewer, the issue of my own faith was of particular relevance. Davies and Baker (1987) have noted that individuals cast themselves differently for different audiences. What assumptions would the interviewees make and in what way would my presentation shape this? Often I opt to wear a small cross on a necklace. In supervision we reflected that crosses are often worn aesthetically rather than as a statement of faith. One participant did however comment upon my cross; clearly it was noted. It did not however appear to be interpreted as a potential sign of faith by all, and reflections with supervisors on early interviews led to ponderings that interviewees might feel the need to convince me of the validity of their beliefs and experiences. Later participants appeared aware of my religious affiliation, presumably through the host organisations. While

this may have avoided the need to 'convince', it sometimes meant that shared knowledge and understandings were assumed. As one participant commented:

'You know about praying anyway so you know where I'm coming from' (P9:751).

Strauss and Corbin (1998) indicated the need not to accept terms and explanations at face value. There appeared to be a delicate balance between developing a rapport and ensuring that idiosyncratic meanings and experiences were fully explored. In the above instance, an attempt was made to highlight the benefit of hearing the interviewee's experiences while acknowledging the commonality of a belief in prayer. Reflecting back to the interviewee, their initial description *'...being lifted...'(P9:748)* did appear to generate further understanding revealing that the participant was referring to a sense that God offered reassurance that it would be alright and He would not let them go. At other times terms were frequently repeated before they were 'heard' and questions put to try and elucidate their meaning. Still others may have passed me unaware, again highlighting the importance of the supervision process. In addition to a desire to 'convince' myself as the interviewer there may have been a sense of witnessing to the potentially larger audience of the research. Reference was made to the interview being predestined:

'I believe I'm sitting here right now talking to you, it has been set for me as well.' (P4:315)

There often seemed to be an overall sense that, by participating, individuals were investing in something related to their faith.

One interview was conducted by telephone and this had a number of implications. Positively it gave increased flexibility over available times and the geographical location from which participants could be drawn. Conducting the telephone interview from my home in the

evening however, gave a very different feel to the interview. At points, the apparent blurring of professional and domestic boundaries felt uneasy. The absence of non-vocal communication, coupled with an unfamiliar accent, made it harder to interpret subtle cues. Egan (2002) highlighted the role of a range of visual cues in communication. Transcribing raised awareness of the compensation for non-vocal communication through the increased frequency of verbal acknowledgments such as 'right', this could be considered more intrusive than a nod of the head.

During an early interview one participant became upset reflecting upon the past. They commented:

'You know, now when I think about it, when you're asking me these questions, I see how much / why I had so much turmoil and the, the feeling that I was just trapped...' (P1:368).

This suggested that rather than just accessing already formatted information, questions and subsequent reflections can sometimes reframe experiences and understandings, as emphasized by narrative therapy approaches (e.g. Payne, 2006). The above participant had been enthusiastic to take part and given informed consent but there was a question raised in my mind as to how informed consent can ever truly be. Psychodynamic orientations in particular suggest that some material may be kept out of conscious awareness to defend the self (Thomas, 1990). In reviewing experiences, individuals may be confronted with forgotten memories or cast incidents in a new light that could not have been predicted. This emphasizes the importance of proceeding sensitively during interviews. In the introduction to each interview, the freedom not to discuss any particular area and to withdraw without explanation was emphasized. At the conclusion of the interview with the above participant, they indicated they needed time to process all that had been discussed. In the absence of an ongoing therapeutic relationship, there were some concerns about the participant's upset

expressed at points during the interview. It was a relief to have safeguards in place to offer alternative sources of support.

The need to be able to access sources of support was again brought to prominence in a later interview. A participant arrived stating that today was probably not the best for an interview relating to their faith. They had made a commitment to the Christian faith within recent months but the previous night, past actions had returned to haunt them, causing anguish and apparently shaking their commitment. From the stand point of scientific enquiry it would be of interest to include participants at points of difficulties in their spiritual walk, however ethically, this could be potentially exploitative of individuals at a vulnerable time. An offer was made to cancel or postpone the interview but the participant indicated strongly that they wished to go ahead. The interview brought into sharp relief the tension between my role as researcher, therapist and Christian. As a researcher this was interesting material to consider, as a therapist there was a sense of clinical duty and as a Christian a feeling that pastoral care represented a moral duty. At points these roles appeared to dovetail, as with a question about forgiveness:

Interviewer: *'Something that other people have spoken about is sort of the role of forgiveness and I wonder what your thoughts are on that?' (P7:491)*

Forgiveness represented an area selected for therapeutic sampling on the basis of earlier interviews satisfying the researcher role, therapeutically for an individual with a faith system the notion of forgiveness appeared to offer a potential route forward and as a Christian the belief in forgiveness offered potential freedom and redemption for a tormented soul. At other points the roles tore me in distinct directions, there was sometimes clear conflict between the desire to satisfy scientific curiosity and the sense of clinical duty not to delve deep into psychological wounds without therapeutic space to address these. Having reopened the

dialogue in response to an interesting point towards the conclusion of the interview, I rapidly closed it down again when it appeared issues had been inadvertently reawakened. The safeguards again offered reassurance as the key-worker was contacted and offered the opportunity for the participant to address issues in a therapeutic context.

