EXPERIENCING SPIRITUALITY IN MENTAL HEALTH INTERVENTION FOR ADDICTION RECOVERY IN SOUTH AFRICA: AN INTERPRETATIVE PHENOMENOLOGICAL ANALYSIS

by

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Declaration

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Exact wording of the title of the thesis as appearing on the copies submitted for examination:

> Experiencing spirituality in mental health intervention for addiction recovery in South Africa: an interpretative phenomenological analysis.

I declare that Experiencing spirituality in mental health intervention for addiction recovery in South Africa: an interpretative phenomenological analysis is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references.

I further declare that I submitted the thesis to originality checking software. The result summary is attached in the Appendices.

I further declare that I have not previously submitted this work, or part of it, for examination at UNISA for another qualification or at any other higher education institution.

29 January 2023

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Title of Thesis

EXPERIENCING SPIRITUALITY IN MENTAL HEALTH INTERVENTION FOR ADDICTION RECOVERY IN SOUTH AFRICA: AN INTERPRETATIVE PHENOMENOLOGICAL ANALYSIS.

Abstract

Within a postsecularist framework, this interdisciplinary study explored the lived experiences of spirituality in mental health intervention for addiction recovery in South Africa. The purpose of the study included the generating of insights for the initiation of collaborative endeavours between mental health professionals and church-based/faith-led community leaders, pastors and volunteers in the development and facilitation of addiction recovery programmes. Devastating statistics in South Africa regarding substance use, and other behavioural addictions, and the dire consequences thereof for individuals, families, communities, and society, show the need for improved, cost-effective addiction recovery programmes. In proposing an ethical, sustainable, and interdisciplinary model, the effects of the COVID-19 pandemic, and continuous technological advancements were also considered. An IPA research design and methodology was used where the individual narratives of the lived experiences of spirituality of three adults who had attended Christian inpatient rehabilitation facilities more than three years ago, and who had not relapsed within the last year, were used to explore converging, and diverging aspects thereof. In-depth case-by-case analysis followed by cross-case analysis, led to the emergence of five group experiential themes: 1. darkness vs. light, 2. God and people: the relationships, 3. journey of change over time, 4. embodied experience, and 5. spiritual overflow: living a new life. The proposed “Joy Seen” model was developed from these findings. The reciprocal and interactive nature of these findings were considered in the development of the model, where with increased spiritual self-awareness and diverse cultural competency of mental health professionals, and with spiritual leaders/facilitators who increase their mental health knowledge and competencies through supportive supervision, a collaborative context for shared learning and healing can occur. Within the context of addiction recovery support groups, the embodiment of shared values and the spiritual overflow of humility, gratitude and hope can grow, as individuals seek authentic meaning and purpose.

Key Words

postsecularism, spirituality, mental health intervention, interdisciplinary, addiction recovery, interpretative phenomenological analysis, embodied experience, collaboration, joy.

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> God, who gives me joy, I thank you for making my heart light, festive, free and jubilant. I praise you for crushing all the misery that hung over me and replacing it with your joy. I need to keep living in your joy and freedom. Thank you and please help me. (Pearson, 2016, p. 167)

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CONTENTS

Abbreviations

AA – Alcoholics Anonymous

ACT – Acceptance and Commitment Therapy

ADHD - Attention-Deficit/Hyperactivity Disorder

AOD – Alcohol and Other Drugs

APA – American Psychological Association

AR – Addiction Recovery

AUD(s) – Alcohol Use Disorder(s)

BMD – Bipolar Mood Disorder

CHW(s) – Community Health Workers

CL - Cover Letter

COVID-19 – Coronavirus Disease 2019

ECP2022 – 17th European Congress of Psychology 2022

EN(s) – Exploratory Note(s)

ES(s) – Experiential Statement(s)

D-PET(s) – Developing Personal Experiential Theme(s)

DSM-5 – Diagnostic and Statistical Manual of Mental Disorders, 5th Edition updated 2013.

GET(s) – Group Experiential Theme(s)

HIV – Human Immunodeficiency Virus

HPCSA – Health Professionals Council of South Africa

ICD-11 - International Classification of Diseases manual, 11th Edition

IPA – Interpretative Phenomenological Analysis

MA(s) – Main Aspect(s)

MDD – Major Depressive Disorder

MHI(s) – Mental Health Intervention(s)

MHP(s) – Mental Health Professional(s)

MRI – Magnetic Resonance Imaging

OCD – Obsessive-Compulsive Disorder

PET(s) – Personal Experiential Theme(s)

PICA - Participant Informed Consent Agreement

PRL - Participant Recruitment Leaflets

PTSD – Post-Traumatic Stress Disorder

PWIDs – People Who Inject Drugs

RC – Roman Catholic

R/S and/or S/R – Religion and/or Spirituality used interchangeably

S - Spirituality

SA − South Africa

SAD – Social Anxiety Disorder

SAMHSA − Substance Abuse and Mental Health Services Administration

SHG(s) – Self-Help Groups

SID(s) – Substance-Induced Disorder

SUD(s) – Substance Use Disorder

UNISA – University of South Africa

WHO – World Health Organisation

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Chapter 1: Introduction

1.1 Introduction and Background

In recent times, there has been an unfolding of a new religio-cultural dynamic in westernised societies. This postsecularist framework includes a tolerance and openness towards differences within the cultural and political spheres (Lombaard, 2015). Habermas et al. (2008) state that "both religious and secular mentalities must be open to a complementary learning process if we are to balance shared citizenship and cultural difference" (p. 20). Within this postsecularist framework, models of health care, such as the biopsychosocial-spiritual, have developed. Ramlall's (2016) research within the South African context emphasises the privilege that therapists have in journeying with their patients through their struggles. As therapists and researchers, we are responsible for journeying with them in an honest and authentic way that includes embracing all dimensions defining their humanity. This includes the spiritual dimension.

Slife et al. (2017a) describe an alternative worldview in the practice of mental health intervention (MHI). They show how traditional psychotherapy is based on the western principles of liberal individualism in pursuing personal, individualistic happiness. However, they show how strong relationism, as a worldview, indicates postsecularist thinking, where "people have a shared being with their context at the outset" (p. 27). The essence of these shared relationships includes cultural and moral traditions, which necessarily include religious and spiritual beliefs.

The epistemological framework for this thesis will be postsecularism. This will be further discussed in Chapter 2 as the framework for the literature review. Increasingly devastating statistics regarding the prevalence and abuse of alcohol and substances, the related exorbitant cost to the country, and the progressively negative implications and consequences for individuals, families and the community show the importance of implementing improved and cost- effective treatment programmes for addiction recovery (AR).

Mahlangu (2016) states that future research should investigate the role/impact of spirituality and the incorporation of this into effective aftercare and reintegration programmes, with the involvement of religious institutions being strengthened.

This thesis has been written as an academic document structured to reflect the interpretative phenomenological analysis (IPA) of the design and methodology used in the research. This IPA design and methodology will be presented in Chapters 3 and 4.

This design is reflected throughout the document by the discursive style of writing by the researcher, where her lived experience, including her journeying through this research study, is inherently intertwined with her engaging with the participants and her interpretation of the data. Levitt et al. (2018) comment on the importance of including these types of reflections which add to the methodological integrity of the study. All the personal reflections of the researcher are presented in greyed textboxes and are written in the first-person. For the rest of the writing, the term 'researcher' will set and clarify appropriate boundaries between all those involved in the research process.

1.2 Contextualisation of the Thesis: Introducing the Researcher and her Background

My Story

Having experienced a bitter divorce in 2001, I found myself in a place of isolation and disillusionment, as I attempted to continue mothering my two beautiful children (Kirsty, who was 11 years old and Jarryd, who was 8) in the way I had prior to the divorce. My naïve mindset was quickly given a reality check by my experience of no maintenance being paid and limited support from family and friends. The divorce had disappointed and disillusioned many people connected to the system. It was a difficult, daily struggle to complete a Master's dissertation in psychology, complete the clinical internship and community service to register as a clinical

psychologist and support my children emotionally and financially. I started my practice in 2004 and continue to practice in the same location 18 years later. There is much evidence of divine intervention in my story.

I am a faith-filled believer in Christ. I was raised in a traditional Christian home where church attendance every Sunday was mandatory. However, through my first marriage, my faith journey became stagnant and gradually of less significance. My divorce was a turning point for me where I searched for authentic meaning and purpose with a deeper spiritual walk unfolding in my loneliness and pain. Unfortunately, my involvement in a romantic and codependent relationship with someone I only realised much later was addicted to alcohol added more pain and trauma to my life and regretfully exposed my son to alcohol abuse. Although the relationship ended, I still wanted to protect my children. I would make excuses for behaviours which portrayed them in a negative way. With much self- reflection, spiritual growth, and psychotherapy, I can now see the lack of boundary setting and codependence inherent within the family system. This was evident with my son, a highly intelligent and gifted child, who could deceive and manipulate me as his life spiralled into active addiction.

In the early years of my practice as a clinical psychologist, I always found it particularly difficult and perplexing to work with those struggling with addiction. I was repeatedly confronted with the high risk and reality of relapse and the related negative consequences thereof. I often felt stuck professionally in this area but relentlessly continued the work with increasing experience, which also included consulting as a clinical psychologist in a Christian Rehabilitation Centre closely connected to my church community. With time, my role at this facility changed as I became more involved in an outreach ministry where, as a church member, I attended social functions sharing the gospel with those admitted to the facility.

In retrospect, I realised that the support and fellowship of those within this ministry were significant in my journey as my son's life spiralled out-of-control.

It was a very dark time. Addiction is always dark and deceptive.

Jarryd would go out with friends, go to clubs, lie, party, and get into fights. He would call during the night, asking me to fetch him, and I would drive, woman alone through the dark streets to protect my son. One night I heard the gate bell ring, and there he was. He did not have his car. His face was covered in blood. I was terrified by the reality of what I was seeing. He was a shadow of his former self. The lies and manipulations escalated. He and his friends took his sister's car without permission. I felt overwhelmed, emotionally exhausted and at times, even lost. I would leave for church on a Sunday morning, and my son would stagger in from wherever he had been.

It was a night in April 2014 when I knew that death was close. Not unlike many other nights, Jarryd called me to please fetch him. It was a long, lonely, dimly lit driveway. Only my car's headlights showed the image of near-death in front of me. My son looked like a walking corpse. The fear overwhelmed me. My son was an atheistic drug addict who desperately needed help.

He told me that night he needed to be admitted to an alcohol and drug rehabilitation facility. The following day, he was admitted. It was a moment in my life that changed me. I sat on my bed after having Jarryd admitted with tears pouring down my face uncontrollably. The trembling of my limbs felt like the outward evidence of a ripple that initiated deep within my core. A sense of desperation reverberated within me. My beautiful and trusted Labrador licked the tears from my cheeks. The mother in me felt broken. The psychologist in me felt useless. Both the love and pain I felt towards my son engulfed me simultaneously. In the depths of my hopelessness, all I knew how to do, was pray. The Spirit of God was alive and close, and I believed.

As Jarryd's mother, I was not allowed any contact with him or permitted to attend the outreach work at the rehabilitation centre. Again, in retrospect, another significant spiritual incident occurred whereby I wrestled with the idea of asking one of my fellow church members, who would go to the rehab, to tell Jarryd I love him, and to give me feedback as to how he was doing. I called Mark, someone I had only briefly met but somehow trusted. He spoke to Jarryd for me. He also ministered to Jarryd and built a solid connection with him while

Jarryd was in rehabilitation. Mark was a significant supporter of Jarryd's recovery and became his stepdad in time. A trusting connection between my son, and unbeknown to me at the time, the man who would become my husband was so important, as Jarryd would otherwise have struggled again to trust me being involved in another romantic relationship.

In rehabilitation, Jarryd also describes how his belief in God and a growing conviction to surrender his life to God developed.

As a mother, I attended supporters' recovery groups. I had and continue to facilitate groups as a clinical psychologist. But the experience of attending certain recovery groups as a mother gave me increased insight into the personal hurt, uncertainties and wavering hope shared by all those connected to the system where active addiction occurs. My journey of supporting Jarryd in recovery, journeying myself through the new territory of taking responsibility for setting clear boundaries, drug testing, and holding Jarryd accountable for his choices and actions, continued for many months following his discharge after a three-month admission.

Jarryd's life path changed. He obtained two degrees in Theology. He wrote two books. He travelled throughout the world, testifying to others. He was also involved in a ministry that offered hope and assistance to sex workers and drug addicts. Mark and I also connected with many of these people, some of whom celebrated with us when we were married in 2017. Mark subsequently qualified as an AR coach, with both of us continuing to learn, grow and assist others in the field of AR.

My PhD study developed from my lived experience on both a personal and professional level. I wanted to further explore others' experiences of spirituality as part of their stories; to gain valuable insight into MHI and AR within the South African context.

The writing of this thesis has itself been a journey of self-discovery, endurance, trauma, perseverance, spiritual growth, and hope. With my proposal having been written and accepted in 2019, I was involved with other believers in initiating a church-based AR group. I continued to run psycho-education workshops within a dual diagnosis inpatient facility and consulted with patients and their families privately in my practice.

In 2020, the world experienced the life changing Coronavirus disease (COVID-19) pandemic. Global politics and medical science were intertwined in fast-changing policies, lockdowns, and searches for a vaccine/cure for this virus (De Backer, 2021). My article summarises some of the emotional upheaval and distress experienced by many people, including those struggling with both substance use disorders (SUDs) and behavioural addictions. Physical lockdowns necessitated the increased use of technology to connect with others. Home contexts were adapted into work environments. Social gatherings became meetings with others in online groups. Face-to-face (in person) AR groups were also necessarily facilitated online. Working as part of a faith-based church initiative, Mark and I facilitated a Sunday evening AR support group online for a year during the most intense time of the pandemic where various levels of lockdown and social distancing were legislated. This online group process gave me invaluable insights into the experience of the use of technology as part of MHI for AR, regarding the benefits and the limitations thereof.

Early in my career, around 2003, I had consulted as a telephone clinician for a corporate wellness entity that provided an employee assistance programme. This was my introduction to working as a therapist via technology. With inexperience and fear, I had found the creating of a safe, therapeutic context challenging at times, and had been frustrated by the work; thus, moving more into face-to-face intervention in my practice. The initial idea, therefore, of facilitating an ongoing group process online during COVID-19 lockdown had seemed daunting. Over time, however, the therapeutic context unfolded into a precious, intimate, and connected environment where each group member, with us, as facilitators, developed a sense of belonging, unity and trust in the others and the group process itself. Powerful intervention is possible online (De Backer, 2021).

With the positive growth in gaining experience working both online and in face-to-face contexts with those struggling with addiction, the accompanying journey of personal pain, trauma and loss were simultaneously apparent. I was

a member of my local church for 15 years. In my private practice as a clinical psychologist, referrals regularly come from the church environment. An opportunity arose to bridge the divide between spirituality/pastors and mental health/psychology (based on a colleague's completed PhD). As a believer (church member) and a professional psychologist with a personal interest in addiction, I was excited about the initiation of an AR group being facilitated within the church context. With time, the divide between the two disciplines, which had theoretically been so well bridged, seemed to practically cause increasing emotional tension and distress between group members and those facilitating the group.

From a Christian, church-based perspective, groups were led by the Holy Spirit. Any seemingly preferential treatment within the group context was assumed divinely ordained and covered by the Christian principle of grace. From a professional psychological point of view, serious mental ill health was being overlooked, and for me, even being addressed in an unethical way. I felt overwhelmed by the lack of personal boundaries, taking dual roles, and the related conflict of interest that resulted.

Although having a strong faith and belief in Christ, I struggled to confront what I experienced as duplicity, of the uncompromising authority of the church presenting under the banner of unconditional love. My struggle with what this meant, and the possible ways of incorporating difference, led to much personal strife and, unfortunately, to me leaving the group. In time, having lost so much trust in the context, my husband and I ultimately left the specific church, which had been so much part of our lives for such long seasons.

My journey continues; in my maturing faith walk, in my personal relationships, in my understanding of the experience of life in today's digital age, and in my journey with those persons trapped in addictive patterns and behaviours.

I have remained a dancer from a six-year-old little girl until today. I have always danced. Dancing alone, dancing for God, dancing in groups, teaching dance, dancing on the beach, dancing on stage, the artist in me has always spoken through my body. Grappling with the experience and meaning

of embodiment, especially as it connects with an understanding of addiction, has renewed my hope in the potential to embody a new life trajectory as each individual lives fully, abundantly, and joyfully in his/her everydayness.

The fullness of my expression of my lived experience continues, even as I wrote this PhD word for word by hand, with the dancer in me, not wanting to lose any nuance of who I am as I danced across the pages. With growth and self-awareness, knowing this is a shared journey of enthused energy. Mark has shared and assisted, as my caring husband and a registered AR coach, by transcribing, typing, checking my data analysis, editing, and referencing this study. Knowing the dancer in me, he showed up my blind spots and caught and held me when I was falling. My story continues.

The study's main research question and purposes emanated from 1.1 and 1.2 above and are described as follows.

1.3 Main Research Question

How do people describe and experience spirituality as part of MHI in their recovery from addiction in the South African context?

1.4 Purposes of the Study

1. This study explored the phenomena of spirituality in MHI from the perspective of the lived experiences of people in their recovery process from addiction. This study only included those persons residing in South Africa (SA),
2. From the experiential themes emanating from the above, this study aimed to generate insight and knowledge towards developing an ethical, integrated and interdisciplinary model that included lower-cost MHIs for AR being incorporated into faith-based community settings. This model would offer alternative, improved methods for providing comprehensive health services to those struggling with SUDs and other addictive behaviours in SA. It was envisaged that the proposed model be used in policy-making, planning and implementation of

comprehensive, interdisciplinary MHI programmes for AR. The initial conceptual aim proposed includes faith-based organisations/communities initiating and implementing interdisciplinary psycho-education workshops and recovery support groups. These would include working with people struggling with SUDs, including alcohol use disorder (AUD) and other addictive behavioural patterns, and

3. It was envisaged that the research findings would add to the existing body of literature in gaining further understanding of the meaning of central Christian concepts also psychological in nature, such as 'freedom from bondage', 'love' and 'service to others', through shared, interdisciplinary interventions to assist those struggling in addiction.

1.5 Evolving Definitions of the Key Terms

From the main research question and related purposes of the study, the three core aspects included spirituality, MHI and AR. As this study evolved over time from the initial proposal submission, including the development of the proposed interdisciplinary model, so too, have the researcher's conceptualisation and understanding of the meanings of the three core terms evolved. This process of the evolving of meanings over time fits into the methodology of IPA used to analyse the data of this study (see Chapters 3 and 4), where through an iterative process of engaging with various levels of interpretation, the meanings of the concepts have gained depth and developed with time.

1.5.1 The Preliminary Definitions of the Key Terms

1.5.1.1 Spirituality.

Schneiders (1986) stated that "spirituality refers to the experience of consciously striving to integrate one's life in terms not of isolation and self-absorption but of self-transcendence toward the ultimate value one perceives" (p. 266).

Kourie and Ruthenberg (2008) emphasised: "that spirituality as 'lived life' evidences and entertains a broad and inclusive perspective" (p. 79).

Increased interest in spirituality has led to a new academic discipline of spirituality being birthed. Schneiders (1986) emphasised the importance of being cognisant of "the distinction between spirituality as lived experience and spirituality as the academic discipline which studies that experience" (p. 257). Experience is thus one of the key terms in Spirituality Studies (which differentiates it from other subjects within Theology).

In researching spirituality and addiction counselling specifically, White and Laudet (2006) emphasised how:

Spiritual experiences are distinguished from other experiences by their acute clarity and authenticity, their intensity (transcending ordinary experience) and their catalytic power. The term *spirituality* includes but has evolved beyond its religious meanings to convey experiences that bring a heightened sense of meaning and purpose to one's life (p. 1).

The researcher's initial working definition of spirituality for this thesis included:

- The personal, lived life experience where the individual reaches out and connects transcendentally to the sacred.

1.5.1.2 Mental Health Intervention.

The National Health Promotion Policy and Strategy 2015 – 2019 defines a health promotion intervention as "an effort or activity aimed at promoting and enabling people to take control of their health and developing skills to practice healthy behaviours like physical activity and prevent unhealthy behaviours (e.g., smoking, illicit drug use or excessive alcohol use)" (p. III).

MHI was initially conceptualised as an intervention that included activities, therapies and treatment programmes implemented by mental health professionals (MHPs). These interventions (according to each professional's specific scope of practice) included psycho-education workshops and recovery support groups to develop functional coping skills. The fostering of healthy thought processing, emotional responses and related behaviours was also pursued. Interventions were aimed at improving mental well-being and ultimately functioned in offering hope and improving the overall quality of life for individuals and their family members.

1.5.1.3 Addiction Recovery.

A person with an addiction uses a substance, or engages in a behaviour, for which the rewarding effects provide a compelling incentive to repeat the activity, despite detrimental consequences. Addiction may involve the use of substances such as alcohol, inhalants, opioids, cocaine, and nicotine, or behaviours such as gambling (Psychology Today, 2019).

According to the Diagnostic and Statistical Manual of Mental Disorders (5th ed.; DSM–5; American Psychiatric Association, 2013), addiction to substances and/or behaviours is classified as SUD and/or addictive disorders. Addictive disorders include gambling disorder, recognised as a diagnosable condition, whereas Internet gaming disorder is listed in section III of the manual in the interim, as further research is still required. Substance-induced disorders (SIDs) are also classified. The exploration of these comorbid (co- occurring) psychiatric conditions was integral to this study, with the inclusion and focus being placed on implementing dual diagnosis intervention programmes as part of the recovery journey.

White (2007) stated:

Recovery is the experience (a process and a sustained status) through which individuals, families, and communities impacted by severe alcohol and other drug (AOD) problems utilise internal and external resources to voluntarily resolve these problems, heal the wounds inflicted by AOD-related problems, actively manage their continued vulnerability to such problems, and develop a healthy, productive, and meaningful life (p. 236).

"Recovery from mental and substance use disorders is a process of change through which people improve their health and wellness, live in a self- directed manner, and work toward achieving their full potential" (Substance Abuse and Mental Health Services Administration (SAMHSA), 2016).

Important aspects of recovery thus included a process of change experienced subjectively by each individual within the context of family and/or community where support and hope were offered in the development of a meaningful life.

1.5.2 Additional Evolving Understandings of the Key Terms

A noteworthy aspect of these three core concepts that became apparent as the research progressed was the innate interrelatedness between all three. Adding to this interrelatedness and complexity of the three concepts is the reality of life today in a world overflowing with digital/technological advancements and fast-paced change, accompanied by the daily entrapments that nurture personal pride and materialism. The global COVID- 19 pandemic, too, has exacerbated the difficulty in differentiating between concepts that are so innately connected to each other.

Lombaard (2022) describes how a postsecularist awareness is evident internationally in a society where an "altered sense of relationship between the physical and the metaphysical" (p. 10) is emerging and where "faith is regarded as normal a part of life as any other – food, sport, art, dancing and all the other aspects of human life…." (p.10). The experience of the spiritual (metaphysical) aspects of life, including the related thoughts, beliefs and practices/actioning thereof, is becoming increasingly accepted as an integral part of balanced living. The significance of the spiritual aspects as part of life should neither be over nor under-emphasised, but simply acknowledged within everyday lived experience that includes technological advancement and unanticipated external factors, such as the COVID-19 pandemic.

In further exploring the concept of MHI, it became apparent that any intervention that ultimately benefits the mental well-being of the individual within society is included under this banner. However, in the collaborative working together of respectful persons with varied forms of expertise (interdisciplinary), the maintenance of a standard of ethics and harm-reduction for the individual being assisted occurs. It is from this ethical standpoint that caring and supportive interventions occur. These are conceptualised as beneficial to mental health and the improved quality of everyday living for the individual. Wilson (1999) shows how through unified learning between various disciplines, wise choices regarding the future are possible. He adds that part of what has been learned regarding human nature and what lies ahead is that "ethics is everything" (p. 325). Humans have taken the long-term contracts that have evolved through culture in sustaining survival over time and "accepted the necessity of securing them by sacred oath"

(p. 326). These morally acceptable precepts and laws guide society's moral ethics and influence individuals' behaviour towards themselves and others.

Ethical care towards self and others is fundamental in understanding any form of recovery. Recovery from SUDs and other addictive behaviours is not synonymous with having been medically cured of a disease. It includes a commitment to ongoing self-reflection and intentional self-awareness that actions change towards a life trajectory of meaning and purpose. It is a process of healing based on the principle of care (including self-compassion and responsible care within communities and the healthcare system) rather than cure.

Cobb et al. (2012) emphasise the importance of spirituality as part of a clinical/therapeutic encounter as "being used as a vehicle for introducing issues such as identity, community, meaning and purpose…" (p. 491). These issues are foundational to the emergence of an individually changed, healthier life within a changing, healthier society and world.

In reviewing the interrelatedness between these three core concepts, a sense of shared, ethical responsibility towards "interdisciplinary solidarity" Cobb et al. (2012, p. 492) becomes apparent. Spiritual care is inherent in the development of compassionate socio-economic and health policies that facilitate a healthier society for all, including those who struggle with addiction. May (1992) posits that in developing a caring society, a conceptual change is needed, where individuals are freed from the bondage of conceptualising a separateness between mind, body and spirit. Human experience, instead, will need to be conceptualised as a "comingling of divine grace and personal choice" (p. 202). These ideas will be further elaborated on in Chapters 5 and 6 of this study.

In addressing the purposes of the study (see Section 1.4), the findings of this study regarding the participants' experiences of the phenomenon of spirituality in MHI for AR in SA will be presented in Chapter 5.

The discussion of these findings (including the experiential themes emanating from the research), and the proposed interdisciplinary model and the relevance thereof within the ever-evolving landscape of addiction, will be presented in the concluding Chapter 6.

Chapter 2: Literature Review

In developing the theoretical argument as the framework for the purposes of this study, the researcher will use *italics* to identify key ideas throughout the literature review. These *italicized* ideas will be interwoven into the argument presented in the conclusion of this chapter.

2.1 Secularism and Postsecularism

The epistemological framework for this study is postsecularism, where from a reflexive stance on secularisation and the radical divide in "the relationship between wholeness and holiness in the modern worldview" (Shults & Sandage, 2006, p. 192), this new framework has emerged.
Mendieta and Beaumont (2019) emphasise how postsecularism could not have emerged within society as it exists without the historical dynamics of secularism.

Premodern societies developed with people conforming to a moral order. Religion was dominant in premodern existence, but a mindset influenced by the Enlightenment and modern philosophical thought dethroned the old. This secularist movement at the time of the Enlightenment arose as "protest against oppressive ecclesiastical control" (Watson, 2015, p. 1460).

Gorski (2016) describes how four decades ago, there was an accepted belief that the world was becoming more secular. Modernisation was bringing about secularisation. With industrial and technological advancement, a shift occurred where this moral order based on religious principles (including ethics and spirituality) was separated from other social, political, legal and healthcare aspects of modern life (Shults & Sandage, 2006). Casanova (2007) distinguishes three meanings of the word secular and the corresponding related understanding of the process of secularisation. He described secularisation as:

1. differentiation of the secular spheres (the separation of state, economy, and science) from religion and religious institutions,
2. the decline of the religious beliefs and practices among individuals in modern societies, and
3. privatisation of religion, often indicated as a normative pre-condition for

modern, liberal democratic politics.

Bustamante (2014) describes that it is the point of view of religious significance and relevance that explains secularism. He adds that "secularism is a stance of modern society or modern state to religion" (p. 6). Secularist thinking became evident in changed legal principles and a shift to democratic political structures. Social norms changed as religion was viewed as a private part of the individual's life, losing its public significance and authority. He emphasised how secularist thinking bases truth on the discourses of contemporary sciences, constructed by humans and thus alterable by humans. Solutions to human problems are seen as pragmatic, where the attitude towards the role of religion is negated, and an attitude of doubt to the validity of all truths is fostered. A dualism exists between the scientific study of health (including psychology) and morality/ethics (spirituality). This way of thinking is reflected in a modern, westernised healthcare model focused on minimising presenting symptoms and not on including intrinsic, moral virtues and character strengths in diagnosis and treatment (Shults & Sandage, 2006).

Taylor (2011, pp. 35-37) describes how principles of religious freedom and the separation of church and state include the recognition of diversity in modern societies. His four-principle secularist model, as a framework in understanding the secular state, includes the secular state:

1. protects people in their belongings, practices, and worldviews,
2. treats people equally,
3. gives all individuals and sectors a hearing, and
4. maintains harmonious relationships and comity between members of society and supporters of different faiths.

Habermas, an agnostic and secular thinker, theorised on the move towards a postsecular state. In postsecular states, "religion maintains a public influence and relevance, while the secularistic certainty that religion will disappear worldwide in the course of modernization is losing ground" (Habermas et al., 2008, p. 21).

Watson (2015) detailed her objections against the secularist assumption that the public domain must be neutral, with the implication that religious beliefs should be kept in the private domain. She questioned the neutrality of this assumption, in that by not mentioning God in the public domain, this possibly constituted practical atheism, whether overtly stated or not. She questioned the supposed inclusivity of secularists who insist that within the public sphere, there ought to be a common language for everyone. By insisting that people whose fundamental beliefs include God should not include God in their language, nor appeal to anything religious, ultimately leads to these people being treated unequally. Any claims of pluralism from a secularist approach become questionable, as religion is excluded. The side- lining of religion is questioned further because religious beliefs affect who the person is. “. "Belief cannot be clinically separated from the character of a person" (Watson, 2015, p. 1459).

> *In a democracy to avoid marginalising some people, a commitment to both/and thinking in line with postsecularist underpinnings where religious beliefs cannot be separated from whom a person is, is necessary.*

Describing her ideas of the postsecular, Graham (2019) includes that which "invite new theorising about religion in relation to lived experience and as part of wider cultural imaginaries and social practices" (p. 227). Habermas et al. (2008) speak of a "change in consciousness" (p. 20). In secularist society, there was a differentiation between social systems and religious communities, with each focusing only on its specific core function, with the religious practice being individual and personal. However, they attribute this "change in consciousness" (p. 20) in recent, postsecular societies to three phenomena. First, these include the perception that global conflict often hinges on religious strife. For example, religious groups and ideas are linked to fears of a terrorist attack. Second, that religion is gaining influence, even within national public spheres. Religious organisations influence laws and policies regulating moral and/or value conflicts. They further describe how "churches and religious organizations are increasingly assuming the role of 'communities of interpretation' in the public arena of secular societies" (p. 20). In aligning with this, this study aimed at mobilising churches/religious communities in MHI for AR in SA, in initiating and implementing recovery support groups for alcohol and/or substance abuse and other

dysfunctional addictive behaviours. The church/religious community would become a micro- context that 'voiced' the prevalence of addiction and the hope for recovery within the community. Third, refugees and immigrants' different cultural and religious backgrounds have become challenging. Society has faced the blatant differences between cultures and religions and the implications thereof in day-to-day living.

Within this pluralistic society, where divergent worldviews are evidenced, this re-emergence of the importance of religion in the public realm implies tolerance and respect for differences (Hill et al., 2000). Irrespective of any particular religious persuasion, people of many diverse cultures, beliefs, meanings and ways of living have begun to tolerate and respect differences. In discussing divergent undergirding values in both religious and non-religious groups, Lombaard (2015) emphasises that "openness characterises both the philosophical groundwork and practical outcomes within post-secularism" (p. 87). Although there is tolerance and openness towards difference, there are still limits. He adds, "Within the religious category, for instance, violent extremism cannot be said to fit within post-secularism's sense of openness; within the non-religious category, virulently anti-religious sentiments, though acceptable and even encouraged, also fit less than comfortably within the post-secular framework" (p. 87).

Cobb et al. (2012), who are involved in healthcare protocols and policy-making, state that various authorities involved with religion, medicine, politics, economics and education, are being challenged to function from an interdisciplinary perspective that includes the spiritual.

> *A spiritual discourse implies the implementation of enhanced collaboration, and respectful ways of treating patients and others. Within this unfolding framework of tolerance and respect for religious- cultural differences, this study explored the spiritual, lived experiences of individuals' journeys of recovery from addiction.*

2.2 Worldviews in Psychology

A worldview is defined by Koltko-Rivera (2004) as

> a set of beliefs that includes limiting statements and assumptions regarding what exists and what does not (either in actuality, or in principle), what objects or experiences are good or bad, and what objectives, behaviours, and relationships are desirable or undesirable. A worldview defines what can be known or done in the world and how it can be known or done. In addition to defining what goals can be sought in life, a worldview defines what goals should be pursued. Worldviews include assumptions that may be unproven, and even unprovable, but these assumptions are superordinate, in that they provide the epistemic and ontological foundations for other beliefs within a belief system (p. 4).

Slife et al. (2017b) describe how this definition includes epistemological, "'what can be known' and 'how it can be known'" (p. 2); ethical, "'what is good and bad', 'desirable or undesirable'" (p. 2); and ontological, "'what exists and what does not'" (p. 2), aspects of our view of human nature. They add that worldviews are open to other worldviews and are changeable.

2.2.1 Contrasting Worldviews of Secularist, Liberal Individualism with Postsecularist, Strong Relationalism

Within the field of psychology, Slife et al. (2017a) describe the implicit influence of liberal individualism in both research and practice. Their concern is that because liberal individualism is so endemic to western culture, with modern psychology having developed within a secular framework, many underlying assumptions in psychology research and practice often remain implied and hidden.

As a contrasting postsecularist worldview, strong relationalism is used to elucidate some of these implicit meanings underlying the development of psychological theories and the practical application. Strong relationalism is where "Relationships are the primordial reality…." (Slife et al., 2017a, p. 27).

Relationalism emphasizes the fundamental relational nature in life.

Liberal individualism includes the underlying assumption that individuals are sovereign over all aspects of their lives and that essential qualities of the individual are contained within. However, in strong relationalism, the individual depends on interpersonal relationships and context to determine and understand meanings. In liberal individualism, the values of autonomy and empowerment are widespread. An implication of these values, as an example within the practice of psychology, includes that individuals can decide their own therapy goals instead of these goals being informed by their moral traditions. A liberal individualism worldview implies a pursuit of personal happiness and well-being, whereas, with a strong relationalism worldview, the individual pursues the quality of a relationship. This pursuit of moral relationships and their meanings (strong relationalism) differs from liberal individualism, where the world and people are resources to be used for the individual's ends. Professional psychology practice presupposes that therapists practice in a way that is as free of their values as possible (liberal individualism). A strong relationalism worldview is characterised by the therapist facilitating an interchange of values between the client and the therapist. Liberal individualism includes emphasis on the individual's need for independence, where therapy aims at freeing the individual from obligations viewed as obstacles to self-expression. A strong relationalism worldview includes embracing obligations as an important aspect of self-development and accepting an existential dependence. The relationist would thus argue that without dependency, there is no love or intimacy. Through consulting moral traditions, decisions are made regarding which dependencies are good or bad. Moral traditions are inextricably intertwined with religious/spiritual and cultural beliefs.

MHPs often use techniques to improve independence skills based on the dominating western worldview of individualism. According to Slife et al. (2017a), however, the absence of developing healthy dependency skills is probably associated with decreased interpersonal intimacy and connection. The ability to love and be loved would be affected. The sense of belonging within a community would be negatively affected. A postsecularist framework for MHI, including models of healing through love, connection and relationship that include care models of psychotherapy rather than cure models, will be elucidated further under postsecularism and mental health intervention (MHI) (see Section 2.4).

Prior to discussing the MHIs, a brief review of the literature regarding the aetiology of addiction is required and follows.

2.3 Postsecularism and Addiction

Literature reviews regarding the aetiology of addiction are rife with varying theories. The aetiology of addiction remains complex and difficult to categorise. As described by Kardaras (2016, p. 56) "the understanding of addiction is sort of like a riddle wrapped in a mystery inside an enigma."

Questioning the underlying causes has led to answers that include genetics, lack of willpower to control impulses, a lifestyle choice, a medical disease, neurobiology and/or neurochemical imbalance, dysfunctional family history and psychological attachment issues, trauma, culturally rooted problems, dysfunctional learning, and moral failure.

Morgan (2019) expresses the need for a consilient model of addiction that integrates all relevant factors in gaining an understanding of the specific individual life. The aetiology differs for each case. Kardaras (2016) adds that it is more important to understand the "perfect storm" (p. 59) of underlying factors that make the individual vulnerable to addiction than to focus on the specific substance use and/or behaviour involved. However, presenting symptoms/criteria related to the substance use and/or behaviour are used to diagnose any comorbid psychiatric conditions that would affect determining the relevant treatment protocol to be implemented by MHPs for the individual.

2.3.1 Classification and Parallel Features of Substance Use Disorders and Behavioural Addictions

There remains an ongoing debate regarding the classification of certain behaviours as behavioural addictions. According to DSM-5 (American Psychological Association [APA], 2013), under the classification of substance-related addictive disorders, only gambling disorder is recognised as a non-substance-related disorder. The World Health Organization (WHO) has in the latest version of the International Classification of Diseases manual, 11th Edition (ICD-11) included a diagnosis for Compulsive Sexual Behaviour Disorder (WHO,

Jan 2021), which can be used in diagnosing those persons who struggle with sexual addiction behaviours, including the viewing of pornography. In the revised version of the DSM-5 (American Psychiatric Association, 2013), the APA has also proposed Internet gaming disorder as a potentially addictive disorder that warrants further study before being officially recognised and included for clinical diagnosis purposes.

