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On recovery from substance addiction through climbing: an Interpretative
Phenomenological Analysis

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ABSTRACT

Exercises and physical activities can potentially prevent or delay the onset of different mental health difficulties such as anxiety, affective, eating, and substance use disorders, as well as schizophrenia, dementia and mild cognitive impairment. In the field of addiction, the idea of exercise being adjunct to substance misuse treatment has been promoted. There has been limited research on the psychological benefits of climbing and specifically on the ways in which an outdoor recreational activity and exercise such as climbing may promote recovery from substance dependence.

The aim of the present study is to explore the ways in which individuals experience recovery from substance addiction through climbing. The present research adopted a qualitative methodology, specifically Interpretive Phenomenological Analysis (IPA). IPA was selected as the qualitative methodology captures the detailed exploration of personal lived experiences. A sample of six participants, including five male and one female participant, were interviewed. The data gathered from semi-structured interviews were transcribed and analysed; the data analysis followed the stages of IPA analysis. Two super-ordinate themes, with five sub-ordinate themes emerged from the participants' accounts. The participants' accounts revealed that an activity like climbing has the potential to entail physical, psychological and social values and also therapeutic elements, which can be crucial to successful recovery. The findings also suggest that the meaning of recovery is individual. Moreover, beyond formal therapeutic support, there are numerous factors which have the potential to contribute to the maintenance of recovery from substance dependence. The findings are discussed in relation to the relevant literature, and the lines of enquiry that have emerged have been located in the current literature, arguments and debates. Methodological limitations, directions for future research and clinical implications for the profession of Counselling Psychology have also been presented.

Key words: climbing; outdoor recreational activities; exercise; mental health; addiction

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CHAPTER I: INTRODUCTION

Substance misuse is a significant national and global public health problem, bothering people at national and global proportions (Centre for Social Justice, 2013; Wittchen et al., 2011; Zangeneh et al., 2007). In 2014, 28.9 million people from Great Britain reported drinking alcohol and in 2016, England and Wales were found to have a greater number of drug abusers than the European Union's average number of drug abusers (Health and Social Care Information Centre, 2016). Of these, under one-third of adults were found to be cannabis users (ibid.) In England, in the year 2014/15, there were 8,149 hospital admissions with a primary diagnosis of drug-related mental health and behavioural disorder, and 1.1 million estimated admissions where an alcohol-related problem, injury or condition was the primary reason for admittance or a secondary diagnosis (National Statistics, 2016). Alcohol misuse costs the National Health Service (NHS) in England £3.5 billion every year (National Treatment Agency for Substance Misuse, 2011-12). Beyond the financial strains that substance misuse imposes, it can also have overarching and negative physical (NHS Inform, 2015; NHS Choices, 2017), psychological (Casadio et al., 2011) and social consequences (Capuzzi & Stauffer, 2012; Centre for Social Justice, 2013; NHS Inform, 2015). Despite these effects, the preventive measures for substance misuse in the United Kingdom are considered to be not only poorly administered, but also seem to be ineffective (Centre for Social Justice, 2013). In schools in the past few years, very little has been done to prevent young people from starting on a path to substance abuse. The only support that children received was the national campaign called FRANK. This has been considered to be inefficient and ineffective, as only one in ten children would call the FRANK helpline to talk about the use of substances (Centre for Social Justice, 2013). Despite the ineffectiveness of the FRANK helpline, its assistance continues to be advocated (NHS Choices, 2015b), claiming that FRANK is a reasonable starting point for those who wish to access a 24-hour helpline and receive in-depth information about substances as well as the drugs-related services available in the UK (FRANK, 2017a).

For those who encounter substance addiction, various factors can prevent them achieving a successful recovery. Internal, external (Xua et al., 2008) and social barriers (Centre for Social Justice, 2013) have been identified to exist, which adversely affect the number of individuals

living substance-free lives. Stigma, depression, neuroticism, personal beliefs and attitudes about treatment have been found to be the internal barriers to recovery (Xua et al., 2008). Also, time conflicts, addiction treatment accessibility, not understanding addiction treatment, entry difficulty and the cost of treatment are often viewed to be a few external barriers to recovery (Xua et al., 2008). Beyond such obstacles however, broad, societal barriers have also been claimed to exist. The Betty Ford Institute Consensus Panel (Betty Ford Institute Consensus Panel, 2007, p. 221) defines recovery as “voluntarily maintained lifestyle composed characterized by sobriety, personal health, and citizenship”. However, the way the term has been applied in documents has led to devastating confusion as not every individual who enters treatment achieves a substance-free life, and a lot of such people are not even given the chance to try in the first place (Centre for Social Justice, 2013). By not specifying that every person in treatment should be given the opportunity to learn about not using substances, a vacuum has been created. Rather than aspiring for a life free of substances, the definition of recovery can actually mean that the providers are able to discharge someone ‘in recovery’ even if they are known still to be using substances (ibid.). There have also been instances where the terminology and criteria for recovery have been applied as an excuse for withdrawing support from individuals with dire ongoing needs (Slade, 2010).

Another potential barrier to recovery can be the prescription of substitutes. Substitute prescribing refers to prescribing a safer alternative to the problem or drug, for instance prescribing methadone mixture to replace street heroin, with the initial aim to replace the dangerous street drug with a safer prescribed opiate (Frank, 2017b). In 2015, in England, 196,000 prescription items for alcohol were dispensed; this number is 1% higher than it was in 2014 and had almost doubled during the preceding ten years. Furthermore, for those who have experienced heroin addiction, substitute prescribing can sometimes be the only addiction treatment that they would ever receive (National Treatment Agency, 2013b). Some also argue the presence of methadone maintenance response to be a great barrier to the recovery. Methadone treatment, rather than being the first step towards the road to recovery, has resulted in many individuals being ‘parked’ on it (Centre for Social Justice, 2013). In one study Whiteford (2014) found that out of 500 individuals in receipt of a substitute prescribing regime, 219 had been engaged in their current treatment episode for

four or more years. There are many hypotheses reasoning the presence of such phenomena. Long-term opiate users can become demoralised, have little belief in the fact that change is possible, and have limited aspirations. They also become 'stuck' in a cycle of low expectations and some may use treatment not as a path to change, but as a way of maintaining a substance-using lifestyle (Bloor et al., 2008; Centre for Social Justice, 2013). Additionally, long-term prescriptions may fail to tackle the root causes of addiction, thereby leading to wider problems (United Kingdom Focal Point, 2012), contributing to an increasing black market as prescribed substances are sold, given or stolen, then consumed by someone other than the intended individual, often with lethal consequences (Corkery et al., 2012; Duffy & Baldwin, 2012). The National Treatment Agency for Substance Abuse (2012) also claims that it is doubtful that prescribing methadone for the long-term actually helps individuals tackle their addiction when not combined with further support; yet in 2012, 49 per cent of those in treatment for addiction received solely methadone prescription, while only two per cent received residential rehabilitation (National Treatment Agency, 2013b).

As far as the treatment of substance dependence is concerned, it is often influenced by the various approaches and understandings that one takes towards its aetiology (West & Brown, 2013). The identification of issues to be addressed in treatment and recovery has been primarily defined by the disease model of alcoholism and has also been translated into a program of recovery (Rhodes & Johnsons, 1994). According the National Institute of Health and Care Excellence's (NICE) (2012) guidelines, evidence-based formal psychosocial interventions should be applied in the treatment of drug dependence. Those who are rather harmful drinkers and have a history of struggle with mild alcohol dependence should seek and receive psychological intervention, such as cognitive behavioural therapies, behavioural therapies or social network and environment-based therapies, focusing specifically on alcohol-related cognitions, behaviour, problems and social networks (National Institute for Health and Care Excellence, 2011). Psychological interventions are an important therapeutic option for individuals with alcohol-related problems, however, even with the most effective current treatment, such as cognitive behavioural therapies and social network as well as environment-based therapies, the effects are modest at best and the treatment is not effective for everyone (The National Institute for Health and Care Excellence, 2011).

Beyond the aforementioned treatment options, residential rehabilitation is also known to be a particularly effective intervention for substance addiction (National Treatment Agency for Substance Abuse, 2012b). However, residential rehabilitation is received only by 2% of those in treatment, and in contrast with the suggestions of NICE Guidelines on the provision of medication and therapeutic support, 49% of those in treatment solely receive medication prescription as treatment. This lack of quality treatment received by addicts struggling towards recovery could explain the reasons behind low rate of 11.5% of those receiving treatment becoming 'free of dependence' (National Treatment Agency, 2012b).

According to research findings, even without specific treatment, high percentages of spontaneous recovery rates are likely to occur (Blanco et al., 2013; Lopez-Quintero et al., 2011; Morse, 2006) and natural recovery from even the most severe episodes of addiction is widespread, and perhaps even commonplace (Yates, 2014). Researchers also argue that recovery takes place at least as much in the community as it does in the treatment settings (Groshkova & Best, 2011) and that treatment is one discrete aspect that can facilitate recovery; also, sustained recovery is often influenced by an individual's interaction with others within a social context (Venner et al., 2006). The meaningful activities taking place in the community have been emphasized by natural recovery researchers to possess the potential to resolve the problems of alcohol and substance misuse (Best et al., 2008, 2013; Correia et al., 2005; Dennis et al., 2004; Granfield & Cloud, 2001; Petry et al., 2000; Rogers et al., 2008; Smith et al., 1998). Considering exercise as a potentially meaningful activity that often takes place in the community, it has been proven that it has beneficial effects on individuals' psychological well-being (Goodwin, 2003; Harvey et al., 2010; National Research Council and Institute of Medicine, 2009; Pasco et al., 2011; Ströhle et al., 2007; Ten Have, de Graaf, & Monshouwer, 2010; Zschucke et al., 2013). Exercise has also been reported to be likely to play a substantial role in the prevention and treatment of mental health difficulties (Callagan, 2004). In the treatment of substance misuse and dependence, the idea of exercise being adjunct to substance misuse treatment has been and continues to be promoted widely (Ala-leppilampi, 2006; Weinstock et al., 2008; Zangeneh et al., 2007). This promotion is based on evidence, which indicates that individuals who engaged in exercise-related activities can achieve longer durations of abstinence during treatment as compared to those who do not complete an exercise-related activity (Weinstock et al., 2008). In terms of

addiction, two of the most widely researched topics are participation in exercise and smoking addiction. Various studies have shown that in comparison to the control groups, those who participate in physical activities can have significantly higher abstinence rates than those who do not engage in such activities (Bock et al., 2012; Marcus, 1999; Marcus et al., 1991; Martin Kalfas & Patten, 1997; Ussher Taylor & Faulkner, 2014).

Amongst the various forms of exercise, outdoor recreational activities and their influence on physical well-being have been widely explored. Researchers assert that interaction with natural surroundings encourages better health and enhances individuals' well-being (Gathright et al., 2006). Also, outdoor recreation activities such as climbing, walking, hiking, orienteering and cycling, kayaking, canoeing and sailing have been shown to be bio-psycho-socially beneficial to mental health (Frances, 2006). The physiological benefits of such activities include improved blood pressure, pulse, vigour, energy and physical well-being (King, 2000; McCreesh, 2001; Palmer, 1995), whilst psychosocial benefits such as improvement in daily living skills and hobbies, increased self-esteem and confidence, development of a positive self-identity, increased decision-making power, improved communication skills, enjoyment of the natural habitat and increased self-awareness and motivation have been recorded (King, 2000; McCreesh, 2001; Mills, 1992; Raine & Ryan, 2002; Siegel Taylor & Evans-McGruder, 1996). Furthermore, improvement in mood and distraction from mental health problems, enhanced coping mechanism, and increased ability to overcome challenges, develop emotional maturity and increase self-acceptance have also been identified as some major emotional benefits of outdoor recreational activities (King, 2000; McCreesh, 2001; Raine & Ryan, 2002; Siegel Taylor & Evans-McGruder, 1996).

Many climbing activities are outdoor activities, whilst others take place indoors with climbing walls designed specifically for the purpose. Some activities are usually carried out with ropes to help limit the risk, whereas others such as bouldering and hill walking are invariably done without ropes. Rock climbing, traditional climbing, sport climbing, soloing, bouldering, ice climbing, competition climbing, hill walking, scrambling and mountaineering are the main activities that can be listed under the categories of climbing, hill walking and mountaineering (British Mountaineering Council, 2014). Climbing, as a form of outdoor or indoor activity and exercise influencing psychological well-being has received limited

attention from researchers. A few studies looked at the health (Kuo & Taylor, 2004) and psychological benefits of climbing (Arbor, 2008; Oppezzo & Schwartz, 2014), some concluding that climbing can be a legitimate educational activity, encouraging the physical, mental, social and emotional growth of the participants (Cook et al., 2007).

In the current literature, there is a dearth of research studies which explore the individuals' experiences of the ways in which a meaningful activity and exercise, such as climbing may contribute to recovery from various forms of substance addiction. The aim of the present study is to address this gap and in line with the recovery approach (Betty Ford Institute Consensus Panel, 2007; UK Drug Policy Commission, 2007), moving from pathology, illness and symptoms to health, strengths and wellness (Department of Health, 2009) to focus on the positive outcomes and factors that contribute to sustaining recovery.

The prime research question of the present study is 'What are climbers' experiences of recovering from substance addiction?' The present study seeks to contribute to the research on addiction by exploring a topic of interest in rich detail by adopting a qualitative methodology, specifically Interpretive Phenomenological Analysis (IPA).

CHAPTER II: LITERATURE REVIEW

2.1 The nature of addiction, dependence and substance misuse

In the literature focusing on substance misuse, addiction has been defined as a brain disease (Leshner, 2006), a sin (Rosin, 2000), a sense of helplessness (Dodes, 2003), excessive behaviour (Orford, 2001), a bad habit (Peele, 2004), a personal choice (Schaler, 1999), an expression of self-determination (Szasz, 2003), a moral and spiritual deficiency (Dalrymple, 2006; Morell, 1996) and a problem of motivation (Miller, 2006). The Mental Health Foundation (Mental Health Foundation, 2014) claims that if and when individuals are required to rely on substances to help them feel less anxious or depressed or to improve their mood, they may be facing the risk of being psychologically dependent. Also, if users rely on substances to achieve certain physical effects, or if they cannot bear the unpleasant physical side effects of not taking substances, they may be becoming physically addicted. According to the National Health Service (NHS Choices, 2013a), addiction is a strong, uncontrollable need to consume various substances, drink alcohol or carry out an activity, for instance smoking or gambling; consuming that substance or nurturing that habit becomes the most important activity for the individual and may then lead to problems in almost all areas of a their life (ibid.).

The Diagnostic and Statistical Manual of Mental Disorders (DSM-V) for substance use disorder combines the DSM-IV categories of substance abuse and substance dependence into a single disorder measured on a continuum from mild to severe. Each specific substance other than caffeine, which cannot be diagnosed as a substance use disorder, is addressed as a separate use disorder; for instance, alcohol use disorder or stimulant use disorder. Within DSM-V, nearly all substances are diagnosed on the basis of the same overarching criteria. Although the diagnosis of substance abuse previously required the detection of only one symptom, diagnosing a condition as mild substance use disorder in DSM-V now requires the presence of at least two to three symptoms from a list of eleven. In DSM-V, drug craving has been added to the list and problems with law enforcement, which stemmed from cultural considerations making the criteria difficult to apply internationally, have been eliminated (American Psychiatric Association, 2013).