3.2.2. Transcribing

Transcribing the interviews allowed them to be re-experienced from a more distal position. This raised further questions about the interview process and the retelling of experiences. In contrast to the recasting of events and experiences suggested earlier, reflections led to the conclusion that sometimes there was a reiteration of previously shared 'scripts'. The context of participants' lives meant that they had shared 'life-stories' in 12-step meetings or therapy groups or alternatively in the form of a testimony within religious settings. From the outset I had been aware that I was not accessing those not affiliated to a religious organisation nor engaged in formal or self-help 'treatment', however the need for ethical safe-guards discussed earlier would have made this problematic. Certain phrases used by participants reflected those in the literature, for example the 12-step notion of hitting 'rock bottom' (AA, 1981). This would appear to be a dominant social narrative within this tradition, it is my view however, that such narratives do not necessarily create phenomena but influence how these are understood and experienced. For participants outside of the 12-step tradition there still appeared to be the notion of a low point prior to change when difficulties had accumulated and a state of desperation was reached.

Reading for the literature review did however cast a shadow of doubt over my perspective concerning the nature of reality. A paper (Niederman, 2003) referred to the concept of 'Chi', stating that there is no direct translation for this in Western Culture. One attempt to capture

the meaning of Chi suggests that it refers to the vital fullness of life (Ueshiba, 1984 cited in Niederman, 2003). I was forced to wonder about the reality of Chi, was it a phenomenon that existed independently of language but which had only been recognised by some cultures, or was it called into being by the very act of naming it? Not completely able to dismiss either view; that culture shapes our experience of actual realities or that 'realities' are constructions of language, the notion of holding paradoxical views in tension represented the conclusion.

In listening back to the interviews, some questions appeared slightly leading, perhaps extending a participant's potential meaning as may be tentatively tested out within a therapeutic context. This is illustrated in the extract below when the researcher suggests that the concept of not having control might be an issue *(P6:94-105).*

P6: ...Um, 'cos I did, I did even ask for help but just you know the options were methadone um, going to see a psychiatrist 'nd, they just never worked for me, I just always went straight back and even worse because I felt bad because I couldn't, I couldn't get myself sorted out ...

P6: [BRIEF PAUSE] and so ...

P6: Yeah

I6: So it sounds that at that time you didn't feel that you had much control over (...)?

At other times, I made attempts in vivo to correct for potentially leading questions, giving a range of possibilities, as in the below example.

Interviewer: *So when you say pain sort of emotional pain or physical pain or? (P3:18)*

It was assumed that they were referring to emotional pain but not wishing to impose this understanding the researcher extended a clarifying question to include physical pain.

Gradually there was some development in interview style as I began to realize 'less is sometimes more'. A later interview illustrates some learning:

***Interviewer:** When you say pain, what sort of pain? (P6:155)*

In listening back to interviews it was not always clear why certain lines of enquiry had been followed over others, and why questions that sprung readily to mind in re-listening had not occurred at the time of an interview. This highlighted the limited capacity nature of the human brain as an information processor. The interviewer must keep track of the current dialogue but also digest what has already been said and consider which leads to follow up, bearing in mind not only the current interview but the analysis conducted to date.

In attempting to capture the interviews on paper in the process of transcription the complex nature of spoken language became evident. Punctuation can clearly change the meaning of words and so the role of interpretation was present at this stage. With each phase of processing it became apparent that context was being lost, for example in transcribing the intonation is not directly recorded.

3.3. Analysis

The initial process of open coding, that is the detailed scrutiny of small segments of text and the assigning of a label capturing the meaning, represented the beginning of a phase of anxiety. I longed for a 'perfectly objective other' to be constantly present to verify the 'accuracy' of each product of the process of analysis. The notion that data may conceivably be understood in a variety of ways was not one easily held onto by the researcher. The concept of 'artistic' woodturning was found to be a useful metaphor:

'Wood turning began for me when firewood destined for our log burner began to 'speak' to me, the conversations generally consisted of a little voice calling "there's something in here let me out". I spend a long time assessing each lump of wood I turn, in an attempt to do justice to the wood...'