Despite controversial debates regarding inclusion criteria and classifications, as ongoing research continues to unfold, our world is transforming rapidly. Contemporary society is presented and overwhelmed with the abundance of high reward stimuli due to the ever-increasing and unprecedented access available through the Internet. Lembke (2021) says, "If you haven't met your drug of choice yet, it's coming to the website near you" (p. 1). An explosive growth of Internet technology offers increased amounts, varieties and potencies of these types of stimuli, including drugs, food, news, gambling, shopping, gaming, sexting, Facebooking, You-tubing, sport, pornography and more. Contemporary society is exposed to and flooded with stimuli that lead to ongoing vulnerability to compulsive overconsumption (Lembke, 2021).

The DSM-5 (American Psychiatric Association, 2013) lists core features of substance use and addictive disorders. These include impaired control, social impairment, risky use and pharmacological criteria. Impaired control includes repetitive engagement in behaviours, with multiple unsuccessful efforts to decrease behaviour. Cravings manifest in strong urges to engage in the behaviour, with the activation of specific reward structures being evidenced in the brain. Despite awareness of the negative physiological and psychological consequences, the persistent engagement with the drug or behaviour persists. Pharmacological criteria include tolerance and withdrawal, with physical symptoms being evidenced. Chamberlain et al. (2016) argue there is increasing evidence that individuals' displaying certain pathological behaviours present with parallel features as people struggling with addictive substances. They highlighted issues including comorbidity, neurobiology and treatment protocols to emphasise similarities between SUDs and behavioural addictions.

Extensive data points to a strong correlation between SUDs and other psychiatric disorders, including major depressive disorder (MDD), bipolar mood

disorder (BMD), social anxiety disorder (SAD), post-traumatic stress disorder (PTSD) and attention-deficit/hyperactivity disorder (ADHD). Similarly, a range of psychiatric disorders, including bipolar disorders, anxiety disorders, ADHD, and SUDs have been associated with behavioural addictions (Chamberlain et al., 2016). Comorbidity has been shown between gambling disorder and ADHD (Grall-Bronnec et al., 2011) and between gambling disorder and obsessive-compulsive disorder (OCD) (Scherrer et al., 2015). Clinical data also indicates strong correlations between SUDs and behavioural addictions (Lobo & Kennedy, 2009).

Although behaviours, such as online gaming and the viewing of pornography are not officially classified as behavioural addictions, ever-increasing evidence of neurobiological disruptions and changes in brain functioning in line with changes evidenced by SUDs is emerging. In a study by Wang et al. (2011), males in early adulthood who had limited prior exposure to violent video gaming showed brain changes after only one week of playing violent video games. The areas of the brain negatively affected included frontal brain regions used to control aggressive behaviour and regulate emotions. Wilson (2015) described how the overconsumption of pornography viewing had been shown to negatively affect the reward-circuitry balance in the brain. These affected brain regions have also been shown to be associated with SUDs (Lembke, 2021).

Similar and effective treatment protocols for SUDs, and behavioural addictions include implementing contemplative practices such as mindfulness (see Section 2.4.2.1.2) and connecting to nature (Kardaras, 2016; Williams & Kraft, 2022).

2.3.2 Exploring Aetiological Possibilities

In line with premodern society, dysfunctional substance use was evidence of moral failure (Stevens-Smith & Smith, 1998). The addicted person was viewed through moralistic lenses by society and was treated with disdain and condemnation.

With shifts occurring in the radically increasing numbers of addicted people,

following World War One, people in society became more open to accepting other possible causes for the addiction problems. New scientific discoveries in physiology and psychology led to an understanding that physiological causes, over which the individual had little or no control, were seen as the root of the addiction. In early 1940, "alcoholism" was defined as a "disease" (Johnson, 1973, p. 242-243) that needed treatment. With the acceptance of this disease model, increased scientific research was supported. Family, twin and adoption studies supported the significance of genetic factors in alcoholism (Schuckit, 1986).

The study of the significance of neurochemical pathways, such as the release of the neurotransmitter dopamine in the brain's reward pathways, is ongoing, as is the scientifically controlled study of myelination in neurobiology (Kardaras, 2016). Lembke (2021) reports how dopamine is released in the brain's reward pathway when a person experiences pleasure. An intricate and complex balance between the experience of pleasure and pain exists. With increased access (exacerbated via the Internet) to substance use and addictive behaviours that provide pleasure and instant gratification, the world has transformed to fulfil these hedonistic desires. Abundance and overconsumption are evident, with the human brain adapting to "now need more reward to feel pleasure, and less injury to feel pain" (p. 67).

Neurochemically, the brain becomes more vulnerable to addiction. Through the protective process of myelination, neural connections become hardwired. Brain images show differences between the brains of children who have received appropriate stimulation through repetition/exposure and those who have not. Significant neurobiological damage to the myelin in neural pathways has been found where overstimulation through exposure to the flashes on screens (e.g., video gaming) has occurred (Kardaras, 2016).

Relational and interpersonal aspects relating to problematic substance use and behavioural addictions became the focus of socio-cultural studies.

The biopsychosocial theory of addiction was incorporated into an aetiological understanding of the problem. The socio-cultural context includes all the aspects of the individual, such as genetics, choice, neurochemistry, neurobiology and learning, with the social ecology and world the individual inhabits. Social fragmentation and alienation result from interpersonal tension, damaged societal

systems, and threats to the natural ecology (Morgan, 2019).

Alexander (2008) theorised about a developing lifestyle where a substitute (the substance and/or behaviour) adapts to the emotional pain experienced in alienation and disconnection by filling the emotional void. Morgan (2019) believes "that the 'soul' of addiction is lack of connection and belonging" (p. xxvii).

Morgan (1999) shows how the inclusion of spirituality in treating addiction problems originated with the founding of Alcoholics Anonymous (AA) in the mid-1930s. The founding member, Bill Wilson, had what he narrated as a spiritual experience. Sharing his experience and ideas initially with a friend and then with others led to a small group of alcoholics regularly meeting and supporting each other. The principles of the AA were birthed out of this process. With a more recent focus on AR research, scientists became interested in the functioning and healthcare benefits of these spiritually based self-help groups (SHGs).

A further example of including the spiritual dimension in understanding the nature of addiction is given by Olthuis in using what he terms the "me-myself-I model" (Olthuis, 2001, p. 88) representative of the three faces of the self. The complexity of human personhood includes 'me', as character, personality and socially constructed identity. 'Myself' is the unique, authentic and connecting self. Connection includes connecting with self, others, God and nature. 'Myself' includes the heart of the spiritual dimension. 'I' stresses agency intending to decide, act and narrate the self-story of life. These faces of self are dynamic and intertwined. The more the three aspects overlap and are synchronous with each other, the more presence, peacefulness and aliveness the person experiences. When a conflicted lack of connection exists between the adaptive 'me' and the authentic 'myself', connection is fabricated by escaping using the substance and/or behaviour to feel connected. The substance and/or behaviour becomes the substitute for authentic, inner connectedness and spiritual peace (Olthuis, 2001).

> *In keeping with a shift in society towards postsecularist thinking, integrating these spiritual principles into recent scientific research indicates the interdisciplinary collaboration regarding the aetiology, and treatment protocols for addiction. The accepted biopsychosocial-spiritual perspective regarding addiction is evidenced* (see Section 2.4.1).

2.3.3 The Dire Need for Intervention

Lembke (2016; 2021) expressed her concern for the spiralling prevalence of dangerously using prescription drugs.

Through a process of learnt connection, an individual initially connects the drug with pain relief and the lack of drugs with the experience of pain. Escalating drug use becomes connected with emotional relief, and the lack of drugs, with escalating pain. Any attempt to reduce the drugs causes physical and emotional withdrawal that is experienced as terrifying, dangerous pain and is experienced much more intensely, needing increased drug use to alleviate the inseparable psychological/physical experience (Szalavitz, 2017). As this process of dysfunctional learning continues, many medical doctors continue to overprescribe "when the risks of the drug overpower any foreseeable benefit" (Lembke, 2016, p. 156). There is a dire need for doctors to intervene by prescribing less and relating more in helping to treat those in addiction.

Addiction has taken a grip on society. Technological advancements enable a culture of fast-paced instant gratification with increased access that feeds into the social monsters of greed and control, breeding criminality. Within this culture of exploitation, the youth should be given knowledge (psychoeducated) regarding the risks of addiction, including the viewing of pornography on the Internet (Wilson, 2015).

Referring to the South African context, Dolley (2022) describes how people's addiction to legally prescribed drugs can result in using illicit narcotics when the requisite prescription is unobtainable. The dark world of trade in illicit and dangerous drugs consists of "layers upon dingy layer of drug networks" (p. 252). "Drug traffickers push death" (p. 254). The simultaneous involvement in other crimes, such as human trafficking, kidnapping, slavery and wildlife trafficking is common with cross-border syndicates bolstering trade.

Matzopoulos et al. (2014) state:

> The combined total tangible and intangible costs of alcohol harm to the economy were estimated at 10 – 12% of the 2009 gross domestic product (GDP). The tangible financial cost of harmful alcohol use alone was estimated at R37,9 billion, or 1.6% of the 2009 GDP (p. 127).

These statistics are alarming and require evidence-based interventions that include addressing the costs thereof in facilitating societal change.

Intervention is needed to initiate change where each person in society takes responsibility towards self and others in the co-creating and fostering of a supportive and healthy community, society and world.

2.4 Postsecularism and Mental Health Intervention

MHI within a postsecularist framework includes a relational worldview, where the phenomenon of spirituality forms part of treatment protocols and programs.

The lived experience of spirituality acknowledges the postsecular "sense of realism" where existential meaning is attached to "some *real* thing" (Lombaard, 2018, p.5).

2.4.1 Biopsychosocial – spiritual Model

Hefti (2011) describes an extended biopsychosocial model in MHI that includes religion and spirituality as a fourth dimension. This builds on the predominant biopsychosocial model for clinical practice and research introduced by Engel (Engel, 1977). Hefti (2011) shows how a holistic approach to MHI would integrate pharmacotherapeutic, psychotherapeutic, sociotherapeutic and spiritual aspects. He conceptualized the holistic and integrative model to gain understanding of the influence of religion and spirituality on both mental and physical health. Through his clinical experience and research at a clinic for psychosomatics, psychiatry and psychotherapy in Lagenthal, Switzerland, he showed that many patients use religious or spiritual coping mechanisms in managing their conditions. He emphasized the need for MHPs to be trained in how to integrate religion and spirituality into clinical healthcare.

Hefti (2011) states that training for MHPs needs to include learning how to

1. gain understanding of patients' particular expression of spirituality with regards to their overall wellbeing
2. take a spiritual history

3. support religious and spiritual coping
4. consider counter transference reactions influenced by the therapists'own religious or spiritual experiences (Koenig, 2002)
5. deliver social and community resources
6. understand and implement referrals to religious professionals/faith-based organizations when necessary.

He emphasized the need for mental healthcare programs to include spiritual issues. "Programs illustrate possible forms of integration" (Hefti, 2011. p.623). In developing a proposed, integrated model, this study aims to provide practical applications for integrating spiritual issues into MHIs for AR in SA.

In his biopsychosocial-spiritual research, Koenig (2009) emphasized the importance of defining spirituality in terms of religion, where religion is a multidimensional construct. This multidimensional construct includes many other expressions of connection to the transcendent and is not limited to institutional forms and practices of religion. Koenig, and his colleagues, use the terms religion and spirituality (R/S and S/R) interchangeably (Koenig, 2009; Koenig et al, 2012; Koenig et al, 2021). Koenig et al. (2012) linked R/S to positive and negative mental health aspects. They showed how various factors known to impact mental health, including biological, psychological, social, environmental and behavioural, are linked to R/S beliefs and activities. Positive mental health is marked by positive emotions such as peace, harmony, well-being, hope, and a positive cognitive state (meaning and purpose and adaptive coping); negative mental health (including SUDs) is shown to often be marked by the absence of these. It is shown that the relationship between religion and mental health emphasises individuals' freedom of choice in their decision- making. Koenig (2009) states that R/S practices can promote an optimistic, hopeful worldview. If these practices function as an aspect of the worldview of the individual, then they need to also function and be included as part of the treatment protocol.

In more recent literature, Koenig et al (2021) reiterate the complexity of both R/S and emotional health as multifaceted constructs, with research needing to focus on the specific associations linking specific dimensions of R/S with

specific dimensions of both positive and negative emotional health (Rosmarin & Koenig, 2020). By focusing on more specific dimensions of both R/S and emotional health, the complexity of the multidimensional nature, and bidirectional interaction between the two constructs is considered.

Connery & Devido (2020) emphasize how an enhanced model for MHIs that incorporates S/R into assessment and treatment protocols can be used to identify both positive supportive strengths, and potential negative effects of S/R on treatment outcomes. “S/R is a significant dimension of many people’s self-understanding and can be a source of meaning and resilience under challenging circumstances” (p.135). Koenig (2009) shows, however, that unhealthy forms of R/S can “enhance fears or guilt, and restrict life rather than enhance it. In such cases, religious beliefs may be used in primitive and defensive ways to avoid making necessary life changes” (p.289), further reinforcing rather than alleviating presenting symptoms. Grubbs & Grant (2020) commenting on S/R and behaviorial addictions agree that “whereas religion and spirituality seem to be a buffer against problems with gambling disorder, they appear to be potential risk factors in other regards, such as negatively contributing to self-perceptions among individuals who struggle with these disorders” (p.152).

Furthermore, these constructs can have an evolving, bidirectional influence both positively and negatively on each other. This bidirectionality is evident where presenting symptoms of emotional distress can influence R/S beliefs and involvement over time, whilst R/S beliefs and involvement can prevent, alleviate or exaccerbate symptoms (Koenig et al, 2021).

Pargament (2007) reiterates the importance of spiritually integrated psychotherapy. He describes how:

1. spirituality is a natural and normal part of life,
2. it contributes to a complete accounting of human strengths and weaknesses,
3. it is a therapeutic fact of life, and
4. MHP are now in the position to move from theorising about spirituality in psychotherapy, to integrate it into practice.

Cobb et al. (2012) state the importance of health care professionals understanding how spirituality works in people's lives to avoid showing disrespect and to facilitate access to and use of spiritual resources for those in treatment. The therapist's value system, with the hidden, underlying assumptions of liberal individualism in psychotherapy training, can negatively affect the therapy process of theistic clients (Slife et al., 2016). The therapist can persuade a client, albeit unintentionally, to accept values, including happiness, autonomy and independence, as part of functional and positive healing. They further emphasise the importance of informed consent, including the therapist's personal values. However, the unawareness of, and often unchallenged acceptance of the underlying western psychology principles often results in therapists themselves not being aware of these disguised ideologies. Tjeltveit (1986) also addresses the ethical problems of value conversion (where clients adopt the psychotherapist's values) and proposes the reduction thereof through competency training of therapists and informed consent being given by clients. This consent includes making the therapist's values overt so that the individual can consider that the competent therapist having different moral, religious or political values may have a varying moral, religious or political impact on that individual. There could be a violation of ethics should a client not be provided with this information.

Including spiritual and religious issues in therapy requires that clinicians develop competence in respectfully integrating spiritual and religious elements as part of therapy. Slife et al. (2016), in agreeing with Tjeltveit (1986), add that psychotherapists' training must include religious and cultural competency in the curricula.

Whitley (2012) states that:

> cultural competence by definition includes religious competence, as individual religious orientation infuses patients' beliefs, values, attitudes, and conventions. Not only does religion (or lack thereof) determine patients' psychological and existential frameworks; it can also play a key role in determining behavioural variables (which, in turn, influence physiological variables) that have a direct bearing on mental health. For

> example, religiosity may influence use of alcohol, use of substances such as cannabis, patterns of sexual activity, sleep, and diet (the latter in the form of fasting often affecting medication adherence). Religious practices permeate most domains of life and cannot be neatly compartmentalized or separated from everyday activities and concerns (p. 250).

Treloar et al. (2014) show that health care professionals are trained and encouraged to develop their multicultural competence to work more effectively in culturally diverse populations. They suggest that:

> when working in the area of addiction treatment, spiritual competence may increase the ability of the provider to help the client to discover or rediscover their own purpose and core values, explore the negative consequences of the addictive behavior on these values, and to develop behaviors that support the identified core values (p. 38).

The role of life meaning and purpose in the recovery process of addicted persons was explored by White et al. (2006). They stated that the past, present and future are linked by life meaning and purpose. Life meaning renders the past coherent and gives value to the present, while purpose enables the person to make a link between current activities and a desired future. They proposed that addiction professionals "become fluent in the diverse languages of meaning reflected in religious, spiritual and secular pathways of recovery" (p. 8). The importance of the individual narrative of the addicted person and how he/she must be helped to construct a personal recovery-enhancing story was emphasised. Personal goals for their future in recovery need to be set. The personal story enables life's meaning and purpose to be explored. Through these first-hand lived experiences in this study, meanings were gained regarding the specific phenomena of spirituality.

These insights are gained to add to the existing body of knowledge and can be incorporated into future training, practice and treatment implementation. This is important for both individual and community-based intervention. Considering cultural factors and context in MHI is necessary (Dein et al., 2012). They emphasise the need for future research to focus on the situated, personal experiences of individuals belonging to particular traditions. As culture and religion

are inextricably woven together (Geertz, 1973), this research aimed to further explore spirituality and mental health, particularly in the SA context where people from diverse cultures live together as South Africans.

2.4.1.1 *Love, a core spiritual value.*

Postsecular MHIs aimed at treating people from diverse cultures with respect for their inherent cultural and spiritual beliefs, includes the core spiritual value of love.

Heinämaa (2020) , in reviewing the works of Husserl (see Section 3.1.1.1) explicates his theory of the concept of personal value, also referred to as the personal values of love. She emphasizes how he linked two forms of infinity to the concept of personal value. “On the one hand personal values disclose infinite emotive depths in human individuals while on the other hand they connect human individuals in continuous and progressive chains of care” (p. 431). Interrelated aspects of Husserl’s personal values of love, as distinguished by Heinämaa, include amongst others, a rootedness in egoic depths and defining of the core of a person; and the transitive relations of care between human beings.

The values of love include an understanding of egoic depths as being potentially limitless; together with ongoing, unconditional care and connection towards others.

A growing body of evidence includes care, rather than cure, models for psychotherapy practice. Olthuis (1994) contrasts relational psychotherapy (a God-is-with-us psychotherapeutic condition) based on an ethos of care, including mutuality and connection, with the predominant ethos in western psychology, of cure, that focuses on mastery and control. He shows how a care model is grounded in a spirituality of compassion, and a spirituality of compassion begins with God (Olthuis, 2001). He emphasises God's presence *with* creation; and the love of God, neighbour, and self as fundamental in developing a relational therapy model centred on love (Olthuis, 2006). Clough (2006) suggests that the best outcome of therapy can be summed up as "We love because he first loved us" (1 John 4:19, NIV). He adds, "It is the action of the Logos, the nature of Being itself, the motivator and director towards growth in all psychotherapy, towards meaning and understanding in all psychology" (Clough, 2006, p. 30).

Receiving unconditional love can be transformational in healing (Vaillant, 2008) and is often about witnessing, where the person in emotional distress experiences having been seen, heard and acknowledged by another. This social connection is where communication through words, touch, gestures and actions helps to soothe and heal some of the past emotional hurt (Cozolino, 2014). Dossey (1993), in describing the place of love in healing, says, "it is a living tissue of reality; a bond that unites us all" (p. 117).

Vaillant (2008) shows how humans learn selective, enduring love through three identifiable catalysts:

1. genes,
2. neurochemistry, and
3. identification.

An example of the genetic component of not receiving and giving love is evidenced in infantile autism. Although not fully understood, the social limitations are "almost wholly genetic" (Vaillant, 2008, p. 97). With neurochemistry, the overproduction of oxytocin receptors and release thereof in human new-borns is evident. Brain oxytocin levels also increase when a mother holds her new-born baby or when puberty is reached, and the adolescent crush is experienced. He adds that interestingly the region of the brain in humans connected to the release of oxytocin includes the anterior cingulate gyrus. This region, linked to the attachment process, depends on the neurotransmitter dopamine and contains opiate receptors. Heroin addiction occurs when a person feels 'comforted' by this lethal 'lover' that is also selective and enduring. Third, humans learn to love through identification with others. Through the attachment with a loving other, the evolving brain learns to love and self-regulate.

Vaillant (2008) says that we learn to love "from the people who love us and let us love them. Successful human development involves, first, absorbing love, next, reciprocally sharing love, and finally, giving love unselfishly away" (p. 101).

In considering the importance of love as integral to MHI to facilitate a process of transformation, simply loving people and not trying to change them is necessary (Cron & Stabile, 2016). When the process includes accepting and

loving people as they are, then the love and compassion for others awaken. Negative forces, such as control, power and manipulation are minimised and lose influence as the love that binds the social connection grows over time.

In experiencing love in this unselfish and non-judgemental way, two other concepts need consideration for this study. These are self-compassion (love towards self) and service to others (love towards others); reiterating a relational worldview.

Olthuis (2006) endorses a We/I structure of humanity, where “in truly loving others I am loving myself: Just as in loving myself truly, I am loving others” (p. 69). An intrinsic, human dance of “Identity as presence-to-self and intimacy as presence-with-another” (p. 69) is implied.

2.4.1.1.1 Self-Compassion: Love towards Self.

Cron and Stabile (2016) emphasise the need to extend the growing love and compassion towards others (as discussed in 2.4.1.1.2) and oneself. Based on the Christian faith, their work shows the importance of learning to look upon oneself as a mother would softly gaze upon her child, and God would softly gaze upon each of His children individually. When a person can show compassion and a loving quality of affection towards self, healing can occur. Any self-judgement, criticism and prosecution regarding certain traits in one's character are then replaced with a compassionate love that views the trait as "a signpost pointing us to travel toward and embrace an aspect of God's character that we need" (p. 228) as one heals and journeys towards wholeness and optimal well-being.

Neff (2011) discusses how the pressures of today's competitive and consumeristic culture exacerbate self-criticism and anxiety. She agrees that it is in acknowledging and accepting one's weaknesses/limitations with kindness that new creative ways of change can be explored. Instead of impulsively reacting to negative thoughts and emotions, it is with kind, mindful awareness that these thoughts and emotions are observed and experienced physically.
Being kind to oneself also includes the intentional practicing of gratitude, where the focus is directed towards thankfulness for the small positives. Practicing gratitude helps with nurturing balance towards healing. She emphasises balancing "the dark energy of negative emotions with the bright energy of love

and social connection" (p. 113). Unselfish love of others, self- compassion and gratitude thus flow together as part of a balanced life.

People struggling with addiction often feel consumed by negative thoughts and emotions (Substance Abuse and Mental Health Services Administration (US), & Office of the Surgeon General (US), 2016). Vicious cycles of emotional turmoil include guilt, shame and self-hatred that are characterised by low self-esteem and self-worth. Any behavioural signs of possible relapse into addictive patterns are initially accompanied by shaming of the self. A cycle of self-sabotage develops where the aspects of the person most needing to change simply do not go away (Shapiro, 2020). Shame escalates, and self-esteem diminishes. Brown (2007) shows how the integral aspect of the human being that enables the belief in the possibility of change is corroded by shame.

Many MHIs aim to build self-esteem to foster resilience in coping with life's difficulties. Shapiro (2020) argues, however, that building self-esteem depends on some achievement and/or success in measuring self-worth. Self- worth fluctuates, being dependent on comparison and changing external factors. It is through self-compassion that the value of the self is recognised as intrinsic and stable. A person in active addiction is already struggling with dependency on a substance and/or a behaviour.

An intervention should be focused on developing self-awareness and self-compassion in the individual.

2.4.1.1.2 **Service to Others: Love towards Others.**

Miller and Weigand (2021) describe altruism as being the lived, actionable service to other human beings and is "essentially an embodied form of our awareness of unity and love" (p. 223). They describe a study done in 2016 with 5 500 participants across India, China and the United States of America. The participants represented varying religions/spiritual beliefs, including Christianity, Islam, Hinduism, Buddhism, non-religious, secular and spiritual-but-not-religious. Although acknowledging and including diverse expressions of beliefs in diverse ways, five universal common spiritual phenotypes were identified:

1. altruism,
2. love of neighbour as self,

3. sense of oneness,
4. the practice of sacred transcendence, and
5. adherence to moral code.

Miller and Weigand (2021) concluded that despite the impact of diverse cultures and traditions on the formation and development of spirituality, the perception of spirituality was intrinsic to all. With further investigations, including the assessment of Magnetic Resonance Imaging (MRI) scans of a longitudinal data set, it was found that the brains of those participants at high risk for depression (obtained through longitudinal family history) showed increased perception of the first two phenotypes, i.e., altruism and love of neighbour as self, exhibited structural cortical thickness of the spiritual regions. These regions included the region of bonding and social connection, suggesting, "a neuroanatomical foundation to relational spirituality" (p. 222), protecting the person categorised as high risk. The implication of this finding is aligned with a postsecularist framework that includes that the body, mind and spirit of individuals, as part of communities, societies, and the world, are innately interconnected. They add that the "finding touched on the cornerstone of all faith traditions: that sacred, transcendent love ignites in service to one another" (p. 222) and that in seeking optimal health, we need to choose to awaken our hearts in love, and "take our spiritual perceptual capacities and merge them into our lives of service and contribution" (p. 235).

For both the giver and receiver, the clinician, the pastor, the volunteer, the person in active addiction, the person in recovery from addiction, and whoever the giver and/or receiver is within a specific context,

> *the awakening of hearts to altruistic love and service to others through intentionally and actively engaging our innate spiritual perceptual capacities is imperative for optimal MHI.*

2.4.1.2 *Collaborating Towards Change: Techniques for MHI*

2.4.1.2.1 Collaboration and Facilitating Change.

The envisaged aim of this study included developing a multidisciplinary model where MHPs and persons involved in faith-based organisations could collaborate in providing care for persons in AR.

> *A care model (rather than a cure model), grounded in self-compassion, altruistic love and service to others will be collaborative in nature, with openness and respect towards interpersonal and interdisciplinary differences being evidenced.*

Greyvensteyn (2019) presented a theoretical biopsychosocial-spiritual framework towards bridging the gap between psychologists and pastors within the South African context. She emphasised the importance of mutual respect and openness to shared learning between the two groups. She describes one of the bridges needed for integrated collaboration between psychologists and pastors to be mandatory, integrated training and cultural competency. She adds that the accompanying attitudes for this proposed bridge would include commitment, open-mindedness and willingness on the part of all involved.

Kehoe and Dell (2021), in describing the benefits of collaboration between clergy and clinicians, show how clergy can offer hope and community through faith traditions, while clinicians can assist in treating symptoms and dysfunctional behavioural patterns. These two disciplines are complementary towards benefiting the person in distress. They describe a historical context of mistrust between the two groups as challenging. Differing value systems, lack of training, and lack of collaborative endeavours exacerbate the ongoing challenge. However, they emphasise the need to overcome the historical challenges, particularly in rural areas with limited access to MHPs, and where those "in faith communities turn to clergy first for help during times of distress" (p. 218). Rabe and Lombaard (2011) show how in SA, pressure on the clergy is also evident within the inner city context of Pretoria central, where the clergy are confronted daily with the extreme suffering and trauma of those living in the area. It was recommended that practical, supportive strategies might include the facilitation of easier access to relevant referrals, including crisis counselling services. The importance of mental health resources for faith-based communities cannot be overlooked, while mental healthcare needs the spiritual influence and wisdom of pastoral professionals and other spiritual healers to facilitate changed lives within ever- changing societies.

> *It is within the context of interpersonal relationships that collaboration and the facilitation of change occurs*.

Miller and Rollnick (2013), in detailing an insight gained from the counselling method of motivational interviewing regarding collaboration and change, emphasise the need to treat others with respect and interest. The practical implementation includes using the art of listening rather than being directive and/or authoritarian in style. All MHI thus includes an awareness of the power differentials within the context. White (2018), an addiction recovery and addiction advocacy expert, states that resistance is inevitable when there is a perceived power differential in the context of a relationship. He further described the need to adjust either to increase or decrease one's perceived power as part of developing a context of mutual respect.

White (2018) states:

> When our power is too high, it breeds envy, competition, and resistance; when it is too low, it can invite disrespect and invisibility. Both extremes can impair engagement and invite aggression. A good habit to get into is that of checking the measure of your perceived power and making adjustments as needed (p. 444).

Adjustments can be made by changing the communication style, altering the dress code and staying aware of the impact of drawing on expertise and/or experience. In describing an openness to learning and change, Dweck (2006) speaks of a growth mindset instead of a fixed mindset. A growth mindset includes embracing challenges, persisting despite setbacks, learning from criticism, and being inspired by others. Nurturing a growth mindset includes a willingness and a decision to change.

When thinking about creating an inviting and safe therapeutic context for change for persons struggling with addiction who seek professional assistance from me, the acronym P. A. C. E. assists with facilitating a mutually beneficial stance and dance of connection. One step at a time.

The dancer in me connects with the work of Hughes (2007; Baylin & Hughes, 2016), who identifies four important traits between the therapist and client that reflect a healthy attachment dance between an infant and caregiver.

These include:

1. **P**layfulness,
2. **A**cceptance,
3. **C**uriosity, and
4. **E**mpathy.

All four traits reflect a depth of connection that is intentional, interested and caring.

- ***Acceptance and Commitment Therapy.***

Acceptance and Commitment Therapy (ACT) confirms this underlying premise that any person who considers a changed life/style needs to accept life as it is in the present and have a willingness to change (Hayes et al., 2012).

Many persons that struggle with addictive patterns avoid the experience of negative emotions and the hurts of past traumas. Avoidance becomes a dysfunctional coping style to circumvent the intensity of emotional pain. Lembke (2021) shows how the person displaying related avoidant behaviours often is aware and at the same time not aware of what he/she is doing. This phenomenon is called denial in addiction, where there is increasing neuroscientific evidence of a disconnect between the reward system pathway, and the cortical regions involved with higher-order cognitive functioning. Planning, storytelling and facing the consequences of behaviour (as part of higher-order cognitive functioning) are negatively impacted. She adds that MHI includes focusing on renewing these neural pathways/connections in the brain.

ACT presupposes acceptance as an alternative to avoidance, where acceptance includes an open, flexible and active quality in being aware of psychological events as they occur. Hayes et al. (2012) caution against an individual using the term acceptance to resign him/herself to the idea that a

changeable situation is unchangeable. Acceptance does not assume an attitude of defeat or resignation but rather a conscious embracing of the situation in the present and empowering change through freely choosing. An open willingness to accept whatever unfolds is implied as part of an ongoing process of living and learning.

Hayes et al. (2012) describe how willingness includes the need for the individual to relinquish control over his/her own agenda. This encompasses a "values-based choice" (p. 276) to confront the fears, hurts, and pain avoided or denied. The implication of this assumption is that for those struggling with addiction, there needs to be a voluntary, intentional, values-based decision made by the individual to begin a journey of change. Coercive practices to involuntarily force individuals into AR programmes may, therefore, exacerbate only power differentials and the individual's resistance to accepting any form of MHI. The longer an individual resists, avoids and/or denies the reality of what must be confronted and changed, the more potential loss, harm and "real-life collateral damage" (p. 272) can accumulate.

Value-based choices are focused on actions in the initiation of change. The individual must be guided to understand that values as feelings are not synonymous with valuing as actions (Hayes et al., 2012). Value-based, committed actions are freely chosen, are not based on feelings, and are lived and on-goingly actioned as the embodiment of the particular value chosen.
Commitment in ACT includes this committed action in moments to ongoing, ever-increasing patterns of committed behaviours that express the individual's personal values. Collaborative work in ACT for those struggling with addiction would include the shared negotiation of strategies of action that embody these personal values of the individual.

When exploring these value-based choices of action, it is also necessary to intervene in a way that does not bring confusion regarding goals and values. Although having goals is important in offering direction and motivating the individual, having to achieve the goals for any fulfilment in life can be counterproductive. The individual cannot always be chasing goals; otherwise, there is always a sense that something is missing in the present moment. This sense may perpetuate a self-defeating attitude often evident in those struggling

with addiction, where the benefits of long-term goals are forfeited to fulfil instant, short-term impulses despite the negative consequences thereof (De Backer, 2021). Goals are thus set to encourage active engagement in the process of change, where the process itself ultimately becomes the embodiment of living fully and authentically. "Goals are the process through which process becomes the goals" (Hayes et al., 2012, p. 331).

- ***The Practice of Mindfulness*.**

The practice of awareness as part of MHI is integral to those in AR implementing new ways of managing thoughts, emotions and behaviours. "Self-regulation includes focusing attention on the self and having to become aware of personal shortcomings" (De Backer, 2021, p. 4). The practice of mindfulness is widely used to develop and internalise these skills.

“An operational working definition of mindfulness is: the awareness that emerges through paying attention on purpose, in the present moment, and nonjudgmentally to the unfolding of experience moment by moment” (Kabat- Zinn, 2003, p. 145).

For the individual in AR, the practice of mindfulness can be used effectively to fulfil varied functions. Morgan (2019) describes how intentional awareness in the present moment helps to facilitate a caring and safe context for healing between the counsellor and the client. He adds that mindfulness can help to soothe emotional reactivity within the context.

As part of recovery, by learning to mindfully be aware of thoughts and observe feelings as they occur in the present, the individual can learn to accept, reflect and let go without self-judgement. Self-regulation is nurtured as the individual becomes more observant and less reactive. Increased self- awareness and self-regulation are empowering, as the possibility of difference and change is experienced. Damaged neural pathways can be reshaped through the intentional practice of mindfulness (Siegel, 2018).

Zemestani and Ottaviani (2016) state that in considering psychiatric comorbidity, the comorbid condition, including depression disorders where reactive affect is experienced, is a high risk for substance relapse. The risk of relapse can be minimised by targeting affect regulation through mindful

awareness and acceptance and learning to relate differently (non-reactively) to the craving response.

As part of the ARRIVE programme in New York, a dual diagnosis intervention for the comorbid condition of ADHD, includes the mindful practice of five-minute dance intervals being incorporated for those who do not experience a sense of calm by sitting quietly (Szalavitz, 2017). The larger AR group members accommodate the distractibility symptomatic of those group members with ADHD in this mindful dance practice. Those with the condition are accepted for who they are within the context of the group. A sense of connection, belonging, and purpose is nurtured.

2.4.1.2.2 Embodiment.

Self-awareness and self-regulation include the awareness of bodily signals. "Interoception refers to an individual's ability to sense the physiological condition of the body" (Weineck, 2018, p. 129). This ability is predicated on the notion of the mind-body connection.

Tschacher (2018) states, "Mind-body reciprocity is a fundamental property of a person's cognition, with emphasis on the role of the body in embodied communication and embodied social cognition" (p. 57). He emphasises three aspects of this. First, the mind-body interaction is reciprocal and bidirectional in nature. Second, this bidirectionality does not imply two clear directions but points to a continuous circular interaction between mind and body. For example, a person's muscles can be activated subconsciously simply by thinking about moving physically. Thus, as a person engages with the environment, cognition and perception occur. There is an entanglement and interdependence between mind, body and environment. An active inference also occurs where "while we act, we continuously infer and predict what to sense as a consequence of our action" (p. 59) and compare for any discrepancies with what is being sensed. Third, embodiment presupposes that the mind and body within the entanglement are qualitatively different (Tschacher, 2018; Kearney, 2021).

All emotions are embodied as they consist of mental and physiological components. Nummenmaa et al. (2014) showed how varying body surface areas are associated with specific emotions using body sensation maps. The maps

point to the activation or suppression of specific body surface areas during an episode of emotional intensity. This localisation of emotions in the body, which is activated physiologically, implies that people "can in principle read emotional states off the bodies of people we interact with" (Tschacher, 2018, p. 62).

The social significance is that social connection is an embodied experience. Reading what is commonly termed body language between people communicates information regarding mental, emotional, somatic, social and spiritual aspects of their lives.

When focusing on co-creating a beneficial therapeutic relationship, the embodied connection between an MHP and a client struggling with addiction needs consideration. Life in the culture of active addiction includes deceit, manipulation and hustling interpersonally (White, 1996). Those in active addiction are usually adept at reading body language to fulfil their needs for instant gratification and pleasure. In developing a therapeutic alliance, the therapist's embodied interactions must be experienced as empathically authentic for the client's perception, cognition and subsequent involvement in implementing shared goals.

Koole and Tschacher (2016) show how various forms of non-verbal synchrony between therapist and client can occur within the therapeutic alliance where affective sharing and empathy are core functions. These include movement synchrony, body language mirroring, physiological synchrony, and central-nervous synchrony, where social coupling is evidenced. The study of proxemics focuses on how physical space is used in social interaction (Hall, 1966). An aspect of embodied cognition is evidenced socially by the use of physical space. The therapist needs to consider these non-verbal factors with verbal communication in connecting with the client. Verbal communication includes the specific use of language in social coupling.

For those in AR, connecting in the language is significant, as a sense of belonging within the group culture of substance use addiction usually includes the adopting of certain slang words, cursing and specific jargon/argot when speaking about drugs of choice and related behaviours (White, 1996).
In any therapeutic context, the embodiment of language sensitive to the culture of AR is imperative (Wakeman, 2013) in facilitating a context where a sense of

respect, professionalism, safety, belonging and hope for the possibility of change is experienced. The individual in AR needs to be supported within the therapeutic context to embody self-awareness. This awareness includes the monitoring of somatic responses and related thoughts. Thoughts and language that foster shaming, scapegoating, blaming and stigmatising others to justify a sense of importance, entitlement and belonging need to be relinquished. Miller and Weigand (2021) reference Timothy Shriver, chairperson of the Board for Special Olympics and disability rights activist, where he encourages others to focus on transcending this behaviour. Linking this insight to spiritual awareness, the focus and embodied response are towards actioning self-compassion and kindness to others in the uplifting and service to each other.

"The presence of being aware is the foundation of awakening the mind and freeing our lives" (Siegel, 2018, p. 348).