In 1964, the World Health Organization Expert Committee introduced the term 'dependence' to replace the terms 'addiction' and 'habituation' (World Health Organization, 2017a). According to this, the term can be used generally with reference to an entire range of psychoactive drugs, such as drug dependence, chemical dependence, substance use dependence, or with specific reference to a particular drug or class of drugs, such as alcohol dependence, or opioid dependence. The Tenth Revision of the International Classification of Diseases and Health Problems (ICD-10) defines dependence syndrome as "being a cluster of physiological, behavioural, and cognitive phenomena in which the use of a substance or a class of substances takes on a much higher priority for a given individual than other behaviours that once had greater value" (World Health Organization, 2017b, p. 4). Central to dependence is the often strong, sometimes overpowering desire to consume substances, alcohol, or tobacco. There may also be an indication that returning to substance use after a period of abstinence causes other features of the syndrome to resurface faster as compared to nondependent individuals (World Health Organization, 2017b).

The American Society of Addiction Medicine (2017) emphasizes the notion of addiction on the basis of the brain disease model, highlighting the physiological changes occurring during problematic substance use and thus defining addiction as "A primary, chronic disease of brain reward, motivation, memory and related circuitry. Dysfunction in these circuits leads to characteristic biological, psychological, social and spiritual manifestations. This is reflected in an individual pathologically pursuing reward and/or relief by substance use and other behaviours." (American Society of Addiction Medicine, 2017, p.1.) Furthermore, according to this definition, addiction is also "characterized by inability to consistently abstain, impairment in behavioural control, and craving, diminished recognition of significant problems with one's behaviours and interpersonal relationships, and a dysfunctional emotional response. Like other chronic diseases, addiction often involves cycles of relapse and remission. Without treatment or engagement in recovery activities, addiction is progressive and can result in disability or premature death" (American Society of Addiction Medicine, 2017, p.1.).

In clinical settings substance dependence/addiction can be assessed in various ways. For instance, one way of measuring alcohol dependence is using the community version of the Severity of Alcohol Dependence Questionnaire. On this measure, a score of 4–19 indicates a

mild dependence; a score of 20–34 indicates a moderate dependence; and a score of 35 or more is indicative of severe alcohol dependence (Stockwell et al., 1983). The World Health Organization (WHO Assist Working Group, 2002) developed ‘The Alcohol, Smoking and Substance Involvement Screening Test (ASSIST)’ to detect the use of psychoactive substances and related problems in the lives of primary care patients. The participating countries were Australia, Brazil, Ireland, India, Israel, the Palestinian Territories, Puerto Rico, the United Kingdom and Zimbabwe. The authors concluded that as a part of an international screening test, the measuring items on the ASSIST are reliable as well as feasible to be used in various settings (WHO Assist Working Group, 2002).

2.2 The aetiology of addiction

Addiction theory underpins the various approaches used in substance treatment interventions (West & Brown, 2013) and it has implications for recovery and for the long-term sustainment of recovery (Goode, 2007). It is beyond the scope of the thesis to provide a fully comprehensive account of each model of addiction and its shortcomings; therefore, the aim here is to offer an insight into some of the models that have been most influential in the treatment approaches applied today.

2.2.1 Psychological Models of Addiction

Psychological models of addiction argue that individuals crave alcohol or other mind-altering substances as a result of various emotional states (Capuzzi & Stauffer, 2012). The behavioural understanding of addiction developed by Ellis and Harper (1975) proposed a behavioural origin to addiction, based largely upon the work of Skinner and Pavlov. The followers of this model argue that addiction is a learned behaviour that can, in turn, be unlearned or, perhaps be replaced with less self-destructive behaviours. These theories form the basis of the cognitively-based interventions that are still in use today, including the practices of motivational interviewing (Miller & Rollnick, 1991) and relapse prevention (Marlatt & Gordon, 1985). For the present research study, it would be necessary to assess the extent to which psychological theories, such as those of Ellis and Harper (1975), could form the basis of an interpretive phenomenological analysis of the potentially therapeutic context of climbing. Furthermore, motivational interviewing can also be potentially helpful

in the current study as it enables the researcher to explore through qualitative data collection participants' motivations to engage in an activity, such as climbing.

The cognitive-behavioural model of addiction focuses on motivators and reinforcers in taking substances, emphasising that individuals take substances in order to experience variety (Weil & Rosen, 1993), explore themselves, alter mood, escape from despair, but also potentially to enhance performance and to achieve sensory experience or pleasure (Lindgren et al., 2010). This model also highlights that dependent behaviour, with respect to the use of various substances, is maintained by the degree of reinforcement experienced by the person, and that alcohol and other substances may be more powerful than natural reinforcers, thus setting the stage for addiction. This model also claims that over time, the brain adapts to the presence of substances in the system, and the individual then experiences unpleasant withdrawal symptoms. To avoid such symptoms, one must consume substance anew, which establishes a cycle of use (Capuzzi & Stauffer, 2012).

The learning and the cognitive behavioural models of addiction are closely related and tend to overlap. Learning models assume that substance abuse results in a decline of uncomfortable psychological states, thus providing positive reinforcement to the user. This learned response continues until physical dependence develops and the aversion of withdrawal symptoms becomes a reason and motivation for continued use (West & Brown, 2013). In the present study, it could be beneficial to explore whether climbing can be seen as a learning process that has the potential to reduce uncomfortable psychological states and act as a reinforcer of less addictive behaviour.

Within the psychodynamic and psychoanalytic models of addiction, authors such as Khantzian (1974), Khantzian, Mack, and Schatzberg (1974), and Wurmser (1974) suggested the origins of addiction to lie in a person's deep-rooted childhood trauma. Psychoanalytic and psychodynamic theorists have been prominent in developing theories of drug dependence based on various personality factors. Over the years, these theories have ranged from suggestions that drug dependence reflects low self-esteem, to gender role conflicts, or feelings of powerlessness that mask a need for control (Blane & Leonard, 1987). Within these models, in the view of Wurmser, addiction is the result of a 'narcissistic crisis' that creates 'neurotic conflict.' A harsh superego then generates intense feelings of rage,

fear, guilt, and anxiety; the use of substances is the easiest escape from such feelings (Wurmser, 1974, 1987). However, psychoanalytic approaches are outside of the scope of the present study by nature of the long time period required to explore dependence from such perspective.

Those critical of the psychoanalytic model argue that it is rather problematic to substantiate such understanding through research, as they deal with concepts that are difficult to operationalise, and the events that seem responsible for the development of addiction may have occurred many years prior to the development of the addiction (McNeese & DiNitto, 2005).

The personality theories of addiction further develop into psychological models of addiction. These theories of addiction assume that certain personality traits, such as dependence, immaturity, impulsivity, and extremely emotional behaviour, accompanied by low frustration tolerance and an inability to express anger, to be responsible for the development of addiction, predisposing the individual to substance use (Catanzaro, 1967; Schuckit, 1986). In some recent findings, Murphy, Stojek and MacKillop (2014) explored the relationship between food addiction and personality traits. The authors found a significantly positive association between addictive eating, Body Mass Index (BMI), negative urgency and perseverance. The researchers concluded that high levels of impulsivity may predispose individuals into developing food addiction, supporting personality theories of addiction. Such theories of addiction broaden the researcher's understanding of the phenomena of addiction; however to investigate the personality traits that predispose individuals to substance use, is beyond the scope of the present research project.

2.2.2 The moral model of addiction and the family models of addiction

The moral model of addiction is based on what is morally acceptable or unacceptable. This model describes addiction as a consequence of a personal choice, and those who engage in addictive behaviours are perceived to be capable of making alternative choices (Capuzzi & Stauffer, 2012). Despite the lack of empirically based research on this model, it still continues to influence many public policies related to alcohol and drug abuse (McNeese &

Di Nitto, 2005), and Frank and Nagel (2017) claim that morality and addiction are still often entwined.

The family-based models of addiction entail the behavioural-, family systems- and family disease models of addiction (Dodgen & Shea, 2000). The behavioural model explains that within the context of the family, there is one member or multiple members who reinforce the behaviour of the abusing family member, and that some members may not be able to relate to a particular individual when the user is not under the influence of substances (Capuzzi & Stauffer, 2012); therefore, the model focuses on the ways in which the roles in families interrelate (Baron et al., 2010). The third family model of addiction, the family disease model, explains that the entire family suffers from a disorder or disease. This approach highlights the need for all family members to enter treatment (National Council on Alcoholism and Drug Dependence, INC, 2015).

2.2.3 The disease model of addiction

Originally, in the 1950s and 1960s, the scientific medical community propagated the idea of alcoholism as a chronic, relapsing disease (Glatt, 1952; Jellinek, 1952, 1960; Keller, 1962; Peele, 1995). Since then, practice has embedded the notion of addiction in the public consciousness as an incurable condition that can, at best, be managed and contained (Yates, 1994). E.M. Jellinek introduced this model originally for alcoholism, but over time, it has been generalized and applied to other addiction problems as well (Stein & Foltz, 2009) and incorporated in the World Health Organisation guidelines (Room, 1983).

The model proposes the prodromal, middle, crucial and chronic stages of the disease of alcoholism, perceived to be progressive and non-reversible (Levine, 1985). Consistent with the irreversibility is the belief that addiction is chronic and incurable and that there is no treatment method to ensure that an addict will not revert to their practices. The goal of an addict is abstinence, a position taken by Alcoholics Anonymous (AA), where members refer to themselves as recovering and not recovered (Fisher & Harrison, 2005). The present study, through its explorative nature, will seek to uncover the utility of such views in the process of substance recovery for the participants.

Some argue that perceiving addiction as a disease removes the moral stigma attached to it and replaces it with an emphasis on the treatment of an illness (West & Brown, 2013). However, the presentation of alcoholism as an irreversible disease has been subject to much debate and criticism (Yates, 1994). Early on, Trice and Wahl (1958 as cited in Yates, 2014, p.102) tested Jellinek's hypothesis and concluded that, "If the concept of a disease process in alcoholism is valid, only the earliest or the most advanced stages are reliably indicated." Similarly, West and Brown (2013) claim that addiction does not always occur through various progressive and irreversible stages as predicted. Furthermore, the disease concept may promote the idea that one is powerless over the disease, therefore normalising relapse. Yates (2014, p.101) also highlights that the notion of a disease "robs those afflicted with it of their individual will" and it is "embedded in a cultural context where individuality and liberty is a paramount aspiration and where appropriate behaviour is an individual personal responsibility." (Yates , 2014, p.101).

2.2.4 Biological models of addiction

Within the biological models of addiction, the bio-physiological and genetic theories of addiction assume that individuals struggling with addiction are constitutionally predisposed to be dependent on substances, thereby supporting a medical model of addiction (Frank & Nagel, 2017). These models also apply the disease terminology and often place the responsibility for treatment onto medical personnel. Biological explanations branch into genetic and neurobiological debates (Altman et al., 1996), popularizing the notion of addiction as a 'hijacking of the brain' (Frank & Nagel, 2017), perceiving the addictive behaviour as a compulsion – beyond one's conscious control and without regard for one's rational judgment (Leshner, 1997; Lewis, 1993).

Early findings claim a strong statistical association between genetic factors and alcohol abuse. Genetic studies of alcohol addiction suggest that adopted children resemble their biological parents more closely than their adoptive parents (Dodgen & Shea, 2000) and that the children of alcoholics can be seven times more likely to be addicted as compared to children whose parents are not alcoholics (Koopmans & Boomnsina, 1995). Volkow and Muenke (2012) conclude that epidemiology and genetic studies support the general concept

that addiction ‘runs in families’; however uncovering the timing, strength and contingent nature of the genetic contribution to addiction remains the focus of challenging research.

The neurobiological theories also argue for a brain disease model of addiction (BDMA), emphasizing that physical brain changes are associated with addiction. These models claim that hereditary traits can make an individual more vulnerable to developing a physical dependence after exposure to a rewarding stimulus. Also, the physical changes caused by repeated exposure to rewarding stimuli strengthen the dependence by deteriorating the brain function critical to self-regulation and motivation to remain abstinent, even in the face of extreme consequences (Hazelden Betty Ford Foundation, 2016; Trifilieff & Martinez, 2014; Volkow et al., 2016). Neuroscience and animal models of addiction (Frank & Nagel, 2017), as well as the identification of the neural pathways and circuits involved in addiction, particularly the mesolimbic reward system, have been predominantly influential in this type of characterization (Leshner, 1997). Further evidence also comes from the possibility that addiction can be treated using pharmaceuticals so as to ease withdrawal and prevent relapse (Erickson, 2007). Animal research also supports this view, claiming that rats and mice can become addicted to a variety of substances through repeated use and will engage in self-destructive behaviours in order to access substances (Bozarth & Wise, 1985; Frank & Nagel, 2017; Panlilio & Goldberg, 2007).

The neurobiological evidence that forms the basis for the brain disease model of addiction is weaker than its advocates acknowledge (Hall, Carter, & Barnett, 2017). Since this model is heavily reliant on animal models and small sample case-control neuro-imaging studies, with highly selected samples of severely addicted persons, it may be premature for the advocates of the brain disease model of addiction to insist upon the pre-eminence of the neurobiological accounts of addiction (Hall, Carter, & Barnett, 2017).

The research area into the consequences of viewing addiction as a brain disease is continuous and growing. Research studies on the clinical impact of the brain disease model of addiction found that this is likely to increase a person’s insight about the reasons for drug use, and reduce experienced sense of guilt, but it may also increase feelings of helplessness and fatalism, undermining one’s ability to change (Barnett & Fry, 2015; Bell et al., 2014). It has also been found that through such perceptions, substance users’ hope and motivations

for recovery can be diminished, predicting a greater likelihood of relapse (Miller et al., 1996). Furthermore, such views can create barriers and keep the substance dependence individuals from receiving sufficient care (Lawrence et al., 2013; Press et al., 2016), as substance misusing individuals can at times internalise or take on board these attitudes and become less likely to be open and honest about their habits, perhaps avoiding care (Frank & Nagel, 2017).

The utility of viewing addiction as a brain disease has also been questioned by individuals who claim to be substance abusers themselves (Meurk et al., 2016). Recent findings stress that individuals reported ambivalent positions about the idea of addiction as a (brain) disease, and many viewed this as a synonym for 'brain damage', which implies that addiction is incurable, carrying a stigmatising label (ibid.). Also, such views can increase the stigmatisation of those who struggle with substance misuse and may entrench, rather than reduce, the negative public attitudes towards individuals with such difficulties (National Academies of Sciences Engineering and Medicine, 2016). Furthermore, a disease model may reinforce public fears of addicted persons by suggesting that their behaviour is an uncontrollable consequence of permanent changes in their brains, apparently produced by their substance use (Phelan & Link 2012). For these reasons, the current study will not draw on the brain disease of addiction. However, if individuals in the present study claim such approach to be influential to their recovery, the researcher will aim to present these accounts.