Jeremy Capper – Woodturner

(With permission)

I reflected that just as a single piece of wood may be turned in multiple ways, so data may be conceptualized in a variety of forms, but all are influenced and constrained by the very nature of the raw material.

As the text was divided into coded segments and grouped into conceptually linked categories it again felt that there was a loss of context and decisions had to be made as to how much text to include in each quote to retain the meaning. A critique of approaches coding fragmented text segments is that this neglects the whole, which would shed light on the component parts (Hollway & Jefferson, 2000 cited in Joffe & Yardley, 2004). In the process of writing up and using exemplar quotes these were again checked back against the original transcript to try and ensure the participants' meaning had been captured, additionally as the researcher had personally transcribed each interview this helped to ensure familiarity with the entirety of each interview. There was a dynamic tension between retaining sufficient context and aiming for conciseness to meet word count restrictions. The anxiety regarding context may relate to the fear of 'contaminating' the data with the researcher's own perspective. Strauss and Corbin (1998) refer to fracturing of the data, at points it felt to me that this was like fracturing the lives held within each generously shared account. Coming across the quote below, I was reminded that the research aim was not that of chronicling a biography of each participant's

story but of finding within the multiplicity of stories an understanding of a particular phenomenon.

If the artist does not perfect a new vision in his process of doing, he acts mechanically and repeats some old model fixed like a blueprint in his mind.

- John Dewey, *Art as Experience*, 1934, p.50

(Cited in Strauss and Corbin, 1998)

Time constraints limited the extent of analysis and reflection it was possible to engage in between each interview; this sense of compromise was a source of constant frustration. Similarly resource limitations meant that theoretical saturation was not reached.

The keeping of a research journal and memos, as discussed in the Method section, allowed the researcher to trace the emergence of ideas generated through the analysis, broader reflections and sources of influence. In the initial supervisory discussion of the research proposal the role of social support as a potential underlying mechanism was postulated, along with discussion about locus of control. Reflecting upon this later I again became aware of the fallacy of 'blank slates' but also the value of maintaining a research journal. Having traced the developing ideas regarding the loss and development of meaning with the process of restriction and elaboration, a low point was reached when a paper was unearthed with similar ideas (Giannetti, 1987). It appeared such thoughts had been thought before and I began to consider that 'there is nothing new under the sun'. Whereas however, the author of that paper had juxtaposed a range of research to suggest that 'a religious perspective concerning life functions as an antidote to a lack of purpose in life' (p.194), the current study appeared to take this a step further, participants accounts suggesting that this lack of meaning and sense of 'just

existing' represents a trigger for change. The theoretical model generated through grounded theory appeared to capture a glimpse of the process in action. Qualitative approaches appear to offer one means of capturing some of the complexity around the issue of addiction, for example the multiplicity of functions that may be served by substance use but then equally the different ways in which religion and spirituality may address such a variety of needs.

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Appendix A).

Target Journal: Addiction Research & Theory - Instructions for Authors

Taken from Instructions for Authors (http://www.tandf.co.uk/journals/authors/gartauth.asp)

FORMAT OF MANUSCRIPTS Manuscripts should be typed in double spacing with wide margins (3cm) on one side of standard A4 paper.

Title page: This should contain the title of the paper, a short running title, the name and full postal address of each author and an indication of which author will be responsible for correspondence, reprints and proofs. Abbreviations in the title should be avoided.

Abstract: This should not exceed 150 words and should be presented on a separate sheet, summarising the significant coverage and findings.

Key words: Abstracts should be accompanied by up to six key words or phrases that between them characterise the contents of the paper. These will be used for indexing and data retrieval purposes.

TEXT HEADINGS All headings in the text should be set over to the left-hand margin, and the text should begin on the next line. Type first level (sectional) headings all in capitals. For second and third level headings, only the first letter of the first word should be a capital. Underline third level headings.

For example: .

FIRST LEVEL TEXT HEADINGS.
Second level text headings.
Third level text headings.

REFERENCES.
Style, statistical reporting, and reference citations should conform to the American Psychological Association's guidelines, from the APA *Publication Manual*, fifth edition.

To conform with the APA *Publication Manual*, fifth edition, references should be alphabetized at the end of the manuscript text, in the following formats:

Kozlowski, L. T., Henningfield, J. E., & Brigham, J. (2001). Cigarrettes, nicotine, and health. Thousand Oaks, CA: Sage Publications.

Weinstein, N. (2001). Smokers' recognition of their vulnerability to harm. In P. Slovic (Ed.), *Smoking: Risk, perception, & policy* (pp. 81-96). Thousand Oaks, CA: Sage Publications.