Embodied presence in the moment, biologically, psychologically, socially and spiritually, opens up a potential realm of possibilities to live more fully and authentically in recovery.

In SA there are currently faith-based organisations that offer AR support groups that provide support structures for those in recovery from substance use and behaviorial addictions, and for their supporters/family members. Most SHGs are held weekly in both face-to-face and online formats. Faith-based group facilitators predominantly speak from their own personal experiences with addiction in creating spiritually informed supportive contexts for sharing and gaining knowledge about AR. Professional registration with the HPCSA is not a prerequisite for these group facilitators. Examples of care models of Christian faith-based organisations offering SHGs for AR in SA, include H.E.A.L (Healing and Educating Addicted Lives) http://www.healministries.com/ and Project Exodus https://www.projectexodus.net/ amongst others.

2.5 Postsecularism and Addiction Recovery

Recovery from addictions includes a process of healing towards wholeness.

In an analysis of the concept of healing, Firth et al. (2015, as cited in Quinn, 1997) show the word haelen (an old English term) as meaning wholeness.

Pargament developed a theory of religious coping. Religious coping often occurs when people call upon a coping method they view as sacred in response to a stressor (Pargament, 1997). Pargament et al. (2000) include how religious coping performs five major functions:

1. to discover meaning,
2. to garner control,
3. to acquire comfort by virtue of closeness to God,
4. to achieve closeness with others, and
5. to transform life.

Medlock et al. (2017), in studying religious coping in patients with severe SUDs, concluded that the use of positive religious coping might modify the course of SUD recovery by promoting engagement in mutual help activities. Positive religious coping was also associated with lower substance cravings during detoxification. Martin et al. (2015) agreed that using religious coping as one of several coping methods may be useful for the subset of alcohol-dependent adults early in recovery. Pardini et al. (2000) also examined the relation between religious faith, spirituality and mental health outcomes among people recovering from substance abuse. "Results also indicate that among recovering individuals' higher levels of religious faith and spirituality were associated with a more optimistic life orientation, greater perceived social support, higher resilience to stress, and lower levels of anxiety" (p. 347).

Newberg et al. (2001) describe the roles of the autonomic nervous and limbic systems in religious and spiritual experiences. In researching neurotheology, they confirm that the neurological impulse of religion/spirituality is biologically rooted in the brain. Heightened neurobiological activity regarding arousal and soothing are linked to spiritual experiences. A balancing and integration of arousal and soothing are significant in recovery/healing towards wholeness, where psychologically, heightened neurobiological arousal motivates action, while heightened neurobiological soothing diminishes fears and is comforting. "In Christian theological language, the Holy Spirit both convicts and comforts" (Shults & Sandage, 2006, p. 189), with the individual needing to be wisely aware of balancing these aspects. Ultimately, recovery is "about taking

responsibility for ourselves" (Beattie, 2009, p. 8).

Taking of responsibility includes an openness to learning on this path towards wholeness.

Health and well-being include an ever-changing process of learning to adapt to the dynamic nature of living. By accepting the nature of health and well-being/recovery in this dynamic way, the integration thereof with the evolving process of spiritual growth and transformation is possible (Shults & Sandage, 2006).

In taking responsibility, the individual needs to learn to love, interweaving the biopsychosocial and spiritual dimensions of life.

2.5.1 Learning to Love

The context of supportive relationships in AR is important in maintaining accountability for the commitment to implementing daily changes. Particularly within an AR support group context, each member is held accountable to the other group members in reviewing the actioning of changed, chosen behaviours in line with each individual's personal recovery goals (Larsen, 1999). Within a safe, accepting and loving context, a sense of belonging is experienced, and changed perceptions of self can begin to develop as each member learns to show authentic love towards self and others.

2.5.1.1 Love, not Codependence.

For many addicted persons, the experience of love has become problematic. The person experiences a sense of entrapment and/or stuckness within a 'loving' relationship. Beattie (2009) states that in normal, loving relationships, there are incidences/times of hurting where behaviours that include worrying or controlling are deemed normal. It becomes problematic when the person cannot stop the behaviour. When the person is worrying too much, controlling too much, and caring too much that codependent (not 'loving') behaviour becomes evident.

Beattie (2009) adds these codependent behaviours usually evolved from the person having been confronted with difficult life circumstances and needing to either control or take care of because there were no other known ways of coping

at the time. However, these behaviours include overcrossing boundary lines, ultimately resulting in further relational pain. Within supportive AR contexts, a person can become aware of these boundary issues, the losses accumulated, and the reality of the situation in the present. The person can learn to tolerate emotional pain and self-regulate through kindness and curiosity towards self.

Recovery from codependent patterns involves honest self-reflection (and often honest feedback from empathic, supportive others) in discovering underlying motives for behaviour and the reasons these motives have developed. Lawford and Engel (2016, p. 104) posit three self-reflective questions (quoted below) as to whether motives for behaviour are driven by compassion or codependency:

1. Is helping my partner a way for me to distract myself from my own issues?
2. Do I want to 'rescue' my partner because it makes me feel worthwhile, good, needed, important, or proud?
3. Am I helping my partner because my identity depends on my ability to help others?

If the person answers the question(s) positively, then emotional work in the AR process would include delving further into the trauma/pain underlying the dependency. Emotional wounds are usually related to a sense of not being loved and/or not belonging, with related emotional insecurities being internalised. This sense of not being emotionally secure becomes entrapping as the person becomes dependent on someone/others for validation. This self-destructive pattern of insecurity, neediness, and related protection of the person who offers 'security', leads to resentment and a loss of self, with further insecurities developing as the entrapping, addictive cycle perpetuates (Beattie, 1992).

2.5.1.2 Freedom From Bondage.

As with all addictive behaviours and patterns, those addicted are trapped. From a postsecularist framework, mind, body and spirit are interconnected, implying that these aspects cannot be separated in the entrapment of addiction, and the freedom experienced in recovery.

Doweiko (1999) assumes that addictive disorders are symptoms of a disease of the human spirit where in seeking existential meaning and purpose,

the individual is confronted with the uncertainties of life and the related experience of doubt. Without hope, doubt leads to disillusionment and despair. However, with hope, the individual can believe in the possibility of something that transcends his/her boundaries.

Merton (1955) showed how:

> If… I trust only in my own intelligence, my own strength, and my own prudence, the means that God has given me to find my way to Him will all fail me. Nothing created is of any ultimate use without hope. To place your trust in visible things is to live in despair (p. 16).

The individual becomes increasingly trapped in the uncertainties, fears and sense of lack of control; and increasingly more vulnerable to seeking some kind of certainty (drug of choice) to relieve the emotional despair and hopelessness experienced. The idea of taking control of the existential uncertainties by using a substance and/or behaviour that predictably numbs and/or avoids the emotional pain, becomes part of a pattern whereby the person self-centredly forces his/her own will on reality (Doweiko, 1999).

Morgan and Jordan (1999) describe a "double idolatry of enslavement" (p. 263). First, a negative addictive script, usually including misrepresentation of authority figures and their control over the person's life, forms part of the addiction to negative beliefs. Second, the person is enslaved by the actual substance and/or behaviour(s).

Recovery includes the acceptance of reality exactly as it is. Larsen (1999) shows how the addicted person him/herself needs to be the one with expertise in discovering (understanding) and then recovering (doing something about the insights discovered). Mate' (2003) says that courage is needed to accept the reality of negative thinking and addictive patterns in gaining an understanding of self through discovering and recovering internal values for that time. This is not forcing or manipulating to control the uncertainties of the external environment but is instead an autonomous, self- regulating internal process.

"from a place of internal self-reference… Autonomy, then is the development of that internal centre of control" (Mate', 2003, p. 277). With this

sense of agency and empowerment, an interplay of these spiritual/psychological aspects exists as the person in redefining of self moves towards freedom from the bondage of addiction.

2.5.1.3 Redefining of Self.

The definition of self is at the core of who a person is. Active addiction and the related consequences often perpetuate self-degrading, negative thoughts and beliefs. Many of these negative beliefs originate from emotional wounds, such as rejection, where the person believes that who s/he is, is unacceptable to others. Fear of abandonment includes the belief that the person will always be alone. Shame presents in a belief of unworthiness (Brand & de Beer, 2022). A person cannot heal beyond his/her self-definition, as the self-definition will create the embodied consequences. Thus, those consequences will perpetually define further growth and becoming of the authentic self (Larsen, 1999).

Virtuous behaviour, as linked to good character, includes upholding healthy morals and ethics. This virtuous behaviour is linked to spirituality, where it is seen to exemplify holiness (Shults & Sandage, 2006). Peterson and Seligman (2004), in developing the VIA Classification of Character Strengths and Virtues, included six virtues and 24 character strengths that display these virtues. These virtues are:

1. wisdom and knowledge,
2. courage,
3. humility,
4. justice,
5. temperance, and
6. transcendence.

Personal development of these virtues underlies the recovery process. Through willingness and courage, the addicted person can, through developing kindness and self-compassion, confront the intensity of the accumulated pain and loss with honesty. The denial, pride, and often egotism of the addictive patterns need to be released through surrender and humility. By taking responsibility for developing underlying core character strengths that display these virtues within the context of living that always includes pain, sickness and death, the

autonomous ability to cope becomes fundamental to healing and health (Illich, 1976). He adds that this autonomous sense of responsibility taking includes acknowledging what has occurred and being subjectively answerable to another.

> *As each individual grows in awareness and internal adaptation to self and expression towards others, so too will the health of society tend more towards wholeness.*

2.6 Embracing the Spiritual

Peterson and Seligman (2004) include the virtue of transcendence in the VIA classification (see Section 2.5.1.3). The character strengths that display this virtue of growing connection and providing meaning to life include:

1. appreciation of beauty and excellence,
2. gratitude,
3. hope,
4. humour, and
5. spirituality.

The experience of transcendence includes a sense of knowing we are "more than we are yet" (Richo, 2019, p. 156). In noticing the beauty of all things, such as art and nature, there is a sense of awe and wonder. Humans intuitively know the "more to living things" (p. 153). Living in this place of awe deepens gratitude for life. Time, the temporality of life is appreciated, with an awareness of the present and hope for the future. This awareness and hope include an understanding of connection. There is the knowledge that no one exists alone but is always connected/attached to someone/thing else. Attachment and interconnection through life are evidenced in the brain's continuous growth and altering of neuroplastic processes (Cozolino, 2014). Richo (2019) states that within intimate partnerships, there is even more than connection, "we find communion" (p. 153), where there is an intimate exchange on a spiritual level.

The character strength of humour displays this appreciation of connection/communion through sharing laughter and smiles (Peterson & Seligman, 2004). This celebration of connection through humour links to the work of Hughes (2007), and Baylin and Hughes (2016) (see Section 2.4.2.1), where playfulness can

be used therapeutically to invite the development of healthy attachment between the therapist and the addicted person.

Finally, in the transcendent seeking of purpose and meaning, by knowing that no person exists alone, the implication is that a person can believe and begin to trust in a power beyond his/her control, with destiny encompassing more than mere personal goals (Richo, 2019).

It is in awakening to this belief in a Higher purpose and meaning, through kindness and curiosity towards self and others that spirituality is embraced.

2.7 Conclusion of Literature Review

As a backdrop for the research study, this chapter introduced the conceptual framework of postsecularism where religious beliefs cannot be separated from whom a person is. The principles of a worldview of relationalism were presented to show the fundamental, underlying significance of relationship.

In a postsecularist age, MHIs should be based on relationality; healing towards wholeness.

An openness, tolerance and respect for differences in religious, spiritual and/or cultural beliefs/practices, and the related implementation of enhanced collaboration, both interpersonally and interdisciplinarily, can occur when a biopsychosocial-spiritual perspective underlies human experience and interaction.

In the turn to relationality there is a recognition of spirituality as a component of human experience and of MHIs in general.

In postsecular MHIs, where the phenomenon of spirituality forms part of the mental health treatment protocols and programs, mutual respect and collaboration between those involved includes the core spiritual value of love. A care model (rather than a cure model) where those involved open their hearts (symbols of love) through intentionally and actively engaging innate spiritual perceptual capacities towards self-compassion, altruistic love and service to others, facilitates the creating of contexts for optimal MHI.

Recovery from addictions includes a process of healing towards wholeness where the personal taking of responsibility in learning how to practically implement/show love towards self and others, is fundamental to the facilitation of change. It is through a responsible, awakened and embodied interweaving of the biological, psychological, social and spiritual dimensions of life that those struggling with addiction can experience hope in a Higher purpose and meaning for life.

Spirituality should be included in MHIs for AR, as care models based on love are collaborative in nature and contribute to healing/wholeness.

Within the South African context, Greyvensteyn (2019) theorized that from a biopsychosocial-spiritual perspective, the gap between psychologists and pastors could plausibly be bridged with integrated collaboration between the two disciplines of mental health (psychology) and spirituality (pastoral ministry).

In MHIs for AR in SA, there are currently HPCSA registered MHPs (including the researcher as a registered clinical psychologist) working with both inpatients and outpatients individually and in groups. SHGs affiliated to local Christian faith-based organizations are predominantly facilitated by lay counsellors and volunteers offering caregiving services in the promotion of positive mental health within the community.

This study focused on enhancing current collaborative endeavours in SA by emphasizing the *practical application* of integrated, interdisciplinary collaboration between those involved in the caregiving contexts/professions of spirituality and mental health. What would an AR context look like and how would it function if caregivers/professionals from both disciplines of spirituality and mental health practically integrated, collaborated and cared together? A proposed model was envisaged and developed for this purpose.

In gaining depth of understanding for the initiating, establishing, securing and strengthening of such contexts for optimal MHIs in AR for the development of this model, the lived experiences of spirituality of the research participants in AR in SA were explored.

In Chapter 3, the conceptual framework of the design and methodology used for the study will be discussed by introducing the theoretical foundations of IPA.

Chapter 3: Conceptual Framework of the Method: Interpretative Phenomenological Analysis (IPA)

3.1 Theoretical Foundations of IPA

IPA is a qualitative phenomenological research method, including an interpretative approach. This is an interpretative method whereby phenomena of interest can be understood through language, which describes the participant's personal lived experience. The IPA approach to qualitative, experiential, and psychological research has three primary underpinnings in phenomenology, hermeneutics and idiography (Smith et al., 2009).

Smith (2011) describes the underpinnings as:

> It is phenomenological in its concern with lived experience, and it is interpretative in recognizing the analysis of experience as a hermeneutic activity. A distinctive feature of IPA is its commitment to an idiographic perspective, to the in-depth analysis of individual cases (p. 6).

3.1.1 Phenomenology

A phenomenological method enables a focus on the individual's own experiences relating to the phenomena of interest. Using this method presupposes that the intentionality or the way that the experience is directed through meaning towards an object or point of interest is the central structure of the experience. A phenomenological method includes studying the structures of conscious experience to gain new insights into a phenomenon (Smith, D. W., 2018).

Within psychology, a phenomenological underpinning provides the psychology researcher with a range of ideas on how to examine and understand lived experience. Aspects of phenomenological underpinnings in the writings of theorists, including Husserl, Heidegger, Merleau-Ponty, Gendlin and Sartre will be identified and discussed.

3.1.1.1 Husserl.

Edmund Husserl, a German mathematician, is credited by most historians

as founding the philosophical movement of phenomenology. He based his work on the assumption that reality is internal to the knower and that experience needs to be examined in the way it occurs, with the focus placed on each thing in its own right (Smith et al., 2009). Neubauer et al. (2019) describe how Husserl emphasized the importance of placing equal value on both objective and subjective experiences; and emphasized that phenomena should be studied as perceived by the individual's consciousness. Smith et al. (2009) emphasize the importance that Husserl placed on finding a way that someone could accurately describe his/her own experience of a specific phenomenon, to explicate the essence of that phenomenon. The essential qualities of the experience, as explicated through a descriptive, phenomenological method, "would *transcend* the particular circumstances of their appearance, and might then illuminate a given experience for others too" (p. 12).

Husserl's transcendental approach to phenomenology was based on the epistemological assumptions that the observer needs to separate him/herself from his/her world of everyday, taken-for-granted experience, *natural attitude*, and adopt a *phenomenological attitude*. This means the focus is turned inward to reflect on his/her perception of objects, instead of on the objects themselves (Smith et al., 2009). Husserl asserted that scientific knowledge rests on inner evidence (Husserl, 1970). Inner evidence is what appears in consciousness (Neubauer et al., 2019). His conception of phenomenology includes the suspension of all suppositions and relates to the directed awareness or consciousness of a phenomenon. "The experience of perception, thought, memory, imagination, and emotion, involve what Husserl called 'intentionality'" (Reiners, 2012, p. 1). As Husserl (1927) described, reflection occurs when focusing our experiencing gaze on our own psychic life. This process of self-consciously reflecting is phenomenological in nature. For Husserl, there is an intentional relationship between the process occurring in consciousness and the object of attention of that process. As part of the phenomenological method, textural (the what of the phenomenon) and structural (the how of the phenomenon) descriptions combine to form the essence of the phenomenon.

As described by Neubauer et al. (2019), Husserl contended that "commonly perceived features - or universal essences - can be identified to develop a

generalizable description” (p. 94).

For the phenomenological researcher, the aim is to study individuals' lived experiences to highlight the universal essence of a particular phenomenon. To achieve this, the researcher needs to set aside personal suppositions. Churchill (1990) describes epoche (the bracketing of presuppositions and biases) as "getting in touch with one's perspective" (p. 51). Husserl's definition of the epoche (1913/1982) included the suspension or bracketing of preconceptions to allow phenomena to come directly into view. As a mathematician, he used the concept of bracketing, where the content of that which is bracketed is addressed separately within a given equation (Smith et al., 2009).

The phenomenological method, as described by Husserl, includes a series of reductions. The "phenomenological – psychological reduction" (Husserl, 1970, p. 235), where realities presumed to exist outside of the participant's experience is suspended, and only the meaning and structure of the experience, as lived by the participant, are sought after. This reduction includes the epoche or bracketing as described. To establish what is at the core of the subjective experience of the phenomenon, i.e., what the essence or eidos of the phenomenon is, techniques such as 'free imaginative variation' are used as part of this 'eidetic reduction'. By imagining multiple variations of the phenomenon through an intuitive process, the essence of the phenomenon becomes apparent.

Although in using an IPA method of inquiry, the researcher attempts to explore the specific lived experiences of other individuals regarding the phenomenon of interest, whereas the phenomenological inquiry, as described by Husserl, focused on his own experience (and mental processes); his specific focus on the process of *reflection*, is significant for the conducting of IPA research. Smith et al. (2009) assert that cognitive processes, including the intricate complexity of various layers of reflection, are at the heart of a phenomenological research project.

3.1.1.2 Heidegger.

Martin Heidegger started his career in theology and then became a philosophy student. Although he was a student of Husserl, his approach to phenomenology was a move away from the transcendental (descriptive)

phenomenology of Husserl to a more hermeneutic and existential (interpretative) emphasis in phenomenology. Heidegger is mentioned under both the sub-heading underpinnings of phenomenology and hermeneutics of IPA research.

Although Heidegger's work originally aligned with that of Husserl, he later challenged Husserl's epistemological focus on the nature of knowledge, which he found to be too theoretical and abstract. He moved towards an ontological exploration of the science of being. "He broadened hermeneutics by studying the concept of being-in-the-world rather than knowing the world" (Reiners, 2012, p. 1).

Todres (2007), in commenting on Heidegger's work, emphasised how Heidegger grounded the 'said' in the 'unsaid'. Although Heidegger sought to understand, for him understanding is grounded in being-in-the-world, and that Being is beyond understanding. He (2007) describes Heidegger as standing "in the mystery of Being" (p. 19) where "being-in-the-world always transcended its forms and intrinsically exceeded linguistic capture" (p. 19).
What is said always points to what is unsaid, and "what is sayable receives its determination from what is not sayable" (Heidegger, 1975, p. 78). There is a tension between what is concealed and what is revealed. For Heidegger, a person is always a person-in-context, engaging intersubjectively and relationally in the world. By contemplating the significance of death and the finite mortality of life, he added and emphasised a temporal dimension to being-in-the-world. As Smith et al. (2009) describe, Heidegger's being-in-the- world includes a relational, practical engagement with the world. This engagement is self-reflective and social in nature and exists within a temporal location.

3.1.1.3 Merleau-Ponty.

Maurice Merleau-Ponty was also committed to understanding our being-in-the-world, but in exploring the interpretative quality of our knowledge of our world, he emphasised the embodied nature of our relationship to the world. For him, the body is not merely a biological entity but instead structures one's situation and experience of the world. In understanding and engaging with the world, he emphasised the role of perception, where "perceiving means having a body, which in turn means *inhabiting a world*" (Merleau- Ponty, 2012, p. X). He emphasised the holistic sense with which humans engage with the world (Tuffour,

2017) where the body is not objectified with the world but instead is inherently the way a human communicates with the world.

Where Husserl's theory of intentionality is a semantic model, where mental content is analogous with linguistic meaning, Merleau-Ponty describes intentionality as constituted by noncognitive, skillful bodily responses in direct engagement with the world (Merleau-Ponty, 2012). Perception is not about private, internal mental skills but instead about an intuitive coherence that things have for humans as they engage with their environments. He insisted that all human experience and understanding are grounded in perception.
Humans are thus anchored in their bodily being-in-the-world.

Merleau-Ponty (1968) described how perception includes an openness to the world and embeddedness in it. There is an "absolute proximity" (p. 8) to things and an "irremediable distance" (p. 8) from them.

The body is a human being's perspective on the world, implying there can be "no understanding of perception at all in abstraction from body and world" (Merleau-Ponty, 2012, p. X).

Smith et al. (2009) emphasised that the importance for IPA researchers regarding the work of Merleau-Ponty is that the fundamental character of our knowledge of the world is shaped by the body as a central element in experience. In researching the participant's experience of the phenomenon of spirituality in MHI for AR, Merleau-Ponty's work on perception and how the body engages with the world is an important theoretical backdrop. As stated, there is "not a single 'spiritual' act that does not rest upon a bodily infrastructure" (Merleau-Ponty, 2012, p. 455).

3.1.1.4 Gendlin.

In adding to Heidegger's conception of the tension between the concealed and the revealed, between the said and the unsaid, Gendlin (1978/79) described the bodily-experiential dimension. He described the body as an intentional body, with implicit meanings and relational understanding.
This depth of bodily relational understandings points to how humans are bodily in situations and that this way exceeds any precise patterning of it. Gendlin described this phenomenon as experiencing "more" (Todres, 2007, p. 21), with the

body being the ultimate medium of the "more." As with the "unsaid" of Heidegger, the "more" is always about the "said," but also often has a "not quite that but something else" quality that includes finding words that do justice to the bodily experience of the "more." During the interviewing process in collecting the data, specific attention will need to be given by the researcher through the use of probes to support the participant in finding words that could elucidate depth of meaning and authentically represent the bodily experience of his/her unique "more."

Gendlin (1996) describes experiences that sometimes cross the lines of thought, feeling, desire, image, and mere inner bodily sensations, to be a bodily sense of some situation, problem, or aspect of one's life. He termed this a "felt sense" (p. 63). Although one can sense the complexity of the multiple, intricate strands involved, the "felt sense" is experienced as a whole. To gain understanding, the person draws on language in describing this felt sense. The phrase or narrative is checked to gauge the fit with the felt sense, and then the phrase becomes part of a new experience that can produce further explicit meanings. He called this process "focusing" (p. 69), where an ongoing back-and-forth interaction between the "more" of the experience and the exploration of language that resonates enables a process of a more refined and deeper understanding to unfold (Todres, 2007).

Gendlin (1991) also shows how body-sense and situation are implicit in each other. "Situations are not without the people whose situations they are. One's body-sense is part of (happens in, makes and re-makes, carries forward, *is*,…) the situation" (p. 66). This implication of carrying forward is vital to the feasibility of any psychotherapeutic change taking place.

For phenomenological research, the methods align with Gendlin's theory in that the researcher seeks to articulate experience as personally had by the participants rather than fitting the experience into a predetermined theoretical scheme. By engaging with the personal accounts of participants' experiences in the research, important understandings can be articulated that could be relevant to others and add to, and extend on, the ongoing, ever- changing and intersubjectively shared understanding of a phenomenon.

3.1.1.5 Sartre.

Where Heidegger emphasised the worldliness of experience, Sartre extended this work regarding human existence by emphasising how we are caught up in projects in the world (Sartre, 1943; 1956). He described how the individual self is not pre-existing, but that our selves are always in the process of becoming, as we engage with the world in which we live, "existence comes before essence" (Sartre, 1943, p. 26) points to this aspect of his theory.

As we are always in this process of becoming, according to Sartre, the emphasis is placed on what we will be rather than on what we are. In focusing on participants' experiences in AR, this theoretical understanding emphasises the unfolding journey of becoming. Continuous, changing experiences contingent upon personal choice offer hope to those in recovery. Hope plays an integral role in recovery interventions, where the person struggling with addiction can hold onto the belief that he/she can make decisions and choices that can influence and positively change his/her life (White, 1996). In Sartre (1943; 1956), he shows how that which is present and that which is absent are both significant as part of this unfolding process as we engage with the world. In this process of becoming, emphasis is also placed on the freedom to choose that which is focused on and the related responsibility and accountability needed to be assumed for one's choices and actions. Sartre shows the complexity of issues that need to be considered in the individual's life in engaging in projects in the world. He emphasises the contexts of the embodied, interpersonal, social, and moral nature of these encounters and how experiences are contingent on the presence and absence of relationships with others (Smith et al., 2009).

Warnock, in prefacing Sartre (2002), shows how his theory of human nature assumes that human beings always have a cognitive connectedness and relationship in some way to the world and always choose to become. This impacts and includes what they choose to do and what they choose to know, through how they choose to see the world. Therefore, "emotion arises when they choose to see the world in a particular way" (p. XV).

Understanding human beings as embodied and emotional beings, existing in the context of personal and social relationships with others who are also

involved in their projects in the world, is foundational in gaining knowledge of human experience in IPA research.

3.1.2 Hermeneutics

In applying IPA, the second theoretical underpinning is the theory of interpretation or hermeneutics. The major concerns of hermeneutic theorists include the reasons for, and methods used in the process of interpretation itself. The researcher includes a "more speculative development of an interpretative account (which considers the *meaning* of such claims and concerns)" (Larkin et al., 2006, p. 117) given that the claims form the phenomenological core of the descriptions of persons-in-context.

Smith (2017) describes how despite hermeneutics having begun as a theory developed in the interpretation of Biblical texts, a lot of contemporary human sciences research focusing on human lived experience, incorporates hermeneutics methodologically. Both the historian who analyses ancient texts, and the contemporary human sciences researcher, are involved with the analysis of data involving human agents. The differences between the work of the historian and the contemporary researcher include that the old texts have stood the test of time, and were usually constructed for public purposes. The contemporary researcher would include real-time interaction with the participant about the person's personal experience. The texts would not have been produced by the participant outside of the invitation of the researcher.

When reflecting on hermeneutics, philosophers Heidegger, Gadamer, Schleiermacher, and Ricoeur have significantly advanced writings on hermeneutic phenomenology, where the fluidity of meaning and openness to new insights and interpretations is acknowledged (Tuffour, 2017).

3.1.2.1 Heidegger.

Heidegger linked phenomenology with hermeneutics. He moved away from the work of Husserl, arguing against a presuppositionless phenomenology. Smith et al. (2009) described how for Heidegger, "phenomenology is concerned in part with examining something which may be latent, or disguised, as it emerges into the light" (p. 24). He questioned acquiring knowledge outside of an interpretative

stance, and this stance was grounded in the lived world of people, language, relationships, and things. He emphasised that a person is always a "person-in-context," who does not impose meaning on a seemingly meaningless world of objects but instead that people are fundamentally part of an already meaningful world. His rejection of a divide between subject and object is captured in Dasein. *"Dasein* means 'there being' (or 'being there'), by which he implies that our very nature is to be *there* – always somewhere, always located and always amidst and involved with some kind of meaningful context" (Larkin et al., 2006, p. 106). Heidegger emphasised the worldliness of existence, where embodied, physically grounded humans are "thrown" into a world of intersubjectively grounded options. The relational nature of engagement in the world is a fundamental part of being a "person-in-context" (Smith et al., 2009).

For IPA research, the researcher necessarily immerses into the participants' world through the lenses of cultural and socio-historical meanings. Heidegger highlights an important aspect of interpretation, (opposing the works of Husserl), where Heidegger (1962) says:

> Our first, last and constant task in interpretating is never to allow our …fore-conception to be presented to us by fancies and popular conceptions, but rather to make the scientific theme secure by working out the fore-structures in terms of the things themselves (p. 195).

For the researcher, this implies that all prior experiences, assumptions, and preconceptions will always be a part of the encounter with the text, but that in interpretation, priority should be given to the text rather than the fore- conceptions. He further shows how sometimes the sequence includes that only in encountering the text, aspects of the researcher's fore-conceptions may become more apparent and overt. This links to the reflexive nature and the complex, cyclical, and dynamic relationship between the interpreter and that which is interpreted (Smith et al., 2009).

3.1.2.2 Gadamer.

Gadamer emphasised history and tradition in his writings about the interpretative process; and, like Heidegger, emphasised the role of presuppositions in interpretation, and the dynamic nature thereof.

Gadamer (1990/1960) states that:

> Every revision of the fore-projection is capable of projecting before itself a new projection of meaning; rival projects can emerge side by side until it becomes clearer what the unity of meaning is; interpretation begins with fore-conceptions that are replaced by more suitable ones. This constant process of new projection constitutes the movement of understanding and interpretation (p. 267).

Gadamer (1990/1960) points out how this dynamic interpretative process also includes a connection between the past and the present, where "the essential nature of the historical spirit consists not in the restoration of the past but in thoughtful meditation with contemporary life" (pp. 168-169). A spirit of openness is thus needed, where learning from the past can be interpreted in the light of the present.

3.1.2.3 Schleiermacher.

Schleiermacher (1998) described the process of interpretation as a dual process, where both a grammatical and a psychological interpretation occur. He emphasised the importance of trying to understand the writer of the text and the text itself (Smith, 2007).

Schleiermacher (1998) clarified this further by stating:

> Every person is on the one hand a location in which a given language forms itself in an individual manner, on the other their discourse can only be understood via the totality of language. But then the person is also a spirit which continually develops, and their discourse is only one act of this spirit of connection with the other acts (pp. 8-9).

Interpretation, for Schleiermacher, is like art, where a range of skills are used to engage in a detailed, holistic, and intuitive process. Smith (2007) agrees that in IPA research, the researcher is not only trying to make sense of the words but also trying to make sense of the person who said the words.

This idea resonates and fits within the model of the hermeneutic circle, where there is an iterative, dynamic interaction between the whole, and the part, at various levels. "To understand the part, you look to the whole; to understand the

whole, you look to the part" (p. 5).

In IPA, there is a double hermeneutic (Smith & Osborn, 2003) where the researcher makes sense of the participants' sense-making. The researcher has a dual role, both as a person engaging with other persons to make sense of phenomena in the world and as a person interpreting the participants' reports of their experiences through the researcher's lenses.
Smith et al. (2009) describes the participant's meaning-making as the first order, while the meaning-making of the researcher would be second order.

3.1.2.4 Ricoeur.

Ricoeur (1970), in his work, describes what Smith et al. (2009) believe is another way a double hermeneutic functions in IPA research. Ricoeur describes two interpretative positions. These are a hermeneutics of empathy and a hermeneutics of suspicion. A hermeneutics of empathy would be trying to adopt an insider's (participant's) view of the original experience; while a hermeneutics of suspicion would involve the questioning and puzzling over various aspects, where the researcher is attempting to draw out, and shed light on the participant's experience.

The importance of an interpretative stance is seen at various levels, where the researcher endeavours to understand (with empathy and suspicion) and give meaning to the original, personal experience of the participant through interactive, engaging and textual interpretation.

3.1.3 Idiography

When doing IPA research, the focus is on specific individuals and how they experience specific situations or events. Larkin et al. (2006) show how IPA research typically involves a few participants and a detailed and in-depth analysis of each of their accounts. Each case is analysed to shed light on the specifics and particularities of the individual's lived experience.

The researcher aims to preserve the uniqueness of the individual experience. Radley and Chamberlain (2001) have also suggested that in health psychology, attention needs to be focused on the study of a case as being

significant when considering issues related to health, illness, and healing. An important aspect of focusing on a case is that health professionals present a patient's personalised, storied account of his/her experience when discussing or presenting aspects of a patient's story. Cases are made and are not simply found. Part of the patient's illness, suffering and recovery process includes communication in their personal story. The patient's presenting symptoms are necessarily not simply symptoms but are presented by the individual in a specific way and context. Personal meanings, family, social and cultural background, and circumstances all contribute to the specific presentation of the symptomatology and the specific presentation of the recovery process. By focusing on a single case, the researcher is thus not objectifying the person and "reporting upon a unique *object*" (p. 328) but is instead, "setting forth those meanings that were portrayed or presented" (p.
328) by the individual to the researcher.

Linked to this concept of objectification, for example, were concerns presented in the recently published works regarding the effects of COVID-19 legislation on the health of people globally. Cayley (2021) showed how the risk of lives being lost during the COVID-19 pandemic had been intertwined with the concept of danger and that although the danger is a subjective, experiential concept, risk curves were based on abstracting population statistics. Commenting on the work of Ivan Illich in "*Medical Nemesis*" (1976), Cayley (2021) showed how the concept of risk used to justify healthcare strategies was not about the individual but about the category to which an individual had been assigned within a system. The implication, for Illich, is that the individual subject becomes disembodied. Individuals' personal stories, experiences and health were thus not necessarily considered in implementing specific and often restrictive healthcare strategies and legislation.

De Backer (2021), in describing the legislation implemented in SA, in response to COVID-19, was specifically concerned about the impact of strict lockdown legislation that included the prohibition of the sale and transportation of alcohol and cigarettes on individuals addicted to these substances. She described how:

> at a micro-level lockdown could be experienced by individuals as not only being held hostage, captive within homes and isolated for the perceived benefit of their physical health, but also isolated and faced with an ongoing sense of uncertainty mentally (p. 3).

De Backer (2021) points out the many varying and interwoven factors that influence and contribute to each person's individual and unique journey of addiction and recovery that need to be considered when implementing suitable healthcare interventions.

With idiographic research, the importance of the particularities and uniqueness of the individual's story is valued. This type of in-depth analysis of the individual narrative through focusing and reflecting can, at times, elucidate pivotal meanings hidden within single utterances and/or single extracts. Smith (2011) describes these significant and valuable utterances as gems in IPA research. These gems often guide and direct the researcher to further elucidate on what initially appeared to be shining through and very apparent, or was only suggestive in content, or was secretive and hidden within the text.

By focusing on the individual's experience, the researcher avoids depersonalising and/or objectifying ways of thinking about human beings and remains faithful to presenting examples unique to a specific participant in the research. Todres (2007) emphasises how the appropriate currency of understanding is "*meaning* rather than *measurement*" (p. 65) in a methodology that never loses sight of the unfolding narrative of human living. Unique stories open possibilities for shared meanings to be explored within individuals' personal lived experiences. He further describes "the dance of the unique and the shared" (p. 66) that allows for open-endedness and freedom of expression methodologically.

Smith et al. (2009), in describing the idiographic focus of this type of research, emphasises how the analytic process "begins with the detailed examination of each case, but then cautiously moves to an examination of similarities and differences across the cases, so producing fine-grained accounts of patterns of meaning for participants reflecting upon a shared experience" (p. 38).

By focusing on the particulars of a case in detail, each individual case can

be analysed to explicate themes that can be compared for convergence and divergence. Warnock (1987) points out how delving deeper into a particular one may also be taken closer to the universal. Carl Rogers (1961), in his quote, "what is most personal is most universal" (p. 26) reiterates this. Commenting on Giorgi and Giorgi (2003), Smith (2004), in describing the idiographic underpinning of IPA and linking it with the essence of Husserl's phenomenological psychology, states that "the very detail of the individual also brings us closer to significant aspects of a shared humanity" (Smith, 2004, p. 43).