2.2.5 Socio-cultural models of addiction

The socio-cultural models of addiction have been formulated by observing the differences and similarities between cultural groups as well as subgroups. According to these models, a person's likelihood of using substances, the way the user behaves, and finally the way addiction is defined, are all influenced by the socio-cultural systems surrounding the individual (Stephens, 1985). The supra-cultural-, sub-cultural-, and the culture-specific models of addiction belong to the socio-cultural models of addiction (West & Brown, 2013). Culture, social organization, addiction and the use of alcohol are connected with the supra-cultural models of addiction (Bacon, 1974; Bales, 1946), emphasising that in cultures where

there is little agreement in regard to alcohol and drug use, a high rate of substance abuse can be expected (West & Brown, 2013).

The sub-cultural models of addiction highlight that age, gender, ethnicity, socioeconomic class, religion, and family background create patterns within specific cultural subgroups for substance misuse (McNeese & DiNitto, 2005; White, 1998). However, according to Capuzzi and Stauffer (2012), counselling psychologists or those working within mental health need to be cautious about stereotyping, and must address diversity issues. The present study intends to avoid stereotyping when engaging with participants through researcher reflexivity and through maintaining an awareness of the similarities and differences between, as well as within, individuals taking part in the study.

2.2.6 Multi-causal models of addiction

Within multi-causal models of addiction, the Syndrome Model (Shaffer et al., 2004) and the Integral Model of addiction (Amodia et al., 2005) conceptualize addiction as an interaction between three factors: the agent or the drug, the host or the person, and the environment, comprising of a numerous entities (Odegaard et al., 2005). This three-part model has been influential in the field of drug treatment for the past 30 years, and has been adopted within public health by healthcare and human service professionals. This model provides an essential framework for assessment and treatment planning and most validated instruments, such as the Maudsley Addiction Profile, the Addiction Severity Index, and the Client Treatment Matching Protocol, would appear to owe their creation to this individualistic approach to the problem (Yates, 2014).

Despite there being many models of addiction, no single model can adequately explain why some individuals become addicted to substances while others do not. An advance in the study of addiction is the realization that addiction is probably not caused by a single factor, and models for increasing the understanding and development of treatment options are multivariate (McNeese & Di Nitto, 2005). Although there may be some similarities in all substance dependent individuals, the aetiology and motivation for the use of substances varies from person to person. The present study takes the position that the debate over which model is correct is only valuable because it assists practitioners in seeing the

importance of adopting an interdisciplinary model of theory and treatment of addiction (Buu et al., 2009; McNeese & Di Nitto, 2005; Stevens & Smith, 2005).

2.3 The prevalence of substance use and misuse

Substance misuse is a significant public health problem of national and global proportions (Centre for Social Justice, 2013; Wittchen et al., 2011; Zangeneh et al., 2007). The National Institute of Clinical Excellence (2011) reported that in England, 24% of the population consumes alcohol in a hazardous manner (33% males; 16% females). In Great Britain in the year 2014/15, 28.9 million people reported drinking alcohol the previous week; this figure equated to 58% of the population. Also in 2014, 38% of the secondary school pupils claimed that they drank alcohol (National Statistics, 2016). Regarding the use of various drugs, in 2015/16, around 1 in 12 young adults and adults (2.7 million people) aged 16 to 59 reported taking an illicit drug (Health and Social Care Information Centre, 2016).

According to the 2016th European Drug Report, levels of lifetime use of cannabis differ considerably between the residents of different countries. England and Wales have been found to be above the European Union's average drug use, with under one-third of adults in England and Wales using cannabis (Health and Social Care Information Centre, 2016). These statistics on the use of substances in the United Kingdom did not differ from the recordings of 2013, where it has been found that in comparison to the Western European countries, United Kingdom had a larger drug addiction problem, showing higher rates of the phenomenon compared to France or Germany (European Monitoring Centre for Drugs and Drug Addiction, 2013).

One method for determining the prevalence of substance abuse is to examine help-seeking behaviours of those seeking medical attention or treatment related to these problems (Hood, 2003). According to the Health and Social Care Information Centre (2016), in England in 2014/15, there were 8,149 hospital admissions with a primary diagnosis of drug-related mental health and behavioural disorder. This figure has soared by 14% from what it was in 2013/14 and is 4% higher than it was in 2004/05. Also, in 2014/15 there were 1.1 million estimated admissions where an alcohol-related problem, injury or condition was the primary reason for admission or a secondary diagnosis; this representation is 3% higher than

it was in 2013/14, and men accounted for nearly two-thirds of such admissions (National Statistics, 2016).

In 2007, Breakthrough Britain identified a fatalistic drug system which 'trapped' thousands of individuals in state-sponsored dependence (Centre for Social Justice, 2013) and years later, this trend still seems to continue. When accessing treatment, between 2014/15, 295,224 individuals were in contact with the drug and alcohol services, and more individuals were being treated for opiate than for alcohol use (Health and Social Care Information Centre, 2016). Also, according to the 2014 statistics, opioid substitution treatment was prescribed to 146,875 individuals in England, showing a slight decline from 2013, where the subscription treatment has been prescribed to 147,640 individuals. Furthermore, in 2014, two-thirds (66%) of those entering treatment in the United Kingdom with a primary drug of opioids use had also received opioid substitution treatment in the past (United Kingdom Focal Point, 2015).

The statistics on the use of various substances is greatly influenced by the presence of new psychoactive substances (NPS), sometimes known as 'legal highs' (Centre for Social Justice, 2013). In the United Kingdom, they are entering the market at the rate of one a week (International Narcotics Control Board, 2013). These legal highs are also outnumbering the illegal drugs classified under the Government's official A, B and C system (United Nations Office on Drugs and Crime, 2012) and currently, the law is incapable of keeping up (United Nations, International Narcotics Control Board, 2013). Sold over the internet, in 'head shops' and on the 'high streets', these new substances are often chemically similar to the banned substances and bring about the same effects. The slight molecular differences mean that they can be sold as bath salts or research chemicals, provided they carry a caution against consumption sign. The result of this slight chemical difference means that new drugs are not covered under the A, B, C system of the Misuse of Drugs Act and they are legal to produce, supply and possess. The rise of these substances can thus counter-balance any slight decline in heroin/ crack cocaine use seen in the recent years (Centre for Social Justice, 2013).

Another estimator of the prevalence of substance misuse is the presence of online substance trade (Centre for Social Justice, 2013). Despite the fact that it is difficult to estimate the size of the online drug trade, there are indications that it is significant and

growing. Between 2000 and 2001, there has been a 300 percent global rise in cannabis intercepted through postal services (UNDON, World Drug Report, 2014). Also, between 31 to 45 per cent of this revenue comes from large scale trading, suggesting that dealers are buying these substances in large quantities on the internet before distributing them locally (Aldridge & Decary-Hetu, 2014). In the United Kingdom, school-aged children are also increasingly having various substances delivered this way and the country is now becoming a leading hub for dealing of internet drugs (United Nations, International Narcotics Control Board, 2013).

2.4 The impact of substance misuse

As previously stated, the prevalence of use and misuse of various substances in the United Kingdom is high and alarming, and it does not come without ramifications. For instance, alcohol misuse costs the NHS in England £3.5bn each year (National Treatment Agency for Substance Misuse, 2011-12). Beyond the financial consequences, the use of substances can also be hazardous for various reasons: individuals can become addicted to a substance, it can cause physical and psychological harm; and it can also have a negative effect on the overall quality of life of the user (NHS Inform, 2015). These influences will be explored in more details below.

2.4.1 Substance misuse and the human body

Substance misuse has a wide range of both short and long-term effects (Ellison, 2013). The presented examples on the physiological effects of the use of new psychoactive substances, cannabis, cocaine, amphetamines, ecstasy and alcohol, are only illustrative, as providing a comprehensive review of the physical effects of each substance is beyond the scope of the present study.

While using NPS, the individuals can never be certain of their physical effects. It is believed that their use can induce coma, seizures and, in rare cases, even lead to death (NHS Choices, 2017). The use of cannabis can lead to lung diseases, including the development of lung cancer and respiratory problems, such as chronic bronchitis and asthma. It can also bring on

high blood pressure (hypertension), and in some cases, lead to infertility. Its regular use can also make concentration and learning extremely challenging (NHS Inform, 2015).

The use of cocaine can have a lethal consequence, leading to immediate death (Phillip & Keen, 2003). Moreover, cocaine overdose can over-stimulate the heart and the nervous system, potentially contributing to the development of a heart attack (Zafar, Vaz, & Carlson, 1997). In pregnancy, the use of cocaine can be harmful to the baby and is likely to cause miscarriage (García-Enguíanos et al., 2002). Whilst the inhaling of cocaine can damage the cartilage of the nose, injecting it can damage the veins and body tissues. Injecting cocaine, if needles are shared, can also increase the chances of catching HIV, hepatitis or other blood-borne diseases (NHS Choices, 2017). Cocaine is also highly addictive, causing a very strong psychological dependence (ibid.).

The use of methamphetamine can be dangerous for the heart, leading to the development of high blood pressure and heart attacks (Frishman et al., 2003). The use of ecstasy, also called MDMA, can affect the body's temperature control and can initiate dangerous overheating and dehydration. It is also possible for individuals to build up a tolerance to the drug, thereby needing to consume more to get the same effect with time (Davison & Parrott, 1997).

The misuse of alcohol also brings about some overarching negative consequences (Bellis et al., 2009). Consuming alcohol over a long period of time damaging the organs within the human body. It also negatively influences the brain and the nervous system, damages the heart, liver and pancreas. Heavy drinking can also increase blood pressure and blood cholesterol levels, both of which are major risk factors for the development of heart attacks and strokes. Long-term alcohol misuse also weakens the immune system, making individuals more vulnerable to infections. The long-term consumption of alcohol can also weaken the bones, thereby placing the user at greater risk of fractures (NHS Choices, 2015a).

2.4.2 Social influences of substance misuse

Drug and alcohol misuse not only influence the human body, but can also be linked to a wide variety of societal issues (Capuzzi & Stauffer, 2012). It can be a pathway to crime (Bradshaw et al., 2014; Hood & Peterson, 1991), poverty, debt as well as welfare

dependence (Centre for Social Justice, 2013). Also, the research into the harms of alcohol and drug addiction indicates that individuals with chronic alcohol and drug use problems are some of the most socially excluded groups of British society (Home Office, 2010). Due to their circumstances and lifestyles, many encounter a range of complex, interrelated difficulties such as homelessness, unemployment, offense, under-achievement (De Leon, 2000) and addiction (Bradshaw et al., 2014; Hood & Peterson, 1991). The use of drugs can also lead to financial problems, problems with education, as well as problems with maintaining commitments, including drug use-related appointments (Mind, 2014).

2.4.3 Psychological effects of substance misuse

Alongside the negative physical and social influences, individuals can also encounter short and long term adverse psychological effects of substance misuse (Casadio et al., 2011).

The use of diverse substances can lead to diverse, but also similar effects. For instance, the use of NPS can result in the reduction of inhibitions and the development of paranoia. Cannabis use can initiate the development of depression, lethargy and can also lead to paranoia. In addition, cannabis users may develop psychological dependence and psychosis. Similarly, those who take cocaine may experience lowered moods as well as psychological dependence (NHS Choices, 2017).

When the psychological effects of the use of ecstasy are concerned, memory problems, as well as effects similar to that of cannabis use such as the development of anxiety, depression and psychological dependence have also been reported (Davison & Parrott, 1997; Johns, 2001). Furthermore, those who take amphetamine can experience confusion, paranoia, psychosis as well as the development of depression and lethargy (NHS Choices, 2017). Amphetamines can also give rise to feelings of agitation and aggressive behaviour (Wright & Klee, 2009).

Amongst the psychological consequences of substances misuse, there are also instances where individuals have two separate conditions; a mental health problem and substance addiction (Rethink Mental Illness, 2013). When trying to deal with both, it is hard to distinguish where one ends and the other begins. It may not be clear which of the two conditions came first as individuals with mental health problems at times also use

substances to cope with the chaos, the distressing emotions and the stigma of conditions such as depression or schizophrenia. However, turning to drugs in order to cope with mental health problems can lead to complications of the illness and interfere with prescribed medication that individuals need to take (Drugs and alcohol information and support, 2014; Johns, 2001).

2.4.4 Families, communities and the misuse of substances

Drug and alcohol abuse, beyond affecting the individual users, also affects families and communities (Centre for Social Justice, 2013). According statistics in 2009 one in seven children under the age of one lived with a substance-abusing parent in England, 2.6 million people lived with a parent who drank hazardously and 335,000 children lived with a parent who was addicted to drugs (Manning et al., 2009). According to 2014 statistics, annually 9000 mothers are hospitalized because of alcohol-related miscarriages, and 100 babies are born every month with an addiction to the substance that their mothers used during pregnancy (NHS Choices, 2014b).

The National Treatment Agency for Substance Misuse (2012a) claims that not all parents with drug problems cause harm to their children, but substance misuse can significantly reduce their ability to provide the necessary practical and emotional care. When considering the consequences of substance misuse for children, the presence of abuse, neglect, emotional difficulties, and the possibilities of the children themselves becoming drug and alcohol abusers, have been reported (Kumpfer & Johnson, 2007). Research has also shown that children who live with addicted or substance misusing parents have poorer educational outcomes. In schools, the performance of such children may suffer, as parental problems dominate the child's thoughts and reduce concentration (Centre for Social Justice, 2013). Also, the children of parents who are addicted to drugs or alcohol are more likely to have health and behavioural problems (Anda et al., 2002).

At times, when parents misuse substances, children become unable to live with their parents, and as a result their responsibility eventually falls on the state or on wider family networks. Whilst free from the physical danger of living around an addicted parent, the disruption to family stability is of significant detriment to the children involved; the loss of a

parent can severely impact the children's educational attainment and mental health (Cleaver et al., 2011).

Mental health problems such as high levels of behavioural disturbance, antisocial behaviour, emotional difficulties, social isolation, precocious maturity, and the presence of anxiety or depression have been noted to be present amongst children whose parents use substances (Anda et al., 2002). Researchers also demonstrated that some of the problems of childhood and adolescence can continue in adulthood; adult offspring of substance-misusing parents have greater problems in terms of substance misuse or areas of adulthood adjustment (Velleman & Templeton, 2007).

2.4.5 The vicious cycle of substance misuse

Some of the consequences of substance misuse exclude individuals from their community and from effective contact with the services they need to help them find the safety, stability and physical and mental health that is required to recover (Landale & Roderick, 2013). Subject to wide discrimination, individuals with addiction and substance misuse are routinely excluded from mainstream services and frequently estranged from their families and non-substance misusing friends. Lack of appropriate support and engagement in the community forms a vicious cycle, and fuels the lack of motivation, loneliness and stress which are among the most commonly cited reasons for relapse (Laudet & White, 2008).

To conclude, substance misuse does not only impose a financial burden on the NHS, but also a human cost; in extreme circumstances, individuals pay with their lives for their use. Since the influence of the misuse of various substances can have such devastating effects, the applied prevention strategies to keep individuals from embarking on the road of dependence are crucial. The following section of the thesis offers an account of the substance misuse prevention strategies currently in place, and also sheds light on the potential barriers to recovery.