Perkins, K. A., Donny, E., & Caggiula, A. R. (1999). Sex differences in nicotine effects and self-administration: review of human and animal evidence. *Nicotine & Tobacco Research*, 1, 301-315.

FIGURES .
All figures should be numbered with consecutive Arabic numerals, have descriptive captions and be mentioned in the text. Figures should be kept separate from the text but an approximate position for each should be indicated in the margin. It is the author's responsibility to obtain permission for any reproduction from other sources.

Preparation: Figures must be of a high enough standard for direct reproduction. They should be prepared in black (india) ink on white card or tracing paper, with all the lettering and symbols included. Axes of graphs should be properly labelled and approporiate units given. Photographs intended for halftone reproduction must be high quality glossy originals of maximum contrast. Redrawing or retouching of unsuitable figures will be charged to authors.

Size: Figures should be planned so that they reduce to 10.5cm column width. The preferred width of submitted drawings is 16-21cm, with capital lettering 4mm high, for reduction by one-half. Photographs for halftone reproduction should be approximately twice the desired size.

Captions: A list of figure captions should be typed on a separate sheet and included in the typescript.

TABLES.
Tables should be clearly typed with double spacing. Number tables with consecutive arabic numerals and give each a clear descriptive heading. Avoid the use of vertical rules in tables. Table footnotes should be typed below the table, designated by superior lower-case letters.

Appendix B).

Background Information Checklist

Age: _____

Gender: ☐ Male ☐ Female

Ethnicity: *(how would you classify your ethnicity)*

☐ White ☐ Indian

☐ Black-Caribbean ☐ Bangladeshi

☐ Black-African ☐ Chinese

☐ Black-Other ☐ Any other ethnic group
Please describe _____

Marital Status: Are you …

☐ Single

☐ Married/Cohabiting

☐ Widowed

☐ Divorced

☐ Separated

Who else, if anyone, currently lives at home with you?

_____

Are you currently in employment/voluntary work or education or have you been in the past?

No ☐ Yes ☐, if yes doing what? _____

Appendix C).

Evidence of a Favourable Ethical Opinion

Written Confirmation of a Favourable Opinion from Leicestershire, Northamptonshire and Rutland Research Ethics Committee for the Initial Project Proposal and Later Substantial Amendment.

Leicestershire, Northamptonshire & Rutland Research Ethics Committee 1
Lakeside House
4 Smith Way
Grove Park
Enderby
Leicester
LE19 1SS

Telephone: 0116 295 7592
Facsimile: 0116 295 7582

04 August 2005

Miss Fiona Robson
Trainee Clinical Psychologist
Leicester University / Leicester Partnership Trust
c/o LPT Research Office
Daisy Peake Building, Towers Hospital
Gipsy Lane, Leicester
LE5 0TD

Dear Miss Robson

Full title of study: **A qualitative analysis of the role of faith, religious and spiritual experiences in overcoming problematic substance use.**
REC reference number: **05/Q2501/76**

Thank you for your letter of 30 July 2005, 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.

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.

The favourable opinion applies to the research sites listed on the attached form.

Conditions of approval

The favourable opinion is given provided that you comply with the conditions set out in the attached document. *You are advised to study the conditions carefully.*

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	*Version*	*Date*
Application	1, 05-Q2501-76	10 May 2005
Investigator CV	1, 05-Q2501-76(cv-pi)041002.doc	10 May 2005
Protocol	2.0, 05-Q2501-76(ra)050507.doc	(None Specified)

Summary/Synopsis	1.0, 05-Q2501-76(fcd)050509.doc	20 May 2005
Peer Review	1	18 May 2005
Interview Schedules/Topic Guides	1, 05-Q2501-76(id-p)050504.doc	20 May 2005
Copies of Advertisements	2, 05-Q2501-76(ra-p)	09 July 2005
Participant Information Sheet	2, 05-Q2501-76(is-p)	09 July 2005
Participant Consent Form	1.0, 05-Q2501-76(cf-p)050502.doc	20 May 2005
Response to Request for Further Information		30 July 2005
Letter of Introduction	2, 05-Q2501-76(il-p)	09 July 2005
Supervisor CV	1, 05-Q2501-76(cv-s)050506.doc	(None Specified)

Management approval

The study should not commence at any NHS site until the local Principal Investigator has obtained final management approval from the R&D Department for the relevant NHS care organisation.

Membership of the Committee

The members of the Ethics Committee who were present at the meeting are listed on the attached sheet.