3.2 Rationale for Using IPA

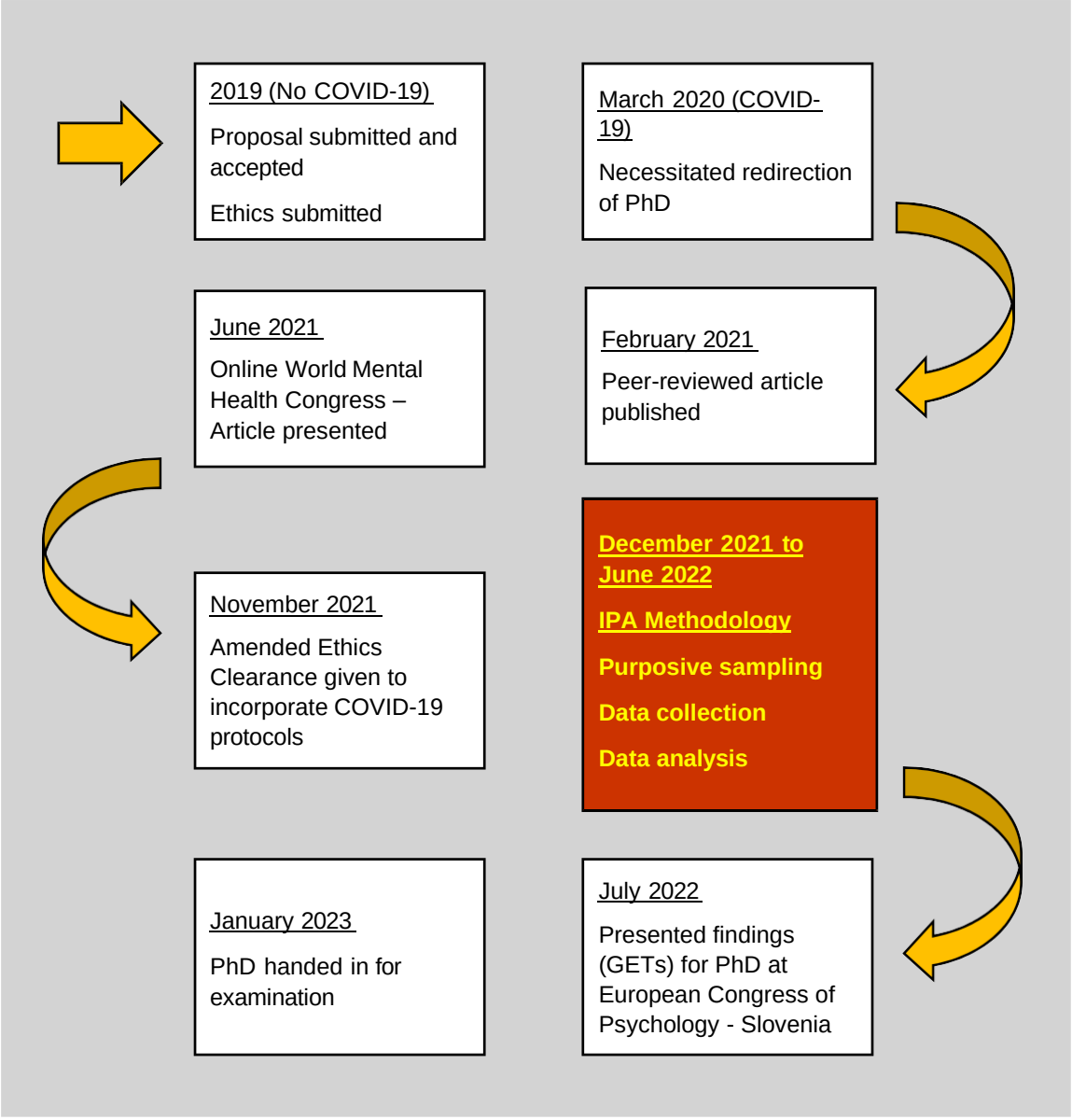
As this study aims to explore the personal, lived experiences of spirituality in mental health interactions for those in AR, IPA has been chosen as the research methodology. Owing to the interpretive and idiographic nature of this method, a depth of understanding of individual life experiences can be explored (Smith & Nizza, 2022). As IPA is an inductive method, the focus will be on meaning-making and interpreting participants' experiences to gather valuable insights, which can add to the existing body of knowledge on the topic.

Chapter 4: Interpretative Phenomenological Analysis Methodology

In commencing with this chapter of the study a visual timeline is presented in Figure 1.

Figure 1

The Research Journey: PhD in Action – Journeying From 2019 to 2023.



Note: Author developed figure.

4.1 Coronavirus Disease (COVID-19) and the Implications Thereof

After the proposal for this study had been submitted and accepted in 2019, registration for the PhD took place in January 2020. While focusing on specific reading related to the research topic, the threat of a global Coronavirus disease (COVID-19) pandemic was announced. On 23 March 2020, the president of SA announced that a national lockdown would be implemented from midnight on 26 March 2020 (Kiewit et al., 2020). There was also to be a complete prohibition on the sale and transportation of alcohol and cigarettes during that period (De Backer, 2021). As a healthcare worker, the researcher continued to work at her practice and in hospitals and experienced some of the impacts that COVID-19 had on the healthcare system and the people of SA. As the PhD study was focused on substance use and addictive behaviours, the researcher's attention was directed to include the changed uncertain realities of the impact of COVID-19. The researcher became involved in implementing online, faith-based recovery support groups. During the phases of lockdown, she also consulted with psychiatric inpatients in COVID-19 wards at the hospital where her practice is situated.

A peer-reviewed article on the topic titled: COVID-19 lockdown in South Africa: Addiction, Christian spirituality and mental health by the researcher was published in February 2021. https://doi.org/10.4102/ve.v42i1.2135

The findings of the article were presented by the researcher at the World Mental Health Congress in June 2021 via an online webinar. https://youtu.be/pG8LXhksQ-Y

A personal reflection on the impact of COVID-19 and online connection.

I have a very close bond with my daughter, Kirsty. She and her husband emigrated to Australia almost four years ago. Despite the obvious adjustments, I was happy for both. I also knew that I could get on an aeroplane and visit whenever I missed her too much. That was until COVID-19 happened!

Suddenly, we encountered lockdowns in countries internationally. There was no possibility of any international travel. The uncertainties of if/when I could visit my daughter again mounted. Owing to being an essential healthcare worker and running a practice in a hospital environment where I consulted in COVID-19 wards, both my husband (the practice manager) and I received COVID-19 vaccines as soon as we could, both for reasons of client contact,and to prepare for the first possibility of visiting Kirsty. But two weeks became two months, and two months extended into two years.

In the interim, Kirsty fell pregnant, experienced nine months of pregnancy, and gave birth to a beautiful baby girl. My precious Cali was born on 10 August 2021. This occurred without me sharing any physical closeness with my daughter and her baby. It was emotionally devastating. The uncertainties experienced globally relating to both physical and mental wellbeing seemed to be continuosly escalating.

Thankfully, however, I shared so many moments with her through the use of technology. Instantaneous photographs, videos and online conversations kept us connected to each other's life. I quickly learnt to value and appreciate technology, when used wisely, in fostering interpersonal connection, even intimate connection, as it remained possible for me to witness some images of Cali's miraculous birth, and the love shared by her humbled parents.

The necessary amendments for ethics clearance needed to be adjusted and resubmitted to accommodate COVID-19 legislation. These adjustments included the need to consider the specific lockdown level for COVID-19 legislated at the time of each pre-interview and interview for each participant. It would then also be decided whether face-to-face or online (using Microsoft Teams) interviews would take place. All necessary COVID-19 legislated protocols, including temperature screening, sanitation, social distancing, and wearing masks throughout the face-to-face interview(s), would be adhered to. Brief telephonic contact would also be

made with each participant before the commencement of any face-to-face interviews to ensure that both the participants, and the researcher were free from any possible COVID-19 symptoms. These symptoms included fever or chills, cough, shortness of breath, fatigue, muscle/body aches, headaches, loss of taste/smell, sore throat, runny nose, nausea and/or diarrhoea.

In line with the global climate of uncertainty and unpredictability regarding the experience of the COVID-19 pandemic, this PhD study also necessarily unfolded unpredictably to accommodate the legislated changes. Smith et al. (2009), in describing the in-depth nature and complexity of using IPA methodology, state that the researcher will undoubtedly confront unpredictability as s/he engages with ”the messy chaos of the lived world” (p. 55). However, with willingness, flexibility, empathy and curiosity regarding the participant’s world and lived experience, the researcher could reflexively gain an understanding of the phenomenon being investigated.

Because the IPA method includes both the reflexive interpretation by the researcher of the participant’s experience and a third hermeneutic level, where the reader is making sense of the researcher’s interpretation (Smith & Nizza, 2022), ”My Story” was included in Chapter 1. In this way, the reader could become familiarised with the context of the subjective, lived world of the researcher and the influence that the researcher’s frame of reference could have had on interpreting the data.

For this purpose, in summarising the researcher’s demographics and experience relevant to interpreting the data:

1. 56-year-old White South African woman (Christian faith),
2. married for five and a half years (2nd marriage),
3. two biological children (32 years – daughter, Kirsty)
   (29 years – son, Jarryd),
4. four stepchildren (37 years – son)
   (29 years – son)
   (27 years – daughter)

(25 years – daughter),

5. mother of a son recovering from drug addiction (8 ½ years in recovery), and
6. 18 ½ years registered clinical psychologist in private practice in Kempton Park, Gauteng.

Socio-cultural demographic of the private practice's client base of the researcher for 2021, including racial and gender demographics is illustrated in Table 1.

Table 1

The Socio-Cultural Demographics of the Researcher's Private Practice of 2021 in Demonstrating her Cultural Competency.

RACE	GENDER		COMBINED
	F	M	
Black	64.5%	48.5%	60.9%
White	31.1%	47.5%	34.8%
Asian	3.8%	3.0%	3.6%
Coloured	0.6%	1.0%	0.7%

With the diverse South African context, the listing of racial and gender demographics is not deemed derogatory but has been included to indicate the cross-cultural experience and competency of the researcher.

4.2 Purposive Sampling and Study Population

A purposive sampling method was used in line with recruiting the participants within a qualitative research paradigm for the specific, lived experience meaningful to each person interviewed. The study setting used to select the participants included seeking persons with lived experience of the phenomenon being investigated. The sample included participants who could add meaning to a perspective rather than a group of people who represented any specific population. The generalizability of the findings to any specific population was thus very limited. Instead, the findings add valuable insight into each participant's contextualised, lived experience. As the research question included investigating the phenomenon of spirituality for those who were in recovery from

addiction, one inclusion criteria included that the participants would have been discharged from a Christian, inpatient alcohol and substance abuse rehabilitation facility for three or more yaers without having relapsed in the preceding 12 months leading to the interview. This criterion was included as 84.2%of South Africans describe their religious affiliation as Christian (Schoeman, 2017).

The Department of Social Development manages the legislated regulation of the treatment of those persons struggling with addiction and admitted to inpatient, alcohol and substance abuse rehabilitation facilities in SA. Minimum standards relating to the medical/physical safety and hygienic environments provided for the service users are assessed. Relevant program implementation including education regarding substance use and related behaviours, and relevant connection to community resources for support are monitored (Act 70 of 2008). Within Christian faith-based facilities, emphasis is placed on underlying Biblical principles, with spiritually informed curricula being presented as part of the daily schedule. The founding director of a rehabilitation facility running for 24 years in Gauteng states “Our goal is to teach anyone who has suffered from addiction how to fully understand why they do what they do and how to bring their own belief systems in line with the Word of God” (House Regeneration, 2021).

By not having relapsed for at least a year and having been in recovery for at least three years, it was assumed that the participants included had made some commitment to changing their addictive lifestyles.

Further inclusion criteria included that participants would be 18 years and older. In accordance with legislation, any person younger than 18 years would have required consent by legal guardians for research ethics to have been granted. It was decided to focus on working with those who were legally classified as adults for research purposes. In qualitative research, and specifically IPA, where an emphasis is placed on specific individuals within specific contexts; detailed, case-by-case analysis necessitated that the participants described their thoughts and feelings about their first-hand experience in English. In this way, richer and fuller verbal descriptions of the phenomenon could be investigated as both the researcher and the participants would be fluent in the language. Finally, it was included within the inclusion criteria, that the participants would reside in the

Tshwane or Ekurhuleni regions of Gauteng, SA. This inclusion criterion enabled the management of time restrictions and travel costs to be reduced by the study being localised in keeping within close proximity to the researcher's place of work, Ekurhuleni, Gauteng and her residence situated in the capital, Tshwane.

The inclusion criteria were specific and limiting to recruiting participants who would become part of a small homogenous sample. In limiting the variability between the participants in this way, any similarities and differences between them would be more indicative of specific individual experiences of the phenomenon being investigated i.e., spirituality within a specific context rather than being influenced by other diverse variables. In determining the value of, and transferability of the research, the reader would need to carefully consider the specific participants within the context of the study (notably during the COVID-19 pandemic) and the relevance of this to other populations and future research with other sample groups.

4.2.1 Recruiting of Participants

In line with the need to recruit a sample of participants who would form a small, homogenous group, a process of referral by gatekeepers was used for this study. The researcher arranged with mental health colleagues (registered with the Health Professions Council of South Africa [HPCSA]) who were involved with MHI for persons in AR, to place Participant Recruitment Leaflets ([PRL] see Appendix B) in their respective reception areas for potential respondents to choose for themselves whether they wanted to take a PRL. This was done to avoid any possible coercion. Anonymity was ensured as all HPCSA registered MHP abide by a legally, prescribed code of ethics.

The PRL directed potential research participants interested to respond to a designated email address with an identifying subject line and provide their name and a daytime contact telephone number. Access to this email address was password protected.

The researcher contacted the potential research participants individually and conducted a 20 to 30-minute informal pre-interview. A full disclosure of the nature and purpose of the study was given by the researcher. The potential

research participants were given the opportunity to ask questions that arose to gain a better understanding of the research study. Of those who responded to the PRL, all were deemed eligible in accordance with the specified inclusion criteria. Suitable dates, times and contexts were discussed for the initial interviews to occur. The researcher shared the nature of her occupation (clinical psychologist), which included consulting on COVID- 19 wards, together with the fact that she was fully vaccinated, with the participants. This afforded the participants freedom of choice to decide on the contexts that would be most suitable to them for their individual interviews.

One participant chose to have a face-to-face interview in her home with all COVID-19 protocols in place. The other two participants decided on online interviews using the Microsoft Teams platform.

The researcher informed the potential research participants of the research study Cover Letter ([CL] see Appendix A) and Participant Informed Consent Agreement ([PICA] see Appendix C) which was emailed by return to each of them for completion and signature. In signing the PICA after the reading the CL, the participants were acknowledging the fulfilment of the specific inclusion criteria as discussed. The consent agreement emphasised the voluntary nature of the research, and the participants' rights to withdraw at any time at their own discretion. Confidentiality and anonymity were protected as stated in South African Law and upheld by the researcher, a registered clinical psychologist with the HPCSA (HPCSA, 2016c). The participants agreed to the audiotaped recordings being made of the interview(s), and the inclusion of verbatim extracts for the publication of reports, academic journal articles, and presentations at conferences. The participants acknowledged having comprehended the nature and purpose of the research study, and their right to review the data, process notes and journal entries during the process. The CL and PICA were then returned by the research participants via email to the designated email address of the researcher.

4.2.2 Sample Size

Smith et al. (2009) in describing IPA research, emphasise both the phenomenological and idiographic nature of IPA research. With the emphasis on exploring the in-depth experience of individual cases and gaining meaning within

the lived world of an individual in relating to the phenomenon being investigated, "IPA studies usually benefit from a concentrated focus on a small number of cases" (p. 51).

For this research study, three participants were included, where the complexity and richness of each individual case were explored, analysed and compared. As there was a delay in the PhD process, due to ethics clearance having to be amended to accommodate all the COVID-19 protocols, the researcher assumed that the limited responses to the PRLs was probably also due to the circumstances of the global pandemic. The researcher decided to interview the three participants and continue with in-depth case-by-case data analysis in the interim.

As Smith (1999) described, the iterative nature and process of analysis in IPA research can also make the point of data saturation difficult to assess. The researcher became increasingly focused on reflecting on the participants who had responded and been interviewed.

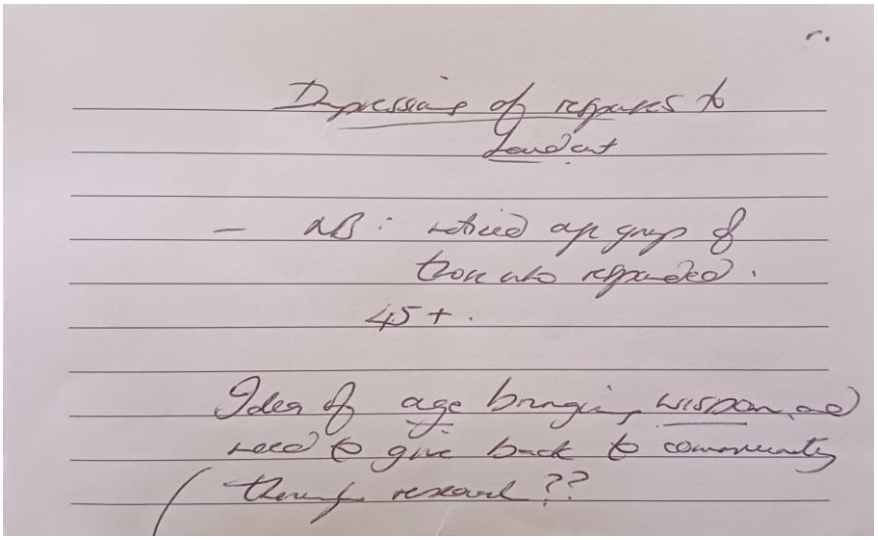
In continuing with the sample of these three participants, from which rich, detailed narratives had been obtained, emphasis and focus were placed on the converging and diverging themes within the small, homogenous sample. The homogeneity of the sample was evident in that all three respondents were over the age of 45 years (see Figure 2). Of the three participants, two were females and one was a male. One female and the male participant had been brought up as children in Roman Catholic (RC) homes, with the other female participant having been brought up by Afrikaans parents who attended the Nederduitse Gereformeerde Kerk. All three had been exposed to strict religious dogma as children, and all three identified themselves as being strong believers in the Christian faith.

All three participants experienced an admission to a Christian faith-based rehabilitation facility for a minimum period of six months. Post rehabilitation the male participant (married with children) was self-employed in his hospitality business. The one female (divorced without children) had returned to work in her degreed profession within a corporate environment. The other female (married with children) returned to work in the financial services sector. During the post-

rehabilitation recovery phase, two of the participants had attended weekly Christian faith-based SHGs, with one participant being a trainee facilitator over the past few months. The third participant attended weekly Christian faith-based home church groups for support.

Figure 2

An Image Taken of the Researcher's Journal Entry Immediately After Receipt of the Initial Participants' Email Responses to Handouts.



4.3 Data Collection Method and Procedure

The context of the COVID-19 pandemic at the time of the data collection process inevitably impacted all aspects of the research process, including the data collection method(s). As one of the female participants had requested a face-to-face interview in her home, and both the other participants had decided on online Microsoft Teams interviews, the pseudonyms were given as research participant A (RPA) for the face-to-face interview and research participant B (RPB) and research participant C (RPC) for those with online

interviews.

Unstructured, qualitative interviews were used for the data collection. All interviewing was done only by the researcher to ensure anonymity. The participants were told during the 20-minute pre-interview that the researcher would not call them by name during the interviews to protect anonymity as much as possible, even from the person who would transcribe the audiotaped recordings. During these telephonic pre-interviews, a full discussion of the nature and purpose of the study was given, and the participants were given the opportunity to ask questions in gaining understanding thereof. The participants were also informed that a research journal would be kept by the researcher throughout the study. Entries in this journal would include the researcher's personal reflections following the interview(s). Process notes would also be made throughout.

The audiotaped interviews of the data collection were each about an hour in length and were informal and interactive between the researcher and each research participant. The format of the interviews included an initial sharing of greetings in the establishing of rapport between the researcher and the participants. In accordance with qualitative IPA research, the researcher aimed to create an environment where the participants could experience sufficient safety to share their personal, first-hand, lived experience of the phenomenon in an open conversational format (Smith et al., 2009). The researcher applied her 18 ½ years of clinical experience in interviewing techniques that included being client-centred and non-judgemental throughout the process to elicit detailed narratives. These narratives included factual information, with the participants' feelings and thoughts regarding the phenomenon.

Each participant was then given a couple of minutes to focus on the topic reflected on after having read the CL and completed the PICA. The initial statement given by the researcher follows:

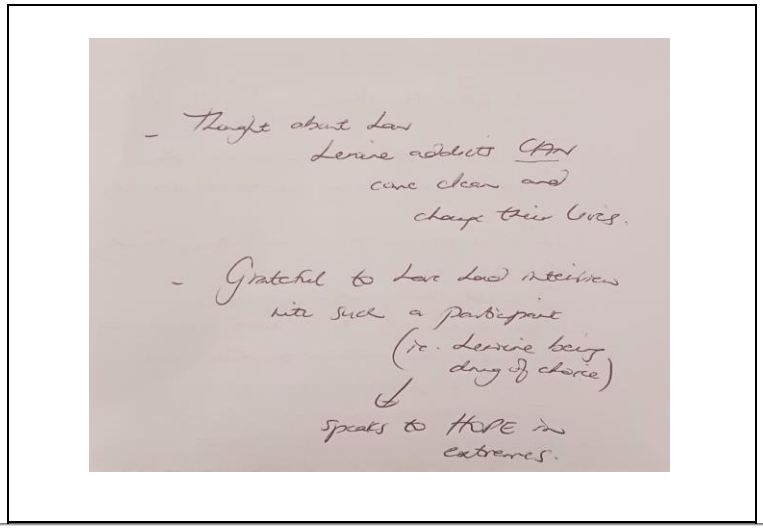
"Please describe for me a situation in which you experienced spirituality as part of your mental health treatment in addiction recovery."

From the participant having responded to the above statement, the interviews spontaneously unfolded through unstructured, open-ended questions

and statements by the researcher. This assisted the participant in providing a fuller description and giving further clarity when needed. Smith et al. (2009) state that "the participant is the experiential expert on the topic in hand and therefore should be given much leeway in taking the interview to 'the thing itself'" (p. 58).The researcher remained reflective of and reflexive throughout the process, being aware of her own experience of this phenomenon. This was necessary not to take any responses for granted or assume to 'know' the participant's personal experience, but instead, to ask questions for richer, clearer descriptions. Process notes taken throughout the interviews, with journal entries following each interview (see Figure 3), were further used as important data during the iterative analysis process.

Figure 3

An Image Taken of the Researcher's Journal Entry Following the Interview with RPA.



Thought about how heroine addicts CAN come clean and change their lives.

Grateful to have had interview with such a participant (re: heroine being drug of choice)

speaks to HOPE in extremes.

[Noteworthy in meta-reflection was the researcher's Freudian slip when commenting on her perception of the courageous journey of the female participant's drug of choice (heroine : heroin)].

4.3.1 Data Collection Procedures With the Inclusion of COVID-19 Protocols

4.3.1.1 Unstructured Interview With RPA.

In adhering to the COVID-19 lockdown legislation, RPA chose to have a face-to-face interview at her home. The participant incurred no travel costs, and the participant was not exposed to any work environment, thus avoiding any possible stigmatisation regarding her history of drug abuse. All relevant COVID-19 protocols were in place throughout the interview process.

4.3.1.2 Unstructured Interviews With RPB and RPC.

These interviews were held online on the Microsoft Teams platform. Both participants willingly offered to cover any data costs incurred by themselves. For both participants owing to COVID-19 restrictions, online interviews were more suitable. RPB had found a private room at his workplace, where he reported feeling comfortable and away from colleagues. RPC had chosen to have the interview online, as she was also working from home. Although there were slight technical disruptions, both interviews flowed spontaneously, with detailed information being given. Loadshedding (an occurrence in South Africa where the electricity supply is suspended for periods to conserve the limited energy reserves) also needed to be considered. RPC's interview ended moments before when the final greetings would have been made online. RPC then sent a WhatsApp text message to the researcher, confirming the power failure/loadshedding on her side.

Greetings and words of gratitude were exchanged via WhatsApp texting between the researcher and the participant.

4.3.2 Transcription

Verbatim transcripts were produced for each participant. Empty margins were left on both sides. These were later used for analysis purposes. The same person transcribed all three transcripts. Although the participants' names were not used during the interviewing, further anonymising the data, including the reference to other people and places, was included in the transcription process. The transcriber worked independently in producing the transcripts before presenting the completed transcripts to the researcher.

4.4 Data Analysis

Following the fundamental principles of IPA, analysing the data was *inductive* and *interpretative* in nature (Smith & Nizza, 2022). Raw data, including the transcripts of the participants' interviews, personal journal entries of the researcher and process notes written following the interviews, were used to extrapolate themes and develop the model (see Chapter 6) through an interpretative engagement with the data by the researcher.

Through the analysis process, the researcher attempted to make sense of the participant's words (and stories) as presented in the data, gaining further understanding of the participants' meanings regarding the phenomenon. Gaining understanding, points to being empathic in trying to know what someone else is experiencing and questioning through analysing and interpreting the meaning thereof (Ricoeur, 1970; Smith et al., 2009).

As IPA is an *idiographic* approach, each case analysis of each participant's transcripts was carried out individually and completely in respect of the individual's unique story and experience of the phenomenon of spirituality in AR prior to any cross-case analysis being applied. The *iterative* nature of the process was evidenced throughout the analysis and writing up of the findings and discussion thereof, as amendments were made to the evolving process, with previous interpretations being revisited and reviewed.

An individual case-by-case analysis of the transcript of each case followed the process from Step 1 to Step 8. For RPA (the participant with a face-to-face interview), the analysis took place on 18/04/2022. The same analytic process was repeated through all the steps (1 to 8 inclusive) for RPC on 14/05/2022. The reason RPC's analysis was done prior to RPB's was due to the expediency of a shorter transcript for RPC. The process for RPB's analysis of all the steps (1 to 8 inclusive) took place on 29/05/2022.

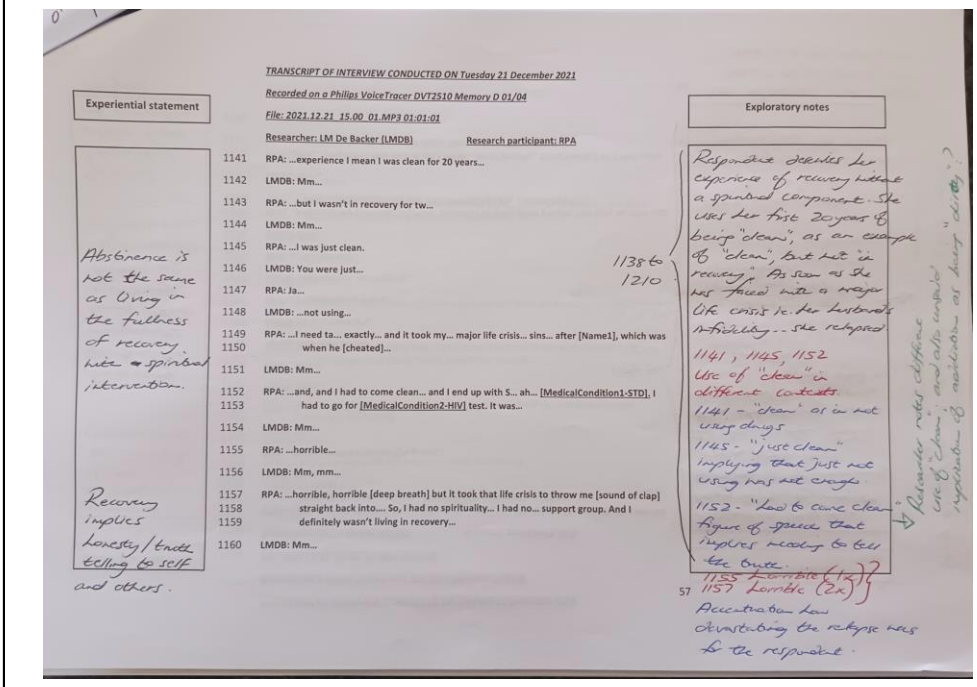
4.4.1 Individual Case Analysis

Step 1: The researcher immersed herself in the data by slowly reading through the transcript.

Step 2: The researcher recorded these notes in the right-hand column of a hardcopy of the transcript titled: Exploratory Notes (ENs) (see Figure 4).

Figure 4

An Image of the Transcription of Participant RPA Showing Exploratory Notes (ENs), Experiential Statements (ESs) and Researcher's Reflections.



While making exploratory notes, the researcher attempted to focus and reflect on the exact words of the participant throughout. The different categories of notes were recorded in different ink colours to assist in easy access and clarity during analysis for the researcher. Three categories of notes included **descriptive**, **linguistic** and **conceptual** notes.

The descriptive notes were written in **black** ink and summarised the actual content and explicit meaning of what was being spoken about.
Linguistic notes were recorded in **red** ink and addressed any linguistic aspects that impacted the potential meaning the participant had tried to convey. Examples of these included using metaphors, specific pronouns, repetition of words, and pauses during the conversation. All conceptual notes were recorded in **blue** ink.

These notes included the researcher's interpretation (including the researcher's personal lived experience and professional expertise) of the meaning that the participant was conveying through the actual words of the text.

The researcher then used **green** ink to include any metalevel interpretations and/or hypothetical ideas and/or links to the existing literature for further ongoing reflection.

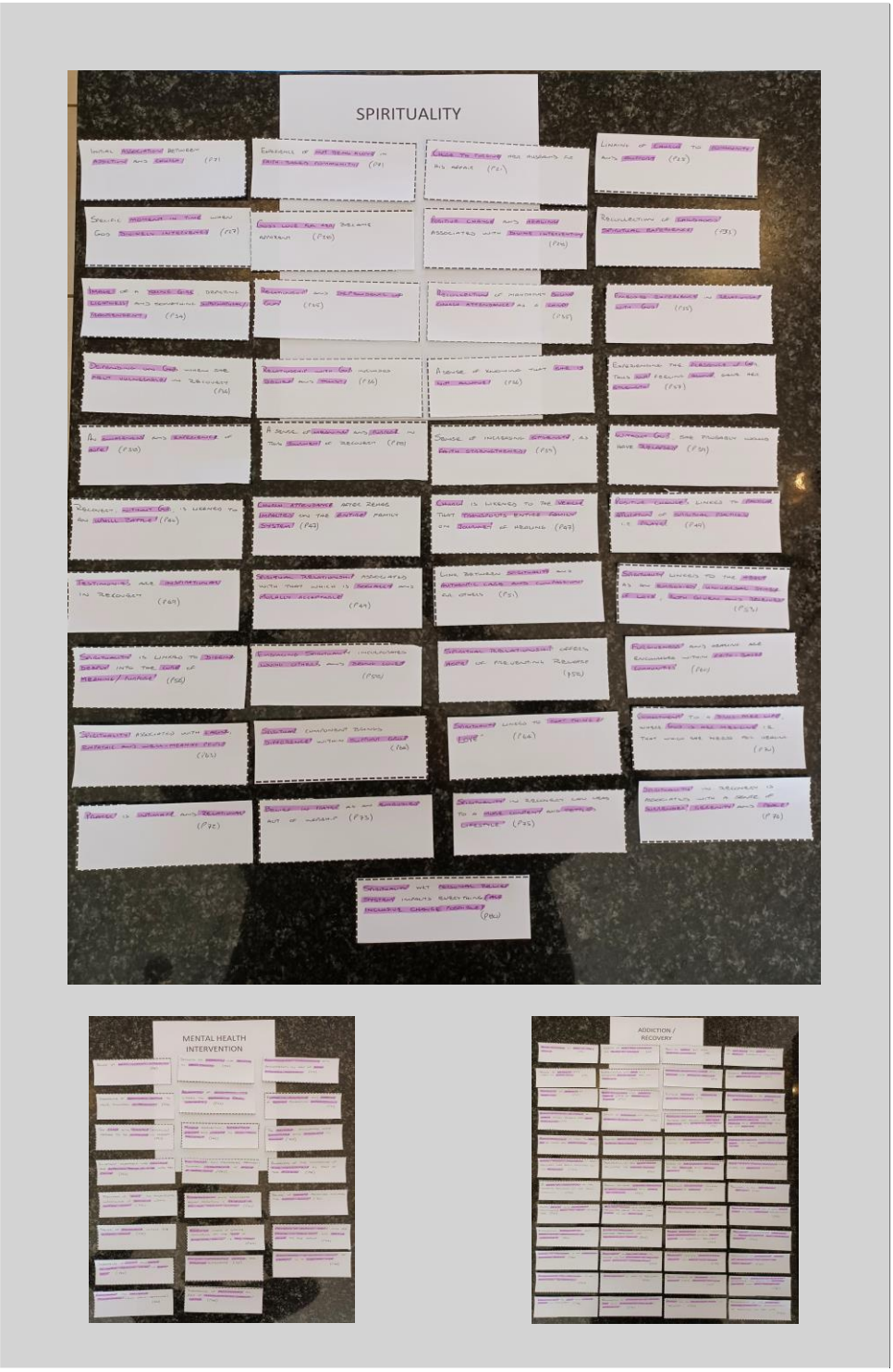
Step 3: The researcher identified Experiential Statements (ESs), which were grounded in the specific data and captured "the psychological substance of the text" (Smith & Nizza, 2022, p. 39) (see Figure 4).

Step 4: The ESs were captured on individual slips of paper with the transcript page number recorded on each slip.

Step 5: The main aspects (MAs) from the title of the thesis of this research study, i.e., Spirituality (S), Mental Health Intervention (MHI) and Addiction Recovery (AR), were identified. These aspects were then assumed as the grouping names, as they were the three core aspects of the study.
Each grouping name was recorded on an individual piece of paper and placed on a table surface, where the ESs were sorted into the respective groupings in transcript page order. Smith and Nizza (2022) encourage using this technique/placement where a broad, spatial view of the groupings facilitates the easy access and moving around of the slips of paper as deemed fit. This was done with each slip being individually read and placed according to the most suitable category. This step was initially implemented by the researcher, followed by the transcriber (who had been exposed to the interview through transcription and who knew the researcher) reviewing the placement of the slips and questioning the researcher where necessary. A final collaborative decision was then made. This contributed to and strengthened the methodological integrity of the analysis. Figure 5 shows Step 5 of the process with the data of RPA being reflected.

Figure 5

An Image Taken of Data Analysis Process Step 5 (Sorting Experiential Statements (ESs) Into Main Aspects) RPA – Spirituality (S), Mental Health Intervention (MHI), Addiction Recovery (AR).

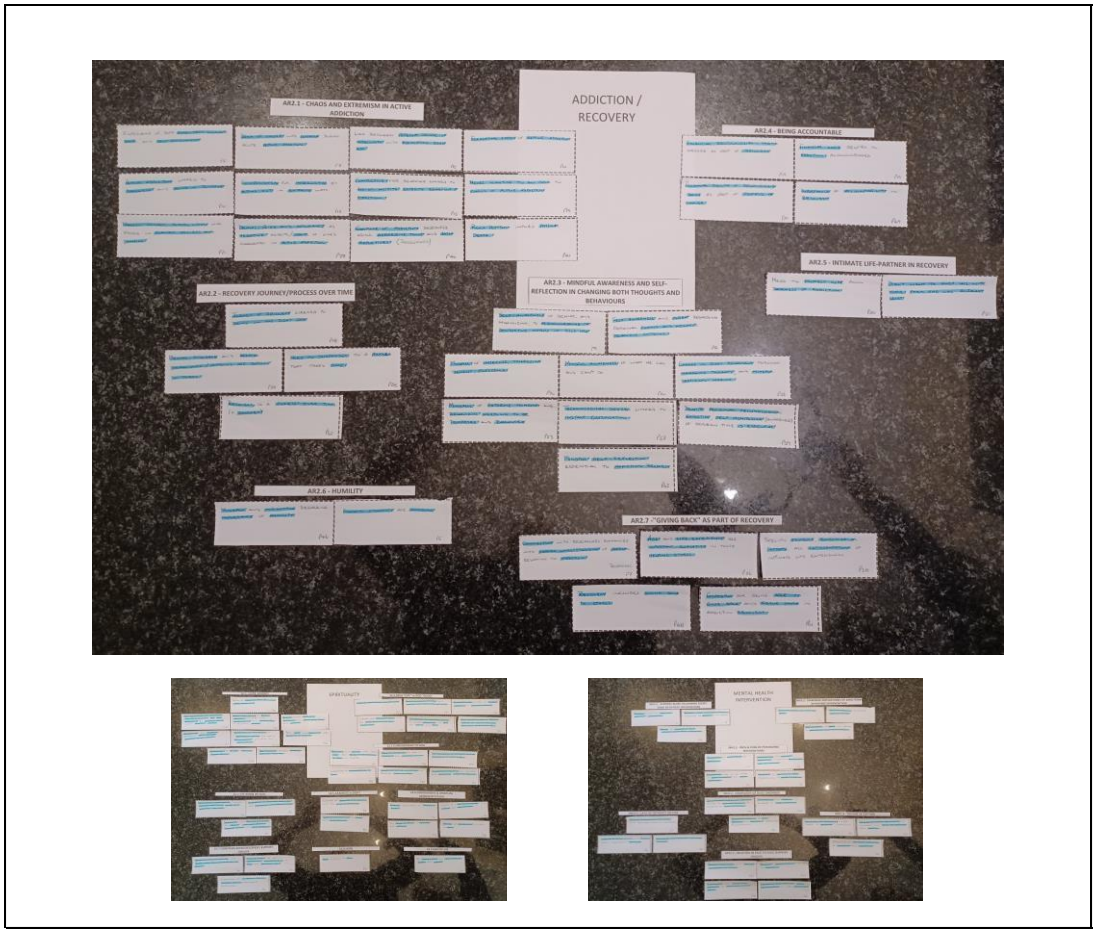


Step 6: Similar ESs were clustered into smaller groups within each of the three groupings identified (S, MHI and AR). Developing Personal Experiential

Themes (D-PETs) were developed for each smaller cluster (see Figure 6).