2.5 Prevention of substance misuse and barriers to recovery

2.5.1 Prevention of substance misuse

According to the latest estimate of the United Nations' Drug Crime Report, the number of young people aged between 15 and 24 who have taken a 'legal high' in the UK was the highest in Europe (United Nations Office on Drugs and Crime, 2013). Also, England has one of the highest rates of early drunkenness in Europe (Kuntsche et al., 2012). Figures are high and alarming and there are serious weaknesses in the current drug and alcohol prevention strategies. In schools, in the past years very little has been done to prevent young people from starting on a path to substance abuse (Centre for Social Justice, 2013). The only support that children received was through a national campaign called FRANK. This has been considered ineffective and inappropriate, since only one in ten children would call the FRANK helpline to talk about the drugs (ibid.). Despite the fact that FRANK programme is considered to be ineffective by many, the NHS advocates its use (NHS Choices, 2015b) claiming that FRANK is a good place to start receiving support for drug abuse as it provides a 24-hour helpline, in-depth information about substances and also advice about drugs-related services in local areas (FRANK, 2017a).

According to the Centre for Social Justice (2014), FRANK should be removed and an effective replacement programme developed, to inform the young people about the dangers of drug and alcohol abuse. They also argue that the Department of Health should develop an information campaign to inform parents and young people about the growing threat of 'legal highs' or New Psychoactive Substances, which in 2012 were related to nearly 100 deaths (Office for National Statistics, 2013). The Centre for Social Justice also claims that as the availability and quality of prevention programmes in schools is often very poor, the schools should be able to apply for match-funding from local Health and Wellbeing Boards so as to provide approved schemes. These could include those offered by external providers, such as charities that have been shown to reduce alcohol and drug abuse among the children (Centre for Social Justice, 2014).

2.5.2 Barriers to recovery from addiction

In the literature on the subject, various barriers to recovery have been identified. Xua et al. (2008) surveyed a sample of 518 drug abusers to explore the barriers that keep individuals from seeking treatment. The researchers found a number of internal and external barriers that keep the substance abusers from getting the help they need (ibid.) Stigma (this leading to being unwilling to share problems and ask for help), depression, neuroticism (this producing a lack of motivation among substance abuse treatment seekers) and personal beliefs, and attitudes about treatment, such as religious beliefs about addiction (for instance, God removing addiction at the right time) and denial (users not believing that they are addicted and perceive that they don't need treatment) have been identified by the authors as internal barriers to the process of recovery (ibid.)

Similarly to the findings of Xua et al. on the influence of stigma on recovery, previous studies also claim the prevalence of stigma, marginalization and social exclusion in relation to psychoactive substance use (Buchanan, 2004; Room, 2005). In some cases, ongoing social disapproval, and an evidence for a stronger desire to be socially distant from alcohol dependent persons than towards those with psychiatric diagnoses, such as depression or schizophrenia have been reported (Schomerus et al., 2010). Also, it is not only the general public that has negative moral feelings towards a substance-dependent person. The phenomena of physician biases towards individuals who are obese, suffer from mental health disorders, who are substance abusers, and who may have eating disorders have also been reported (Puhl & Brownell, 2001). There is widespread evidence that when healthcare providers share the biases of the general public, their approach can result in care that is either deficient, distancing or judgemental and lacking in care (Puhl & Brownell, 2001). Researchers found that medical education does not necessarily change such views (Mayda et al., 2015).

Considering further barriers to recovery, Xua et al. (2008) also reported systematic or environmental circumstances, that are out of a person's control, and which can therefore be potential external barriers to recovery. A few of these circumstances are: time conflicts (not

being able to get off work for treatment, household obligations, busy schedules and not having time for substance-abuse treatment), addiction treatment accessibility (living too far away for the place of treatment, not knowing where to go for the treatment, having difficulty getting to and from treatment) and not understanding the addiction treatment options. Entry difficulty, such as being wait-listed for a facility, and having to go through too many steps to access support, have also been documented to prevent drug abusers from seeking treatment. The cost of addiction treatment is also often perceived to be an external barrier to recovery (Xua et al., 2008).

The Centre for Social Justice (2013) identifies some barriers to recovery that are broader and societal in nature. It claims that the term 'recovery' has entered the mainstream lexicon of addiction treatment in the UK but the way it is used in documents has led to 'debilitating confusion'. Not everybody who enters treatment achieves a substance-free life, and too many are not even given the chance to try. By not specifying that every person in treatment should be given the opportunity to stop the use of substances, a vacuum has been created. Rather than aspiring for every substance-dependent individual to lead a full life that is free from substances, the definition of recovery now means providers can discharge someone 'in recovery' even if they are still vulnerable to the habit of substance use (Centre for Social Justice, 2013). There have also been instances where the terminology and criteria for recovery has been used as an excuse for withdrawing support from individuals who have ongoing needs (Slade, 2010).

In 2015 in England, 196,000 prescription items were dispensed for alcohol; this figure is 1% higher than it was in 2014 and is nearly double of the level ten years ago (Centre for Social Justice, 2013). The total Net Ingredient Cost (NIC) for items prescribed for alcohol dependence in 2015 was £3.93 million, which is 15% higher than that in 2014 (National Statistics, 2016). Also, for those struggling with heroin addiction, substitute prescribing can be the only helpful addiction treatment (National Treatment Agency, 2013b). Some also argue against the presence of 'methadone maintenance response', viewing it to be a great barrier to recovery. Methadone, rather than being a first step on the road to recovery, has become a substitute-drug with too many addicts 'parked' on it (Centre for Social Justice, 2013). Whiteford (2014) found that out of 500 individuals in receipt of a substitute prescribing regime, 219 were engaged in their current treatment episode for a period of 4

or more years. There are many hypotheses explaining the presence of such phenomena. Long-term opiate users can become demoralised, have little conviction that change is possible, and have limited aspirations. They also get 'stuck' in a cycle of low expectations and some may then use treatment not as a path to change, but as a way of sustaining a substance-using lifestyle (ibid.).

Substitute prescribing, such as the prescription of methadone, does not necessarily stop heroin-dependent individuals from using substances and in fact, one can draw parallels between the subscription of methadone policy and 'supplying an alcoholic with vodka in place of preferred gin' (Centre for Social Justice, 2013). The findings of Bloor et al. (2008) also support this view, claiming that methadone prescription does not lead to a higher rate of abstinence from heroin; long-term prescription fails to tackle the root causes of addiction, thus leading to wider problems (United Kingdom Focal Point, 2012). For instance, long-term prescription of methadone can fuel an ever-increasing black market, as prescribed substances are sold, given or stolen, and then consumed by someone other than the aimed individual, often resulting in lethal consequences (Duffy & Baldwin, 2012). According to Corkery et al. (2012) deaths involving methadone have risen by 50 per cent since 2006, and over 50 per cent of all the deaths where methadone was present showed that the substance had been obtained from illegal sources. To support the detrimental impact of long-term prescription of methadone, the National Treatment Agency for Substance Abuse (2012) claims that it is doubtful that prescribing methadone for the long-term actually helps individuals tackle their addiction when not combined with further support; yet in 2012, 49 per cent of those in treatment for addiction received nothing but methadone prescription, while only two per cent received residential rehabilitation (National Treatment Agency, 2013b).

Nonetheless, some argue that substitute prescription also carries certain benefits (Lind et al., 2005). One of the benefits of methadone is that it can bring some order to the user's life (National Treatment Agency for Substance Abuse, 2012). The user's health can also be stabilised and improved by not injecting and HIV rates can also be contained (ibid.). Some also reason that the crime rate in relation to drugs tends to fall as the state supply means that the user is no longer associated with the world of illicit drugs (Lind et al., 2005). However, numerous studies have shown that long-term substitute prescribing,

concentrating on the biological elements of the addiction experience—while having a significant impact upon illicit drug use and its consequent criminality and joblessness- is largely unable to completely eradicate these behaviours in the majority of individuals (Best et al., 1998, 1999; Best, Harris, Gossop et al., 2000; Best & Ridge, 2003). Illicit drug use and criminality appear to continue at a reduced level in most cases of prescription (Eley et al., 2002; Eley-Morris et al., 2002; Lind et al., 2005; McIvor et al., 2006; Yates, et al., 2005).

To conclude, there are serious weaknesses in the substance misuse prevention strategies that are applied nationally. Also, there are numerous extensive barriers to recovery. However, in defiance of such barriers, individuals still achieve stable recovery (Yates, 2014). In light of this, the meaning of recovery and its application in the treatment of dependence is often puzzling. The following section of the thesis gives a brief overview of the current approaches taken towards the term ‘recovery’ and the ways in which it influences the support provided to those who aspire to achieve it.

2.6 Recovering from addiction

There is an international consensus on the meaning of recovery, such as improvements in the state of wellbeing, meaningful engagement in community life, and reductions in substance use (Betty Ford Institute Consensus Panel, 2007; UK Drug Policy Commission, 2007). In the United Kingdom, most mental health services are based on the medical model of mental health, carrying the assumption that experiences result from difficulties within the brain. Services have also been based on what might be called a ‘paternalistic approach’, the idea that professionals know the best and their role is giving advice and the patient must obey the said advice and be compliant (The British Psychological Society, 2014). A shift can be observed within these services, moving from pathology, illness and symptoms to health, strengths and wellness (Department of Health, 2009). Also, instead of focusing on vulnerabilities, services are highlighting the importance of supporting the individuals’ recovery through active empowerment and strength (Barnes, 2011), helping individuals live the kind of life they want, whether or not the challenging experiences continue to exist (The British Psychological Society, 2014). Policy makers and practitioners, notably in the UK’s most recent National Drug Strategy, are also advocating a new surge of interest in this concept (Home Office, 2010; Landale & Roderick, 2013), thereby increasingly realizing the

importance of focusing on positive outcomes rather than solely attending to the pathology of substance abuse and dependence (Venner et al., 2006). Ashton (2007) claims that this reappearance of interest in recovery seems to have been driven by a media-led dissatisfaction with the perceived failures of the substitute-prescribing policy of the previous two decades. However, it also seems to owe much to a movement to redefine the nature and direction of treatment processes (Day et al., 2005).

Within the notion of recovery, some argue that recovery from substance addiction can be broadly understood in social terms, as a social contagion that is transmitted through the processes of social control and social learning (Moos, 2007). Within this view, individuals learn to recover by observing and imitating others, and are nurtured through the initial stages of recovery by peers and recovery community, such as mutual aid groups (Humphreys, 2004). Recovery, as a social process, also culminates in a change in social identity (Buckingham, Frings & Albury, 2013; Jetten, Haslam & Haslam, 2012;) that is driven by supportive peers and social networks that offer opportunities for social learning (Moos, 2007). Within this change, the individual moves from an excluded identity of a user, to a recovery identity that is internalised and learned through exposure to recovery peers and recovery groups that create a sense of belonging and a set of social supports that protect against the future relapse (Buckingham, Frings, & Albury, 2013). Because of this, Best, Bird and Hunton (2015) argue that recovery is contextually shaped – it is socially constructed and socially negotiated, and is located in the culture and values of particular communities.

An exploration of the literature on the values of community recovery reveals the emergence of the term ‘social capital’, which is often used by sociologists to describe the connections within and between social networks (Yates, 2014). The word was perhaps first mentioned in 1916 by the American schools’ inspector, Lyda Hanifan, explaining that “I do not refer to real estate, or to personal property or to cold cash, but rather to that in life which tends to make these tangible substances count for most in the daily lives of people, namely, goodwill, fellowship, mutual sympathy and social intercourse among a group of individuals and families who make up a social unit...” (Hanifan, 1916, p. 130). According to Sheldon and MacDonald (2009), Hanifan’s notion of ‘social capital’ was rooted in her belief in self-help and peer support. Whatever its origins, it is reasonable to think that the term has become a

shorthand for all that is good about community spirit in the linked fields of sociology, social policy, and social work (Yates, 2014).

Researchers on recovery, such as White and Cloud (2008), and Best and Laudet (2010), have taken the term 'social capital' and changed it to 'recovery capital' to describe the changes they have observed in the resilience and robustness of individuals' social and emotional circumstances of long-term, abstinent recovery. The authors described recovery capital to involve dramatic improvements in self-esteem, civic and social engagement, physical and psychological health, and the overall well-being of the individual (Best et al., 2010). Best et al. (2010) argue that "The best predictor of the likelihood of sustained recovery is the extent of 'recovery capital' or the personal and psychological resources a person has, the social supports that are available to them, and the basic foundations of life quality, i.e., a safe place to live, meaningful activities and a role in their community (however this is defined)" (Best et al., 2010, p.8).

Despite the values that the recovery movement offers (Bresford, 2012; Harper & Speed, 2012), it has been a controversial subject. Some argue that the term 'recovery' unhelpfully implies that there is an illness that one is supposed to recover from (The British Psychological Society, 2014), and authors such as Slade et al. (2012) and Machin and Repper (2013) emphasize that recovery does not mean that individuals should be able to do without help; as large numbers of individuals experience ongoing, disabling difficulties, it is vital that the idea of recovery is not used as an excuse to cut services or withdraw support from those who need it (Harper & Speed, 2012). Yates (2014) also argues that despite many services being recovery orientated, they lead to negative attitudes towards recovery in those who wish to overcome substance misuse. Services warn substance users and their partners to be continually on their guard against relapse and constantly vigilant for signs of the imminent return of their 'disease'. Furthermore, many harm-reduction-oriented treatment services reason for continuing maintenance, prescribing opioid replacement therapy. According to the author, in practice, both groups are encouraging a wider societal view of addiction as an incurable disease that can only be managed—either with continuing attendance at recovery meetings or with continued prescriptions for substitute substances. Thus, a public view of relapse, as an inevitable event for most individuals, underpins many of the negative attitudes that are directed toward this group (Yates, 2014). The present study aims to add to

studies which explore individuals' personal meaning of recovery so that treatment approaches can be further informed of the needs of those who wish to achieve substance-free lives.

2.7 Treatment of substance addiction

There is research evidence that the individuals grappling with substance misuse and dependence difficulties, who participate in self-help groups and/or receive professional treatment have better outcomes in comparison to those who do not (Miller et al., 2001; Moos & Moos, 2005). However, Yates (2011) argues that "While there has been a great deal of progress regarding the evidence base for various types of addiction treatment intervention, the field remains characterized perhaps more by what we do not know than what we do. More succinctly, most of the evidence indicates that treatment works, but very little is known about how it works or who it works best for." (Yates, 2011, p.109)

2.7.1 The application of therapeutic interventions to overcome substance addiction

In the United Kingdom, there are many organisations that provide help in treating substance dependence. For individuals being impacted by such difficulties, the General Practitioner (GP) is usually the first point of contact. GPs provide help and advice and recommend specialist addiction services, both at the national and local levels. The treatment for addiction aims to focus on individuals and their needs (NHS Choices, 2013).