Notification of other bodies

The Committee Administrator will notify the research sponsor and the R&D Department for NHS care organisation that the study has a favourable ethical opinion.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

05/Q2501/76	**Please quote this number on all correspondence**

With the Committee's best wishes for the success of this project,

Yours sincerely

Dr Carl Edwards
Chair

Email: marlene.chapman@lnrsha.nhs.uk

Enclosures:

Standard approval conditions
Site approval form (SF1)

SF1 list of approved sites

Leicestershire, Northamptonshire and Rutland Research Ethics Committee 1
1 Standard Court
Park Row
Nottingham
NG1 6GN
Telephone: 0115 9123344 ext 49435
Facsimile: 0115 9123300

7th November 2005

Ms F Robson
Trainee Clinical Psychologist
Department of Clinical Psychology
104 Regent Road
Leicester
LE1 7LT

Dear Ms Robson

Study title: **A qualitive analysis of the role of faith, religious and spiritual experiences in overcoming problematic substance use**
REC reference: **05/Q2501/76**
Protocol number: **2.0**
Amendment number: **1**
Amendment date: **22/08/2005**

The above amendment was reviewed at the meeting of the Sub-Committee of the Research Ethics Committee held on 04/11/2005

Ethical opinion

The members of the Committee present gave a favourable ethical opinion of the amendment on the basis described in the notice of amendment form and supporting documentation.

Approved documents

The documents reviewed and approved at the meeting were:

- Covering Letter from Chief Investigator detailing proposed change
  Dated 22/08/2005
- Notice of Substantial Amendment
  27/08/2005

Membership of the Committee

The members of the Ethics Committee who were present at the meeting are listed on the attached sheet.

Research governance approval

All investigators and research collaborators in the NHS should notify the R&D Department for the relevant NHS care organisation of this amendment and check whether it affects research governance approval of the research.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

05/Q2501/76:	**Please quote this number on all correspondence**

Yours sincerely

Ms Linda Ellis
Committee Co-ordinator

E-mail: linda.ellis@rushcliffe-pct.nhs.uk

Copy to:

R&D Department for NHS care organisation at lead site

Enclosures *List of names and professions of members who were present at the meeting and those who submitted written comments*

Appendix D).

Participants Letter of Invitation

University of Leicester

School of Psychology
Clinical Section

Address

Dear Participant,

I am writing to ask if you would like to take part in a research study. This is being conducted as part of my training with Leicester University, to become a Clinical Psychologist.

We are interested in learning more about how faith, religion and spirituality can help people in overcoming problematic substance use. Taking part in the study would involve sharing your story of overcoming problematic substance use and how faith, religion and/or spirituality have helped you in this. This would be through an interview with myself, Fiona Robson, organised for a time convenient to you. The interview would last for up to an hour and a half and would be audio-taped. The information you share will remain anonymous, all identifying information being removed when the study is written up.

If you would be willing to be involved in this study, please complete the tear off slip below and return it in the stamped addressed envelope provided. If you have expressed an interest in taking part by returning the tear off slip but it is not possible to offer you an interview, the investigator will contact you by letter or telephone to let you know.

If you would like any more information about the study you can leave a message with the University secretary, on *telephone number*, and I will return your call.

Thank-you for your time. I look forward to hearing from you

Yours sincerely

Fiona Robson
Trainee Clinical Psychologist

Tear off slip.....

My name is: _____*(Block capitals please)*

I am willing for Fiona Robson, Trainee Clinical Psychologist, to contact me at the below address/telephone number to discuss the research project.

Your address *(Block capitals please)*:

_____

_____

_____

_____

_____Your telephone number: _____

_____

I understand that returning this slip does not mean that I am obliged to take part in the study and that I am free to withdraw at any time.

Signed.....

PLEASE RETURN SLIP WITHIN FOUR WEEKS OF RECEIVING THIS LETTER

Appendix E).

Participants Information Leaflet

Participant Information Leaflet
Version 2, 9.07.2005

A qualitative analysis of the role of faith, religious and spiritual experiences in overcoming problematic substance use.

Chief Investigator:
Fiona Robson, Trainee Clinical Psychologist supervised by Dr Sue Kellett (Clinical Psychologist) and Dr Marilyn Christie (Clinical Psychologist).

Contact details of Chief Investigator:
Work Address/Telephone Number

You are being invited to take part in a research study. Information regarding why the research is being conducted and what it will involve is laid out below. Please take time to read the information carefully to help you make a decision about whether or not you are willing to take part. If anything is unclear or you would like further information, please leave a message at the above number for the chief investigator, Fiona Robson.

What is the purpose of the study?
We are interested in learning more about the role that faith, religion and spirituality can play in helping people to overcome problematic substance use. The understandings gained may provide information about how treatment approaches can take account of, and provide for, peoples' spiritual needs.