Figure 6

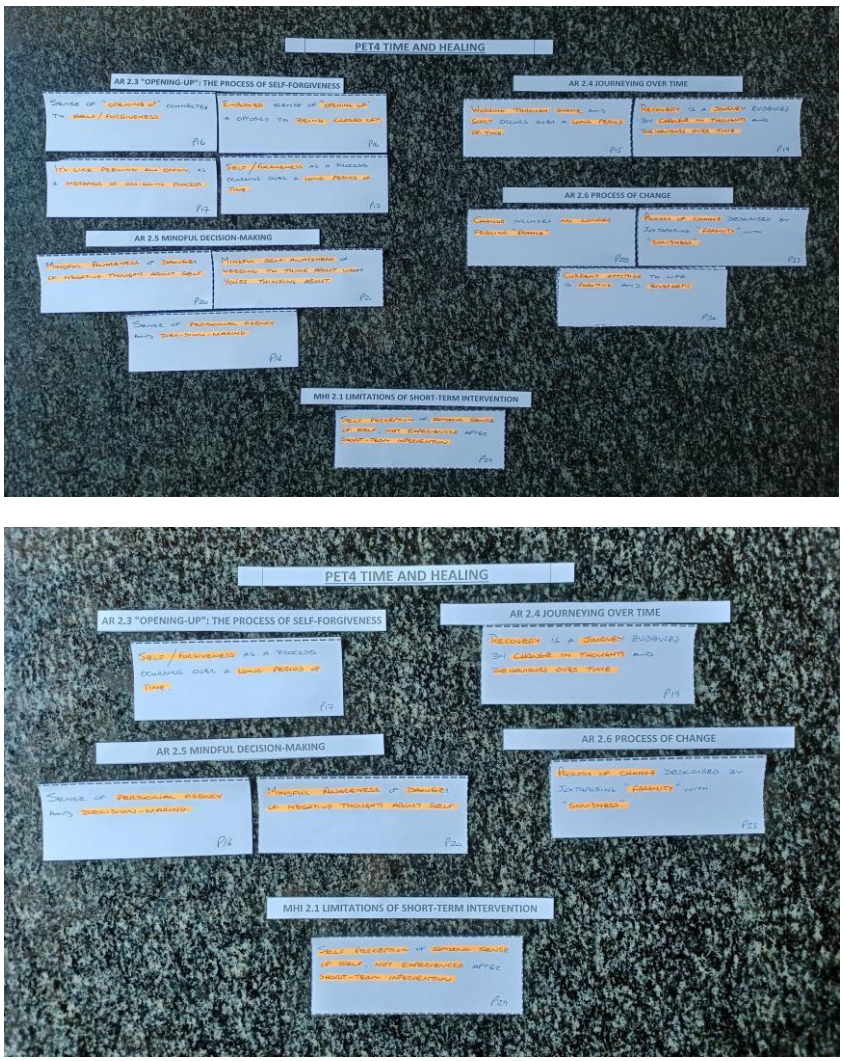
An Image Taken of Data Analysis Process Step 6 (Grouping Experiential Statements (ESs) Into Developing Personal Experiential Themes (D-PETs) Under Main Aspects) RPB – Addiction Recovery (AR), Spirituality (S) and Mental Health Intervention (MHI).



Step 7: All three groupings with their corresponding D-PETs and associated ESs were placed on the table surface for review by the researcher and transcriber. Similar D-PETs became apparent across the groupings and were clustered with corresponding ESs. These reviewed clusterings were then renamed with the emerging Personal Experiential Themes (PETs).
Following this, the ESs deemed most suitable in support of the corresponding D-PET and PET were retained. This was replicated for each PET (see Figure 7).

Figure 7

An Image Taken of Data Analysis Process Step 7 (Personal Experiential Themes (PETs), Developing Personal Experiential Themes (D-PETs) and Experiential Statements (ESs) - Initial and Refined) RPC.



Step 8: The PETs were tabulated with their corresponding D-PETs, ESs and relevant quotes extracted from the transcript by the researcher.

4.4.2 Cross-Case Analysis

Following the individual case analysis of each case, a cross-case analysis was conducted to identify convergent and divergent themes across the cases.

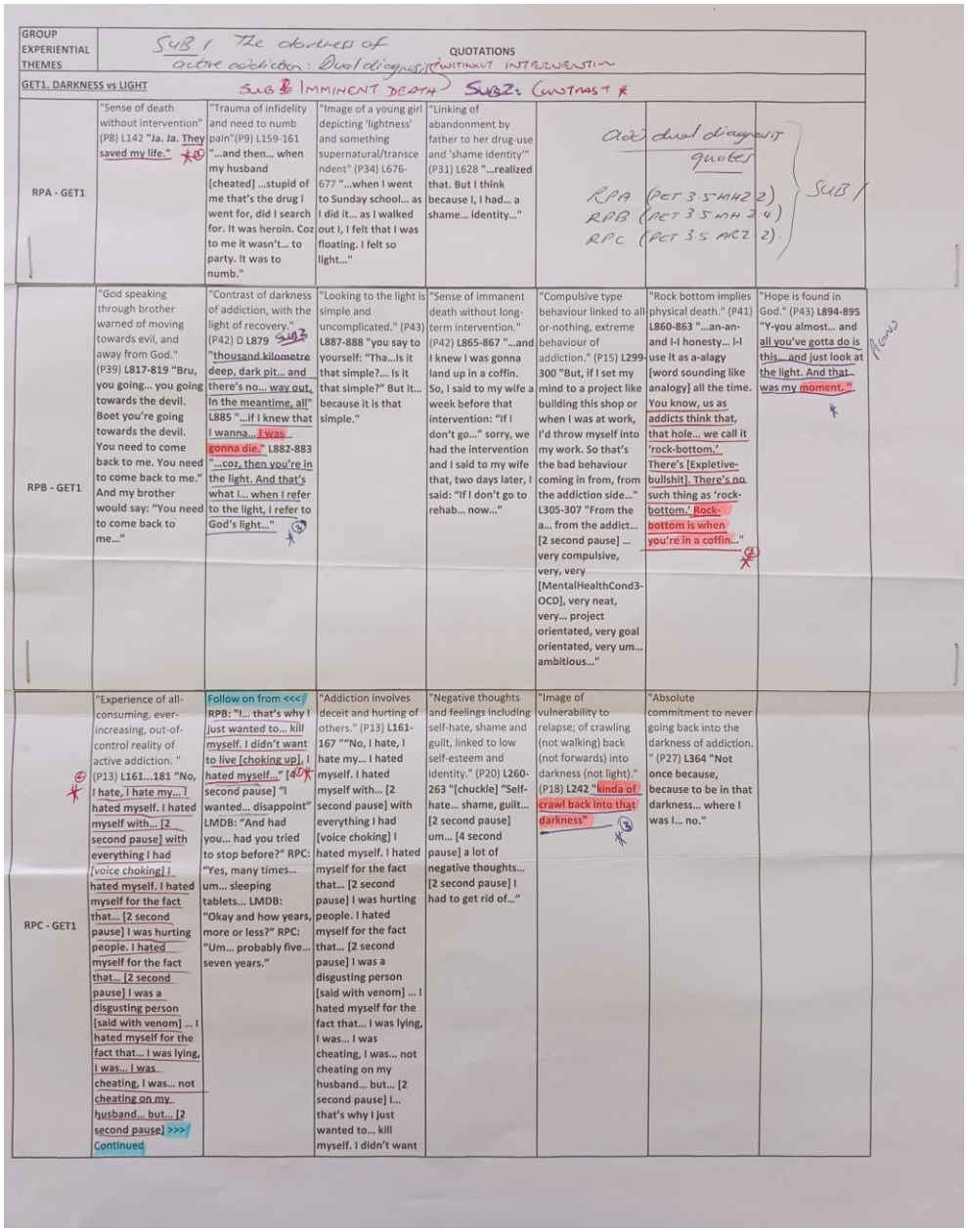
Step 1: Each participant's PETs was tabulated alongside each other for the purpose of viewing to establish any commonalities between them. To strengthen the shared association of the emerging commonalities, the researcher revisited the corresponding quotes and made final decisions regarding the reordering of the PETs collaboratively with the transcriber. The reordered PETs were then tabulated for ongoing analysis.

Step 2: Each participant's reordered PETs were individually recorded on slips of paper and then grouped with each other participant's corresponding slips of paper. Further analysis of commonalities and differences across the cases resulted in the refined, final Group Experiential Themes (GETs) being identified. As discussed by Smith and Nizza (2022), the commonalities signify points of connection (convergence) while simultaneously pointing out significant differences in the participants' experiences (divergence).

Step 3: Through an intuitive and holistic review process (see Figure 8), both the convergent and divergent aspects within each GET led to the emergence of sub-themes being identified, with each sub-theme being represented with relevant verbatim quotes.

Figure 8

An Image Taken of the Development of GET 1 with Sub-Themes and Supporting Participant Quotations.



GROUP EXPERIENTIAL THEMES	SUB 1 The darkness of active addiction: Dual diagnosis without intervention						
GET1. DARKNESS vs LIGHT	QUOTATIONS SUB 2: IMMINENT DEATH			SUB 3: CONTRAST			
RPA - GET1	"Sense of death without intervention" (P8) L142 "Ja. Ja. They saved my life."	"Trauma of infidelity and need to numb pain"(P9) L159-161 "...and then... when my husband [cheated] ...stupid of me that's the drug I went for, did I search for. It was heroin. Coz to me it wasn't... to party. It was to numb."	"Image of a young girl depicting 'lightness' and something supernatural/transcendent" (P34) L676-677 "...when I went to Sunday school... as I did it... as I walked out I, I felt that I was floating. I felt so light..."	"Linking of abandonment by father to her drug-use and 'shame identity'" (P31) L628 "...realized that. But I think because I, I had... a shame... identity..."	AC2 dual diagnosis quotes RPA (PCT 3.5 MH2 2) RPB (PCT 3.5 MH 2 4) RPC (PCT 3.5 AC2 2)		SUB 1
RPB - GET1	"God speaking through brother warned of moving towards evil, and away from God." (P39) L817-819 "Bru, you going... you going towards the devil. Boet you're going towards the devil. You need to come back to me. You need to come back to me." And my brother would say: "You need to come back to me..."	"Contrast of darkness of addiction, with the light of recovery." (P42) D L879 SUB 3 "thousand kilometre deep, dark pit... and there's no... way out, in the meantime, all" L885 "...if I knew that I wanna... I was gonna die." L882-883 "...coz, then you're in the light. And that's what I... when I refer to the light, I refer to God's light..."	"Looking to the light is simple and uncomplicated." (P43) L887-888 "you say to yourself: "Tha...Is it that simple?... Is it that simple?" But it... because it is that simple."	"Sense of immanent death without long-term intervention." (P42) L865-867 "...and I knew I was gonna land up in a coffin. So, I said to my wife a week before that intervention: "If I don't go..." sorry, we had the intervention and I said to my wife that, two days later, I said: "If I don't go to rehab... now..."	"Compulsive type behaviour linked to all-or-nothing, extreme behaviour of addiction." (P15) L299-300 "But, if I set my mind to a project like building this shop or when I was at work, I'd throw myself into my work. So that's the bad behaviour coming in from, from the addiction side..." L305-307 "From the a... from the addict... [2 second pause] ... very compulsive, very, very [MentalHealthCond3-OCD], very neat, very... project orientated, very goal orientated, very um... ambitious..."	"Rock bottom implies physical death." (P41) L860-863 "...an-an-and I-I honesty... I-I use it as a-alagy [word sounding like analogy] all the time. You know, us as addicts think that, that hole... we call it 'rock-bottom.' There's [Expletive-bullshit]. There's no such thing as 'rock-bottom.' Rock-bottom is when you're in a coffin..."	"Hope is found in God." (P43) L894-895 "Y-you almost... and all you've gotta do is this... and just look at the light. And that... was my moment." (Read)
RPC - GET1	"Experience of all-consuming, ever-increasing, out-of-control reality of active addiction. " (P13) L161...181 "No, I hate, I hate my... I hated myself. I hated myself with... [2 second pause] with everything I had [voice choking] I hated myself. I hated myself for the fact that... [2 second pause] I was hurting people. I hated myself for the fact that... [2 second pause] I was a disgusting person [said with venom] ... I hated myself for the fact that... I was lying, I was... I was cheating, I was... not cheating on my husband... but... [2 second pause] >>> Continued	Follow on from <<< RPB: "I... that's why I just wanted to... kill myself. I didn't want to live [choking up], I hated myself..." [2 second pause] "I wanted... disappoint" LMDB: "And had you... had you tried to stop before?" RPC: "Yes, many times... um... sleeping tablets... LMDB: "Okay and how years, more or less?" RPC: "Um... probably five... seven years."	"Addiction involves deceit and hurting of others." (P13) L161-167 ""No, I hate, I hate my... I hated myself. I hated myself with... [2 second pause] with everything I had [voice choking] I hated myself. I hated myself for the fact that... [2 second pause] I was hurting people. I hated myself for the fact that... [2 second pause] I was a disgusting person [said with venom] ... I hated myself for the fact that... I was lying, I was... I was cheating, I was... not cheating on my husband... but... [2 second pause] I... that's why I just wanted to... kill myself. I didn't want	"Negative thoughts and feelings including self-hate, shame and guilt, linked to low self-esteem and identity." (P20) L260-263 "[chuckle] "Self-hate... shame, guilt... [2 second pause] um... [4 second pause] a lot of negative thoughts... [2 second pause] I had to get rid of..."	"Image of vulnerability to relapse; of crawling (not walking) back (not forwards) into darkness (not light)." (P18) L242 "kinda of crawl back into that darkness"	"Absolute commitment to never going back into the darkness of addiction. " (P27) L364 "Not once because, because to be in that darkness... where I was I... no."	

Step 4: Final GETs with sub-themes and relevant verbatim quotes were tabulated (see Figure 9).

Figure 9

An Image of the Tabulation of the GETs and Sub-Themes with Key Quotations Developed From the Data Analysis Process.

GET1. DARKNESS vs LIGHT

1.a The darkness of active addiction: Dual diagnosis

RPA	**26_502**	severely depressed, broken.
RPB	**41_844...846**	So, I wouldn't be able to off myself, to shoot myself so I wanted the dealer or the cops or somebody … ...pull out a gun and shoot me…
RPC	**3_30...34**	I tried to commit suicide. …I hit rock bottom.

1.b Imminent death

RPA	**8_142**	They saved my life.
RPB	**41_862-863**	Rock-bottom is when you're in a coffin…
RPC	**13_167-168**	I just wanted to… kill myself. I didn't want to live. I hated myself…

1.c Contrast of darkness of addiction, with the light of recovery.

RPB	**42_875…882**	…I was gonna die. ...thousand kilometre deep, dark pit… ...then you're in the light.
RPC	**18_242 & 27_364**	kinda of crawl back into that darkness… ...Not once because, because to be in that darkness… where I was I… no.

GET2. GOD AND PEOPLE: THE RELATIONSHIPS

2.a The relationship with a Triune God is one of love, surrender and closeness

RPA	**64_1289**	…it's just that thing of love…
RPB	**29_606**	I just knew that God had my back…
RPC	**9_118**	...it's here, it's close, it's… it gives you… strength.

2.b A caring community

RPA	**46_925**	...and they all jumped on board.
RPB	**49_1021…1023**	I've got a… ….it's a brotherhood… …more than a community.
RPC	**28_380**	To have someone to reach out to…

GET3. JOURNEY OF CHANGE OVER TIME

3.a A significant spiritual moment

RPA	**28_553-554**	... That spiritual um… moment completely turned my perspective
RPB	**32_656...664**	I was looking at the flames… this massive bonfire… …that moment… …where the Holy Spirit… …and I could feel it.
RPC	**22_293…296**	...and it hit me… ...how amazing it was… what happened at the cross."

3.b Peeling the onion

RPA	**23_454**	…but after putting in a few solid years in recovery
RPB	**62_1296**	...Everything is a process. Everything is a journey…
RPC	**19_254**	...it's a journey. ...it's like… ...peeling away of an onion.

GET4. EMBODIED EXPERIENCE

4.a Feeling it physically

RPA	**35_692-693**	I could feel… the warmth in my heart…
RPB	**33_670…681**	…so when I… your body… it's almost like pins and ah… mm… ah, ah goosebumps… …and you can feel a sense of… clarity and peacefulness…
RPC	**22&23_302…316**	...I also got baptised there... Amazing… Mm… in winter.

GET5. SPIRITUAL OVERFLOW: LIVING A NEW LIFE

5.a Attributes of a New Life

RPA	**21_403**	I forgave him.
RPB	**46_960**	…I needed to… be humbled
RPC	**26_355-356**	I had hope. I had the future in front of me.

5.b Inspiring and serving others

RPA	**66_1335-1336**	I wanna help. …I wanna inspire others…
RPB	**61_1274**	Because I want to give back.
RPC	**33_452-453**	**… "you've got this energy about you. …how do you do it?"**

Step 5: The five GETS were further explored and interpreted as findings of this study (see Chapter 5).

Step 6: These findings of experiencing spirituality in MHI for AR in SA were used in the development of a proposed model for enhanced collaboration interdisciplinarily in the implementation of spiritually-informed MHIs for AR in SA (see Chapter 6).

4.5 Methodological Integrity as the Basis for Trustworthiness in IPA

The assessment and evaluation of the trustworthiness and authenticity of qualitative research need to accommodate the underlying interpretative stance of the research, which has been problematic when compared to the rigorous measurement of reliability and validity in quantitative research (Smith & Nizza, 2022). Practical ways to evaluate qualitative psychological research were published in the APA journal article reporting standards for qualitative research (Levitt et al., 2018) that guide the need to maintain both specificity and generality throughout the research study in a balanced way (Smith & Nizza, 2022).

Instead of using decontextualised criteria in evaluation, methodological integrity comprises and is evaluated using the procedures of fidelity and utility for qualitative research. Fidelity to the subject matter indicates "an intimate connection that researchers can obtain with the phenomenon under study" (Levitt et al., 2017, p. 10). Utility points "to the effectiveness of the research design and methods, and their synergistic relationship, in achieving study goals – answering questions and/or resolving problems" (p. 10). In addition to this, for IPA qualitative research evaluation, specifically, four key quality indicators are given by Nizza et al. (2021) and include:

1. constructing a compelling, unfolding narrative,
2. developing a vigorous experiential and/or existential account,
3. close analytic reading of the participants' words, and
4. attending to convergence and divergence.

Based upon the works of Levitt et al. 2017, Levitt et al. 2018 and Nizza et al. 2021 the methodological integrity of the research will be presented in a tabular format against questions posed regarding the information needed to show the

integrity of the research (see Table 2).

Table 2

Tabulation of the Methodological Integrity of the Research (Levitt et al., 2017, Levitt et al., 2018 and Nizza et al., 2021).

Question posed	Study compliance
In upholding *fidelity* to the subject matter • Was there adequate data?	• A small, homogenous sample was used with in-depth, case-by-case data collection and analysis to provide rich descriptions of the participants' lived experiences of spirituality in AR and provided adequate data to gain insights into their individual and shared meanings into the phenomenon.
• Was the researcher's perspective managed in both data collection and data analysis?	• Rich, personal self-reflective descriptions were presented to the reader throughout. • Reflexivity was evidenced in self-reflective journaling by the researcher and then reflecting on these entries in personal supervision. Themes or patterns that became apparent through this supervised reflection were discussed for increased awareness and understanding needed to manage any possible researcher bias. As a trained and experienced clinical psychologist, inculcated,

	metalevel self-reflection occurred during the interview process, reading of transcripts and data analysis. • In dialoguing with the transcriber of the data during the analysis process, because of the transcriber's knowledge of the researcher, he could assist with pointing out further possible blind spots/biases throughout the data analysis process.
• Were the findings grounded in the evidence?	• Findings were generated from in-depth, case-by-case analyses of rich narratives regarding the phenomenon. Verbatim quotes were used to gain contextual and experiential understanding of the personal narratives. The transcriber was involved in checking, questioning, reflecting and validating emerging themes in determining fidelity to the participants' narratives.
In upholding *utility* in achieving the study goals • Were the contributions meaningful?	• A model is proposed (see Chapter 6) as a practical, interdisciplinary and collaborative intervention in the psycho-social support of and mental health treatment of those recovering from addiction. In

	adhering to the principles of evidence-based, phenomenological research, the researcher proposed this model that "invites conversation rather than seeks the final word" (Walsh, 2012, p. 6) in contributing to the existing body of knowledge on the topic.
• Were the data contextualised?	• The context of COVID-19 and the related protocols, and settings (including online) for the research were presented. By clearly describing the data collection process, the reader can view the findings according to the appropriate context, and thus decide on the appropriate fit for future research.
• Was there coherence among the findings?	• The analysis was conducted on a case-by-case basis with individual discrepancies/differences being noted and discussed. By using the IPA format of presenting the findings in a narrative form with verbatim quotes, data coherence was established.
• Was there consistency throughout the process?	• Consistent step-by-step descriptions of the data analysis process were provided. The

• Were there any supplementary checks added?	implications of amendments needed due to the COVID-19 pandemic were included. • Supplementary checks included journal entries and related supervision of the researcher. Feedback from the supervisor of this study following individual chapter drafts/submissions and feedback discussions, was incorporated into the unfolding process throughout. The researcher presented at both an international online congress and an international face-to-face congress on aspects of the research study. The speakers/delegates attending these congresses included professionals in the fields of spirituality, theology, medicine (including addiction medicine) and mental health from various countries worldwide. Feedback from the congresses became part of the reflection, interpretation and iterative analysis process with the necessary adjustments in line with the feedback being made. The researcher's stance remained open to receiving critique, with new learnings

	gained and incorporated throughout the study.
• Was a compelling, unfolding narrative constructed?	• The analysis and findings were presented to tell the story of the experiences of spirituality in AR for each participant. Verbatim quotes substantiated the interpretations. The personalised style of the researcher was presented in her creative manner of storytelling throughout.
• Was a vigorous experiential and/or existential account developed? • Was there a close analytic reading of the participants' words? • Was there attention given to convergence and divergence?	• The initial in-depth, idiographic, case-by-case analysis, followed by comparing the three cases, showed the similarities and differences in developing the group experiential themes (see Figure 9).

4.6 Ethical Considerations

As a PhD student and registered clinical psychologist who undertook a research study, the researcher adhered to all Government Gazetted laws, particularly regarding the prevention and treatment of substance abuse. Cognisance was taken of the HPCSA's ethical guidelines for good practice in the healthcare professions and the Professional Board of Psychology specific rules of conduct within the profession. All required ethical guidelines of practice and stipulations of the University of South Africa (UNISA) Board of Ethics were adhered to (UNISA, 2016).

Basic internationally recognised moral principles of ethics as stipulated in UNISA's Policy on Research Ethics (p. 11) include:

1. autonomy (research should respect the autonomy, rights and dignity of the research participants),
2. beneficence (research should contribute towards the welfare of people),
3. nonmaleficence (research should not cause harm to the research participant(s) in particular, or to people in general), and
4. justice (the benefits and risks of research should be fairly distributed among people).

Various underlying core ethical values and standards have the status of basic ethical principles in health research, as described by the HPCSA. These include the principle of best interest and well-being (including beneficence and nonmaleficence); the principle of respect for persons (including autonomy and confidentiality) and the principle of justice (HPCSA, 2016).

4.6.1 Beneficence, Essentiality and Relevance

With the increasing prevalence of addiction in SA, this research has added to the body of knowledge regarding the role of spirituality in the implementation of mental health treatment. This includes the aftercare and reintegration of substance abusers into their communities with the proposal of the model (see Chapter 6). The Prevention of and Treatment for Substance Abuse Act (2008) includes that treatment provides for “psycho- social programmes that address the relationships, emotions, feelings, attitudes, belief's, thoughts and behavior patterns of service users” (p. 16) and that programmes for early intervention should include “promoting the well- being of the service user and the realization of his or her full potential” (p. 22).

By having gained specific knowledge regarding the spiritual experiences of the participants, this knowledge enables the development of changed strategies and protocols within the healthcare sector for the involvement of faith-based community organisations in the rendering of mental healthcare services in future. Greyvensteyn (2019) showed that integration is required within Psychology and

Pastoral Ministry, where collaboration occurs both within and between the disciplines.

4.6.2 Researcher Competence, Commitment to Research, Transparency and Respect

"Researchers should be both personally and/or professionally qualified for the research that they undertake" (UNISA, 2016, p.11). The researcher has addressed the aspects of her competence and commitment to the research in her personal story in Chapter 1. Evidence of transparency has been reported on in the section regarding methodological integrity (see Section 4.5).

The researcher remained culturally sensitive to the individual differences between participants and respected that which was sacred. This sensitivity and respect were important throughout, as the participants shared their personal spiritual experiences. Further guidelines (HPCSA, 2016) emphasise that the well-being of the research participants always rests with the health researcher. For this study, the researcher (a registered clinical psychologist) was suitably qualified professionally to assess any acute emotional distress or evidence of post-traumatic symptoms and was positioned to respond immediately to the participants by offering emotional containment and referring the participants to a suitable mental health colleague who was not involved with the research. This potential referral for further debriefing would have been to minimise the risks of harm to the participants. In her capacity, the researcher would have covered any costs for this debriefing session.

4.6.3 Confidentiality, Privacy and Anonymity

"The National Health Act (Act No. 61 of 2003) states that all patients have a right to confidentiality, and this is consistent with the right to privacy in the South African Constitution (Act No. 108 of 1996)" (HPCSA, 2016b, p. 2). The HPCSA's ethical rules include that confidential information can only be divulged with the express consent of the patient (HPCSA, 2016b).

Confidentiality was central to trust between the researcher and the participants. Without the assurance of confidentiality and anonymity, the

participants would have been reluctant to engage fully and so might have withheld vital information that would have negatively impacted the integrity of the research.

4.6.4 Autonomy and Informed, Non-Coerced Consent

According to UNISA's Policy on Research Ethics (2016),

> Autonomy requires that individuals' participation should be freely given, based on informed consent and for a specific purpose as required by the POPI Act. Direct or indirect coercion, as well as undue inducement of people in the name of research should be avoided (p. 12).

The participants had the right to choose whether to participate in the research. The prospective participants were given detailed information regarding the nature and purpose of the research before the research commenced. All documents included the researcher's name, qualifications and contact number. The participants agreed to be interviewed, and audio recorded. Appropriate steps were taken to ensure securing the electronic devices on which the voice-recorded interviews were stored, with only pseudonyms being used for identification purposes.

Confidentiality and anonymity were assured. Consent was given for the future publication of the research results, including the use of verbatim extracts. These could also be used for presentations at conferences and congresses.

Written and informed consent was given by the participants, accompanied by their signatures. In adherence to the principle of informed consent, proper documentation was kept.

Participants were advised that in line with HPCSA's Ethical Guidelines for Health Researchers (2016c), informed consent cannot be an isolated event but instead includes an ongoing dialogue between the researcher and the participants. Participants were free to withdraw from the research by revoking their consent at any time throughout the process. No coercion of participants occurred. There was no financial gain or other type of reward for the participants.

4.7 Summary of the Chapter

In summarising the chapter, the researcher has shown compliance with all the ethical standards and protocols. Methodological integrity has been discussed and maintained in the study. With the process of purposive sampling, data collection and data analysis having been followed, the GETs, their sub-themes and key quotes are (see Figure 9):

GET1. Darkness vs Light

1.a The darkness of active addiction: Dual diagnosis

1.b Imminent death

1.c Contrast of darkness of addiction with the light of recovery

Quote: kinda of crawl back into that darkness… Not once because, because to be in that darkness… where I was I… no.

GET2. God and people: The relationships

2.a The relationship with a Triune God is one of love, surrender and closeness.

Quote: … it's just that thing of love…

2.b A caring community GET3.

Journey of change over time

3.a A significant spiritual moment

3.b Peeling the onion

Quote: … it's a journey. … it's like… …peeling away of an onion.

GET4. Embodied experience

4.a Feeling it physically

Quote: …so when I… your body… it’s almost like pins and ah… mm ah, ah goosebumps… …and you can feel a sense of… clarity and peacefulness

GET5. Spiritual overflow: Living a new life

5.a Attributes of a New Life

Quote: I had hope. I had the future in front of me.

5.b Inspiring and serving others

These findings will be further explored in Chapter 5, with the development of the proposed model being presented and discussed in Chapter 6.

Chapter 5: Findings of Experiencing Spirituality: Group Experiential Themes (GETs)

From the cross-case analysis described in Chapter 4 the emerging group experiential themes are summarised in Figure 10.

Figure 10

Group Experiential Themes (GETs) as Developed From the Data Analysis Process Described in Chapter 4.

Note: Author developed figure which was used in the researcher's presentation at the 17th European Congress of Psychology 2022 (ECP2022) in Ljubljana, Slovenia.

In discussing the findings, each GET will be explored by narrating aspects of each participant's unfolding personal experience. Both converging and diverging sub-themes will be considered through personal quotes from each participant, and further interpretations within the contexts of each participant's lived experience.

5.1 GET 1: - Darkness vs Light

This GET emerged with three prominently related sub-themes being evident. These included:

a. the darkness of active addiction: dual diagnosis

b. imminent death
c. contrast of darkness of addiction, with the light of recovery
d.

5.1.1 GET 1.a: The Darkness of Active Addiction: Dual Diagnosis

All three participants describe the harshness and darkness of living in active addiction. It was recalled as a devastating time when everyday living was experienced as out-of-control, toxic and traumatic.

RPA described being introduced to heroin as a teenager by her then boyfriend and friendship group while residing in her European country of birth. She emigrated to SA to get away from her boyfriend and stayed off drugs for the next 20 years. She built her life in South Africa. She got married to her husband and has two adolescent children. However, when confronted with the trauma of her husband's infidelity, she relapsed using heroin.

> …and then when my husband cheated and sss …you know our problems started and sss… stupid of me that's the drug I went for, did I search for. It was heroin. Coz to me it wasn't… to party. It was too numb (RPA).

To numb the pain and cognitively minimise the intensity of the relapse for herself, she eventually mixed heroin and crystal methamphetamine, smoking them together so as not to have to inject the heroin. This was evidence of her distorted thinking to justify to herself that she had diluted the problem.

> …to kind of water it down (RPA).

The need to minimise the problem is part of the denial of the intensity, destruction and loss associated with active addiction (Bisaga, 2018). Negative thoughts and feelings, including self-hate, shame, and guilt form part of a perpetuating pattern of low self-esteem and a damaged sense of personal identity.

> But I think because I, I had… a shame… identity… I always saw him as better than me. You know… so, I always sss… thought we weren't equal. That I was… below him… (RPA).

RPC, a participant who experienced the hurt and loss of her marriage due to her long-term addiction to sleeping tablets, also speaks of the destruction of active addiction.

> Self-hate… Shame, guilt… um… a lot of negative thoughts…
>
> No, I hate, I hate my… I hated myself. I hated myself with… with everything I had [voice choking] I hated myself. I hated myself for the fact that… I was hurting people. I hated myself for the fact that… I was a disgusting person [said with venom] … I hated myself for the fact that… I was lying, I was… I was cheating
>
> …but… I… that's why I just wanted to… kill myself. I didn't want to live [choking up]. I hated myself… (RPC).

RPB, who recalls first dabbling in drugs from the age of 14, describes his active addiction to cocaine as only having escalated at the age of 42. RPB describes the possible reasons for his escalating drug use, including the passing away of his brother, followed by his leaving the corporate world and returning to self-employment. Decreased finances led to an increased sense of personal insecurities and a lowered sense of self-worth. RPB describes the escalating chaos of active addiction.

> … at the end of the day. Um… and then it… and then… those insecurities just made me go into a dark place and that's when the cocaine… in the July of 2017 really, really took… look it grabbed me, ja. It jus, jus… it took over my life... created a lot of chaos… and I spent a lot of money… I was… I was spending sixty thousand rand on cocaine a month (RPB).

Emphasis is placed on the darkness, the sense of being in bondage and the experience of having lost control of his life.

> June is co… as I was doing some crazy shit … I, I… in seventeen, eighteen months I did so-some weird kak … fighting with cops… a-a… I… and, and that part of my… part of my extremism, I couldn't go the dealer on the road, I had to go to the top guy I went to the kingpin …um I, I would… he'd be parked… here… windows open in a Merc… and
>
> the cops were here, I would pull up and, and do the deal… a-a-a… I just didn't care… Ja, a gangsterism… the gangsterism. The… unleadership. But… I was so… hell bound to finish my… journey…but I was too shit scared to do it myself. So, I wouldn't be able to off myself, to shoot myself

> so I wanted the dealer or the cops or somebody … pull out a gun and shoot me… (RPB).

In this description, a Freudian slip is evident. The participant speaks of “hell bound,” which could denote being both “hell bent” or determined to die; and also “bound for hell” which links to another part of the interview where RPB sensed his brother posthumously, warning him he was going towards the devil, i.e., moving towards a place of torment, darkness, and death.

> Bru, you going… you going towards the devil. Boet you’re going towards the devil (RPB).

When considering the experiences of these periods of havoc and mayhem, all three participants describe clear indications for DSM-5 psychiatric dual diagnoses. A dual diagnosis is given when a psychiatric condition is diagnosed with a co-occurring substance use disorder. The experience of paranoid thoughts and behaviours is evidenced in RPA and RPB’s narratives. RPA speaks of how experimenting with a toxic and dangerous mix of drugs led to paranoia.

> …and, and then it really started taking a toll on me. I became… very paranoid… um… tha he was cheating again, and he was spying on me and… ja. And… you know there, there was things… I think at a point he did put a tracker in my car I was on drugs he was checking. But I never managed to find anything but… and then I would hide the camera in the house to spy on him (RPA).

RPB also commented on the link between his cocaine use and paranoid/persecutory psychotic episode.

> I always had this shadow – here this dark shadow and I knew it was my… and, and, and obviously I was in… I was all coked-up and… in, in psychosis… so that… exacerbates the paranoias (RPB).

The complexities involved in the diagnosis and appropriate treatment of those struggling with dual diagnoses were shown. The comorbid conditions can become problematic to differentiate and diagnose, regarding whether the substance use disorder is primary or secondary to the co-occurring mental health condition.

RPB had previously been diagnosed with BMD and ADHD. His concern was that he had experienced having been misdiagnosed due to his substance use; and that his addiction also complicated the prescription of suitable and necessary medication for him.

> …at the first two rehabs they diagnosed me with bipolar …so I was on Epilim and all sorts of… kak… I was on Dopaquel, Seroquel and I just wasn't… I think that was part of… my relapsing… to be honest. I wasn't… because I didn't have those… I'm hyperactive… and that's bullshit that's part of the psychiatry that I don't… that I, I've got to be honest I detest. Not everybody is Bipolar and all this kak. It wasn't making me… I wasn't feeling goo… I wasn't feeling myself.
>
> …where they, they diagnosed with ADHD so… that I can understand… coz… I can relate to, to the… the none… um… so, so I'm very impulsive… I, I'm very… prone to all the… qualities of a ADHD person (RPB).

The ongoing emotional turmoil and escalating distress are witnessed in each participant's account. Depressive mood symptoms and increasing suicidal ideation were apparent. RPA likened her dysfunctional substance use to being broken, while her mood was severely depressed.

> …severely depressed, broken.
>
> I got suicidal because of just not coping with… the way k… things were happening at home and… there was physical violence (RPA).

RPB, as quoted, took increasing life-threatening risks as his way of attempting to get himself shot and killed by a drug lord.

In the case of RPC, she had been hospitalised following a serious suicide attempt.

> Um, well I tried to commit suicide. So, I ended up in, umm [name of hospital] So … yah… I mean that kind of… I hit rock-bottom (RPC).

The experience of suicidal thoughts and related behaviours link to the second sub-theme under the GET of Darkness vs Light, i.e., Imminent Death.

5.1.2 GET 1.b: Imminent Death

Similarly, to RPC, as quoted above, who linked her suicide attempt to having "hit rock-bottom," RPB was outspoken regarding this commonly used jargon in addiction and recovery communities.

> You know, us as addicts think that, that hole… we call it 'rock-bottom.' There's bullshit. There's no such thing as 'rock-bottom.' Rock-bottom is when you're in a coffin… and I knew I was gonna land up in a coffin (RPB).

RPA also commented clearly on her inherent knowledge that if she had not been assisted regarding a long-term admission into a rehabilitation facility, she believed that she would have died prematurely.

> Ja. Ja. They saved my life (RPA).

White (1996) describes the relationship between death and the addict. He says that:

> Death is a constant companion of the addict, appearing at times as a demon to be fought off and appearing at other times as a seductive lover to be embraced. When we combine organic impairment, high risk- taking behavior, chronic depression resulting from losses experienced during the addictive career, the increasing fear of insanity, escalating feelings of shame and guilt, and the continued consumption of drugs that lower inhibitions and impair judgement, death appears more and more frequently in the form of a seductive lover (p. 161).

Death by suicide can become the seemingly only option for the addicted person. RPC emphasised the increasing self-hatred she experienced and the vicious cycle of addictive behaviour where she consumed her drug of choice, was deceptive and lied to significant others, hurt them, and felt the related guilt and shame. This resulted in a cyclic pattern of ever-increasing self-hatred and suicidal ideation.

> … but… I… that's why I just wanted to… kill myself. I didn't want to live. I hated myself… (RPC).

This darkness of addiction was contrasted by two of the participants to the

light of recovery in a third sub-theme.

5.1.3 GET 1.c: Contrast of Darkness of Addiction With the Light of Recovery

The opposite of experiencing the harsh and seemingly never-ending place of darkness in addiction can be seen to exist in direct contrast to the light of recovery.

RPB was explicit in his experience of the darkness vs the light.

> … if I knew that I wanna… I was gonna die. Five-thousand kilometre deep, dark pit… and there's no… way out. Coz, then you're in the light. And that's what I… when I refer to the light. I refer to God's light… (RPB)

For him, the light he described was the light of God.

RPC clearly depicted her absolute commitment to a place where she would never wish to return. She described the powerful image:

> … kinda of crawl back into that darkness. Not once because, because to be in that darkness… where I was I… no (RPC).

This quote of RPC was captured in Figure 11 showing the opening of a well. The darkness of the well represents the darkness of addiction to which RPC never wishes to return.

Figure 11

Image Used in the Presentation at ECP2022 to Depict the Preceding Quote of RPC Which Encapsulates the Aspects of GET 1.

Note: This and subsequent pictures are non-copyrighted and in the public domain.

This image of crawling, not walking; backwards, not forwards; into the darkness, not into the light, clearly contrasting the physical, emotional, and spiritual place of addiction she had previously experienced with her current circumstances and sober lifestyle.

The overall sense of this group experiential theme includes the reality of the experience of active addiction as being chaotic, out-of-control and destructive, leading towards death. There is a clear indication of the experience of mental dysfunction, with psychiatric dual diagnosis being apparent. The opposite of this place of destruction is experienced as being that of light, depicting the possibility and hope of change and recovery.