The psychological approaches towards the treatment of dependence vary depending on the theoretical models underpinning them (The British Psychological Society & The Royal College of Psychiatrists, 2011). Psychological interventions can be classified into behavioural, cognitive, psychodynamic, humanistic, systemic, motivational, disease, and social and environmental approaches. For instance, behavioural approaches are based on the foundation that excessive drinking is a learned habit and therefore influenced by principles of behaviour, teaching the individual a different behavioural pattern in order to reduce the harm emerging from excessive drinking (ibid.). Contingency management, a behavioural approach towards the treatment of substance dependence, offers a system of reinforcement designed to make continual alcohol use less attractive and abstinence more

attractive (*ibid.*). Incentives are offered through four main methods, such as voucher-based reinforcement, prize-based reinforcement (Prendergast et al., 2006), cash incentives and clinic privileges (Stitzer et al., 1992). Whilst behavioural approaches towards the treatment of dependence highlight the learnt nature of substance misuse, in order to prevent or avoid relapse, cognitive approaches emphasize the role of thinking and cognition in engaging in substance using behaviour (The British Psychological Society & The Royal College of Psychiatrists, 2011).

Social approaches applied in the treatment of dependence stress the importance of the social environment, such as families or wider social networks. A type of social approach towards the treatment of substance dependence is social network and environment-based therapy. Such therapy takes into consideration the individual's social environment as a way to help achieve abstinence or controlled drinking. These therapies include social behaviour and network therapy (SBNT) and the community reinforcement approach. Social behaviour and network therapy encompasses a variety of cognitive and behavioural strategies to assist individuals build social networks supportive of change (The British Psychological Society & The Royal College of Psychiatrists, 2011). This involves the envelopment of the substance user and their social network, such as family and friends (Copello et al., 2002) with the aim to build positive social support for change in substance use. The community reinforcement approach (Hunt & Azrin, 1973; Meyers & Miller, 2001; Sisson & Azrin, 1989) highlights maintaining abstinence through the development of activities that do not promote alcohol use, for instance social and recreational activities and employment, whilst also involving family members in the process of recovery (The British Psychological Society & The Royal College of Psychiatrists, 2011).

Within the treatment of substance dependence, at times a combination of approaches is applied and described under the term of 'multimodal' treatment. Such methods stress that a combination of various treatment options is more influential than each individual component (The British Psychological Society & The Royal College of Psychiatrists, 2011).

As the field of mental health has been challenged with implementing evidence-based practices (Drake et al., 2005; Goodheart et al., 2006), the substance abuse/dependence treatment field has also been required to re-consider approaches applied by practitioners

(Capuzzi & Stauffer, 2012). In America, in 2010, the Substance Abuse and Mental Health Services Administration's National Registry of Evidence-based Programs and Practices listed as much as 96 interventions for substance abuse prevention and treatment (Substance Abuse and Mental Health Services Administration, 2014).

Cognitive behaviour interventions, which include self-control training, community reinforcement, contingency management, behaviour contracting, social skills training and behavioural couples/families counselling, have been found to be the most effective processes to treat alcohol addiction. Further research also suggests that other cognitive behavioural approaches are also effective for the treatment of drug dependence of cocaine and opioids (Capuzzi & Stauffer, 2012).

According to the National Institute of Health and Care Excellence (2012), evidence-based formal psychosocial interventions should be applied to treat drug dependence. These should be appropriate to the needs and circumstances of the service user and include: contingency management and behavioural couple's therapy for drug-specific problems and a range of evidence-based psychological interventions, such as cognitive behavioural therapy for common comorbid mental health problems (National Institute for Health and Care Excellence, 2007). Moreover, according to these guidelines, community reinforcement approach, social behaviour network therapy, relapse prevention-based therapy and psychodynamic therapy should also be applied. Further, cognitive behavioural relapse prevention-based therapy and psychodynamic therapy should not be used as first-line psychosocial treatments. They may be reserved for individuals who have not benefited from first-line treatments such as brief interventions, contingency management and self-help groups, or in cases where clinical judgement suggests they may be appropriate in the particular circumstances of the given case (National Institute of Health and Care Excellence, 2012).

Also, according to the National Institute for Health and Care Excellence (2011), the treatment of dangerously heavy alcohol drinkers and individuals with mild alcohol dependence should include psychological intervention, such as cognitive behavioural therapies, behavioural therapies or social network and environment-based therapies, which specifically focus on alcohol-related cognitions, behaviour, problems and social networks. In

the case of harmful drinkers who have a regular partner willing to participate in treatment, behavioural couples therapy should also be offered. These guidelines highlight that after detox professionals should consider offering acamprosate or oral naltrexone in combination with an individual psychological intervention such as cognitive behavioural therapies, behavioural therapies or social network and environment-based therapies, that focus specifically on alcohol misuse and its eradication.

NICE guidelines (National Institute for Health and Care Excellence, 2011) also highlight that in the cases of those who misuse alcohol and have comorbid depression or anxiety disorders, alcohol misuse must be treated first since this may lead to significant improvement in the person's condition. If depression or anxiety continues affecting the person after three to four weeks of abstinence from alcohol, professionals should undertake an assessment of the depression or anxiety and consider referral and treatment in line with the relevant NICE guideline for the particular disorder.

The National Institute for Health and Care Excellence (2011) concludes that psychological interventions are an important therapeutic option for people with alcohol-related problems. However, even with the most effective current treatments such as cognitive behavioural therapies and social network or environment-based therapies, the effects are modest at best and treatment is not effective for everyone (The National Institute for Health and Care Excellence, 2011). Despite that the present study aims to explore individuals' experiences of climbing and recovery, it also intends to look at factors, potentially beyond climbing, that contribute to sustaining recovery. Therefore, the current research, where relevant, aims to offer the opportunity to participants to potentially share and reflect on the influence of various psychological interventions on their recovery journeys.

2.6.2 Residential rehabilitation for treatment of addiction

In the treatment of substance misuse and addiction, residential rehabilitation is known to be a particularly effective intervention. Research has shown that abstinence-based residential treatment of addiction is a lot more successful than community-based prescription of substitute medication with the best units having a 60% success-rate at getting individuals to leave the program dependence-free (National Treatment Agency for Substance Abuse,

2012b). However, residential rehabilitation is received by only 2% of those under treatment, and against the suggestions of the NICE Guidelines on the provision of medication and therapeutic support, 49% of those under treatment receive only medication. Commissioners are also withdrawing support for effective services. In 2013, 55% of local authorities have cut funding to residential rehabilitation centres, whilst harm reduction services, which can maintain individuals in their addiction, have been preserved under the NHS ring-fence (Centre for Social Justice, 2013). According to the National Treatment Agency (2012b), this lack of quality treatment received by many who struggle with addiction could explain why the national figures for leaving 'free of dependence' are as low as 11.5%.

2.8 The role of natural recovery and meaningful activities in recovering from addiction

Natural recovery research emphasises overcoming addiction without having to undergo any formal treatment (Landale & Roderick, 2013). Even without any specific treatment, large-scale epidemiological studies have shown high percentages of spontaneous recovery (Blanco et al., 2013; Morse, 2006; Lopez-Quintero et al., 2011). In line with these findings, according to Yates (2014), 'natural' recovery from even the most serious episodes of addiction is widespread, and is perhaps even commonplace. In Europe, the majority of these natural recovery episodes appear to take place outside the formal treatment setup and even in defiance of the orders and advice of treatment providers. Morse (2006, p. 169) argues that "the ability of many addicts to decide to quit and to be responsive to contingencies generally is an inconvenient fact for those who wish to conceptualize addiction as purely a brain disease." Yates (2014) highlights that understanding this process of natural remission and the structures or elements that both make recovery possible and sustained will help to identify the most critical aspects of treatment interventions in general and after-care processes in particular.

In the research area of natural recovery (Landale & Roderick, 2013), meaningful activities taking place in the community have been identified as the key contributors to resolving alcohol and substance misuse problems (Granfield & Cloud, 2001). Best et al. (2008) reason that the key predictors of successful recovery include supportive social networks and meaningful activities that are grounded in community settings. To support their claims, the authors surveyed the experiences of 107 former problematic heroin users who attained

long-term abstinence. Participants have been recruited opportunistically and a majority (79%) at the time of the survey worked in the addictions field. Data collection took place through the application of a brief self-completion instrument, which consisted of quantitative questions, asking participants about heroin careers and desistance, but also enquiring about the ways in which participants became and managed to remain drug-free. The authors found that on average, participants had heroin careers lasting for just under 10 years, punctuated by an average of 2.6 treatment episodes and 3.1 periods of abstinence. The most commonly expressed reason for achieving abstinence was 'tired of the lifestyle', followed by reasons relating to psychological health. When participants have been asked to explain how abstinence was sustained, participants quoted both social network factors, such as moving away from drug-using friends and support from non-using friends, and practical factors, such as accommodation and employment, as well as religious or spiritual factors. Generally, participants did not make reference to treatment either in achieving or sustaining abstinence, in contrast to 12-Step, which was endorsed widely. The authors conclude that the study supports a careers perspective for examining heroin careers and indicates that, while achieving abstinence is possible for chronic opiate users, the path to sustained abstinence is complex and often reliant upon external support systems. However, the sample of this study consisted principally of professionals in the addictions field, who have been recruited opportunistically; therefore, the results cannot support claims for generalisability. Another limitation of the study is that individuals' responses may have been susceptible to recall and self-serving biases, as the events of achieving abstinence occurred long periods prior to the completion of the brief questionnaire. A further limitation of the study is that the data-collecting instrument has not been validated, and the researchers had no data to report on its psychometric performance (Best et al., 2008).

When Best et al. (2013) looked at the measures of recovery such as physical and psychological health, overall quality of life, substance use, and the presence or absence of meaningful activities, those in treatment who reported abstinence and engagement in meaningful activity demonstrated having the highest quality of life. The authors concluded that holistic approaches that acknowledge the importance of participation in meaningful activities are likely to be beneficial to the successful recovery of individuals.

To further support the role of meaningful activities in recovering from substance dependence, Best et al. (2013) explored associations between the subjective measures of quality of life, physical and psychological wellbeing, gender, and indicators of abstinence and meaningful activity among new and existing drug treatment clients in two areas of England. The two English Drug Action Team (DAT) areas were identified based on having routine monitoring data available for analysis. Participants were drug users who were either new or existing clients at the two DAT sites and completed at least one Treatment Outcomes Profile (TOP). Treatment data were collected routinely at the point of treatment entry and at three months from treatment initiation. The authors utilised three measures of quality of life from the TOP. These included clients' rating of their physical health, psychological health and overall quality of life for the previous 28 days. Each of the three quality of life items demonstrated good concurrent validity. The quality of life and wellbeing measures were assessed against two factors, such as any use of heroin or crack cocaine in the last 28 days, as a measure of abstinence, and any form of education, training or employment in the last 28 days, as a measure of meaningful activity. On the DAT1 site, 10,470 individuals completed TOP, inclusive of those new to treatment or already in treatment. The majority of cases were male (71.7%), and 98.7% were white, with 98.1% describing themselves as British. The second site provided at least one completed review form for 783 participants. Participants were 586 (74.8%) males and 197 (25.2%) females. At the second site participants were predominantly white (81.2%), with 12.1% Asian, 5.1% of mixed race and 1.5% of other ethnic groups. On the first site, analysis revealed that those who had at least one day of meaningful activity reported better physical health ($t = 20.36$, $p < .001$), psychological health ($t = 16.78$, $p < .001$) and overall quality of Life ($t = 18.32$, $p < .001$). On the second site, the authors also found a clear relationship between meaningful activities and quality of life. Clients engaged in at least one day of training or employment at review reported better physical health ($t = 5.33$, $p < .001$), psychological health ($t = 5.05$, $p < .001$) and overall quality of life ($t = 6.22$, $p < .001$). The limitations of the study lie in the fact that the data were based upon unverified self-reports and that substance use was not biologically corroborated. Despite of these limitations, the researchers highlight the importance of the application of a holistic approach to supporting problematic substance use, acknowledging the prominence of participation in meaningful activity (Best et al., 2013).

Recovery's social and political movement has emerged from a relatively small number of empirical studies, identifying longer-term approaches to be necessary to support individuals with dependence difficulties (Groshkova & Best, 2011). This approach indicated that recovery takes place at least as much in the community as it does in treatment settings such as detox units and residential rehabilitation centres (ibid). Similarly, Venner et al. (2006) also advocate that treatment is one discrete aspect to recovery, and sustained recovery is often influenced by an individual's interaction with others within a social context.

In line with this view, the Community Reinforcement Approach (CRA) employs environmental contingencies in order to prevent drinking and drug abuse (Meyers & Squires, 2001). It incorporates multiple modalities such as behavioural therapy, stress management, medication, marital counselling, job skills training and motivational enhancement (Meyers & Miller, 2001; Wolfe & Meyers, 1999). Another important aspect of the approach is social and recreational counselling, which is implemented with the aim to increase entertainment from sober activities and also to project a sober life as more rewarding than a life revolving around the use of substances (Siporin & Baron, 2012). Specifically, the CRA therapist helps individuals identify non-drug sources of recreation to replace drug based recreation, followed by the provision of support in applying these into everyday practice (Meyers & Squires, 2001). The findings of quantitative studies (Correia et al. (2002; 2005) support the evidence for the effectiveness of such approaches. The authors found a correlation between non-substance related behaviours and substance-free reinforcement scores (Correia et al., 2002), reporting that young adults engaging in creative behaviours and meaningful activities showed decreased substance use (Correia et al., 2005). Other studies on alcohol dependent participants and cannabis users conducted by Dennis et al. (2004); Smith et al. (1998) and Petry et al. (2001) also demonstrated a decreased substance use as compared to the standard treatment controls when individuals participated in targeted social recreational activities.

In line with the above findings, Hood (2003) also suggested that leisure, taking place within a social context, can be used as an alternative for substance misuse and can be quite effective in the prevention and treatment of alcohol abuse. The author found that leisure allowed women who had difficulties with alcohol-dependence to learn about their strengths and weaknesses, talents, limitations and their interests, and to help them take new risks,

which in turn led to a reduction of alcohol consumption. These findings are reinforced by Cook (1985, p. 1399), who also claims that “individuals provided with healthful, nonchemical ways of gaining rewards and pleasure will be less likely to engage in drug and alcohol abuse.” Further research also proved an inverse relationship between drug use and engagement in non-drug-related social activities (Rogers et al., 2008). Rogers et al. highlighted that participating in non-drug-related activities may have the potential to help individuals maintain abstinence and prevent relapse. To test their hypothesis, the authors analysed changes in the frequency and enjoyment of activities among 78 methadone-maintained individuals. Participants were assigned to one of the following 52-week interventions: (a) usual care only (UC), (b) take-home methadone doses contingent on cocaine- and opiate-negative results (THM), or (c) take-home methadone doses for cocaine- and opiate-negative results and monetary-based vouchers contingent on cocaine-negative urinalysis results (THM V). Cocaine use was assessed by urine analysis on a thrice-weekly schedule. Frequency and enjoyability of non-drug-related activities were assessed with the Pleasant Events Schedule (PES) at baseline, mid-treatment, and end of treatment. In previous studies the Pleasant Events Schedule demonstrated acceptable test-retest reliability (0.81), concurrent validity (0.70), and predictive validity (0.65) (MacPhillamy & Lewinsohn, 1982). Studies also suggest that the Pleasant Events Schedule can discriminate between cocaine-dependent outpatients and matched controls without drug abuse, as well as between individuals with different levels of cocaine-dependence severity (Van Etten et al., 1998). Rogers et al. (2008) stratified and randomly assigned participants to the treatment conditions, with no significant differences in participant characteristics assessed at baseline between. According to their findings, individuals assigned to the take-home methadone doses for cocaine- and opiate-negative results and monetary-based vouchers contingent on cocaine-negative urinalysis results condition achieved the greatest abstinence from cocaine and opiate use (THM V), followed by the take-home methadone doses contingent on cocaine- and opiate-negative results (THM) and usual care only (UC) conditions. The take-home methadone doses contingent on cocaine- and opiate-negative results (THM V) condition had the highest Pleasant Events Schedule (PES) frequency ratings at mid-treatment and at the end of treatment, followed by the THM and UC conditions. There were significant differences ($p < .05$) between the THM V and UC conditions on ten of twelve PES-derived subscales. As the design of the study has been rigorous, it provides

good evidence to support the authors' conclusions that non-drug-using activities may themselves function as reinforcers and facilitate abstinence (Rogers et al., 2008).