Who is taking part?
Everyone who takes part in the study will have a history of problematic substance use, either with alcohol and/or drugs (heroin/cocaine/crack). By problematic we mean that the substance use has previously affected physical or mental health, or that it affected social or occupational life. It is not necessary that people are completely abstinent now (i.e. no longer using *any* substances) but they need to have made a significant move away from problematic use. As we are interested in the role of faith, religion and spirituality in overcoming problematic substance use everyone taking part will consider that this has been important in helping them overcome their problematic substance use. In total between 8 – 12 people will be taking part, all interviewed individually.

Do I have to take part?
It is up to you to decide if you would like to take part or not. If you decide that you would like to take part, you will be asked to read this information sheet again and then to sign a consent form. You will still be free to withdraw at any point, without giving a reason, and it will not in any way affect any treatment you may be receiving within the National Health Service.

What will happen if you take part?
Taking part in the study will involve sharing your story of trying to overcome problematic substance use and how faith, religion and/or spirituality have helped you with this. You will be interviewed by the investigator, Fiona Robson. This interview will be audio-taped, this is so that information is not forgotten, additionally the investigator may take notes during the interview. The interview would last for up to an hour and a half.

The investigator will contact you to arrange a convenient time for the interview. If you have to travel for the interview, your expenses will be repaid. If you travel by public transport you will need to bring the receipt for this with you. Due to time limitations, not everyone who agrees to take part will be interviewed. If you have expressed an interest in taking part by returning the tear off slip but it is not possible to offer you an interview, the investigator will contact you by letter or telephone to let you know.

Will my responses be anonymous?
During the research, the information that you give will not be shared outside of the research team, unless it was felt that you or someone else was at risk of harm. For the analysis and write up of the study all identifying information, such as your name, will be removed. The tape recordings of the interviews will be stored securely and destroyed once the research is satisfactorily completed.

Your key worker, or the leader of the organisation through which you have heard about the research, will need to be aware that you are taking part in the study.

What are the possible disadvantages and risks of taking part?
While it is hoped that talking about your experiences will be a positive experience talking about some past or present situations may be upsetting. If you become distressed, you can choose not to discuss a particular situation or to stop the interview. It is important that you access sources of support if this is required and if the chief investigator were concerned about your welfare they would highlight this to your key worker or the leader of the organisation through which you were contacted.

What if I am harmed by the study?
The study does not set out in anyway to cause you harm. However, if you have any cause to complain the chief investigator holds a contract with the National Health Service and complaints can therefore be dealt with through this service.

What will happen after the interview?
After the interviews, the information will be analysed and written up as a research document to be submitted to the University of Leicester. It is hoped that the results will also be published in scientific journals. All identifying information will have been removed from the interviews to protect your anonymity. You can request a summary of the main findings of the study by contacting the chief investigator.

Who is organising and sponsoring the research?
The study has been organised by Fiona Robson, a Clinical Psychology Trainee at the University of Leicester, employed by Leicestershire Partnership Trust. The University of Leicester is the sponsor.

How do I get further information?
If you would like to any more information about the study please leave a message for the chief investigator, Fiona Robson, on ***Telephone Number***, and I will return your call.

Thank-you for taking the time to read this information sheet
-please see the attached letter and response slip if you are interested in taking part.

Appendix F).

Advertisement for Participants

Research Study
Oct 2005 – Jan 2006

The Role of Faith, Religion and Spirituality in Overcoming Problematic Substance Use.

Leicester University

- **Do you have a history of problematic substance use?**

  (Heroin, cocaine/crack or alcohol use)

- **Has faith, religion and/or spirituality been important in helping you overcome this?**

If so, would you be willing to share your story for research looking at the role of faith, religion and spirituality in overcoming problematic substance use?

It is not necessary that you are completely abstinent now (i.e. no longer using *any* substances), however you would need to have made significant progress away from problematic drug or alcohol use that has previously affected your physical or mental health, or that has affected you in terms of your social or occupational life. Participating in the study would involve an interview lasting up to an hour and a half. Interviews would be audio-taped and written up with identifying details removed. Participants must be over 18 and fluent in spoken English.

If you are interested in taking part or for more information, please leave a message with the University administrator on *telephone number*, quoting the reference number A1.

Appendix G).

Interview Topic Guides – Initial and Final Versions

Initial Interview Topic Guide

Introduction

- Introduction of self and research
- Confidentiality and its limits
- Questions and Consent
- Procedure and structure for interview

"I'm interested in hearing your story of your journey towards overcoming problematic substance use and how faith, religion and/or spirituality have helped in this."