5.2 GET 2: God and People: The Relationships

The GET of God and people: The relationships are divided into two sub-themes. These include:

a. the relationship with the Triune God is one of love, surrender and closeness
b. a caring community
c.

5.2.1 GET 2.a: The Relationship With the Triune God is one of Love, Surrender and Closeness

Within this GET, the importance of relationships became apparent. All three participants affiliated with the Christian faith, which was evidenced in their descriptions of relating with different persons of the Trinity. Previously in Chapter 4, selection criteria included that the participants had been to a Christian rehabilitation facility. The spiritual orientation towards the Christian faith was based on research conducted: “74% of the South African population indicated that religion plays a significant role in their lives (Lugo & Cooperman, 2010), and 84% of South Africans describe their religious affiliation as Christian” (Schoeman, 2017, p. 5).

In each participant’s relation to the Triune God, different aspects of these intimate relationships were emphasised. RPA described the ***love*** she

experienced, RPB emphasised the ***surrender*** of his self-will in the relationship, and RPC focused on the ***closeness***, she knew and felt.

> …it's just that thing of love… (RPA).

Figure 12 captures the essence of what RPA quoted referring to love.

Figure 12

Image Used in the Presentation at ECP2022 to Depict the Preceding Quote of RPA Which Encapsulates the Aspects of GET 2.

Throughout her interview, RPA referred to the love of God and His presence as integral to her recovery. In comparing the possibility of recovery without the love and presence of God to her personal experience, she clearly emphasises her continuing need for God as part of her changed life.

> …I will never use again. No man… [deep breath] No loss, no… grief or… anger or anything the life will throw at me… will make me use because I will turn to God, I'm not going to turn to self-medication coz, God is my medication. He's only one that can… help me… (RPA).

Reflecting on her initial admission into the long-term rehabilitation facility, where she speaks of being strengthened by the knowledge of His love, she adds:

> But… I, I definitely would have struggled more along the way, I think. Because I, I… don't have much strength. I'm, I'm… ah… I'm a slave to my emotions and my low… my self-esteem was very low… and my self-worth was very low. And… it would have been a… uphill battle… and I did feel stronger when the girl told me "God brought you here." Then I start

> thinking that's it. [claps hands] This is gonna work.
> Because that never happen in [RehabName2]. No one ever told me "God wants to k" … you know… …things changed in me (RPA).

Olthuis (2001) describes how love calls us to repentance, reconciliation and change or transformation. He adds that "God's love is the oxygen that sustains the universe" (p. 69) and that "Without love, the ether of existence vaporises, the fabric of life unravels" (p. 69).

RPA had been experiencing her life unravelling and spiralling downwards until having been experientially aware of His forgiving, unconditional and eternal love for her. A personal and intimate connection between her and God developed.

RPB, too, points to a personal and intimate connection:

> Because I, I just knew that God had my back… (RPB).

He is grateful for this connection. RPB's gratitude towards God was repeatedly expressed throughout.

> …I thank God I've got a bit of understanding about this stuff. …and I… because I think I'm older as well that I… and thank God that I'm on the right path, is that I'm able to identify where I'm doing wrong and where I'm not doing wrong and I'm sort of growing up now… (RPB).

However, he speaks of how his self-awareness, insight and change in relating with God progressed from an initial place of pride and denial and wanting to do things on his own; to remembering God; and ultimately surrendering to Him.

> I don't need anybody's help… you know, I've done it my whole life on my own. I don't need… [wi-fi signal drop which distorts conversation for 4 seconds] and, and, and I wasn't remembering that God's protected me this, this whole… this… in my entire life. I didn't have to study to be successful… …you know… so if I take the stuff that I've learnt and… He did it. Knowing that I should have done an MBA and gone to high… ah, to school ah… having said that I was still successful… I still had a really good family. I was still chilled. I was still the salt of the earth person. I was still uncomplicated and that with the grace of God… not out of my own doing… I believe. I

> know I, I been… now looking back… now looking back. Because I, I just knew that God had my back…
>
> …peace, surrender, ah… trusting in God…
>
> …but I, I understand that implicitly, the foundation of recovery and the foundation of life is God (RPB).

For RPC, who describes a cultural history of being brought up attending conservative and traditional Afrikaans-speaking churches in South Africa where she did not experience a relational connection to the Holy Spirit, as a person of the Triune God; she enthusiastically connected to His Spirit while in a charismatic Christian-based long-term rehabilitation facility.

> Especially the… the… I think something… that you get a lot from in the Afrikaans churches… is you don't get a lot of exposure from the Holy Spirit… and I think that's a mistake. That's a huge mistake… (RPC).

She not only experienced distance from God during her active addiction, but her perception of God as an authoritative and far-removed figure was challenged by her new experience of the Holy Spirit as being alive, being present, and being close to her. His proximity seemed to offer protection, comfort, and strength to her.

> So… it, it… I think the Holy Spirit for me made it real…
>
> But with the Holy Spirit… it's here, it's close, it's… it gives you… strength (RPC).

Although all three participants uncompromisingly prioritise their relationship with the Triune God in relating to Him, their spiritual practices differ significantly. RPA accentuated the importance of prayer, RPB accentuated fellowship, and RPC emphasised reading Biblical text.

RPA shared how she believes in the power of prayer. This is her way of communicating with God.

> …but I, I, I know… Lea, I know He answers prayers because He's, He's been answering prayers… for me for the last six years like…

Lea, all my prayers are being answered (RPA).

Throughout her interview, she reflected on how she speaks to God in prayer and trusts Him to lead, guide, and assist her through varying circumstances.

RPC uses Biblical texts for guidance and reassurance. She holds fast to the promises of God for affirmation regarding her identity. She quoted scriptures repeatedly during her interview.

> You are my daughter and I… in you I am well pleased" and that just… uh… opened up, started opening up…
>
> I've got my verses stuck on the wall, and one of them is… um… Isaiah 62 verse 3… where God said, 'You shall be so beautiful and prosperous as to be thought of as a crown of glory and honour in the hand of the Lord and a royal diadem exceedingly beautiful in the hand of your God.' So, I sometimes need to… you know… you have to remind yourself, you have to… and then you think 'Wow, if God says that I'm exceedingly beautiful in the hand of your God' (RPC).

The other participant, RPB, spoke of the importance of fellowship with others in growing his relationship with God. He knew of God from childhood, due to his Catholic upbringing. However, while been surrounded by others, also partaking in praise and worship, reading of Scripture, quiet-time, step work (AA, 1976) during his long-term rehabilitation, that led to him surrendering his self-will to God, and letting the process of recovery unfold, with his submission to the will of God.

> …reading the Bible, having the quiet-time…
>
> …they made you understand that you needed God… …in order to heal. First… and then follow those processes – Step 1, 2 and 3… 4, 5 and 6 etcetera… so, so… so when you understand what it means… because I knew it prior to my addiction… I knew at that moment: 'Okay, I know what… I know what his means. This is God. This is, this is spirituality'(RPB).

RPB was outspoken that although he knew he was connecting with the Holy Spirit, he did not necessarily connect in the same way as others in the

facility. He mentioned how he did not connect with how certain individuals engaged in praise and worship activities. He perceived this act of worship as trance-like but could continue relating with the Holy Spirit in his way with others.

> I didn't connect with the… going into a trance thing… …if that makes sense? You know what I'm saying? But I do believe in that, that connection. That, that feeling… that… of the Holy Spirit… …I, I get what that means… (RPB).

Although the three participants identified and related to various aspects and character traits of the Triune God and emphasised varying ways of doing this, they were all clear about a need to be in a personal and intimate relationship with Him.

5.2.2 GET 2.b: A Caring Community

In analysing the data, another converging sub-theme across the data was the importance of relationships with significant other people who witnessed the recovery journeys.

While sharing their narratives, all three participants spoke of specific individuals as having been integral to their healing processes. Although all three participants were speaking about persons whom they had met years ago (see inclusion criteria, Chapter 4), each mentioned the specific person(s) name(s) with conviction and fondness on numerous occasions during the interviews.

> …someone from there… ah… mentioned [RecoveryGroupName1] … ah… [RecoveryGroupLeader1] … [RecoveryGroupLeader1] and [RecoveryGroupLeader2] … so then we made, made contact with them and they came to the house here… so that must have been… December 2015. It was like a month… before. Ja. So, then we started attending the [RecoveryGroupName1] meetings… and then… the… following [RecoveryGroupLeaderName1]'s advice and the groups advice. They say you… you need long-term rehab. Which… I… I knew I needed. And they the one's that referred me to [RehabName1], and… off I go. Off I went. Ja… Ja. Ja. They saved my life (RPA).

> Correct and that's when I let the devil in. So, the minute I start to dabbling

> in, in drugs the da… the devil takes over and I am very clear on that. I'm very clear on that. And I only refound… my spirituality three months into my long-term, my last stint. And I knew… that… when the intervention happened and, and the guy that I'm involved with in [RecoveryGroup] with [RecoveryGroupLeader1], and them… [RecoveryGroupFounder] … the leader of, the leader of or the founder of [RecoveryGroup] … [RecoveryGroupFounder] … when he said to me: 'You're going away for long-term'… in that time I knew I need to, I, I needed fi… find my spirituality (RPB).

Where RPA and RPB point to support group leaders as having been significant, RPC spoke of the facilitator at the rehabilitation facility.

> And I received a lot of exposure from [name of rehab facilitator] from the Holy… about the Holy Spirit… and… and I think that was a very important… um… thing for me which of course carried on through [name of the church RPC attends] (RPC).

Two life group leaders working at the local church who voluntarily ran a life group at the facility were important to her.

> Uh… it, it takes a long time… um... it was actually… [Life group couple names] that said to me once… and, and that just… um… 'You are my daughter and I… in you I am well pleased' and that just… uh… opened up, started opening up… (RPC).

The sub-theme of the significance of being a part of a caring community included having experienced a sense of belonging to a psycho- social/spiritual support group.

All three participants emphasised the importance of ongoing support groups as part of their recovery experiences, especially in the early stages after being discharged from long-term rehabilitation facilities. RPA and RPB both attended a psycho-social faith-based AR support group. They both continue to attend a group weekly for ongoing support. However, after having attended her group now for six years, RPA said that she had decided that she would stop attending soon. RPC described the fellowship with her church- based life group,

which she attends weekly, as an integral aspect of her healing.

RPA focuses on authentic care for each other within the support group context in nurturing a deeply valued sense of belonging. She used the metaphor of glue to accentuate the bonding between the members of her support group.

> …because what we learn there… …you know… how to be good people, how… to be decent. So, the right sss… the glue …the… wo… hum… I think [RecoveryGroupName1] has such a loyal, loyal group and… we keep going… it's because… being… bringing spirituality to the group… I think we really… successfully show each other… we actually care about… the, the guy sitting next…now that just arrived with a crack addiction our… and we do, we actually do really… care about… ah them (RPA).

In speaking about his lived experience within the context of the AR support group he is a member of, RPB emphasised the necessity for commitment and continuity regarding attendance. He also expressed the sense of closeness and intimacy he shared with others in the group.

> You gotta go to a physical group and stay in… plugged-in same. I need to go to my physical group and stay connected to my Christian-based group. Say… you, you got to keep ongoing …and then going to group every week… and going to group every week. And being part of that Chris-Christian group that reminds me in my Christianity. So, I've got a… I've got a… at… it's a… it's a brotherhood… more than a community (RPB).

RPC experienced her church life group as the community where there are people she can reach out to for support whenever she may feel emotionally and/or spiritually vulnerable.

> To have someone to reach out to, to say, "Aag I'm having a bad day" or whatever…

She added:

> Um… to have someone to reach out to. My family of course is, is also very important to me… (RPC).

This link between family members, the church, the community, and recovery

was depicted by RPA in two specific metaphoric images:

1. Definitely. And I told him when I came back, I said, “With or without you, I will never stop going to church now” and they all jumped on board. And I actually inspired my own kids… and now they, they come with us to [ChurchName1] … and
2. …and its people that I sss… tha, tha, that didn’t pray, didn’t go to church… you know, they kind of like carrying the torch alone almost… (RPA).

The first metaphoric image is that of the church being analogous to a mode/vehicle of transport that takes all those on board on a shared journey to reach a destination. She was committed to church attendance and the related fellowship but added how her family members had *“all jumped on board,”* both in their individual faith journey and as supporters of her recovery journey.

In the second image, RPA likens those persons who attempt to heal from addiction without personal relationships, both with God and significant others, as “carrying the torch alone.” The image could be describing an attempt to bring light to oneself; by oneself. As shown in GET 1, the darkness of active addiction was contrasted with the light (as a spiritual symbol) of recovery. For RPA, her experience has been that those who attempt to heal from addiction on their own, often relapse and return to the dangerous cycle of darkness and entrapment. On being questioned regarding the importance of connection and community, she replied:

> Ja, it definitely… …helped in my personal… opinion. Because I’ve seen other people. You kno, co, that one wom at [RehabName1] that didn’t embrace… the spirituality of it… …and… they didn’t fare well at all. I mean… lot of people… there’s only 2 or 3 that were there with me that are still clean. Everyone else has relapsed… and its people that I sss… tha, tha, that didn’t pray, didn’t go to church… you know, they kind of like carrying the torch alone almost… (RPA).

This group experiential theme pointed to the shared experience of the importance of a personal relationship with the Triune God, with the ongoing support

of a caring community, while journeying in recovery.

5.3 GET 3: Journey of Change Over Time

The third GET describes a journey of change over time. This GET included two sub-themes:

a. a significant spiritual moment
b. peeling the onion

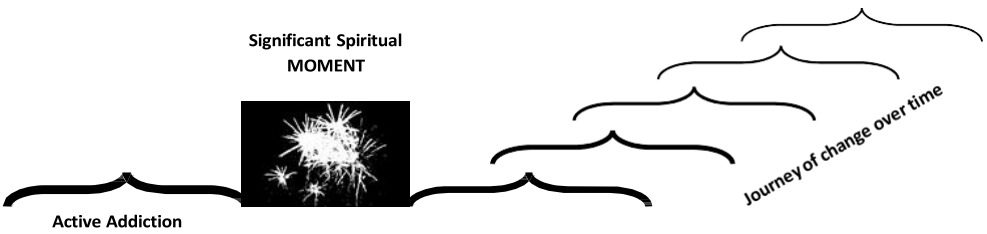
The research participants described both specific, significant spiritual moments in time and ongoing, long-term journeys of change over time.

5.3.1 GET 3.a: A Significant Spiritual Moment

Miller and Weigand (2021) shows how our inner and outer realities can align in moments that may seem random and/or improbable. Physical phenomena often occur in sync with those significant moments of changed awareness and/or perceptions. All three participants describe a specific, experiential, spiritual moment in his/her journey that signifies the beginning of each one's individual journey of change over time. Figure 13 depicts what the research participants described.

Figure 13

A Spiritual Moment Signifying the Transition From Active Addiction in the Journey of Change Over Time.



Note: Author developed figure.

Although all three participants had been admitted into facilities for short-term (usually about 21 days) intervention, they all emphasised the importance of long-term intervention and treatment. During admission into long-term rehabilitation facilities, all three participants' significant, spiritual

moments were experienced.

> That I did very… I… that… that's experience… that… God puts me there and I was meant to be there. Just, changed my whole perspective of… instead of feeling, which I was feeling until then that I was being put there because I was horrible person……I was destroying my family and I need to get my act together. Like that… on… that I needed to get my act together. That spiritual um… moment completely turned my perspective and, and I start seeing it from that day has… something… like… it was actually like life for me it was like God was loving me in such a way that I was given the opportunity. Not for [RPAHusbandName] and not for my kids but for me. To heal and to turn my life around, and to be who I'm supposed to be (RPA).

She describes the spiritual moment when God's love for her became apparent and a fundamental part of her lived reality. She had arrived at the facility and was feeling very depressed. She had been introduced to a girl who would be her mentor. She described the conversation between herself and the girl.

> So, there I'm feel sorry for myself. I've got a cry and sobbing and, and I said 'How did I got here? How did I end up here?' And she, she look at me and she says, 'God brought you here.' And to me it was like the [makes a sound similar to a buzzing bell] … You know… life and, and sss… and sparkles flew. I've ne… and that's just… resonated in me in such a way… on that particular moment, [sound of striking of a tabletop with a wooden ruler to accentuate the point being made once for each word] of that particular day, of that particular point in my life that everything changed. Everything changed for me from that first, first, first day (RPA).

A powerful revelation of God's abundant love and forgiveness was also evident in the particular moment described by RPC. In narrating about a Biblical/Scriptural session with the facilitator at the rehabilitation facility.

> But he was telling the story about the Cross, and I just remember it hit me. The story what he was telling it was just… and I don't know exactly what he was speaking… but it was about… he was telling about something about the Cross. And, and it hit me… actually how amazing it was what happened at the Cross (RPC).

Her transformative journey began through her encounter with the story of the Cross (i.e., the Christian gospel) being revealed to her in a personal, impactful way. The participant repeated the phrase “it hit me,” accentuating that powerful moment of impact through repetition. She was amazed by the experience and filled with excitement, enthusiasm, hope and awe.

RPB also recalled a spiritual moment for him after he had been admitted to the long-term rehabilitation facility for three months.

> I was looking at the flames… this massive bonfire and it was like in a corral… with these trees around and I was looking at the sparks going up… past the trees and, and, and… wha… that moment… where the Holy Spirit… and I could feel it (RPB).

Later in the interview, the participant confirms that flames have a symbolically spiritual meaning for him.

> The, the, the flames are eternal life.
>
> I knew at that moment: ‘Okay, I know what… I know what this means. This is God. This is, this is spirituality. This is… okay you need to go with the process now’ (RPB).

It was at this significant moment that he surrendered and began his journey of change.

5.3.2 GET 3.b: Peeling the Onion

This converging sub-theme accentuated the extended, evolving, and dynamic recovery process. RPC used the metaphor of the peeling of an onion to depict her recovery journey.

Figure 14 portrays the act of peeling an onion as described by RPC.

Figure 14

Image Depicting RPC's Description of the Process of Journeying Over Time Which Encapsulates the Aspects of GET 3.

> It's a long, it's a long process. It's not a easy process. It's like an onion… because you peel away one layer and then tomorrow you find yourself… I know, you know, I'm in that place again where… I… I'm stuck. And then you have to go back again... you know, and then you peel another layer away. It's a journey. It's not just something you… ah… you… ek meen [reverted to Afrikaans] I mean… It's, ja, it's a journey. It's, it's like I say a peeling away of an onion. It's… what… how I read the Bible back then is not how I read the Bible now. Because you change and, and you grow, and you experience things differently (RPC).

This descriptive imagery includes the concept of multiple layers, and as one layer is peeled back, another layer is revealed. She emphasises the difficulty of the process, with aspects of the self being exposed and confronted. The shedding of tears when peeling an onion could also relate to the discomfort, vulnerability, and unpleasantness at times of the ongoing journey. RPB commented on some of the struggles he continues to face as consequences of his irresponsible choices during active addiction. As quoted, RPB had spent large amounts of money on drugs in the past. As already stated, with him having left the corporate world with the loss of a high, stable salary, his insecurities increased, his drug use increased, and he became entrapped in a vicious cycle. He continues to struggle financially in self- employment as he endeavours to recover financially and move forwards with his changed sober lifestyle.

> Ja, so it's been a struggle, hey. Financially it's been a struggle.
>
> So, so ja… I come from corporate… um… I left corporate in twenty… eleven opened a, a, a restaurant… sold it that restaurant and then I went

> to rehab… um… tried… ah… tried to start something and it's been… ja. It's been a bit… ja, it's been a tough 4 years (RPB).

RPB accentuates the notion of a changed lifestyle being a continuing process and journey over time.

> You know… life's a process… growing a business is a process. Growing a relationship is a process.
>
> People don't understand that recovery is a journey… and I only learnt that in rehab. But I'm… I'm being… that journey or the understanding of journey is actually… getting… better and better and the understanding… because of my time out, out now and, and consistently being connected and staying plugged into… my recovery group (RPB).

RPB here reiterates the importance of ongoing attendance at his psycho-social support group (as discussed under GET 2).

RPA and RPC both voluntarily spent extended time at their respective rehabilitation facilities and voluntary follow-up half-way homes. They both knew experientially that time in recovery is an important criterion that fosters significant and healthy lifestyle changes. RPB would also have spent more time as an inpatient in his rehabilitation facility if he could have afforded the cost. He, too, experientially knew this healing journey occurs over time, and therefore, also spent another six months voluntarily in a half-way home.

> So, I stayed another month there although I had finished my programme… and then… I still was my decision as well, to go to half- way house… for another month. (RPA)
>
> Um, well it was six months in um, let's say the core… rehab and then six months in the half-way house. Because I mean I, I needed to get this right. That's what I felt like (RPC).
>
> Went away for six months. I would have liked to stay for longer, to be honest… with hindsight but because I'm self-funded both, all three rehabs… um… um… finances… financially I wasn't… I cou… I couldn't afford it. Then, then I went to… a half-way house for… five or six months (RPB).

In describing the change that occurred over time, RPC juxtaposed her original sense of feeling fragile and vulnerable with newfound strength and solidness.

> And this is after [rehab name] … I've never felt that… I, that fragileness is gone. I must say strong. Will I say stable? Will I say… solid (RPC).

RPA reiterated her experience of change over time: After

putting in a few solid years in recovery (RPA).

It is noteworthy that both RPA and RPC used the word "solid" when describing their new, changing lifestyles. Synonymous with the idea of solidness is possibly the idea that their lives will no longer easily feel broken. They are now well-grounded and firm in their decisions and choices. RPA acknowledges that she confidently knows that her life has changed for the positive. This experience of continuously journeying in recovery is described by White (1996) as moving (emphasising, once again, the action and the growth involved) from a culture of addiction into a social culture of a changed lifestyle in a recovery community.

5.4 GET 4: Embodied Experience

The GET 4 Embodied Experience consisted of a single sub-theme: Feeling it physically.

All three participants' experiences described the physical/tangible manifestations of concepts that they identified as being spiritual. As discussed in Chapter 3, the works of Merleau-Ponty (2012) and Gendlin (1991), among others, emphasise the significance of gaining an understanding of phenomena by acknowledging humans as embodied beings.

This converging sub-theme of having tangibly experienced a spiritually related concept within their physical bodies was apparent.

RPA described how her experience in her relationship with God had changed and grown. She recalled how her grandmother (not her parents) had insisted that she attend Sunday School in the RC Church as a child. There was a single incident she recalled and linked to spirituality.

> One experience of spirituality which was when I was a kid… ah… we had

> to go to Sunday school. My granny took me for my, for my First Confession in my life and I walked out of there… I must have been 9 years, no 8 or 9 when I went to Sunday school and I, a, as, as I did it… as I walked out I, I felt that I was floating. I felt so light that I was floating in the ground. I swear. After that I… and then it never happened again (RPA).

Interestingly, in her recollection of a brief encounter with what she termed 'spirituality', the experience was one of physical lightness and floating. In reflection, consideration was given to the concept of light, as being both experienced as the opposite of darkness (as discussed in GET 1) and having been recalled as a physical lightness, as opposed to what could be experienced as burdensome and heavy-laden.

It was only when her journey of recovery began that RPA's experience of the church changed again, from being boring to experiencing God as her Helper through His love for her. Her embodied experience in her relationship with God is evidenced:

> It, it became completely different experience for me because I could feel it. I could feel… the warmth in my heart when we were church and… you know it, it was completely different. Completely different (RPA).

She repeatedly linked spirituality to the heart as an embodied, universal symbol of love. She experienced an embodied sense of change at the core of the emotional being, i.e., the heart.

> …to leave an impact in, in the addicts' heart.
>
> The Spirit is going to help you. Just open your heart to it and pray.
>
> …bursting with like just joy in my heart (RPA).

Even in her cognitive commitment to her ongoing journey of recovery, she references her heart in emphasising her cognitive knowledge of the spiritual concepts of honesty, integrity, and self-love.

> I don't want to sound complacent, but I know in my heart I'm never going to use again (RPA).

RPB associated the moment (as discussed in GET 3) when he became

spiritually aware of the Holy Spirit, while in long-term rehabilitation, with his surrendering to the process and the beginning of his journey of recovery. In exploring his quote further, he gives a rich description of the sensory/somatic manifestations tangibly embodying that which he was aware of spiritually.

> So, when I was sitting around this campfire, I was looking at the flames… this massive bonfire and it was like in a corral… with these trees around and I was looking at the sparks going up… past the trees and, and, and… wha… that moment… where the Holy Spirit… and I could feel it. You know, you know your body… I've had those moments. I know what it feels like.
>
> So, so its… so when I… your body… it's almost like pins and ah… mm… ah, ah goosebumps… (RPB). Figure 15 captures this imagery.

Figure 15

Image used in the presentation at ECP2022 to depict the preceding quote of RPB which encapsulates the aspects of GET 4.

RPB goes on further to describe his embodied experience:

> …but its deeper in the bone kinda feeling so that you know that some… it's almost like some, something is taking… entering you, not taking over. Entering your body and you can feel a sense of… clarity and peacefulness and, and that's one thing… that we as humans… me as myself struggle to maintain. Is… that sense of… Godly peace… and I've had it in… so I know what it means, and I know what it feels like to… when the people say: 'You

> need to find peace in God' I know what it means. I understand it profoundly (RPB).

RPB knew the peace of God experientially. His physical experiences, including the sensation of goosebumps, together with a clarity of mind (his embodied forms of "clarity and peacefulness"), inspired him and moved him into actioning and fully engaging in his recovery journey.

RPC's embodied form of spiritual amazement and awe was experienced when she was baptised in the swimming pool at the long-term rehabilitation facility where she had been admitted. It was during a South African winter when the temperature of the surrounding air, and the water in the pool would have been extremely cold. She, however, described:

> And I also got baptised there. Yes, because I mean I come from an Afrikaans church. You don't get baptised. My goodness. Ja. Amazing. Mm… in winter (RPC).

RPC's inclusion of both the fact that her experience of baptism was counter-cultural to her traditional, religious Afrikaans upbringing where children are baptised as babies, and that it occurred during the winter season accentuates her sense of amazement at this embodied spiritual experience. She was invigorated and enthused by physically feeling something so different. The hope of authentic, significant change (difference) became tangible for her.

Although the participants' experiences all include physical manifestations, the divergence within the GET relates to the differences evident in the specific spiritual concepts that each participant associated with these physical manifestations. As discussed, RPA linked her experience to love, RPB linked his experience to peacefulness, and RPC spoke of her spiritual amazement and awe.

RPB was also the only participant who gave rich descriptions of the various tattoos inked on his body.

> And at that point I thought, just to remind me… so all these, all these markings on my arm are reminders of my brother but then I've… have to tell myself: 'Okay…' Ja, so it means… so, this is a rose that… a feather coz this… I'll give you down… I'll make you understand… it's a bird, a clock with

> my brother's dates on it… um… my brother's name… the flames, the wings. He was a soccer ball um… this here we did, we did because of his cancer… …um… he loved music… and this is just me… The, the, the flames are eternal life (RPB).

RPB linked intimate details of his life, including the traumatic loss of his brother, to specific symbols embodied as tattoos. These images function as permanent, daily reminders of significant aspects of his life story. His tattoos, for him, thus symbolically portray his lived experiences through this embodied art form.

The physical embodiment of change (as portrayed in various ways) from a place of active addiction to living life in recovery links to GET 5: Spiritual overflow: Living a new life.

5.5 GET 5: Spiritual Overflow: Living a New Life

The final GET was Spiritual Overflow: Living a new life. This GET consisted of two sub-themes:

a. attributes of a new life
b. inspiring and serving others

AA includes in the final step of the Twelve Steps that having had a spiritual awakening, the message is carried forward to others, with the principles being practiced and evidenced in everyday life (AA, 1976).

5.5.1 GET 5.a: Attributes of a New Life

RPA, RPB and RPC described what they experienced as the spiritual overflow of a new life. Virtuous growth and the embodiment of developing personal character strengths were evident for each in individual ways.

RPA's narrative included an emerging theme of forgiveness. She describes how she chose to forgive her husband for his affair.

> So, I, I forgave him. I made a conscious decision to forgive and move on (RPA).

And how, for her, forgiveness and healing were encouraged within the

faith-based community to which she belonged.

> Church helped me… deal with it… and heal from, and heal and forgive… him… you know… which… without that spirituality how would I? (RPA)

RPC described a process of self-forgiveness. As explained, she likened her journey to the peeling of an onion, whereby various layers of self- discovery occur.

> Um… just started to… make me realise that… there is forgiveness. I can forgive myself. I can let it go (RPC).

In the repeated use of the pronoun “I” in the above quote, she not only emphasises her forgiveness of self; but could also be describing a personal sense of agency, whereby she was cognitively making healthy choices and so beginning to re-establish a sense of personal, internal control over her life and future well-being.

The character strength of forgiveness is classified under the virtue of temperance, as is the character strength of humility, as strengths that protect against excess (Peterson & Seligman, 2004).

When considering a lifestyle change from the patterns of bondage associated with addiction, where instant self-gratification and overindulgence of personal vices and pleasures are indicators of the related emotional struggle in addiction, then the awareness and nurturing of the virtue of temperance are necessarily important.

RPB repeatedly expressed how he had been humbled through his ongoing journey of healing. He also showed insight and self-awareness regarding knowing this was what he needed.

> Ja, completely. So… so, from used to earning good money… to struggling financially it’s… humbling.
>
> I needed to… be humbled by youngsters telling me what to do. I had guys younger than me telling me what to do (RPB).

Character strengths classified under the virtue of transcendence (Peterson & Seligman, 2004) include gratitude and hope. These strengths link to the

appreciation, understanding, and provision of the meaning of life.

The expression of gratitude was apparent throughout RPB's interview. He had experienced life addicted to cocaine and was overtly humbled and grateful to be living this changed, new life.

> I thank God I've got a bit of understanding about this stuff.
>
> …and I… because I think I'm older as well that I… and thank God that I'm on the right path, is that I'm able to identify where I'm doing wrong and where I'm not doing wrong.
>
> I honestly… and… and thank God… because people that, that have never had that.
>
> Lea, I'm-I'm-so… I'm so… grateful for this opportunity (RPB).

This sense of hope and optimism towards life and a changed sense of self was shared by RPA and RPC.

> To heal and to turn my life around, and to be who I'm supposed to be. Coz I was definitely… I was a wreck (RPA).
>
> I was good. I, I was feeling good. I was… I was happy. I had hope. I had the future in front of me (RPC). Figure 16 portrays the hope and future that RPC spoke of.

Figure 16

Image Used in the Presentation at ECP2022 to Depict the Preceding Quote of RPC Which Encapsulates the Aspects of GET 5.

For all three participants, life in recovery has included hope, meaning and

purpose. The second sub-theme of this GET 5 is converging, whereby an aspect of the purpose and meaning of life includes:

5.5.2 GET 5.b: Inspiring and Serving Others

The twelfth step of the AA Twelve Step programme includes “Having had a spiritual awakening as the result of these steps, we tried to carry out this message to alcoholics, and to practice these principles in all our affairs” (The Twelve Steps: A Spiritual Journey, 2012, p. 211).

The participants shared this desire to encourage others by sharing their stories and mentoring others struggling with addiction and the related havoc and devastation that seems synonymous with the addictive culture and lifestyle (see GET 1). They are all engaged in actively implementing the twelfth step as part of their journeys.

RPA stated:

> I’m there because I wanna help. And I know that’s what I experience and… restoration… I wanna inspire others (RPA).

> Because I want to give back.
>
> I mean, I’m no - I’m no expert but I’m on a journey of my-my-myself but I… all I can is unplug and-and-and share my experiences (RPB).

For RPC, her newfound zest for life and inspiration to others was evidenced in her description of how she had inspired her boss with her physical and mental vitality. As shown in the last quote in the tabulation of the GETs. RPC states how her boss commented:

> He said, ‘You come into every meeting, and you are so… happy and you are so… you’ve got this energy about you. How is it possible… how do you do it?’ (RPC)

He was an important witness, who could testify to her vibrant attitude and positivity.

In the participants’ changed perspectives of how they presently make sense of their lives, they can all provide wise counsel and embody a sense of hope and

enthusiasm to share with others.

Chapter 6: Discussion

6.1 Model Framework: A Journey of Shared, Enthused Energy

In reviewing the findings (as presented in Chapter 5), the interactive and reciprocal nature of the five GETs becomes apparent. The participants in this study were asked to describe their lived experiences of spirituality in their recovery from addiction. Each of these GETs represents both converging and diverging experiences of spirituality. With the overlap and integration of these themes, the researcher's experience as a clinical psychologist and the experience of COVID-19 (see Section 1.2), an ethical, sustainable, and interdisciplinary model is developed and proposed, where MHP engage in various ways in mobilising faith-based organisations to include psycho-education workshops and AR support groups. The model points to proposed, practical applications to spiritually-informed, interdisciplinary MHIs for AR in SA.

Based on the findings (as discussed in Chapter 5) of this study, the proposed model framework is encapsulated in the following words:

A journey of shared, enthused energy.

The composition of these words was specific and derived from the findings to create the descriptive naming of the framework.

A – The word 'A' points to the singular nature of the journey. It is an individual and personal journey for each person. This links to the idiographic nature of IPA committed to analysing each individual case in-depth, including the details and salient meanings that are specific to the individual's lived experience (Smith & Nizza, 2022).

Journey – This word includes:

1. the ongoing journey of each individual in recovery, journeying together with significant others,
2. the personal journeys of MHPs as they learn and grow in knowledge and shared understanding regarding AR, and
3. the journey of MHPs in ongoing collaboration with other persons committed to the healing of those in recovery.

The word 'journey' links to GET 3.b (Chapter 5), which emphasises the converging theme that healing takes place over an extended period of time, and incorporates an unfolding, dynamic process of change. The word 'journey' further denotes movement or travel from a specific point to another. In reviewing the findings, each individual journey gained momentum and direction through continuing, intentional self-awareness and self-reflection. Improved emotion regulation, healthy boundary setting, and functional decision-making were evidenced over time. All three participants spoke of ongoing, mindful self-awareness moving forwards:

> Hold on I still have my warning signs. Ja, I've still got all my stuff here. Ja, I know what my warning signs are and what my default settings and what my tends, it is all stuff that I learned from the programme and from [RecoveryGroupName1]… so, I know how to catch myself now… you know, that if I'm delving like negative thoughts… ah… Stop it!... and I pray over it and… you, I overcome it (RPA).

> I hated being in that place so, I am very aware of what I can do and what I can't do so I won't touch alcohol, I won't be extreme… um… I'm, I'm very cautious (RPB).

> I, you have to think what you think about. You cannot just… allow yourself to think about… not liking yourself. You have to… you cannot allow yourself to have negative thoughts. You have to think about what you think about (RPC).

of Shared – 'of shared' speaks of an experience being experienced by more than one person. This experience includes both the relationship, as in a relationship with God or significant others, and/or the relatable aspects or commonalities within a relationship, such as the commonalities between members of an AR support group.

GET 2.a and 2.b (in Chapter 5) clearly show the importance of relationship. This includes relating to God, family and community, MHPs and others. RPA and RPB both emphasised the shared support of others in their recovery groups. O'Connor (2016) describes how "If good recovery groups show us anything, it's

the difficulty of hiding from yourself when you're surrounded by people who share similar experiences" (p. 58). It is in the sharing that feedback is given, any denial is exposed, and personal insight is gained. Increased insight and shared knowledge also need to continuously be sought by all those involved (including MHPs and facilitators) in any intervention in AR.

Enthused - Merriam-Webster (n.d.) defines the adjective 'enthused' as feeling or showing enthusiasm. Following this, the definition of the noun enthusiasm includes being a strong excitement of feeling that it inspires zeal, and that it includes a belief in special revelations of the Holy Spirit. The word enthusiasm is derived from the Greek word 'enthousiasmos', meaning “inspiration or possession by a god” (Merriam-Webster, n.d.).

For this study, the word shows the interactive nature of the GETs. The lived experience of each participant includes a specific spiritual moment linked to an encounter with God (GET 2.a and GET 3.a), where there was an embodied (physical) response by each participant in different ways (GET 4).
This encounter initiated a motivating sense of excitement and eagerness to ongoingly, through self-awareness and focus, change thought and behavioural patterns. This intentional focus was directed towards a new life trajectory (GET 5) for all the participants.

Energy – Each participant's experience pointed to embodying a new life. The vitality and actioning of this life are encapsulated in the word 'energy'. O'Connor (2016) states that "Living in recovery is living with passionate commitment" (p. 123) and that "Commitments are dynamic because they also need to be embodied in action" (p. 128). There needs to be continuous forward movement and growth in this changing, new life. The spiritual experience of this journey of recovery is dynamic, energising, vital and alive.

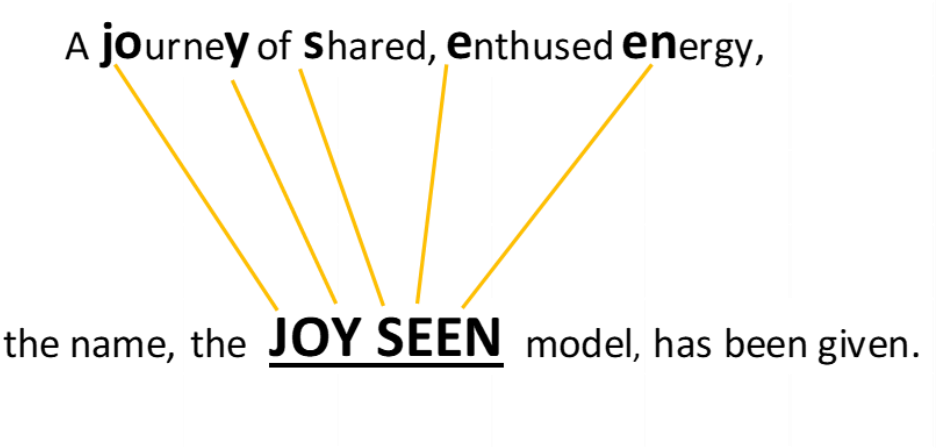
From this framework, as described above, a model is proposed. The model's name was derived by combining certain letters from the framework representative of the five GETs.