2.9 The benefits of exercise, physical activity and its application for the treatment of mental health problems

Exercise has the potential to simultaneously influence the individuals' physical and psychological health, and this could have positive cost implications for the NHS (Daley, 2002). Also, often given the lack of treatment, delay in seeking treatment, and high morbidity due to mental illness, in addition to the standard evidence-based treatments, physical activity and exercise are highly likely to play a substantial role in the prevention and treatment of mental health difficulties (Callagan, 2004). Some also argue that exercise could be '*the medicine*' for mental health problems (Dunn & Jewell, 2010).

According to the National Research Council and Institute of Medicine (2009), individuals with good health habits, including regular exercise, generally also have good mental health. Those who have mental health difficulties die 10-15 years earlier as compared to the rest of the population, and the major contributing factors to such deaths include preventable cardiovascular diseases, resulting from poor lifestyle choices like physical inactivity (Parks et al., 2006).

Based on cross-sectional and prospective epidemiological data, physical activity has been found to protect against feelings of distress, depression and anxiety, while enhancing psychological well-being (Physical Activity Advisory Committee, 2008), increasing self-esteem, and reducing stress. Various research findings also provide convincing evidence in support of the aforementioned claims. Zschucke et al. (2013) assert that exercise and physical activity can both prevent or delay the onset of different mental health issues, such as anxiety, affective, eating, and substance use disorders, as well as schizophrenia, dementia and mild cognitive impairment. According to the authors, when used as sole or an adjunct treatment for mental health problems, exercise and physical activity can have therapeutic benefits for individuals. Goodwin (2003); Harvey et al. (2010); Ten Have, de Graaf and Monshouwer (2010); Ströhle et al. (2007); and Pasco et al. (2011) also claim that exercise is beneficial in terms of psychological well-being. In an adult US population, regular physical

activity has been associated with a significantly decreasing prevalence of recurrent major depression, panic disorder, agoraphobia, social phobia, and specific phobia (Goodwin, 2003). A negative cross-sectional association has also been found between depression and the leisure-time spent in physical activity of any intensity (Harvey et al., 2010), and lower rates of any affective, anxiety, or substance use disorder have been claimed amongst individuals who exercised for at least one hour per week (Ten Have, de Graaf, & Monshouwer, 2010). Also, the overall incidence of mental disorders and co-morbid mental disorders, as well as the incidence of anxiety, somatoform, and dysthymic disorders has been found to be inversely proportional to the amount of physical activity (Ströhle et al., 2007). In conclusion, physical activity can play a role in preventing mental health problems and improving the quality of life of those experiencing such difficulties (Department of Health of Physical Activity and Health Improvement and Protection, 2011).

2.9.1 Physical activity, exercise and its use for the treatment of substance misuse and dependence

Regardless of the well-established overall health benefits of physical exercise and the knowledge that many people grappling with addiction want to be physically active (Neale et al., 2007), the literature seems to pay little attention to sports activities in adult alcohol and drug treatment programmes. Also, despite the benefits which programmes of exercise potentially offer, mainstream funding has mainly favoured pharmacological and psychological interventions which have focused on reducing the harms associated with alcohol and drug misuse (Landale & Roderick, 2013). There is little research (Crabbe, 2000) and even less prospective research into how sport and exercise may help individuals resolve alcohol and drug use issues and support the maintenance of sobriety (Landale & Roderick, 2013). In this regard, the present study can potentially make a contribution to the literature by exploring the use of physical activity, in the form of climbing, that may have the potential to contribute to substance dependence recovery.

In the treatment of substance abuse and dependence, Ala-leppilampi (2006) and Zangeneh et al. (2007) promoted the idea of exercise as an adjunct to substance misuse treatment. According to the authors, given the benefits of exercise, it can be considered a very effective form of health promotion and/or harm reduction. According to the authors, it is therefore

something that should be recommended immediately, even if its application has not ultimately achieved a direct reduction in substance misuse. In support of this view, Weinstock et al. (2008) also proposed exercise to be an adjunct intervention for substance use disorders. The authors examined the association between the completion of exercise-related activities such as swimming, jogging and basketball in substance use disorders treatment outcome in a sample of 187 participants who were undergoing intensive outpatient treatment with contingency management. The authors found that those engaged in exercise related activities achieved longer durations of abstinence during treatment than those who chose not to complete exercise-related activities. Their findings suggest that exercise may be beneficial to individuals undergoing treatments for disorders related to substance abuse.

There are numerous quantitative studies examining the benefits of exercise for recovering from tobacco addiction and the mechanisms through which this may take place i.e. Haasova et al. (2013, 2014); Marcus (1999); Martin, Kalfas & Patten (1997). In 1981, it was proposed that exercise could aid smoking cessation (Hill, 1981). A few years later, experimental studies showed that cardiovascular-type exercises could indeed have an acute effect on reducing both psychological withdrawal symptoms and the desire to smoke in abstinent smokers. This has been the case for both brief, five to ten minute sessions of moderate intensity exercise among smokers who have been abstinent overnight, and also for thirty to forty minute sessions of vigorous intensity among smokers who have been trying to quit smoking (Haasova et al., 2013; Haasova et al., 2014; Roberts et al., 2012; Ussher, Taylor & Faulkner, 2007).

Ussher, Taylor, & Faulkner (2014) reviewed an extensive number of exercise interventions for smoking cessation. The authors identified 20 trials with a total of 5,870 participants and the largest study they looked at was an internet trial with 2,318 participants (McKay et al., 2008). These studies varied in the timing and intensity of the smoking cessation and the exercise programmes offered. According to the authors' review, four studies showed significantly higher abstinence rates in the physically active group versus a control group at end of treatment (Bock et al., 2012; Marcus 1999; Marcus et al., 1991; Martin, Kalfas, & Patten 1997) and one study found a significant benefit for exercise versus control on

abstinence at the three-month follow-up and a benefit for exercise of borderline significance ($p = 0.05$) at the 12-month follow-up (Marcus et al., 1999).

The mechanism underlying the observed beneficial effect of exercise on withdrawal and cravings is unclear (Ussher, Taylor and Faulkner, 2014). Therefore, through exploring participants' experiences, the present study intends to shed some light on links between an exercise activity, such as climbing and beneficial reductions in substance dependence. It has been proven that exercise has some similarities to smoking in its effects on stimulating the central nervous system (Russell, Epstein, & Erikson, 1983); it also has an effect on the neurobiological processes in the brain (Dishman & O'Connor, 2009), including increasing the beta-endorphin levels in smokers (Leelarungrayub et al., 2010), providing an alternative reinforcer to smoking (Marlatt & Gordon, 1985). Another possible mechanism through which exercise influences smoking cessation is through the attention to somatic cues, distracting smokers from the cravings and negative cognitions that can be experienced during smoking abstinence (Ussher, Taylor, & Faulkner, 2014). Also, exercise may influence the cognitive functioning in smokers through reducing the attentional bias to smoking images (Janse van Rensburg, 2009; Taylor & Hodgson, 2009; Oh & Taylor, 2014).

Literature focusing on exercise and smoking addiction reported that in terms of protecting the individuals from smoking relapse, exercise has been found to be positively associated with coping (Steptoe et al., 1989), self-esteem (Spence, McGannon, & Poon, 2005) and overall physical health (Garber et al., 2011) for continuing smokers (Colbert et al., 2001; Hedblad et al., 1997; Senti et al., 2001) and amongst smokers who have quit (Albrecht et al., 1998; Niaura et al., 1998; Shinton 1997). In terms of the health benefits of exercise, it has also been reported that it has the potential to reduce smoking cessation weight gain in the long-term (Farley et al., 2012) and to decrease cravings for sweet foods during the first week of abstinence (Teo et al., 2014). The weight control benefits of exercise may be of particular importance to female smokers who experience fear of cessation weight gain (Linke et al., 2013; USDHHS 2001; Weekley, Klesges, & Reyle, 1992); this often being reported to be a motivator for continued smoking (Clark et al., 2004; Sorenson et al., 1992; USDHHS 2001). The present study intends to add to a small number of literature which explores the benefits of exercise, through an activity, such as climbing, on substance dependence recovery.

2.10 Outdoor recreational activities, climbing, psychological well-being and the aim of the present study

2.10.1 Outdoor recreational activities, climbing and psychological well-being

Empirical and theoretical research asserts that nature and outdoor activities possess restorative and therapeutic benefits (Gathright et al., 2006). Also, a direct correlation has been found between individuals spending time in natural surroundings and stress-reduction (Hartig et al., 2003; Kaplan and Kaplan, 1989; Ulrich et al., 1991). Also, outdoor recreation activities such as climbing, walking, hiking, orienteering and cycling, kayaking, canoeing and sailing have been shown to be bio-psycho-socially beneficial to the individuals' lives (Frances, 2006). The physiological benefits of outdoor recreational activities include improvements in blood pressure, pulse, vigour, energy as well as physical well-being (King, 2000; McCreesh, 2001; Palmer, 1995). The psychosocial outcomes consist of the development of daily living skills and hobbies, increased self-esteem and confidence, the development of a positive self-identity, increased decision-making skills, improved communication skills and enjoyment of the natural habitat as well as increased self-awareness and motivation (King, 2000; McCreesh 2001; Mills, 1992; Raine & Ryan, 2002; Siegel Taylor & Evans-McGruder, 1996). The emotional benefits of outdoor recreational activities have been shown to entail improvements in mood and also help individuals distract themselves from mental health problems. Enhanced coping mechanisms and increased ability to overcome challenges, developed emotional maturity and an increased level of self-acceptance have also been identified as major emotional benefits of outdoor recreational activities (King, 2000; McCreesh 2001; Raine & Ryan 2002; Siegel Taylor & Evans-McGruder, 1996).

For instance, Siegel Taylor and Evans-McGruder (1996) explored meaningful components of the experience of an outdoor recreational activity, such as sea kayaking, amongst individuals with spinal cord injury. Participants engaged in sea kayaking expeditions through an outdoor experience organization specifically created for persons with disabilities. One woman and two men volunteered to take part in interviews with the first author. Interviews were recorded, transcribed and analysed thematically. In order to ensure

trustworthiness of the collected data, the authors applied triangulation by also interviewing a kayaking guide and a recreational therapist who accompanied the kayakers. Throughout the research process, field notes were used to aid reflexivity. The reliability of the findings has been ensured through both researchers being involved in the data analysis. The themes identified by both authors matched closely. Transferability and credibility of data took place through member checking, where participants reviewed and evaluated the thematic analysis. The authors found that sea kayaking as a physical activity has been recognized by participants as a way of promoting a positive physical and mental change. Participants described the outdoor activity as meaningful, important, or fun, expressing the pleasure of taking part in a challenging and novel activity with others in a natural setting. Participants also seemed more pleased to see themselves as individuals “who felt safe conquering challenges presented by an unpredictable natural environment than to accept an identity defined by the confines of living quarters, paved surfaces, and passive leisure” (Siegel Taylor and Evans-McGruder, 1996, p. 45). The authors concluded that participants’ accounts emphasize the value of an outdoor environment, where therapeutic possibilities of outdoor adventure activities may take place. The findings of the study may be transferable to research samples with similar characteristics, but for more general claims to be made about the therapeutic nature of an outdoor activity, such as sea kayaking, further research needs to explore the experiences of those who do not define themselves as suffering from a disability, such as spinal cord injury.

Many climbing activities are outdoor activities, whilst others take place indoors, such as indoor climbing walls. Some activities are usually carried out using ropes to help manage risk, whereas others, such as bouldering and hill walking, are invariably done without ropes. Rock climbing, trad (traditional) climbing, sport climbing, soloing, bouldering, ice climbing, competition climbing, hill walking, scrambling and mountaineering are the main activities that are considered to be categorized under climbing (British Mountaineering Council, 2014).

Research on climbing and climbers to date have mainly focused, for instance, on establishing the physiological characteristics of climbers (Cole, 1990; Dietrich, 2005; Haddock & Funk, 2006; Jones et al., 2008; Rohrbough et al., 2000; Schoffl, 2013; Schöffl et al., 2006; Schweizer et al., 2005; Wallace et al., 2010; Watts, 2004;), risk taking in rock

climbing (Llewellyn & Sanchez, 2008; Martha et al., 2009; Slanger & Rudestam, 1997; West & Allin, 2010) and in extreme sports (Brymer, 2010), climbers' personality and sensation seeking alongside risk taking (Breivik, 1996; Fave, Bassi, & Massimini, 2003) and the relationship between personality (Magni et al., 1985; Watson & Briony, 2004) behavioural traits (Robinson, 1985) and participation in rock climbing, identity development in rock climbing (Robinson, 2004).

A study conducted by Kuo and Taylor (2004) explored the specific health benefits of climbing. The authors found that alongside the physical benefits, the problem solving that climbing requires can potentially boost brain function. Other studies also claimed outdoor climbing to decrease symptoms of ADHD, improve memory (Arbor, 2008) and enhance creativity (Oppezzo & Schwartz, 2014). Further research on climbing has been conducted by Cook et al. (2017), who explored the use of indoor rope climbing and bouldering in a school setting. With the informed consent of parents, the Ancaster Senior Public School provided climbing opportunities to all of its students (around 96% of students taking up climbing) for 15 periods of wall climbing per week, each session lasting 60 minutes. According Cook et al.'s (2017) findings, as a result of the programme, the school tracked fewer office referrals, fewer student suspensions and an increased student involvement in a combined skill and fitness-based program. Based on school staff observations, Cook et al. (2007) claimed that climbing has numerous and significant benefits for students. The authors described climbing to have the potential to increase students' perseverance and trust, developing goal setting, problem solving, team work and communication skills. Furthermore, the authors claimed that climbing can enhance self-esteem, while also contributing to overall physical fitness levels, including cardiovascular and muscle endurance as well as strength and coordination development. According to the authors, climbing can also provide partakers real life experiences in working through and meeting challenging situations, offering the opportunity for these skills to be transferred to everyday life situations. Further benefits of climbing, such as contributing to the development of students' self-confidence, personal trust, willpower and courage, but also helping students learn to focus and concentrate and travel beyond their personal comfort zones into the world of adventure-based learning, have been described as major benefits of climbing. The authors conclude climbing to be "the ultimate metaphor for life. The magic seems to be in the perceived nature of risk

involved with the climb. Ironically, the fears we all have about failing are met face-to-face there on the wall. Through incremental risk-taking via the various wall problems, we learn to ask for help, develop trust, accept challenge by choice, break through mental, physical and emotional barriers, and rely on the personal powers that we summon to meet and successfully overcome the challenge at hand “(Cook et al., 2007, p. 15).