Substance Use

- I wonder if you could tell me a bit about what life was like when you had a problem with substance use, before things began to change.
  - *What was the main substance or substances you were using?*
  - *How long approximately were you using for?*
- When do you think things began to change?
- What do you think led up to things changing?
- What was important in helping things to change?
  - *Any formal treatment?*
- How would describe yourself and your life now?
- Has your view towards substance use changed?
  - *How?*
- Looking to the future, what do you think will be important in helping you keep up the progress you've made?

Spirituality/Faith/Religion

- What does the term spirituality mean to you?
- What would you say are your key religious or spiritual beliefs?
- Can you tell me about any spiritual or religious practices you engage in?
- Do you have links to any particular religious or spiritual groups or organisations? *(Preceding onset of difficulties, during and after.)*
- Can you tell me a bit about these groups?
- Can you tell me a bit about your involvement with these groups.

- Is there anything else you think it important to say about your journey towards overcoming problematic substance use?

Background Information Collection

'I wonder if I could just ask for some general background information':
Age, Ethnicity, Marital and Family status, Employment status, living arrangements etc.

General Prompts

- Can you tell me a bit more about that?
- What do you mean by 'X' / What does that mean to you?
- How do you make sense of that?
- Can you give me an example?

Ending

- Thanks
- Debrief
- Procedure for obtaining information about the study findings.
- Checking if interested in validation interview?

Final Interview Guide

Introduction (as in Initial Interview Guide)

Background Information Collection

"Ok, so what I'm interested in is hearing your story of your journey towards overcoming problematic substance use and how faith, religion and/or spirituality have helped you in that."

Substance use

- I wonder if we could begin by thinking about your substance use and what it might have offered you at different points in time.
- When you first started using substances what was happening in your life more generally?
- You've agreed to take part as someone whose substance use became problematic. What were the things that made your substance use a problem?
- Were there any changes in the problems over time?
- What led up to you beginning to move away from problematic use?
  - *Had you tried to make changes before that?*
  - *Had you ever reached a similar point before?*
  - *What was life like generally at that time for you? (Existential crisis ideas?)*
  - *Why do you think change happened at that point?*
- What was important in helping things to change? (*Int/Ext factors*)
  - *What enabled you to make the changes then?*
  - *Did you have any formal treatment*
  - *Did you go to any self-help groups?*
  - *Did other people have any role in helping things change?*
- Were you ever bothered by cravings?
  - *How did you manage these?*
- Did you have times of lapse/relapse?
  - *What happened / how was this overcome?*
- Had you ever felt able to control your substance use before?
  - *How do you make sense of having some control now?*
- Has your view towards substance use changed?
  - *In what way?*
- What were the views of the family you grew up in about substance use?
- What are your goals for the future around substance use?
- Thinking about the future what do you think will be important in helping you keep up and continue the changes you've begun?
  - *Some people have spoken about particular sayings they remind themselves of that they find helpful. Is that true for you to any extent?*
- How would you describe yourself and your life now?
  - *Has there been any change in what's important to you?*
  - *Has there been any change in the people you mix with?*
  - *Has there been any change in how you cope with problems?*
  - *Some people have found helping others has somehow helped them – what do you think about that?*

Spirituality/Faith/Religion

- Can you tell me about your spiritual or religious beliefs growing up (if any?)
  - *Did you have any links with any religious or spiritual groups or organisations?*
- Did your family or other important people in your life have any spiritual beliefs?
  - *Were you aware of anyone praying for you?*
- What would you say are your main religious or spiritual beliefs now?
  - *If none before what made you open to spiritual/religious ideas?*
  - *What if you had heard those ideas a few years earlier?*
- What do you think spirituality/religion or faith offers you? / What does spirituality add to life?
- How does spirituality/your faith help you not to use substances?
- Can you tell me about any spiritual or religious practices you engage in (if any?)
  Prayer?
  - *Do you have any ideas about how you think prayer works?*
  - *What changes when you pray about a situation?*
- Have you had any specific spiritual experiences that you remember?
- Do you have any links with any religious or spiritual groups or organisations? Why/why not?

- Is there anything else you think it important to say about your journey towards overcoming problematic substance use?

General Prompts (as in Initial Interview Guide)

Ending (as in Initial Interview Guide)

Appendix H).

Transcription Conventions

The notation used in the transcripts for the current study was partly derived from that used by Potter and Wetherell[8] (1987) and also Larkin and Griffiths[9] (2002). To protect anonymity, personal names were replaced with pseudonyms and potentially identifying information, such as place names, with generic terms e.g. [City].