6.2 The Joy Seen model

From the words of the proposed model framework ‘A journey of shared, enthused energy’; the proposed model name is developed (see Figure 17).

Figure 17

Proposed Model Name Development.



The Joy Seen model points to the joy the participants had seen, experienced, and are embodying in personal, lived experiences in AR.

Narratives that included the depths of despair, loss, disillusionment, and shame in active addiction, unfolded with moments of joy. C.S. Lewis (2016) states it is important to distinguish joy from both happiness and pleasure. For him, the only common characteristic is that once a person has experienced it, the person would want it again. Dalai Lama and Tutu (2016) describe how the Archbishop, a spiritual leader, described joy as being much bigger than happiness. He described the difference between the two to include that happiness often depends on external circumstances, while joy is a state of mind and heart. The Dalai Lama, a spiritual leader, agreed with the Archbishop that ultimate satisfaction and meaning in life include the learnt wisdom of living with joy. "…we can transfer joy from an ephemeral *state* into an enduring *trait*, from a fleeting feeling into a lasting way of being" (Dalai Lama & Tutu, 2016, p4).

Where happiness and pleasure are circumstantial and short-lived, a sense of joy encapsulates long-lasting peace, contentment, serenity, hope and enthusiasm. The participants expressed their aspects of joy as follows:

Bursting with like just joy in my heart coz, like…

I see it working… I've just… like a new serenity (RPA).
And you can feel a sense of… clarity and peacefulness… and, and that's one thing… that we as humans… me as myself struggle to maintain. Is… that sense of… Godly peace (RPB).

It gave me presence, it gave me… I think hope.

I had hope. I had the future in front of me (RPC).

The proposed Joy Seen model, developed out of the findings detailed in Chapter 5, aims to enhance current MHI in SA for those struggling with addiction. Certain identifiable shortcomings became apparent through the in- depth, iterative data analysis process that included the meanings of the participants, and the researcher's meanings, interpretations and personal experiences.

These shortcomings included:

1. a lack of spiritual awareness and competency among some MHPs,
   Okay so, my dad's bipolar so that means that I'm bipolar, you know… and that's bullshit …that's part of the psychiatry that I don't… that I… I've got to be honest I detest.…ah when it comes to… to addicts. Not everybody is bipolar. (RPB)

   RPB was angered by what he perceived to be the overprescription of medication to treat someone who has a history of addiction. Other aspects of treatment, including his spirituality, were being overlooked and
2. a lack of formal training/education and supportive supervision of many persons involved in facilitating SHGs for AR
   …and then I got having therapy… with [TherapistName1]… and [TherapistName2] and then slowly I start… we start working in our marriage, our relationship improved… um… and I start feeling stronger, you know… (RPA)

   Although RPA was involved with her SHG (Christian faith-based), she experienced the need to attend concurrent professional

psychotherapy to enhance her healing journey.

6.3 Components of the Model

The proposed Joy Seen model consists of eight significant components emanating from the study. The specific delineation and naming of the components was an unfolding process over time.

The backdrop to the research included the researcher's personal history (as the mother of a son who struggled with addiction) and her professional experience (as a registered clinical psychologist) (see Section 1.2). Findings from the study included the research participants' lived experiences of spirituality in MHI for AR. Interpretations and meanings of these findings were further impacted by the contexts of the COVID-19 pandemic, the researcher's ongoing experiences within clinical psychology private practice in SA, and the facilitation of recovery support groups in various contexts (including faith-based communities).

Further feedback and learnings gained during her attendance and presentation at the 17th European Congress of Psychology in Ljubljana, Slovenia in 2022 were considered and incorporated into the development of the model. The components address the above shortcomings and will be discussed separately. This discussion will be followed by a graphic representation illustrating the interconnections between them and the holistic nature thereof. The eight components include:

1. HPCSA: the regulatory body
2. Dual diagnosis: acknowledging comorbidity in treatment
3. Training of MHPs
    a. Additional training in dual diagnosis
    b. Additional training in a biopsychosocial-spiritual perspective
4. SHGs and the facilitators thereof
5. Confidentiality: an ethical and legal right
6. Spiritual bypassing: a culture of denial
7. Introducing competency-based, supportive supervision
8. An integrated and interdisciplinary collaboration

6.3.1 HPCSA: The Regulatory Body

The HPCSA is the regulating authority over the health professions in SA. MHPs including psychiatrists, clinical psychologists, other categories of psychologists, psychometrists, occupational therapists and registered counsellors, need to be affiliated and registered, as a prerequisite for any and all professional mental health practice(s) (HPCSA, 2022).

6.3.2 Dual Diagnosis: Acknowledging Comorbidity in Treatment

In this study, axis 1 diagnoses, as classified in the DSM-5 (APA, 2013) that were experienced and discussed by the participants, included, SUD, SID, MDD, BMD, PTSD, ADHD, and OCD. The participants all reported having experienced symptoms indicative of dual diagnosis (GET 1), where SUD or SID occur comorbidly with other psychiatric axis 1 and/or axis 2 diagnoses.

The complexities involved in these diagnoses include identifying the nature of the relationship between the SUD or SID and the other condition. Weich and Pienaar (2009), in research done in the Western Cape, South Africa, describe the prevalence of this complexity. Sometimes mentally unfit people use drugs to self-medicate their symptoms. While others who are primarily addicted to substances develop other secondary psychiatric conditions. This complexity needs to be acknowledged and addressed, as persons with a dual diagnosis typically present with varying negative outcomes. They further include increased aggression, high rates of non- compliance to treatment, more carer distress, more homelessness, increased Human Immunodeficiency Virus (HIV) infections, and increased suicide risk, as some of these outcomes. They add that in SA, few dual diagnosis patients receive adequate intervention for their comorbid conditions.

Anic and Robertson (2020), in research in the Gauteng region of S A, confirm the high prevalence of psychiatric inpatients with comorbid SUDs.
Their concerns include the inadequacy of diagnosing SUD only when comorbidity is present. For improved service development and clinical implementation, an integrated dual diagnosis treatment approach is recommended, with collaboration between service providers and stakeholders involved.

Findings (as presented in Chapter 5, with particular emphasis on GET 1)

confirm the need for implementing dual diagnosis intervention programmes as part of the recovery journey.

6.3.3 Training of MHPs

6.3.3.1 Additional Training in Dual Diagnosis for MHPs.

In South Africa, minimum standards for formal education and training standards and competencies for MHPs are regulated by the HPCSA and professional boards. It is proposed that minimum standards in university curricula place further emphasis on additional training in dual diagnosis.

Akindipe et al. (2014a) show that 71% of the world's population living with HIV reside in Sub-Saharan Africa, with SA being one of the three countries with the highest number of people diagnosed. They add that in addressing treatment protocols, more focus needs to be placed on People Who Inject Drugs (PWIDs) and drug addiction, as illicit drug use is a huge health concern in Africa.

This requires the provision of drug abuse prevention and treatment services, including harm-reduction, training and capacity building in drug addiction, and provision of reproductive health care services for drug users (Akindipe et al., 2014a). Additional addiction medicine training in dual diagnosis is corroborated by Weich and Pienaar (2009) in emphasising the importance for medical students and psychiatric registrars to recognise and manage substance disorders, and by Anic and Robertson (2020) in discussing how clinicians were inconsistent in diagnosing and treating the severity of a comorbid SUD among psychiatric patients.

6.3.3.2 Additional Training in Biopsychosocial-Spiritual Approach.

As shown by the GETs of this study, including spirituality in addiction treatment is significant. A further aspect of the training of MHPs that needs consideration includes incorporating a biopsychosocial-spiritual approach to training and treatment intervention. The inclusion of a spiritual perspective implies cross-cultural diversity and competency.

South Africans are culturally diverse, with vast differences in spiritual/religious beliefs, rituals, languages, food, and socio-economic demographics. Cultural competence includes understanding one's cultural heritage

and implications thereof, through in-depth self-reflection. These reflections regarding one's cultural group belief system and the related cultural perceptions thereof, better position one to respect cultural diversity, including the spiritual beliefs of others (SAMHSA, 2014).

The training of MHPs would necessarily need to include self-reflective work regarding personal, cultural and spiritual beliefs, with the relevant clinical supervision providing the context to acknowledge and respectfully explore differences and biases in cultural and spiritual beliefs as part of the university training curricula.

6.3.4 SHGs and the Facilitators Thereof

Various church-led and faith-based AR support groups are currently functioning throughout SA. Most of these groups are facilitated by pastoral and/or lay counsellors, addiction recovery/life coaches, those in recovery from addiction themselves and volunteers. These groups are functioning in person and online.

SHGs are important contexts where members encourage and support each other by sharing personal experiences. A context for developing coping mechanisms is promoted through the experience of a sense of belonging and safety (Yalom & Leszcz, 2020). Although many facilitators of these groups are voluntary members of associations related to AR, such as the Association of Supportive Counsellors and Holistic Practitioners, Board of Addiction Professionals South Africa and Council for Counsellors in South Africa, these associations are currently not mandated by law as regulatory bodies. The implication is that facilitators are not held legally accountable for upholding ethical principles regarding working with a vulnerable group of people with a high risk of comorbid mental disorders.

Within the model, a proposed collaboration between MHPs with formal training and registration with the HPCSA and other persons facilitating SHGs will be addressed later in this chapter.

6.3.5 Confidentiality: An Ethical and Legal Right

One concern addressed in this model is the ethical principle of confidentiality.

The National Health Act 61 of 2003 states that all patients have a right to confidentiality, and this is consistent with the right to privacy in The Constitution of the Republic of South Africa, 1996. Registered MHPs are regulated by the ethical rules of the HPCSA (2016c), which include that a practitioner may not divulge information regarding a patient without the written consent from the patient.

Many SHGs for AR in SA require members to complete biographical documentation when initial contact is made. Many of these forms include a confidentiality clause that allays some of the apprehension felt by vulnerable persons on entering a group context, particularly within the location of a church or faith-based organisation.

First, in these locations, many vulnerable persons who struggle with addiction often struggle with shame, guilt and self-doubt. Confidentiality is comforting, as personal stories will seemingly not be shared or judged by people who may be perceived as self-righteous within the church. Second, there can also be an unsaid sense of trust in these contexts, as they are often socially accepted as comprising of members who are trustworthy and upholding moral principles.

However, as most church-based and faith-led SHGs are not regulated by law, the understanding and practical implementation of confidentiality as part of group process remains limited. This can become problematic and potentially harmful for those struggling with substance use and other mental disorders, and their supporters.

I recall in 2014, when Jarryd first entered rehab, I was told that as part of the programme, as a parent, I would need to attend a specified Christian-based SHG once a week for a certain period before being allowed to have telephonic contact with Jarryd. Feeling overwhelmed by simply accepting that Jarryd was in rehab, entering an almost obligatory group context felt intimidating and anxiety-provoking. As a supporter of an addict, I also signed an agreement that included a confidentiality clause. Within a few minutes of the group commencing, the facilitator and a few members started speaking about someone who had attended the previous week and was not present that day. The person's name was mentioned, as details from the previous meeting were discussed. The

registered clinical psychologist in me immediately kicked in, and I felt horrified. I felt numb and silenced, as there was no way I could trust people who might speak about my details in the same way in my absence. My sense of loneliness and helplessness at that time was magnified, instead of being supported, due to what I perceived as an untrained misconception of the principle of confidentiality.

Telehealth medicine, as practiced by MHPs, particularly during and following on from the COVID-19 pandemic, is also regulated by the HPCSA (HPCSA, (2020). Online communication between health care providers and patients is regulated. For example, WhatsApp texting needs to function within the legal bounds of confidentiality. This principle becomes increasingly difficult to uphold when WhatsApp groups run concurrently with face-to-face group meetings. A lack of knowledge and understanding by untrained facilitators of SHGs can result in an unintentional breach of confidentiality.

My personal experience of co-facilitating an AR group within a church context, and the concurrent use of a shared WhatsApp group with members of the group ended with me ultimately leaving the group (both on the online platform and face-to-face). This was due to my concerns as a registered clinical psychologist with the ongoing breaches of confidentiality and the potential emotional distress and/or harm being caused. Although WhatsApp has recently changed the settings on the platform, at the time of this incident, everyone on the group could see when someone had been removed by the group administrator from a WhatsApp group. In this instance, in particular, this occurred without any shared explanation on the platform with other members. This 'removed' person was then named and discussed in future face-to-face meetings, without any explanation of context, or respect of boundaries having been maintained. Unfortunately, due to power differentials within the church context, any concerned feedback from myself was deemed critical and unnecessary and was consequently, overlooked.

> This saddened me both as a church member and as a psychologist as I witnessed the noticeable emotional distress and psychological hurt experienced by other vulnerable and exposed members of the group.

The concern regarding confidentiality in SHGs will be discussed later in the chapter as part of supportive supervision and collaboration between MHPs and other facilitators of recovery support groups.

6.3.6 Spiritual Bypassing: A Culture of Denial

As part of working through the underlying psychological aspects of addiction, including trauma and loss, towards an active rebuilding of one's life, the pain can often feel emotionally overwhelming. An inability to tolerate the intensity of the related feelings, can result in the unfolding of a process of avoidance where the intensity of the emotional experience is circumvented and denied.

Although engaging with one's faith and belief system is meaningful as part of the fulfilled restoration, over-spiritualising can also be another psychological defence mechanism to circumvent addressing the emotional distress and psychological roots thereof. Welwood (1984) calls "this tendency to try to avoid or prematurely transcend basic human needs, feelings and developmental tasks, 'spiritual bypassing'" (p. 64).

Mathieu (2011) describes how spiritual bypassing becomes more about checking OUT than checking IN, although the difference is subtle, particularly for believers. As opposed to checking IN, self-reflecting and confronting the loss, the related emotional trauma, and the pain thereof, checking OUT involves avoidance and denial of the psychiatric/psychological reality.

Spiritual bypassing is a psychological defence mechanism where spiritual practices and/or beliefs are used to avoid and/or deny emotional wounds.

McKenna (2017) points to three reasons Christians often engage in spiritual bypassing. First, for some, there is a distorted belief that grace somehow destroys our human, sinful nature, undermining humanity's brokenness in withstanding the

temptation of sin and the importance of the interplay between the psychological and the spiritual. Second, facing real issues takes courage, with many people simply expecting God to solve the problem, and third, addressing underlying psychological wounds entails taking personal responsibility. In our fallen nature, a sense of entitlement can exacerbate the idea that somebody else (even God) should be taking responsibility for the pain and fixing it.

Linked to a sense of entitlement is the struggle for ego-centredness and the instant gratification and fulfilment of personal desires. Mathieu (2011) warns against the misappropriation of spiritual principles, such as prayer, in being used defensively to perpetuate the belief and need for instant gratification of personal wants. Spiritual practices, such as prayer, meditation, reading scripture and fasting, are all powerful and important tools in healing journeys. However, those struggling with addiction need to stay mindful of how and why they engage in these practices, particularly regarding the possible triggering of the "inner-addict" (p121) who may anticipate the high and seek instant fulfilment of needs through these practices.

The researcher's concern is that within SHGs that are only faith-based, with no kind of formal education and training, supervision, or intervention from MHPs, it seems plausible that the underlying group culture can become one of spiritual bypassing. Overt dual diagnoses may be overlooked and side-lined, to the ultimate detriment of certain individual's mental health journey and recovery.

Mathieu (2011) adds, "Spiritual bypassing involves bolstering our defences rather than our humility. Bypass involves grasping rather than gratitude, arriving rather than being, avoiding rather than accepting. It serves as a protection and as a roadblock momentarily, intermittently, or pervasively" (p 40). Spiritual bypassing as a cultural norm within an SHG can thus possibly serve as a roadblock on the journey to recovery from addiction for those in the group.

As confirmed by the research findings (see Section 5.5.1), with the existing body of evidence, core values such as gratitude and humility need to be addressed and strengthened as part of this vital new life in recovery. Pseudo-presentations of gratitude and humility (which could be more about grasping and bolstering ego defences) may mask a lack of knowledge and competency or deny

underlying emotional trauma and pain. This process could become the norm in an SHG where facilitators have no supervision, no regulated registration, and/or accountability to a regulating authority.

The HPCSA, through professional boards, in accordance with statutory regulations, enforces an ethical code of practice with policies and standards for health intervention. For example, the primary purpose of Regulation 993 of 16 September 2008 (Regulations defining the scope of the profession of psychology), was "intended to rather protect an unsuspecting public from unregistered people – who fall outside the regulatory purview of the Board from performing psychological acts that have serious consequences" (Clinical Psychologists Forum, n.d.). The HPCSA holds a core value of protecting the public and guiding the professions.

6.3.7 Introducing Competency-Based, Supportive Supervision

In seeking to address some of the previously discussed shortcomings, the Joy Seen model, includes a proposed intervention of competency-based supportive supervision of the facilitators of church-led and faith-based SHGs (including pastoral and/or lay counsellors, addiction recovery/life coaches, those with lived experience in AR, and other relevant volunteers). It is proposed, as indicated by the words in the framework of the model, that the journey in the field of AR needs shared, enthused intervention. Findings of this study (particularly GET 1) indicate that this intervention would be best served by the inclusion and collaboration of registered MHPs, who, through formal training and clinical experience, could help to avoid underlying DSM-5 psychiatric/psychological issues being overlooked when working with those in AR.

Assegaai and Schneider (2019) describe the current implementation of supportive supervision as part of South Africa's national community health worker programme. It was found that although the critical need for supervision and support was evident, the current policies in place lacked specific guidelines regarding the implementation thereof. Avortri et al. (2018) reviewed some difficulties in implementing supportive supervision interventions in low- income countries within the African context. They discuss how part of quality health care supportive supervision, is imperative and should be implemented ongoingly over

time. Varying cultural, social, organisational and contextual factors need to be considered, as these affect the efficacy of the intervention. O'Donovan et al. (2021) showed current challenges in the supervision of volunteer health workers in Uganda to also include a lack of specific guidelines on the supervision process. However, they added that supervision was linked to increased motivation among the volunteer health workers as they had felt valued and appreciated due to the supervisory process.

Supervision was also reported to hold voluntary healthcare workers more accountable. Ongoing training and personal development were supported by ongoing supportive supervision. Although these studies explore the narratives of community health workers, it is deemed appropriate to consider the findings to offer valuable insights into the roles and functions of recovery support group facilitators. These two roles overlap because both have undergone basic training in working with community members who need support and basic psycho-social healthcare intervention. Many of those involved are voluntary workers who receive limited or no monetary compensation for their involvement. Pedersen et al. (2021) state that in response to an ever- increasing global mental health burden, which includes resources and technical expertise, non-specialists (including community health workers, other professionals with limited mental health training, organisational staff and voluntary community workers) are needing to be assessed and trained in competency development.

In proposing to combine supportive supervision and the assessment and training in group facilitation competencies, a competency-based approach to clinical supervision as described by Falender and Shafranske (2011) is considered. Although clinical supervision guidelines, as described, relate to the training of MHPs (APA, 2014; 2015), for this study, the identifying of diverse competencies or outcomes to be monitored and developed for the upholding of ethical, evidence-based, psycho-social support have been considered.

Falender and Shafranske (2011) describe how competence includes having knowledge of a specific domain, being able to apply practical skills in that domain and includes the attitudes and values required to form competence for that domain. Domains include, among others, interviewing, relationships, diversity, ethics and professionalism. Basic training/course work and skills practice are, therefore, insufficient for ethical and sustainable mental healthcare delivery.

Instead, an ethical and accountable approach must include the ability to demonstrate competence (knowledge, skills, attitudes and values).

In clinical supervision, measurable, observable outcomes are assessed with emphasis placed on what has been learnt and can be competently implemented. This approach to supervision implies a collaborative stance between supervisors and supervisees, as reasonable learning outcomes are developed, implemented and assessed. Self-assessment becomes integral as part of the process, simultaneously developing the skill of metacompetence, and the understanding of the importance and continuing need to build competence. This is necessary for professional development and ensuring high-quality care that serves the best interests of all those receiving the healthcare intervention (Falender & Shafranske, 2011). The above discussion includes a prior agreement between supervisees and the supervisor on clearly defined variables to monitor competence. For example, it is envisaged that supervisees could agree to reflective process notes of debriefing sessions between co-facilitators following recovery groups being used to address specific challenges encountered as part of the recovery support group process, in the subsequent supportive supervision session with the supervisor.

Within the supervisory relationship, the supervisor would value, model and uphold ethical behaviour, including the principle of confidentiality (discussed earlier in this chapter as mandated by law), both in the development of the competence of the supervisees, and in the upholding of the best interests and mental well-being of the public. The supervisory relationship provides the context for shared learning, with the implication of openness to ongoing training by all involved.

As part of the Joy Seen model proposed, it is also envisaged that in SA registered clinical mental health interns, those doing community service, and MHPs could provide supportive supervision in a group format, both online (supportive telesupervision) and/or face-to-face, depending on the practical logistics thereof. Yalom and Leszcz (2020) includes as part of the benefits of providing group therapy supervision in a group format that "the participants' self-reflection on the supervision group can be very instructive in illuminating the dynamics of the therapy groups" (p 652). Challenges in facilitating AR groups can be discussed and normalised through shared experiences and support from

peers. Supportive telesupervision in a group format would facilitate accessing a greater number of recovery support group facilitators who meet in more remote areas of the country. Jordan and Shearer (2019) report that the benefits of telesupervision include the supervision of facilitators from more diverse and rural populations and shared learning with people who would otherwise be inaccessible. For practical purposes, the number of persons who could be accommodated within a group format would probably range between 15 and 20 persons, depending on whether the intervention was face-to-face or online. It is recommended that owing to the nature of online platforms, particularly when using mobile phones, a maximum of 15 persons would be advised for optimal group facilitation to occur.

For this study, owing to the COVID-19 regulations at the time, two of the participants in the research were interviewed online (see Chapter 4). Despite some challenges with technology, both participants gave rich descriptions of embodied experiences, with RPC feeling connected and comfortable enough to display personal details of intimate objects in her home.

I don't know whether you are able to see I've

got my verses stuck on the wall (RPC).

De Backer (2021) describes the benefits of online recovery groups established during the COVID-19 lockdown in SA to include a sense of community, taking responsibility, and the experience of shared compassion and care. It seems viable for online group supportive supervision of psycho- social recovery support group facilitators to be a plausible option within the South African context.

In addressing the sustainability of such a model within the South African context, the challenges of lack of funding and the need for continuous, ongoing intervention are considered. O'Donovan et al. (2021) include the need to address these challenges for increased efficacy of supportive supervision in community-based healthcare programmes. Owing to the current limitations of financial resources within the healthcare sector in SA, the Joy Seen model is proposed. This means the enlisting of clinical mental health interns and those currently undergoing their community service as part of the cohort of professionals who

would provide supportive supervision to the recovery support group facilitators. As the proposed cohort members are currently already state-funded through government-paid salaries, the potential additional costs of implementing this model would be significantly minimised. The remaining cohort members, being registered MHPs, would comprise those MHPs, who would avail themselves of incorporating voluntary, pro bono work (i.e., supportive supervision) into their clinical practice.

By including supportive telesupervision, travel costs involved in travelling to supportive supervision sessions for supervisors and recovery support group facilitators would be minimal, as the group supervision sessions would be held online. In suggesting how to improve supportive supervision, O'Donovan et al. (2021) recommend remote supervision using mobile phones. For this model, it is suggested that data coverage costs be funded, if possible, by the local church-led/faith-based organisation where the recovery support group was initiated. The sustainability of the model thus includes a collaborative, unified, working together of MHPs and others representative of church-led/faith-based organisations ongoingly. In further proposing the need for continuity as part of sustainability through ongoing collaboration, feasible time-frames are considered. Due to clinical mental health interns and those undergoing community service being employed by the South African government on an annual basis, their tenure makes it possible for each of them individually, to be available to their respective communities (including respective recovery support group facilitators) for supportive supervision for at least an uninterrupted 12-month period. This length of time would be deemed beneficial in initiating and developing stability and continuity between the supervisor and supervisees. An incoming supervisor will be available on an annual basis (as per legislation concerning clinical mental health internship and community service) to continue with the process, which will unfold in a new way given the changing group dynamics.

6.3.8 An Integrated and Interdisciplinary Collaboration

Ultimately, the Joy Seen model, points to an integrated and interdisciplinary collaboration between MHPs and pastors, self-help group facilitators (including lay

counsellors, addiction recovery/life coaches, those in recovery from addiction themselves, and volunteers).

In researching nyoape addiction in Gauteng, SA, Fernandes and Mokwena (2016) states the requirement for specific, integrated rehabilitation services to be developed. These should include issues relating to the personal behaviour of those struggling with addiction, their mental health, and ways of coping with the social environment. Mokwena (2015) shows how nyoape users post inpatient rehabilitation, often struggle as they return to unfavourable social environments, which promote relapse. In researching the specific aftercare needs of nyoape users in the Hammanskraal community, Mahlangu (2016) emphasises the importance of education and awareness as core elements in preventing relapse. Family members ought also to be assisted through life skills education on how to be involved effectively with the person who is struggling with AR. Khumalo (2021) adds that a collaborative approach where communities and related support structures aim to include harm-reduction measures, with other recovery interventions in curbing addiction to whoonga is needed. He adds that the strengths of the community members need to be validated in encouraging communal peer support. Professional interventions (including harm-reduction strategies) need to be formulated and implemented considering the underlying socio-cultural, political and economic factors that contextualise the abuse of substances and the related behaviours.

Akindipe et al. (2014b), in a study with participants from drug treatment centres in Cape Town, SA, emphasise the importance of an *integrated* care model in treating SUDs and other comorbid psychiatric disorders. Their concern with the present system in SA, where two separate and independent government departments manage those struggling with dual diagnosis, is a significant difficulty in implementing integrated addiction medicine and treatment programmes. The Department of Social Development manages those struggling with SUDs and SIDs, while the Department of Health regulates the treatment of those diagnosed with other comorbid psychiatric conditions. The importance of integrated care for persons diagnosed with a dual diagnosis is acknowledged and incorporated into the Joy Seen model. This is a possible way of facilitating a process of change where MHPs collaborate with others involved in the healing journeys of those in

AR despite some of the governmental complexities inherent within the healthcare system.

This study's interdisciplinary, collaborative endeavour envisages shared learning between the disciplines of Psychology and Spirituality. There needs to be an ongoing dedication to learning, with professional humility and self-reflection (Wampold et al., 2017), as all those involved in this collaborative journey work together to build unity and promote growth. Any dissention that cannot be resolved through healthy conflict resolution between those representing different disciplines will result in dissention and tension filtering downwards to the unsuspecting public and those attending SHGs, with the potential to cause harm to a vulnerable, high risk group of people.

Core competencies needed for interprofessional collaborative practice (Interprofessional Education Collaborative Expert Panel, 2011) have been classified under four competency domains, i.e., 1) values/ethics, 2) roles/responsibilities, 3) interprofessional communication and 4) teams and teamwork.

6.3.8.1 Values/Ethics for Interprofessional Practice.

Specific emphasis must be placed on values, such as mutual respect and trust, that underpin professional relationships. As discussed earlier in this chapter, the ethical understanding of the principle of confidentiality, within the context of SHGs (both face-to-face and online), for example, would be an aspect of this competency domain of interprofessional ethics that would need to be defined and upheld by all involved. As part of developing a climate of mutual respect, it becomes imperative to embrace cultural diversity and individual differences within and across the professions.

6.3.8.2 Roles/Responsibilities.

Owing to the complexity of healthcare intervention, there is a call interprofessionally for recognizing the limits of professional expertise, and the need for cooperation, coordination, and collaboration across the professions in order to promote health and treat illness. However, effective coordination and collaboration can occur only when each profession knows and uses the others' expertise and capabilities in a patient-centred way (Interprofessional Education Collaborative Expert Panel, 2011, p. 20)

This implies a well-communicated, clear delineation of ethical and legal

boundaries regarding the specific roles and responsibilities of all those involved.

6.3.8.3 Interprofessional Communication.

Using respectful language presented confidently and with clarity is necessary. An openness and active listening to others are fundamental to shared understanding. When communicating interprofessionally, it remains important to avoid the unnecessary use of professional, discipline-specific jargon. This type of jargon can become problematic as persons of other professions may not have an understanding thereof. Using jargon may also be experienced as creating professional distance by emphasising a perceived power differential between professionals.

6.3.8.4 Teams and Teamwork.

Interprofessional competency implies having the knowledge, skills and necessary attitudes and values to learn to be a good team player. Being a team member includes relinquishing some autonomy in collaborating with others in the team. The authority one has based on professional expertise should not be confused with or misinterpreted to represent power or status.

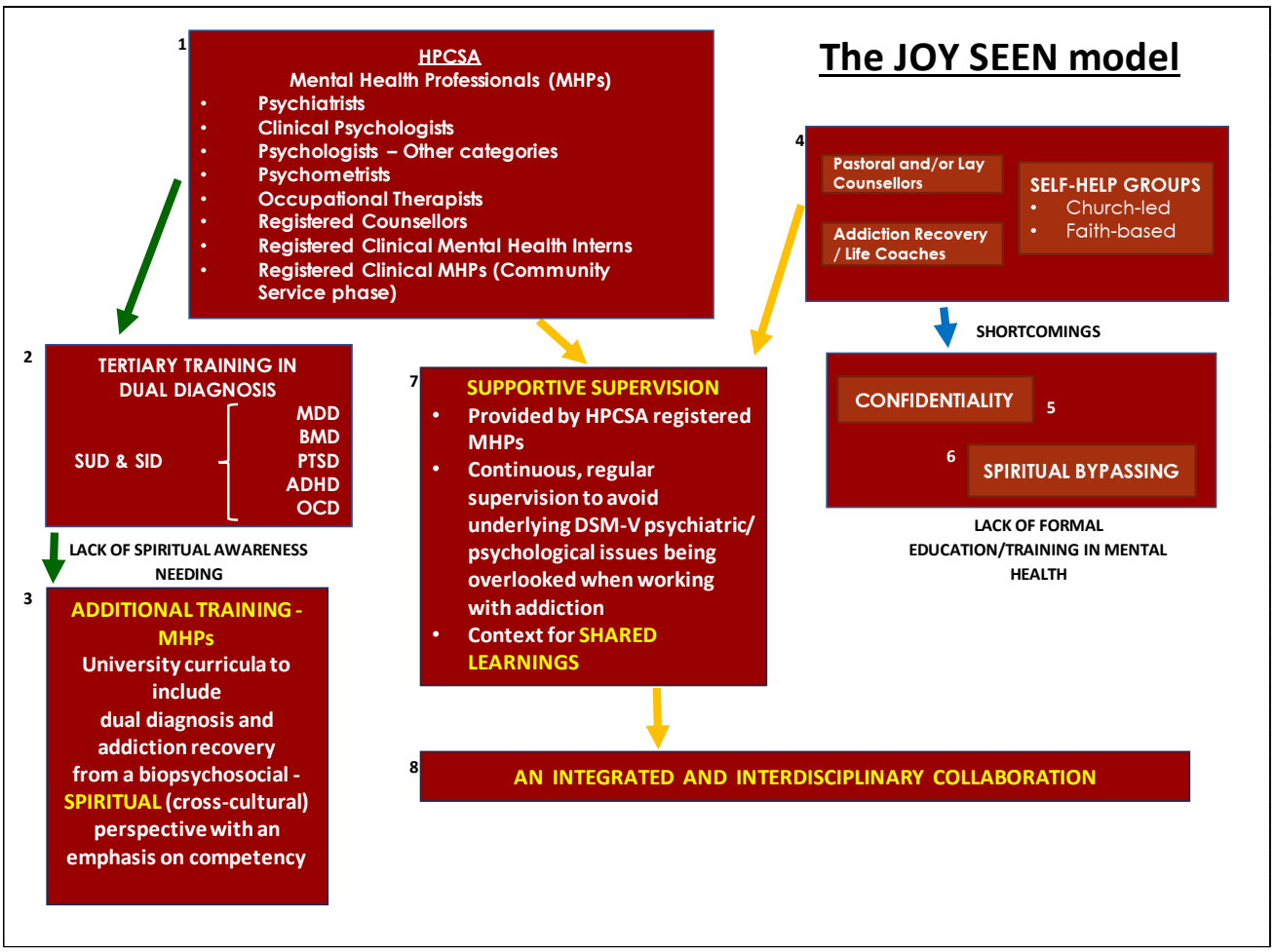
Team-based care thus includes shared problem-solving and shared decision-making that acknowledges diversity and the expertise of others in the team (Interprofessional Education Collaborative Expert Panel, 2011).

In reflecting on the Joy Seen model, it is envisaged that integrated and interdisciplinary collaboration is feasible. However, MHPs will need to remain vigilant against any misuse of the supervisory relationship for prideful selfish gain/advancement instead of humble, personal, and professional growth.

Because the model proposes a biopsychosocial-*spiritual* approach in the implementation thereof, self-help group facilitators of church-led and/or faith-based groups will need to guard against relegating the biological, psychological and social aspects to any position/level of lesser importance than the spiritual aspects. Instead, the spiritual needs to be viewed as an inherent, everyday aspect of life and wholeness. Figure 18 portrays a comprehensive diagram of the Joy Seen model.

Figure 18

The Visual Representation of the Joy Seen Model.



Note: The various components of the Joy Seen model are elaborated upon in 1. HPCSA (see Section 6.3.1); 2. Dual diagnosis (see Section 6.3.2); 3. Additional Training – MHPs (see Section 6.3.3); 4. SHG facilitators (see Section 6.3.4); 5. Confidentiality (see Section 6.3.5); 6. Spiritual bypassing (see Section 6.3.6); 7. Supportive supervision (see Section 6.3.7); and 8. Integrated and interdisciplinary collaboration (see Section 6.3.8).

Green arrows - this visual representation shows how HPCSA registered MHPs are trained in the assessment and treatment of SUDs & SIDs and comorbid conditions. For them, additional training in spiritual awareness when working with dual diagnosis and addiction recovery is needed.

Blue arrow – the facilitation of faith-based SHGs by pastoral/lay counsellors and addiction recovery/life coaches includes the lack of formal education and training in mental health. Problematic MHIs regarding confidentiality and spiritual

bypassing can occur.

Orange arrows – indicate continuous, regular, competency-based, supportive supervision by HPCSA registered MHPs of faith-based SHG facilitators where practical, clinically and spiritually informed, evidence-based integration, and collaboration of shared learnings can occur as part of healing towards wholeness for those in AR.

See Figure D1 for an enlargement of Figure 18 above.

Considering the fast and ever-changing digital landscape and worldviews on SUDs and behavioural addictions, the model will be viewed against this ever-evolving backdrop in continuing this discussion.

6.4 The Fast-Paced, Ever-Evolving Landscape of Addiction

In reviewing and re-evaluating the participants' lived experiences of spirituality in journeying in AR, it has become increasingly apparent that within a global atmosphere of continuous technological advancement and the related "fast-paced culture of conspicuous consumption" (Schalow, 2017, p. ix), it is necessary to briefly review the concept of addiction and its relevance to the application of the proposed Joy Seen model.

Wilshire (1998), in exploring the primal roots of modern addiction, speaks of human life still hungering for a primal connection to Nature and the regenerative rhythms thereof. He believes that addictions develop in an attempt to fill the void and emptiness experienced and caused by the loss of ecstatic connection to the regenerative source of human life. The repeated gratifying of this emptiness with substitutes leads to an adaptive process that is insidious, cumulative and destructive. Lacking the willingness to confront the pain or the underlying fears, humans continue existing in this vicious cycle or "trance of addiction" (p. xiv). He adds, "Missing is any sense that anything is missing. A restless somnambulism reigns" (p. xiv). A lack of conscious self and social awareness is pervasive. Attempts at understanding addiction have included the conceptualisation of wholeness to include the contradictory dividing or "conceptual chopping" (p. xv) of humans into mind, body and spirit. As shown in GET 4 and GET 5 (Chapter 5), embodied experiences in living a changed, new

life need to be conceptualised as a whole. He uses the terminology for humans as being body-selves. Body-selves are inherently supposed to be connected to the world. It is in this place of ecstatic connection that the integrated, cohesive self being awake and aware no longer needs substitute ecstasies (addictions).

Technological advancement, however, has dramatically increased the pace at which humans needs can be gratified. Schalow (2017) describes "the shadow of technology" (p. 91). Commenting on the work of Heidegger (1977), who was concerned about the dangers of the technological age including a radical change in humans' relationships to themselves and nature, he further emphasised both the revealing and concealing nature of cyber technology. As the instantaneous exchanges of information that captivate humans' desires are revealed, so too is the dangerous level of self-indulgent, instant gratification concealed.

In a capitalistic economy, where progress, status, and success are measured by financial gains, the fast-paced, global reach via technology magnifies the potential for humans to become increasingly used as resources for financial gain and become disconnected from self, others and Nature.
There seems to be an increasing loss in the ability to wait for anything. There needs to be an instant solution (quick fix) to everything, with more people surrendering to "periods of idleness and indifference, in short, to boredom" (Schalow, 2017, p. 101). Vital connection to a meaningful life can easily dissipate within a cultural framework of impulsivity, boredom, alienation and depersonalisation in this current digital age.

In considering substance use and behavioural addictions in this way, addiction can be viewed as a "signpost" (Schalow, 2017, p. ix) of the times. It is a warning of the lurking danger of this fast-paced technological culture that disconnects in its entangling web, but also a global indicator of the need to become aware of the danger.