While the programme received acknowledgment for its educational excellence (Hamilton-Wentworth District School Board Profiling Excellence Award), several limitations of the authors' claims must be taken into consideration. Firstly, the data have been collected through staff observations, and there has not been direct access to students' own experiences. The authors make a reference to a journal where students' perceptions of the climbing wall program have been collected; however, the reader has no direct access to this. Secondly, despite stating that the data collection took place through staff observations, it remains ambiguous to the reader whether the use of questionnaires, video recordings or the use of notes have been applied to collect the data. Thirdly, the authors fail to offer an explicit description of participant recruitment and sampling and provide no reference to the observers' demographics and of the potential ways in which their own biases may have influenced the formulation of the research question and the data collection. Fourthly, there is also lack of in-depth description of the presence of rigour in the data analysis process. Finally, the authors express that around 96% of the school pupils showed interest in the climbing activity, and they fail to explore the experiences of those who decided not to climb. Also, as presented previously, the authors claimed fewer office referrals, fewer student suspensions and an increased student involvement as a result of the programme. However, correlation is not causation and further research would be necessary to explore climbing's direct influence on such behaviours. Despite the promising attributes of climbing taking place in an educational environment, further rigorous research is required before making general claims of its bio-psycho-social benefits.

2.10.2 The aim of the present study

The present study is concerned with the main research question of ‘What are climbers’ experiences of recovering from substance addiction?’. In line with the IPA approach, the study intends to understand participants’ perspectives and to offer a detailed and nuanced analysis of the lived experience of a small number of participants, with an emphasis on the convergence and divergence between them (Dallos & Vetere, 2005). Approaching the research question through a qualitative lens, the present study aims to address a gap in the literature on the addiction recovery experiences of those who climb. In line with the recovery approach (Betty Ford Institute Consensus Panel, 2007; UK Drug Policy Commission, 2007) the study also aims to move away from pathology, illness and symptoms to health, strengths and wellness (Department of Health, 2009), focusing on positive outcomes and factors that contribute to sustaining recovery. As there is little research (Crabbe, 2000) and even less prospective research into how sport and exercise may help individuals resolve alcohol and drug use issues and support the maintenance of sobriety (Landale & Roderick, 2013), the present study also aims to add to studies that explore the role of meaningful activities (i.e., Best et al., 2008, 2013; Correia et al., 2002, 2005; Dennis et al., 2004; Granfield & Cloud, 2001; Siporin & Baron, 2012), leisure (i.e., Cook, 1985; Hood, 2003; Rogers et al., 2008) and exercise (i.e., Haasova et al., 2013, 2014; Marcus (1999); Martin, Kalfas, & Patten; 1997; Weinstock et al., 2008) in recovering from substance dependence. Through the exploration of the pursuit of an activity such as climbing, the present study also aims to make a contribution to studies which explore the influence of outdoor recreational activities (i.e. King, 2000; Mccreesh 2001; Mills, 1992; Raine & Ryan, 2002; Siegel Taylor & Evans-McGruder, 1996; Palmer, 1995) and climbing (Arbor, 2008; Cook et al., 2007; Kuo & Taylor, 2004; Oppezzo & Schwartz, 2014; Willig, 2008) not only on substance dependence recovery, but also on individuals’ general well-being.

CHAPTER III: METHODOLOGY

3. Qualitative approach

The aim of the present study is to explore the experience of individuals recovering from addiction who climb. In order to meet this aim, four types of qualitative methodologies were considered: Grounded Theory, Discourse Analysis, Narrative Analysis and Interpretive Phenomenological Analysis.

Whilst the grounded theory is a sociological approach (Willig, 2001), IPA is a psychological methodology concerned with giving a detailed and nuanced account of the personal experiences of a smaller sample (Smith et al., 2009). In order to facilitate the aim of this project, the application of IPA over the grounded theory has been decided.

Whereas IPA is concerned with cognitions and sense-making, discourse analysis is perceived to be sceptical regarding the accessibility of cognitions, focusing more on language in terms of its function in constructing social reality (Nunn, 2009). In comparison to this, IPA recognises that cognitions are not transparently available from verbal reports, which is why it engages in an analytic process in the hope of being able to say something about the sense- and meaning-making involved in participants' experiences (Smith, Flowers, & Osborn, 1997; Smith et al., 2009). These properties of IPA make it more favourable to be applied in the present study than the application of the discourse analysis.

Narrative analysis, a social constructionist approach, also engages with meaning-making, and was considered for the present study. However, the narrative is only one way of making meaning, including discourse and metaphor, and therefore it was believed that the IPA could include consideration of narrative in the sense-making of participants, without being constrained by such focus (Smith et al., 2009).

3.1 Interpretive Phenomenological Analysis (IPA)

IPA was initially adopted within the domain of health psychology (Flowers et al., 1997; Osborn & Smith, 1998; Senior et al., 2002; Smith, 1996), but it has since also been applied in social and counselling psychology research (Coyle & Rafalin, 2000; Golsworthy & Coyle,

1999; Macran et al., 1999; Touroni & Coyle, 2002; Turner & Coyle, 2000). The benefits of such approach in the present study are that it allows the exploration of experiences, cognitions and the personal accounts of individuals (Willig, 2001). It is an approach to qualitative, experiential and psychological research, which has been informed by the three key areas of the philosophy of knowledge: phenomenology, hermeneutics and ideography (Smith, Flowers, & Larkin, 2009).

3.1.1 Phenomenology and IPA

Phenomenology is a philosophical approach, which is considered to be the study of human experience. Phenomenology provides a framework to psychologists about how to comprehend and examine a lived experience. Husserl, Heidegger, Merleau-Ponty and Sartre are considered to be the four major phenomenological philosophers (ibid.)

Based on Husserl's work, the founding principle of phenomenological inquiry is that experience should be examined in its own terms, in the ways that it occurs. Husserl also argued for focusing on each and every particular thing in its own right. In order to do this, individuals need to step outside of their daily experience of natural attitude and adopt a phenomenological attitude through reflexivity (Husserl, 1970, as cited in Smith, Flowers, & Larkin, 2009). Reflexivity can take place through bracketing. IPA researchers, through bracketing, consider and put aside the taken-for-granted ways of living in the everyday world (Smith, Flowers, & Larkin, 2009).

From the second major phenomenological philosopher, Heidegger, IPA researchers implemented some key ideas of humans 'being thrown into a world' of objects, relationships and language. His work also encouraged the IPA researchers to consider human existence as temporal, perspectival and in-relation-to-something. Heidegger also accentuated the importance of interpreting people's meaning making within a phenomenological inquiry, which has been adopted by IPA scholars (Smith, Flowers, & Larkin, 2009).

Merleau-Ponty (1962), the third major phenomenological philosopher, argued that the body is what shapes the fundamental character knowledge about the world and that the place of the body is a central element in experience. IPA researchers acknowledge that this can

never be entirely captured or absorbed, but that doesn't mean that it should be overlooked or ignored (Smith, Flowers, & Larkin, 2009). Similar to such concepts, IPA researchers embraced the importance of analysing people who are engaged in embodied, interpersonal, affective and moral encounters from Sartre (1943).

3.1.2 Hermeneutics, Idiography and IPA

The second key area of the philosophy of knowledge and a major underpinning of the IPA is hermeneutics. According to Bleicher (1981), hermeneutics can be defined as the theory or the philosophy of the interpretation of meaning. Schleiermacher, Heidegger and Gadamer are the three most crucial hermeneutic theorists (Smith, Flowers, & Larkin, 2009). Schleiermacher was the first person to systematically write about hermeneutics in a generic form. He argued that if one is engaged in a detailed, comprehensive and holistic analysis, one may acquire a better understanding of the subject at hand as compared to those who provided the data for analysis. However, from an IPA perspective, the researchers should not claim that their analysis is truer than the accounts of the research participants', but view analysis to be something that has the potential to offer meaningful insights (ibid.).

Alongside Schleiermacher, Heidegger also articulated the case for hermeneutic phenomenology. For him, phenomenology is concerned in part with examining things which may be disguised and hidden, but he was also interested in looking at things that only emerge into light, and are integrally connected with the deeper latent forms of meaning. He argued that the foundation of interpretation is laid on fore-conceptions and interpretation can never be an assumption-less state. When researchers are attempting to interpret, the fore-structure is always present and can be an obstacle to interpretation. IPA researchers from Heidegger's interpretive phenomenology re-evaluated the role of bracketing, viewing it as a cyclical process and something that can only be partially achieved (Smith, Flower and Larkin, 2009).

Gadamer (1990, 1960, as cited in Smith, Flowers, & Larkin, 2009), the third most central hermeneutic theorist, argued about the importance of history, and the effect of tradition on the interpretive process. He claimed that whilst interpretation focuses on the meaning of a text, meaning is strongly influenced by the moment at which that interpretation is made.

Similarly to Heidegger, he also proposed that before conducting interpretation, researchers can emphasize their preconceptions up front, but preconceptions may also come to light once the interpretation is underway. He also argued that the things themselves that are being interpreted can influence the fore-structure, which can then also significantly influence interpretation. Similarly to Heidegger, Gadamer also raised the importance of researchers needing to allow the new, interpreted stimuli to speak to them in its own voice, therefore, he advised approaching new objects with a spirit of openness (Smith, Flowers, & Larkin, 2009).

Amongst the hermeneutic writers, the hermeneutic circle is the most resonant idea that has been applied (Bleicher, 1981). This refers to the dynamic relationship between the part and the whole at various levels. In order to understand the part, one would need to look at the whole and understand the whole; one also needs to look at parts to understand the whole (ibid).

Within IPA from the outset, the phenomenological inquiry is also an interpretive process, as researchers are continuously trying to make sense of what is being said. Also, IPA is a 'double hermeneutic', with researchers making sense of the participants, who are also making sense of their experience. Within a double hermeneutic, the researchers have a dual role: they are not the participants, they only have access to what has been shared, but they also perceive the data through their own, experientially-informed lens (Smith & Osborn, 2003). The double hermeneutic can operate through a hermeneutics of empathy or hermeneutics of suspicion (Ricoeur, 1970). Whilst working within the realms of the hermeneutics of empathy, the researchers aim to reconstruct the original experience in its own terms. Within the hermeneutics of suspicion, researchers use theoretical knowledge from the outside to reveal a phenomenon (Larkin et al., 2006). Within IPA, the centre-ground position combines a hermeneutic of empathy with hermeneutic of suspicion, where researchers take on an insider perspective and attempt to stand in the participants' shoes to see what it is like for them, but they also stand alongside them to ask, question, and puzzle, and in the process, explore the whole experience from a different angle (Conrad, 1987).

Idiography, the third major influence on IPA, is concerned with the particular. Idiography is committed to analysing the particular in depth and in detail. It engages with single cases on

their own right, but it can also attend to the process which moves from examination of a single case to the more general claims (Harre, 1979). From idiography, IPA researchers adopted analytic procedures, moving from single cases to more general statements, and at the same time retrieving particular claims for the involved individuals (Smith, Flowers, & Larkin, 2009).

3.1.3 Phenomenology, IPA and Counselling Psychology

As presented above, phenomenology is the study of experience, and focuses on what the experience of being a human is like with its various aspects, providing a framework to psychologists about how to comprehend and examine a lived experience (Smith, Flowers, & Larkin, 2009). IPA, born out of phenomenology, is a qualitative approach to research, and is also concerned with the human lived experience; it postulates that experience can be understood via examination of the meanings which people impress upon it. These meanings, in turn, may illuminate the embodied, cognitive-affective and existential domains of psychology. As seen above, IPA also acknowledges the role of the researcher in the construction of meaning-making, stressing close engagement with and the researcher's influence upon the produced data (*ibid*). These characteristics of IPA and phenomenology closely match with the philosophical stance and ethos of Counselling Psychology. Counselling Psychology is a profession that adheres to the scientist-practitioner model of professional practice (Corrie & Callahan, 2000), emphasising the role of the practitioner as producer as well as user of theoretical and research knowledge (Verling, 2014). Similarly to IPA, Counselling Psychology is also engaged with measuring the more relational, subjective elements of therapy, advocating 'methodological pluralism' (Cooper & McLeod, 2011), where diverse epistemological and methodological perspectives to research can be appreciated and valued for what each of them is capable of contributing to psychology as a human science (*ibid.*). Counselling Psychology as well places emphasis on meaning, subjectivity, values and insight (Blair, 2010) valuing the contribution of qualitative research methods to the production of research (Morrow, 2007).

3.2 Methods

As climbing can be physically and psychologically a demanding activity, in order to understand participants' experiences of such activity, the present study requires a qualitative, experiential and exploratory stance, aiming to produce an in-depth, rich data about human experience from which the researcher would be able to make claims (Reicher, 2000).

3.2.1 Design

Participants in the study were invited to engage in semi-structured interviews that were, on an average, approximately an hour long (Smith et al., 2009). Semi-structured, one-to-one interviews tend to be the preferred means for the generation of qualitative data in IPA. They are easily managed, allowing a rapport to be developed and giving participants space to think, speak and be heard (Smith et al., 2009). Semi-structured interviews can also be applied flexibly, with the participants having an important stake in what is covered (Chang et al., 2013).

Data analysis in the present study followed the 'Stages of IPA Analysis', aiming to be descriptive and interpretive, seeking deeper meaning about the ways in which the participants tended to figure and make sense of their experiences (Smith, Flowers, & Larkin, 2009).

3.2.2 Participants

Sampling procedure

IPA is committed to understanding people in a particular context, and it therefore utilizes small, purposefully selected and carefully situated samples; for this reason, the participants in the study represent perspective, not population (Smith et al., 2009). According to Smith and Osborn (2007) there is no necessary correct number of participants for a qualitative study. Smith et al. (2009) and Braun and Clarke (2013) highlight that three to six participants can be reasonable for a student project using IPA, therefore the present study aimed to reach the proposed number of participants.

The criteria for participation have been:

- Over 18 years of age
- Being in recovery or having experience of recovery from substance misuse
- Participants to have experience of climbing formally or informally

Participant recruitment strategy

With an aim to generate insight and understanding of the topic of interest, the present study adopted both purposive (Patton, 2002) and snowball samplings (Coolican, 2004; Henry, 1990). The participants were recruited through 'Advertising flyers' (Appendix D) in climbing centres and recovery centres. The research was advertised through social networking websites to reach the required number of individuals.

Participants' demographics

The American Psychological Association (APA, 2010) and Braun and Clarke (2013) advocate the importance of systematically collecting demographic information, so as to adequately describe the sample of a study. The participant demographic Information Sheet (Appendix C) in the present study included: age, gender, ethnic background, employment status, relationship status, type of substance addiction, duration of substance addiction, type of formal or informal support received, types of climbing practiced/practicing and the years for which climbing was practiced. The table below provides an insight into the background of the participants.