I#	I – indicates speech from the interviewer. The number following this refers to the code assigned to the participant from that interview.
P#	P – indicates that speech from the participants and is followed by their assigned participant code number. Instances of joint speech are indicated by text from each speaker being placed adjacently on the page, as illustrated below: **Line Number I#: text P#: text**
(...)	Parentheses enclosing three full stops indicate that a segment of transcript has been omitted due to the recording being inaudible or irrelevant to the analysis.
(best guess)	Parenthesized words represent possible hearings when the recording was unclear.
[ ]	Square brackets highlight non-verbal elements within the dialogue e.g. [PAUSE] or contextual information. When non-verbal elements of the dialogue are highlighted, e.g. [WORD EMPHASIZED] this refers to the preceding word. Where a contextual word within the brackets is followed by a question mark this represents a best guess at the relevant contextual information e.g. [Father?]
/	A forward slash indicates a clear change in the direction of speech.
...	A series of full stops indicates that the speaker trailed off or was interrupted, leaving an incomplete sentence/ word.

[8] Potter, J. & Wetherell, M. (1987). *Discourse and social psychology: Beyond attitudes and behaviour.* Thousand Oaks, CA: SAGE

[9] Larkin, M. & Griffiths, M.D. (2002). Experience of addiction and recovery: The case for subjective accounts. *Addiction Research and Theory*, **10 (3)**, pp.281-311.

Appendix I).

Example of Open Coding

P3: [PAUSE] I'd been sharing a lot of needles, um, I'd never really injected safely, always shared, shared equipment./ [PAUSE] I stopped work so that I could / wouldn't have the money to keep spending on drugs because I knew while I was working it just weren't going to happen for me, I was just going to use at work, you know earn the money. I could see the, I could see the cycle, I thought I've got to break it somewhere./ I think I only got tested out of sheer boredom to be honest because I was back on valium (...) I got tested./When the results came back positive [PAUSE] it scared the shit out of me and they said to me you know, "You carry on doing what you're doing, one, we won't treat ya, you won't get any treatment for it, and another thing is you'll probably die as well, there's a good chance of that"./ Um, that's when I thought, I've got to stop but I don't know how to./ I'd heard of a rehab before, I hadn't got a clue what it was, I knew one person that had been and relapsed./ I thought I've gotta / I'll give anything a go, don't care what it is, you know/ um because I knew that detox wouldn't be enough because I'd relapsed before after a detox 'nd ...(...) /

I3: And did you have a choice of rehabs or?

P3: Yeah I did but to be honest I just picked this one. I said I want to go / I wanted to go to [County] but um I think this is as far as [City] would fund (seemed to be if I can remember that bit). I came down here, got shown round, thought 'this seems alright', 'yeah ok well'. Didn't do a great deal of thinking about it to be honest./ I mean, you know it was that higher power thing in't it, must have been to have come here. /

- Unsafe using practice
- Having money linked to drug use (cycle) try to break cycle - stop work.
- Boredom leading to being tested
- Positive test results → 'scared shit out of me'
- Got to stop but don't know how to.
- Knowledge regarding rehabilitation (Treatment)
- Willing to try anything (Treatment).
- Treatment (detox) not enough - relapsed before.
- Choice of rehabilitation centre - not a great dealing of thinking about this.
- Belief role Higher Power in coming to particular rehabilitation centre.

Appendix J).

Exemplar Memoranda

Memorandum extract on data management

02.02.06 (P1-P6 coded & categorised)

Reviewing the category with the working title 'Self-awareness/checking motives' and the category entitled 'Dealing with issues', it would appear that both of these categories are about dealing with things that come up, either on an intra or interpersonal level. At this level of abstraction it would therefore seem that these categories can be merged under the heading 'Dealing with issues'.

Considering the category 'Values?', items within this category at present mainly seem to have come from one participant. It would seem that this category (except for 'sharing happiness' component which has been merged with 'Help Others') links to the concept of dealing with issues and can therefore be subsumed within this category.

Memorandum – Spirituality replace function served by drugs

- Idea arising after categorising data from Interview 3

- Replacement addiction cf drugs pseudo-spirituality?

- (Supervision Nov/Dec) - Psychic pain - substance use relieves {Avenue for}
  - Spirituality relieves pain (or not) {exploration}

- (Supervision Jan) – Spirituality replacement for drugs - buzz
  God = higher buzz?
  {Avenue for exploration}

- Problem → Drugs (& relapse)
  ↓
  Problem → Spirituality

e.g. Problem - pain → relief/coping/problem-solving
e.g. P4 learn to 'deal with issues' (but generality of treatment programme too)
& forgiveness
Support (P6) – others and God providing support
Meaning in suffering

- Altered state of consciousness – meditation etc. experience power

- Shy/confidence
- Identity
- Purpose of life

-Replacement theory – could set in context of functional type model (nb. Paper referring to developing rewarding alternatives to substance use?)