In looking at this photograph of my granddaughter Cali and marvelling at her development and growth within a year, I am aware of the potential insidious dangers of too much screen time, particularly for little toddlers. 'Should I be video calling via online platforms to her so much? Will she even know me if I do not call her as much as I do?' However, I would like to believe that it is with shared awareness, conversations, and love that my daughter Kirsty and I navigate the physical distance between us through the vigilant use of technology in protecting little Cali's physical, psychological, social and spiritual well-being.

Human beings are faced with the challenge of individually needing to choose to reconnect with the self in a search for the personal and authentic meaning of each life in today's digital world. Mate' (2022) emphasises the importance of continued awareness and self-compassion on the road to finding meaning and healing. Even though the culture of today feeds off the maintenance of a stressful tension between a hardwired drive for attachment, despite the sometimes sacrificial and emotional cost thereof, and true authenticity, the individual has the "response ability" (p. 112) to choose a new way of being-in-the-world. He speaks of re-creating an imagined, different life; re-creating a life that is truly worth choosing.

Re-creating would include envisioning a hope-filled future. There would be a sense of meaning and purpose as described by the participants of this study in GET 5 (Chapter 5). As described by Wilshire (1998), technology often aids in sharing a sense of sacred connection through sharing beautiful images of nature seen visually (or even sharing video calls with a granddaughter in Australia). It remains the individual's responsibility not to become constricted by, and addicted to, the allure of the images in envisioning life holistically and meaningfully as part of the greater Whole.

The journey to recovery, if viewed as the rediscovery of the authentic self, thus includes the creating of "life-affirming meaning" (O'Connor, 2016, p. 154) by embracing and embodying this new way of living. It is knowing that within a culture of technology and instant gratification, there is the possibility of transcendence and authentic integration. It is also in the knowing that by embracing inherent traumas, sorrows and pains of life, the promise of transcendent joy exists beyond the constricting strongholds and bondage of addiction.

6.5 Meaning-Making: A Shared, Enthused Collaboration

Based on the previous discussion of the Joy Seen model, it is proposed that an integrated and interdisciplinary collaboration would need to aim towards creating authentic, life-affirming meaning for all those involved.

Wilshire (1998) describes how, from the Greeks, there are "two words that still inform our language, *poiesis* and *techne*. We translate both as 'making'" (p. 225). Where the end cannot be predicted, but the intrinsic value is revealed, poetic making, a true art form, exists. Where the end can usually be predicted, but intrinsic value and unintended consequences cannot be assessed, technical making exists. He poses the question of "whether certain technologies might wed true art forms and contribute to constructive and empowering myths of living" (p. 225). He proposes that a radical reorientation would be needed to 're-myth' life-making new wholes, where parts coordinate differently to empowering the regeneration of these new wholes. He also proposes that what would be needed would include a functioning community, where he includes therapists and theologians, among others, as part of "a new breed who might be called

'imagineers'" (p. 229). In the imagining of the Joy Seen model, it is hoped that MHPs, pastors, spiritual healers, lay counsellors, addiction recovery/life coaches, those who have struggled with addiction themselves, and other volunteers can imagine and become the parts of a functioning community that can orientate themselves in such a way so as to create life-affirming meaning through shared, enthused learning, in the formation of a newly, connected whole.

Within the proposed Joy Seen model, various ways of meaning-making by these 'imagineers', whether through *poiesis* and/or *techne*, are combined, integrated and collaborated (see Joy Seen model – *Figure 6.2*) in hopes for a new, unified way of making meaning and finding purpose through supportive supervision and the facilitation of AR SHGs in the personal journeys of healing for all involved.

I remember the night so clearly. It was mid-2016, a winter's night, on the streets of Pretoria, the capital city of SA. I had joined a small group of people who met weekly with a group of homeless people who gathered in a storm drain culvert under a road in one of the suburbs. Jarryd, who was already well acquainted with some people and often initiated sharing food, conversation and prayer, had invited me to join. My son knows my heart for people. He also has lived experience regarding my fears.

It was dark, with the only flicker of light emanating from a small fire kept alight by burning small pieces of plastic. I remember that initially, my senses were on high alert. I was vigilantly aware of every movement, despite not seeing much. It was as if time stood still as I listened to my heartbeat. I was consciously connected to my own body. There was a deep awareness of my connection to my son, too, as the familiarity of his voice and his ability to make others laugh echoed through the culvert under the road. The laughter was infectious and connecting. I began to speak with people. Some people were

sober and interested in what others were asking and saying. Could this possibly have been an alternative form of psychoeducation? There was no formal workshop needed, but instead, a small group where psychological expertise and knowledge about addiction, spiritual awareness and human connection were shared.

Some people that night were struggling with open, physical wounds. Most of those present were struggling with varying degrees of trauma and inner wounds. Despite vast differences in our stories, socio-economic differences and cultural differences, there was a shared sense of community for those few hours in this small, isolated group of people.

And then, one of the younger women who had also joined us and was known to me began to sing. Her voice was angelic as it reverberated against the walls of the culvert. Her songs were songs of praise and worship. For me, the presence of the Holy Spirit was tangible. People were touched and moved as so many different voices joined in. Some voices sang words; others simply made sounds. There was a connection through the music; deep, authentic, human and spiritual connection.

That night I knew with my whole being that a spirit of community for healing was possible, even if from humble beginnings within small, isolated groups.

6.6 Experiencing Spirituality: Transcending the Vice of Addiction

Erikson and Erikson (1997), in commenting on the works of Erik Erikson, the psycho-social development theorist, describes the final stage of life as moving towards becoming increasingly human; "we must discover the freedom to go beyond limits imposed on us by our world and seek fulfilment" (p. 126). Although his theory about this time of 'transcendence' is linked to old age, it is in his understanding that in this moving towards or rising above the burdening distractions of the modern world, the character strengths of honesty and steadfast humility are fostered. In further emphasising the aliveness and actioning of these

words, the beautiful and soulful description that "Transcen*dance* may be a regaining of lost skills, including play, activity, joy and song…" (p. 127) is used.

In likening this description to the narratives of the participants lived experiences of spirituality in this study, their evolving experiences included reflective and mindful journeying with God, self and others. These journeys were hope-filled and intentional, with personal responsibility being taken for setting boundaries both internally and externally, vertically and horizontally. There was movement and activity in rediscovering the authentic, lost aspects of each of their selves. By dancing through layers of pain and denial and honestly and humbly confronting the harsh realities of their lives in addiction, new possibilities and new lives emerged. Through the spiritual awakening of self-structures committed to the nurturing and savoring of life and peace; wholeness and connectedness were experienced (McGee, 2019). Dances of transcendent joy began to flow.

6.7 Implications of This Study: Strengths and Limitations

The findings of this study necessitate the acknowledgement and inclusion of spirituality as an innate part of MHI for AR in SA. Considering the current statistics on addiction, the current social-political climate and history, the current healthcare system and the effects of COVID-19, an ethical, sustainable and interdisciplinary model for spiritually-informed AR intervention has been proposed. A cost-effective way of implementing the model has been offered, including state-funded MHPs who collaborate with others (particularly from church-led, faith-based organisations) connected to the recovery journeys of those struggling with addiction. It is envisaged that ethical SHGs for these people, their family members and supporters can be implemented over an extended period of at least 12 months. The collaboration of interdisciplinary professionals also provides the context for shared learning and the development of creative and resourceful ways to mobilise and encourage community members to awaken to action through self-awareness, reflection and service to others.

The choice of an IPA research methodology was relevant to the phenomenon being investigated, i.e., the lived experience of spirituality within the context of MHI for AR in SA. IPA supported gaining in-depth insights into detailed

narratives of the participants' lived experiences regarding this phenomenon. All the necessary steps for an IPA were covered. Although valuable knowledge and future possibilities can be added to the existing body of knowledge, the findings cannot easily be generalised to any broader population, as the sample size was small, and the sample of participants was homogenous in nature. With such a small and homogenous sample, the depth and complexities of both similarities and differences between the participants need to be viewed with reference to the specific context of the study, with the reader then reflexively considering the degree of fit with other similar situations that might be encountered (Smith & Nizza, 2022).

Owing to the legislated levels of COVID-19 lockdown and their varying levels of in person restrictions imposed, the research study was interrupted and changed to accommodate these restrictive laws. The request for ethical clearance was resubmitted to include all COVID-19 protocols. The recruitment of participants was hindered by the pandemic, with its related restrictions and health implications. These globally experienced phenomena, at the time, may have given rise to the limited number of respondents.

A noteworthy detail regarding the homogeneity of the sample was that all the respondents, who became the participants for this study, were older than 45 years, even though the inclusion criteria had stated for 18 years and older.

> And… like now I'm the only… I'm las… I'm the oldest… I'm the one with the most years in [RecoveryGroupName1] group at the moment… (RPA).

> …the youngster that goes into addiction at the ages of 15, 16, 17, 18 haven't got the twenty years that I had of spirituality… it… harder for them to get… to understand what that… peace, surrender, ah… trusting in God… means… so it takes them so much longer to recover… they take so much longer to recover, and I see it.

> I mean, I'm no -I'm no expert but I'm on a journey of my-my-myself but I… all I can is unplug and-and-and share my experiences (RPB).

Erikson's description in Erikson & Erikson (1997) of the transcen*dance* of old age (see Section 6.6) is that through wisdom gained and life lived, the person

rises above and reaches out to the beauty of life in the imminent presence of death. The question is posed: Is it possible to link the participants' midlife experiences of the chaos of active addiction, their narrated near-death experiences and their transformative journeys of recovery to a deeper revelation of this transcen*dance*, and need to give back to society?

6.8 Potential Future Research

Following the previous discussion, further research exploring the importance of age as a contributing factor to self-awareness and continuing growth in spiritual maturity in AR may give rise to the possibility of significant, evidence-based research outcomes. Longitudinal studies, including various developmental stages, would further add significant data regarding the lived experiences of spirituality. As stated by Koenig et al (2021) much research is still needed regarding the age when R/S most likely affects mental health, and how mental health affects R/S over a lifetime. These bidirectional effects need further exploration.

With the diverse landscape of the South African context, the framework of the research study could be replicated with other small, homogenous samples, each representative of specific sociocultural and socio-economic groupings.

Future research could also include focusing on the experiences of spirituality for those who have struggled with addiction who are of different faiths (i.e. non-Christians) and/or non-believers in gaining further insights into the phenomenon in MHI for AR.

6.9 Critique of the Researcher

Over the course of the past four years as I have journeyed with the reading, researching, writing and rewriting of my PhD thesis, from cover to cover, my own life has been filled with moments of extreme personal joy and moments of extreme personal pain. Long hours of clinical work in my office with patients, in hospital wards with psychiatric patients, and in facilitating groups (including AR groups), brought moments of extreme vibrance and moments of extreme fatigue to my life. Both births and deaths of close family members occurred over the past four years. My own lived experiences, both prior to this research study and during the process itself, are necessarily nuanced between the written lines of this thesis.

In critiquing myself any hidden or implicit nuances can become clearer for the reader in gaining depth of understanding as part of shared meaning-making. Reflecting on myself (the researcher):

- as a believer in Jesus Christ.

  Living and making sense of my life from a Christian perspective may have impacted my initial connection to the participants in assuming that we already shared some fundamental meanings about life.
- as a formally trained, registered and experienced clinical psychologist working fulltime with a wide demographic of patients (see Table 1)
    - I remain legally bound to be self-aware and vigilant of my potential biases and the impact thereof on treatment. These biases (such as assuming that because Christians share fundamental beliefs, their meanings about life should be similar) were then regularly addressed in personal supervision.
- as a woman, wife and mother.
    - Through ongoing self-reflection during the research process, I became aware of my subtle bias with regards to gender differences. My personal story seemed to enhance my compassion towards the female participants, particularly with regards to themes of emotional abuse and deception. Again, however, this bias was made overt, and addressed in supervision.

As this research study began prior to the COVID-19 pandemic, and was completed after the pandemic had ended, I, as the researcher remained flexible and open to the unfolding changes and uncertainties that were presented as part of the research context. Masking and unmasking; a physical and symbolic representation of hiding and revealing, of addiction and recovery for all those involved, including myself, in the research process.

6.10 Conclusion

This study was aimed at increasing valuable knowledge interdisciplinarily between the disciplines of psychology and spirituality. The purposes of the study included the proposal of an ethical and sustainable model for MHI for AR in SA. This model would be representative of the proposed practical application of an interdisciplinary spiritually-informed programme for AR where integration and collaboration between the relevant people involved occurs. The phenomenon of spirituality as part of MHI for AR in SA was explored using IPA methodology. The 5 GETs that emerged were:

1. Darkness vs Light
2. God and people: The relationships
3. Journey of change over time
4. Embodied experience
5. Spiritual overflow: Living a new life (see Figure 9)

Shared meanings and understandings of the research participants regarding their experiences of spirituality in MHI for AR, together with the researcher's personal and professional experiences, meanings and interpretations, were used to further develop the proposed Joy Seen model. It was concluded in the review of the literature (see Section 2.7) that:

- in a postsecularist age, MHIs should be based on relationality; healing towards wholeness
- in the turn to relationality there is a recognition of spirituality as a component of human experience and of MHIs in general
- spirituality should be included in MHIs for AR, as care models based on love are collaborative in nature and contribute to healing/wholeness

Within the South African context, researching from a biopsychosocial-spiritual perspective, Greyvensteyn (2019) theorized about the possible bridging of the gap between psychologists and pastors in an integrated and collaborative way. The

current interventions for AR in SA occur primarily:

- in the field of addiction medicine, dual diagnosis programmes and psychotherapy (regulated by the Department of Health) and/or
- in rehabilitation centres for the treatment of SUDs/SIDs (regulated by the Department of Social Development) and/or
- in SHGs facilitated by spiritual leaders, lay counsellors, careworkers and volunteers, often within the context of faith-based organizations (non-regulated)

In this study, a model for the **practical application** of an **integrated and interdisciplinary collaboration** (see Section 6.3.8) between MHPs and pastoral/lay counsellors, faith-based addiction recovery/life coaches and facilitators of SHGs, that developed out of the findings regarding the participants experiences of spirituality in MHI for AR in SA is proposed. The Joy Seen model includes additional training of MHPs in dual diagnosis and AR from a biopsychosocial-**spiritual** perspective (see Section 6.3.3) and competency based **supportive supervision** by registered MHPs of facilitators of faith-based SHGs (see Section 6.3.7) in addressing the shortcomings that became apparent in this study (see Section 6.2).

The Joy Seen model offers the possibility of practically initiating, establishing, securing, and strengthening collaborative contexts for optimal MHI for AR in SA. The value of this study lies in the new knowledge gained regarding the experience of spirituality in MHI for AR being incorporated in an integrated and collaborative way into meaningful and caring clinical praxis in the journey towards healing.

I am so very grateful to have shared this journey of enthused energy with the participants. Even though seemingly by its nature, "Spirituality defies both description and prescription" (Mate', 2022, p. 468), I have again encountered and witnessed the courageous tenacity and resilient spirit of those journeying towards healing from addiction.

May we together all continue to learn and grow.

May there be Joy Seen.

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Appendix A: Cover Letter to Participant

Date: _____

Dear _____

Thank you for your interest in my PhD research on experiencing spirituality in mental health intervention for addiction recovery in South Africa: An interpretative phenomenological analysis.

I, Lea De Backer, under the supervision of Prof Christo Lombaard value the unique contribution that you can make to my study in the College of Human Sciences in the Department of Psychology, UNISA. I am excited about the possibility of your participation in it. You were selected to participate as you fulfil the following inclusion criteria for this study:

1) You can describe your experience in English.
2) You are 18 years or older.
3) You have been discharged from an inpatient Christian alcohol and substance abuse rehabilitation facility for three or more years without having relapsed in the past twelve months.
4) You reside in either of the Tshwane or Ekurhuleni region of Gauteng, South Africa.

The purpose of this letter is to reiterate some of the things we have already discussed and to secure your signature on the Participant Informed Consent Agreement form that you will find attached.

The research model I am using is a qualitative one through which I am seeking comprehensive depictions or descriptions of your experience. In this way I hope to illuminate or answer my question: “What was your experience of spirituality in mental health intervention for addiction recovery in South Africa?”

Through your participation, I hope to understand the essence of spirituality in mental health intervention for addiction recovery as it reveals itself in your experience. You will be asked to recall specific episodes, situations, or events that you experienced during your addiction recovery process to date. I am seeking valid, accurate, and comprehensive portrayals of what these experiences were like for you: your thoughts, feelings, and behaviours, as well as situations, events, places, and people connected with your experience. By agreeing to take part in this research the information you provide will be used for research purposes, including dissemination through peer-reviewed publications and conference proceedings.

I value your participation and thank you for the commitment of time, energy, and effort. It is anticipated that the knowledge gained through this research will add value to the lives of those in addiction recovery. All your personal information will remain

confidential and will be disclosed only with your permission as required by law. You will spend a maximum of two hours, in interview, with the researcher. If you were to experience any emotional distress, emotional support and containment will be offered immediately, followed by measures to mitigate any negative consequences.

Interviews will be either face-to-face, which will be conducted adhering strictly to all COVID-19 protocols, or online using Microsoft Teams. The nature of which will be determined in compliance with COVID-19 regulations applicable at the time of interview. Interviews will be audio recorded for the purpose of transcribing the respective interview(s). The transcripts thereof, together with other records, will be kept for five years in password protected files for audit purposes. Thereafter they will be permanently destroyed and/or removed from electronic storage devises. You will not be remunerated nor receive any incentives for your participation in the study.

The research was reviewed and approved by the UNISA Ethics Review Committee. If you have any further questions before signing the Participant Informed Consent Agreement form or if there is a problem with the date and time of our meeting, I can be reached at 0836717136. My supervisor, Prof Lombaard, can be contacted during office hours via email CJS.Lombaard@up.ac.za . Please note that you are able to withdraw consent at any time or in the case of any serious unethical behaviour, you can report this at the University's toll free hotline 0800 86 96 93 or the chairperson of the Ethics Research Committee, Dr Kgashane Johannes Malesa, on email maleskj@unisa.ac.za .

Thank you,

Lea De Backer

MA Clin Psych (UNISA)

Appendix B: Participant Recruitment Leaflet

- Can you identify and describe your EXPERIENCE of SPIRITUALITY in your ADDICTION RECOVERY?
- Would you be interested in SHARING YOUR EXPERIENCE for ACADEMIC RESEARCH purposes?

I, Lea De Backer a registered Clinical Psychologist, am currently conducting research for my PhD thesis titled:

> "Experiencing spirituality in mental health intervention for addiction recovery in South Africa: An interpretative phenomenological analysis."

I am researching under the supervision of Prof Christo Lombaard and would value the unique contribution that you could make to my study being conducted under the auspices of the College of Human Sciences in the Department of Psychology at UNISA.

Each potential research participant will need to answer "Yes" to each of the following inclusion criteria for this study:

1) I can describe my experience in English
2) I am 18 years or older
3) I have been discharged from an inpatient Christian alcohol and substance abuse rehabilitation facility for three or more years, without having relapsed in the past twelve months
4) I reside in either of the Tshwane or Ekurhuleni region of Gauteng, South Africa

Should you be interested and meet the above inclusion criteria kindly email me at LeaDeBacker@vodamail.co.za using the subject line "PhD Research Participant".

Thank you,

Lea De Backer

MA Clin Psych (UNISA)

Appendix C: Participant Informed Consent Agreement

I, _____, hereby agree to participate in a PhD research study “Experiencing spirituality in mental health intervention for addiction recovery in South Africa: An interpretative phenomenological analysis” registered with the Department of Psychology at the University of South Africa (UNISA). I understand the purpose and the nature of this study.

I am participating voluntarily and understand that I can withdraw from the research at any time and at my own discretion.

I understand that personal information including my name, date of birth, proof of residential address and information regarding my inpatient admission to a Christian rehabilitation facility will be used to ensure that the participant criteria are met.

However, throughout the research process and resultant publication thereof, conference presentations and published academic articles, confidentiality and anonymity will be protected in accordance with South African Law and the ethical rules of the Health Professions Council of South Africa (HPCSA) to which the researcher subscribes.

I agree to meet either face-to-face or online making use of Microsoft Teams in the event of an online meeting. The nature of the interaction will be determined by legislated COVID-19 regulations applicable at the time. I agree to meet on the following date _____at _____for an initial interview of 1 hour. In the event of a face-to-face meeting, I agree to meet at _____which is a location suitable to me and agree to comply with all in-person COVID-19 protocols including but not limited to:

1) Temperature screening
2) Sanitization
3) The wearing of a face mask during the engagement
4) Social distancing.

Should I incur any travel and/or data costs (if applicable), these will be covered by the researcher.

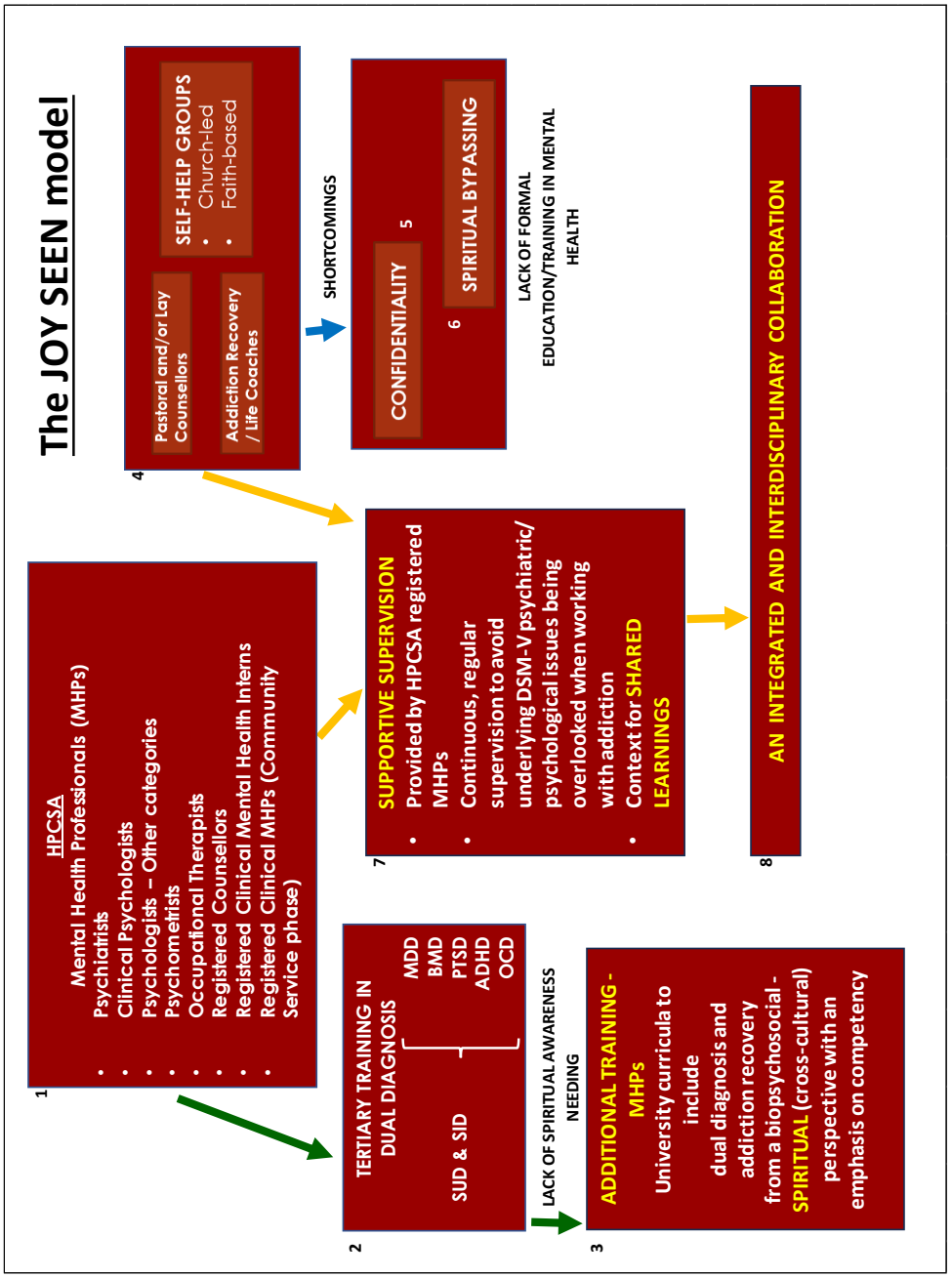
If necessary, I will be available at a mutually agreed upon time and place for an additional interview of no longer than 1 hour requested by either of us.

I also grant permission to the tape recording of the interview(s) and the inclusion of verbatim extracts in published reports. I understand that I will have access, upon request, to all process notes, journal entries, transcripts and recordings for my personal review.

_____	_____
Research participant's signature	Researcher's signature
_____	_____
Date	Date

Appendix D: Figure D1 – An Enlargement of The Joy Seen Model

The Visual Representation of the Joy Seen Model.



Note: The various components of the Joy Seen model are elaborated upon in 1. HPCSA (see Section 6.3.1); 2. Dual diagnosis (see Section 6.3.2); 3. Additional Training – MHPs (see Section 6.3.3); 4. SHG facilitators (see Section 6.3.4); 5. Confidentiality (see Section 6.3.5); 6. Spiritual bypassing (see Section 6.3.6); 7. Supportive supervision (see Section 6.3.7); and 8. Integrated and interdisciplinary collaboration (see Section 6.3.8).

Appendix E: UNISA Ethical Clearance Certificate Dated 29 November 2021

UNISA

COLLEGE OF HUMAN SCIENCES RESEARCH ETHICS REVIEW COMMITTEE

29 November 2021

NHREC Registration # :
Rec-240816-052
CREC Reference # :
06110819_CREC_CHS_2021

Dear Mrs LM De Backer

Decision:
Ethics Approval from 29 November 2021 to 29 November 2026

Researcher(s): **Name: Mrs LM De Backer**
Contact details: 06110819@mylife.unisa.ac.za
Supervisor(s): **Name: Professor CJS Lombaard**
Contact details: ChristoLombaard@gmail.com

Title: Experiencing spirituality in mental health intervention for addiction recovery in South Africa: A Phenomenological study.

Purpose: PhD

Thank you for the application for research ethics clearance by the Unisa College of Human Science Ethics Committee. Ethics approval is granted for five years.

The ***medium risk application*** *was reviewed by* College of Human Sciences Research Ethics Committee, in compliance with the Unisa Policy on Research Ethics and the Standard Operating Procedure on Research Ethics Risk Assessment.

The proposed research may now commence with the provisions that:

1. The researcher(s) will ensure that the research project adheres to the values and principles expressed in the UNISA Policy on Research Ethics.
2. Any adverse circumstance arising in the undertaking of the research project that is relevant to the ethicality of the study should be communicated in writing to the College Ethics Review Committee.
3. The researcher(s) will conduct the study according to the methods and procedures set out in the approved application.
4. Any changes that can affect the study-related risks for the research participants, particularly in terms of assurances made with regards to the protection of participants' privacy and the

confidentiality of the data should be reported to the Committee in writing, accompanied by a progress report.

5. The researcher will ensure that the research project adheres to any applicable national legislation, professional codes of conduct, institutional guidelines and scientific standards relevant to the specific field of study. Adherence to the following South African legislation is important, if applicable: Protection of Personal Information Act, no 4 of 2013; Children's act no 38 of 2005 and the National Health Act, no 61 of 2003.
6. Only de-identified research data may be used for secondary research purposes in future on condition that the research objectives are similar to those of the original research. Secondary use of identifiable human research data require additional ethics clearance.
7. No fieldwork activities may continue after the expiry date (**29 November 2026**). Submission of a completed research ethics progress report will constitute an application for renewal of Ethics Research Committee approval.

Note:

*The reference number **06110819_CREC_CHS_2021** should be clearly indicated on all forms of communication with the intended research participants, as well as with the Committee.*

Yours sincerely,

Signature :

Prof. KB Khan
CHS Research Ethics Committee Chairperson
Email: khankb@unisa.ac.za
Tel: (012) 429 8210

Signature : PP

Prof K. Masemola
Executive Dean : CHS
E-mail: masemk@unisa.ac.za
Tel: (012) 429 2295

Appendix F: Photograph Release Form

We, Dylan Jacobs (DJ) ID number[redacted] and Kirsten Leigh Pearson (KLP) ID number[redacted], being the parents of Cali Jacobs (DoB 10 August 2021), hereby give our mother, Lea Maryna De Backer (UNISA Student No. 06110819) informed, written consent to include Cali's name and the image (included in this letter of consent) in her PhD research study titled:

Experiencing spirituality in mental health intervention for addiction recovery in South Africa: An Interpretative Phenomenological Analysis.

By agreeing to this, we understand that this consent is given for research purposes, including dissemination through peer-reviewed publications and conference proceedings.

Signature (DJ): _____ Signature (KLP): _____

Date: 12-01-2023 Date: 12.01.2023

Researcher's signature: _____

Date: 12-1-2023

Appendix G: Condensed Curriculum Vitae: Lea Maryna De Backer

PERSONAL INFORMATION

Name	Lea Maryna
Surname	De Backer
Identity Number	670104 0020 08 0
HPCSA Registration (Category & Number)	Clinical Psychologist (Private Practice) PS 0081787
Nationality	South African
Languages	English (First) Afrikaans (Second)
Marital Status	Married
Criminal Record	None
Next-of-kin	Husband, Mark De Backer, 0722191263
Contact	LeaDeBacker@vodamail.co.za

ACADEMIC QUALIFICATIONS

Degree	Year of Completion	Institution	Comments
PhD Candidate (Department of Psychology)	2019 - Present	University of South Africa	In process
MA: Clinical Psychology	2003	University of South Africa	Cum Laude
BA: (Honours) Psychology	1996	University of South Africa	Part-time study 1992 - 1996
BA	1992	University of South Africa	Part-time study 1986 - 1992
Matriculation Certificate	1984	Brakpan High School	

EMPLOYMENT HISTORY

Position	Institution	Period
Clinical Psychologist in private practice	ARWYP Medical Centre, Kempton Park	2004 to present
Psychometrist	Prof. John Flowers – Clinical Psychologist in private practice	2001 to 2002

ACADEMIC PRESENTATIONS

Congress	Location	Date
17th European Congress of Psychology	Ljubljana, Slovenia	08 July 2022
World Mental Health Congress	Online Webinar	23 June 2021

ACADEMIC PUBLICATIONS

De Backer, L. M. (2022). Experiencing spirituality in mental health intervention for addiction recovery in South Africa: An interpretative phenomenological analysis. In M. Juriševič (Ed.) *17th European Congress of Psychology: Psychology as the hub science: Book of abstracts,* (p. 324). *Psihološka obzorja / Horizons of Psychology, 31.*

De Backer, L. M. (2021). COVID-19 lockdown in South Africa: Addiction, Christian spirituality and mental health. *Verbum et Ecclesia, 42*(1), a2135. https://doi.org/10.4102/ve.v42i1.2135

REFERENCES

Dr. Sanjna Keerath

Psychiatrist (Colleague)

011 655 5647

Leona Morgan

Clinical Psychologist (Colleague)

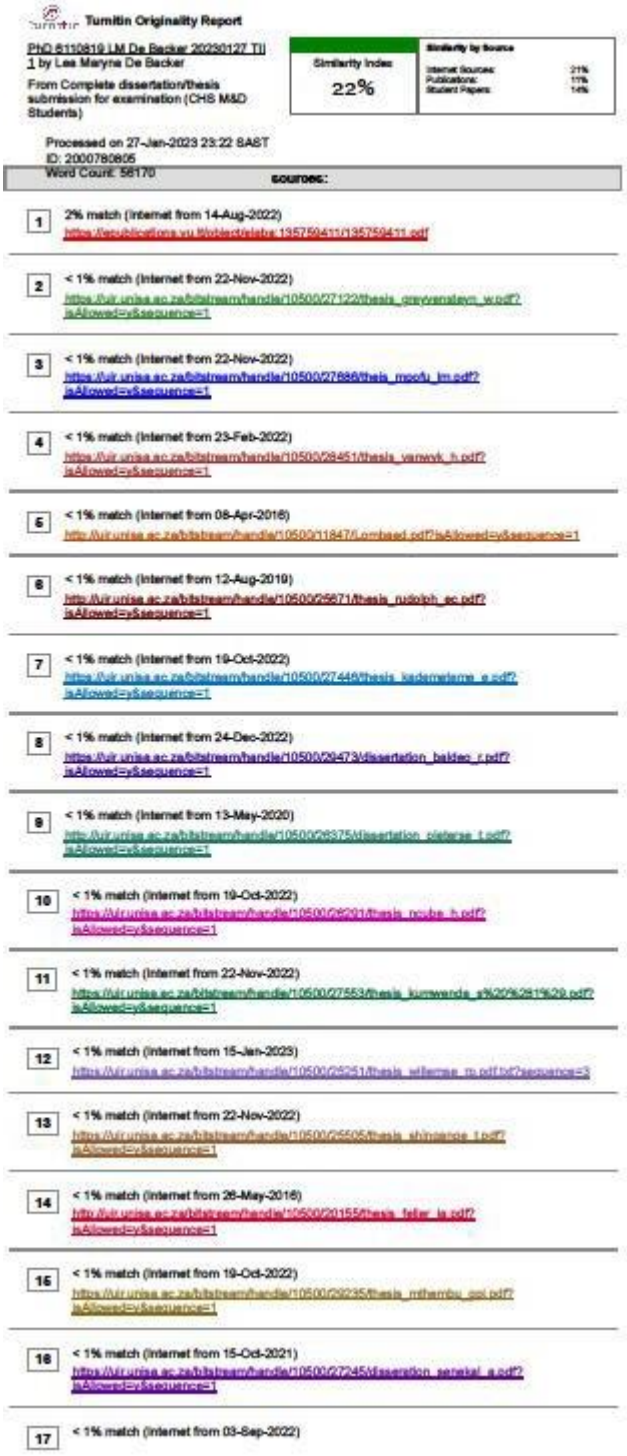
083 259 3178

Cindy Padiachy

Occupational Therapist (Colleague) 072

395 2420

Appendix H: Turnitin Report and Analysis



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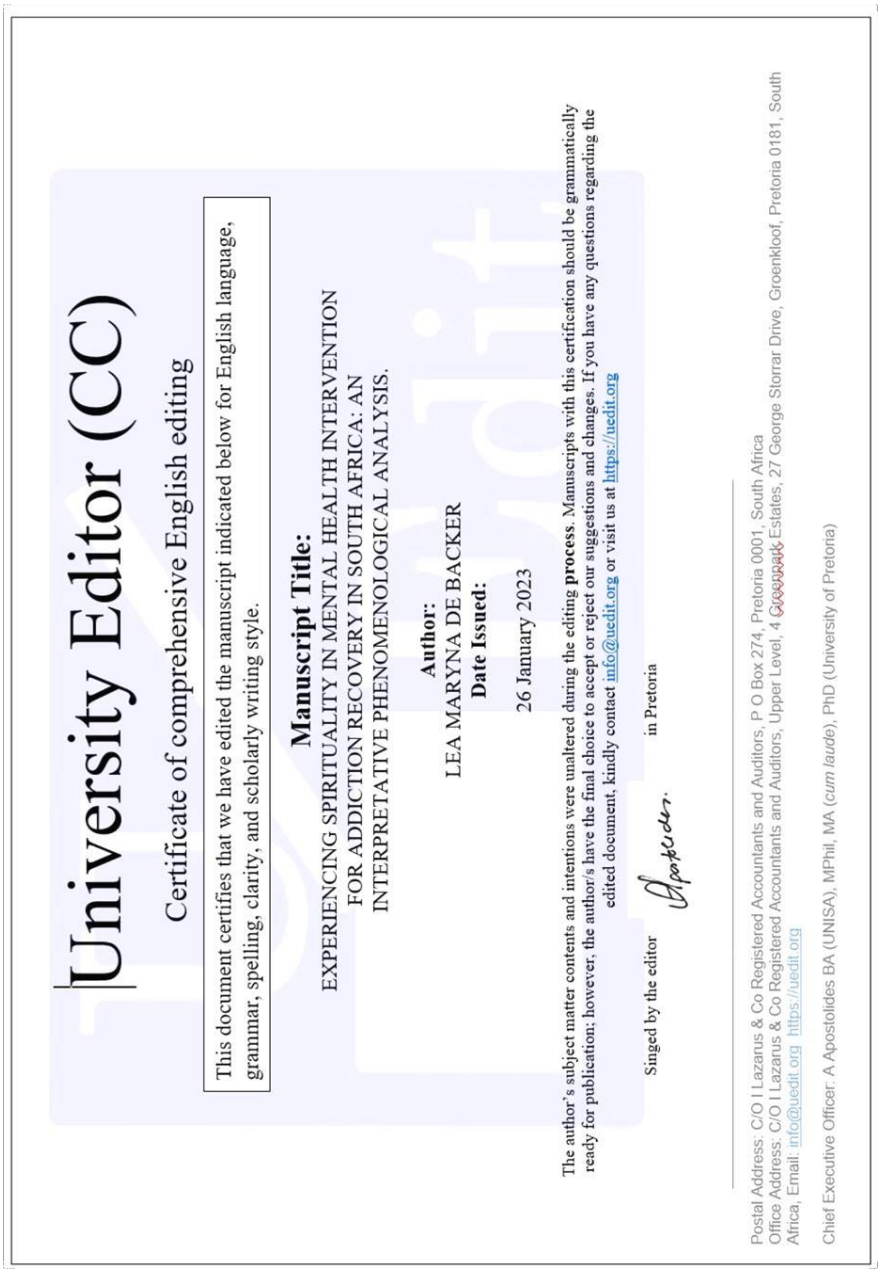

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