Table 1 *Participants' demographic information*

<i>Pseudonym</i>	<i>Rebel</i>	<i>Helena</i>	<i>Brian D.</i>	<i>Yan</i>	<i>Ospray</i>	<i>Tom</i>
<i>Age</i>	52	25	52	56	60	34
<i>Gender</i>	Soft male	Female	Male	Male	Male	Male
<i>Ethnic background</i>	Not identified	White British	White European	British	White British	White European
<i>Employment status</i>	Employed	Employed	Employed	Employed	Employed	Student
<i>Relationship status</i>	Married	Single	Divorced	Married	Living with partner	Married
<i>Type of substance addiction or substance use</i>	Poli-drug user	Ketamine, speed, 'party drugs'	Alcohol and drugs	Heroin, crack cocaine and alcohol	Alcohol	Heroin, 'party drugs' weed, speed, ecstasy
<i>Length of substance addiction</i>	38 years	9 years	28 years	29 years	40 years	10 years
<i>Type of formal/informal support received</i>	No drug or alcohol services; experience of triage appointments	Counselling	Spirituality-Buddhism and Alcoholic Anonymous	12-step fellowship and counselling	No involvement of services	Key worker and counselling
<i>Types of climbing practicing/practiced</i>	Mountaineering, ice and rock climbing, free soloing, hill walking, field runner	Indoor and outdoor sport climbing, bouldering, and traditional climbing	Traditional and sport climbing	Outdoor and indoor sport climbing, scrambling, hill walking	Indoor sport climbing	Top rope and lead climbing
<i>Years of climbing</i>	31 years	6 months	31 years	8-9 years	10 years	4 years

3.3 Data collection method

Methods of data collection and analysis should be appropriate to the research question (Willig, 2001). As IPA aims to design data collection events that elicit detailed stories, therefore interviews were deemed to be the most appropriate data collection method to be applied. Interviewing is often viewed as a professional conversation, with the goal of getting the participants to talk about their experiences and perspectives, to capture their language and concepts in relation to a topic that the researchers have determined (Kvale, 2007; Rubin & Rubin, 1995). Semi-structured, one-to-one interviews are generally the preferred means for generating such qualitative data (Smith et al., 2009). Semi-structured

interviews can be characterized by open-ended questions, which are developed in advance and prepared with probes and prompts (Morse & Richards, 2002).

3.4 The interviewing process

Whilst collecting data through semi-structured interviews, the researcher aimed to keep the research question in mind, but at the same time, also encouraged the participants to expand on anything that they found relevant to share in relation to the topic (Josselson, 2013).

The 'Interview Topic Guide' (Appendix A) was developed following Braun and Clarke's (2013) guidance on designing and piloting the interviews and Smith and Osborn's (2003) detailed proposition about approach, question construction, and guiding.

In order to attain a well-prepared interview guide, Braun and Clarke (2013) recommend that testing out the interview guide on a trusted friend could be quite beneficial to the research process. In the present study, the researcher piloted the interview questions with a colleague. The pilot interview encouraged the researcher to refine the interview questions, which made the interview process much more fluid. Also, throughout the data collection, the researcher was aware of the potential experience of hierarchical relationships, the possibility of the researcher being perceived as expert. This, at times, can override other aspects of identity and experience and participants can often become distressed when discussing sensitive issues (Braun & Clarke, 2013). To manage the latter, the researcher aimed to allow the participants to express their feelings, as well as acknowledging and containing their experiences within the context of the ongoing interview (ibid.).

Seven face-to-face, semi-structured interviews were conducted with six participants. The need to conduct a second interview with one of the participants (Tom- pseudonym) emerged from not wanting to end the interview abruptly and to allow the needed space for the participant to express and share his thoughts, feelings and experiences. All the interviews, on an average, lasted an hour.

As stated above, all the interviews were conducted in a face-to face manner. However, prior to data collection with the aim to reach the required number of participants and consider

convenience of participation, it has also been planned to conduct and record interviews through Skype. Prior to data collection, the advantages (Hanna, 2012) and disadvantages (Deakin & Wakefield, 2014; Sturges & Hanrahan, 2004) of using such medium have been considered. However, data collection through Skype was not required as all interviews could be arranged to take place face-to-face.

It is not possible to do the form of interviewing required for IPA without audio recording (Smith & Osborn, 2003), therefore all the interviews were audio-recorded and transcribed verbatim. Consent to audio-record the interviews was taken from participants in the 'Participant information sheet and consent form' (Appendix B).

Rubin and Rubin (1995) propose researchers to transcribe interviews straight after interviewing, as this allows the emergence of reflection on the interview process, and also enables the researchers to adjust the interviewing style and questions before the next interview. Throughout the data collection, this proposition has been followed.

3.5 Data analysis

The transcription and data analysis was conducted alongside interviewing. The analysis approach has been interpretive, seeking deeper meaning (Smith, Flowers, & Larkin, 2009) around how the participants experienced climbing during their recovery.

The literature on the analytic method in IPA has not prescribed a single way for working with the data. The procedures of analysis can be quite flexible as long as the focus remains on the participants' attempts to make sense of their experiences. Nevertheless, there are general processes involved in the IPA analysis: moving from the particular to the shared, from descriptive to interpretative. There are also general principles that can be applied, such as commitment to understanding the participants' point of view, and engaging with personal meaning-making in certain contexts (Smith, 2007).

Smith, Flowers, & Larkin (2009), for the novice researcher approaching IPA for the first time, recommend a step-by-step guide to conduct a systematic IPA analysis. The aim of the steps is to offer a sense of manageability and order and to minimise the potential for the

researcher to feel overwhelmed by the amount of data (ibid). The analysis of the collected data has been approached following the stages of IPA Analysis described below.

Table 2 *Smith's (2009) Stages of IPA Analysis (from Smith, Flowers, & Larkin, 2009)*

Step	Description
Step 1: Reading and re-reading	Reading and re-reading Each transcript has been read several times in order to develop close familiarity with the content.
Step 2: Initial noting	Descriptive, linguistic and conceptual notes have been made in the right-hand margin of the transcript.
Step 3: Developing emergent themes	Titles of potential preliminary themes that emerged from the data have been given.
Step 4: Searching for connections across emergent themes	Connections between the themes have been searched for, and related themes have been grouped together under headings. Any cluster was compared to the original transcript in order to check whether it was reasonable. This phase has been conducted according to existing theory and the researcher's experience, and it relied upon analytic and interpretative process, as is consistent with the IPA method.
Step 5: Moving to the next case	The analysis moved to the next transcript and the process was repeated again while the researcher tried to bracket the ideas that have emerged from the previous analysis.
Step 6: Looking for patterns across cases	A table of themes and sub-themes was produced, and patterns across cases were looked for.
Step 7: Writing up	The final shared themes were translated into a narrative account

In order to determine that the data analysis is credible and dependable, research supervision has also been used to ensure the integrity of the analysis. Interview transcripts with a draft written analysis have been provided to the director of studies, who commented on the trustworthiness of the produced data. Based on this feedback, where necessary,

corrections have been made and further suggestions for analysis have been taken into consideration. Overall, these processes ensured triangulation (Braun & Clarke, 2013) and a good 'fit' between interpretation and representation of participants' experiences.

3.6 Ethical considerations

Ethical approval for the research was granted in March 2015 by the University of the West of England Faculty Research Ethics Committee (FREC) (Appendix E).

In order to protect the wellbeing of the participants and take into consideration the safety of the researcher throughout the study, the Code of Ethics and Conduct published by The British Psychological Society (The British Psychological Society, 2009) was followed, bearing in mind the core requirements for ethical practice: obtaining informed consent and avoiding deception; maintaining confidentiality and privacy; ensuring the participants' right to withdraw (without explanation or negative impact); not subjecting the participants to unnecessary risk, and being honest and accurate about reporting the research results (Braun & Clarke, 2013; The Ethics Committee of the British Psychological Society, 2009).

Ethical considerations in practice

The study strictly followed the ethical considerations described by The British Psychological Society (2009). At the beginning of the interviews, a printed copy of the 'Information sheet and informed consent form' (Appendix B) was given to the participants describing the nature of the study and openly providing an outline of the aims of the study. Within this form, the participants were also asked to give their consent to audio-record the interview and give consent for their data to be used within any publications or presentations arising from the study. The 'information sheet and informed consent form' also asked the participants to convey their wish to review the interview transcript prior to using their interview data, having the opportunity to withdraw any particular comments that they did not want to appear in public domain. One participant requested the interview transcript to reflect on the interview, whilst another asked for some amendments to be made to the transcript with the aim of reducing the chances of compromising their anonymity. The

'Information sheet and informed consent form' also stated that the participants have the right to withdraw at any point from the study, even after the data collection. This form also guaranteed anonymity, the promise to terminate the interview at any point if the interviewee felt uncomfortable, and the exclusion from the transcript or records of anything that the interviewee did not wish to be seen by others. In order to ensure that the participants' identities remained confidential and reported anonymously within the research, the participants were asked to pick a pseudonym that they wished to be used in their data presentation.

The collected data was kept in a password protected folder on a PC and only the researcher and the research supervisor had access to it. In order to ensure the anonymity and confidentiality of the participants, the participants' demographic information was kept separate from the interview data in a password protected folder on a PC. At the completion of the degree, all collected data that could identify the participants will be deleted.

During the interviews, if the participants found their participation to raise challenging issues that needed further attention, in the 'Research Participant Debriefing Form' (Appendix F) they were advised to consider contacting MindLine or the Samaritans or the British Psychological Society (BPS), the UK Council for Psychotherapy (UKCP), the British Association for Counselling and Psychotherapy (BACP) for further support and guidance.

3.7 Reflexivity

I am a Counselling Psychologist-in-training, with openness and curiosity towards the lived experiences of people; because of this, IPA felt to be compatible not only in terms of my professional, but also in terms of my personal world view. Alongside psychology, I also have a great interest in exercise and physical activity. I am a fully qualified personal trainer and fitness instructor, encouraging others to lead an active lifestyle. Climbing was introduced into my life seven years ago, and since then I have practiced it passionately. It is a sport and leisure activity that shapes my day-to-day life; it also has a great positive influence on my family and social connections. Experiencing the benefits of climbing on my well-being has been a major contributor to exploring the subject of the study, and this is something that I acknowledged throughout the process of data collection. I have been aware that my

positive approach towards climbing had an influence not only on forming the interview questions, setting a positive tone for climbing, but also on participants' accounts, probably discouraging them from sharing less favourable experiences encountered within climbing.

I have no personal experience of substance dependence, but my parents' alcohol addiction has had an overarching bearing on my life and on my well-being. At times I struggled to come to terms with this, and I realised that my willingness to help people recover from these difficulties is rooted in my experience of the detrimental effects of alcohol misuse.

To encourage a reflexive stance, throughout the interviews I have used field notes (Braun & Clarke, 2013; Whittemore et al., 2001) with the aim to bracket (Ahern, 1999) deliberately put aside (but not abandon) my own experiences and beliefs about the phenomenon under exploration (Hein & Austin, 2001). The field notes taken at the end of each interview looked at: the participant's self- presentation and surroundings, involved a reflection on my personal reaction to the participant and how the interview went, summarized important features of the participant's responses, and noted ideas for future data analysis (Braun & Clarke, 2013). In the present study, in order to further encourage a reflexive practice, as mentioned in the interviewing process section, the interview questions have been piloted with another colleague.

Additionally, a reflexive interview has also been carried out, which allowed an in-depth exploration of the personal meaning of the subject. During this interview, my experiences of climbing and addiction, and the reasons behind conducting the present study have been explored. Throughout the reflexive interview, my extremely positive approach towards climbing became evident. Also, through this interview, I realized climbing to be present in my life as a 'healthy addiction', having a positive influence on my psychological, but also physical well-being. The reflexive interview also revealed the presence of unsuccessful recovery stories in my family, which gave rise to the aspiration of conducting a study that explores positive outcomes and factors that contribute to sustaining recovery. Overtly acknowledging my prejudices through the reflexive interview aided the data analysis in various ways. It highlighted the need to bracket my experiences (as much as possible) and emphasized the importance of remaining curious and open towards participants' stories, without imposing my own feelings and assumptions.

Prior to the collection of the data, I did not fully comprehend the intimate and personal nature of the interviews and had limited understanding of the potential influence of these encounters on me not only as a researcher, but also as a person. Looking back at the field notes, it is transparent that throughout the data collection I felt touched by the participants' honesty and willingness to share their experiences. I also realised the privileged position that I have been in, being able to hear and record the participants' experiences. From the field notes it is also apparent that as during the data collection some participants described extremely challenging experiences, witnessing their accounts at times felt upsetting and overwhelming. The challenging nature of the interviews encouraged me to be more considerate around the practicalities of interviewing and also helped me improve my interviewing skills. I booked time slots for more than an hour with the participants, I never conducted two interviews in one day and left enough time to process and make sense of participants' accounts. Over time, there was a decline in my anxiety prior to the interviews and I was able to be more real with the participants, remember my interview guide, follow the participants' stories and be present with them, respecting their accounts.

Prior to the interviews the participants were made aware of my passion for climbing and during the data collection process, I was asked further questions about this and also about my own experiences of addiction. Despite the fact that I felt comfortable with sharing personal information, I have been aware of the potential influence that such information may have on the participants' accounts; therefore, I aimed to keep this minimal, hoping that my approach would not shut the participants down from bringing their experiences to the forefront.

Since climbing can be a small community, throughout the data collection process, I had to bear in mind the potential of meeting the participants whilst climbing. This required extra care and consideration, and also emphasising the anonymity and confidentiality of participation in the study.

According to Adams (2010), the joys of a good interview require reflective practice, empathy and awareness of the researcher's ethical responsibility. I feel that my training in Counselling Psychology and my work as an in-training counselling psychologist helped me to

be open, empathic and respectful of the participants' accounts, encouraging and supporting them to share difficult experiences.

CHAPTER IV: FINDINGS

Interpretative Phenomenological Analysis (IPA) of seven semi-structured interviews conducted with Ospray, Brian D., Yan, Rebel, Tom and Helena (pseudonyms) resulted in the development of two super-ordinate themes with five sub-ordinate themes. Exploration of these would form the basis of this chapter, with each of the themes illustrated by verbatim extracts from the interviews. In presenting the verbatim extracts, some minor changes have been made. Hesitations, word repetitions, and utterances have been removed in order to improve readability. The researcher recognises that these themes are one possible account of the participants' experiences, and were selected due to their relevance to the research questions.

Table 3 *Super-ordinate themes and sub-ordinate themes*

Super-ordinate themes	Sub-ordinate themes
1. Experiences of recovery	1a Meaning of recovery 1b Markers of recovery
2. Recovering through climbing	2a Climbing and one's physical and psychological well-being 2b Lifestyle and social effects of climbing 2c Climbing as therapy

4.1 Experiences of recovery

The first super-ordinate with two sub-ordinate themes provides an insight into the participants' experiences of their personal meaning of recovery. This theme also presents the supporting factors that the participants found significant in motivating and enabling

them to move away from substance using behaviours. The importance of counselling, attendance of recovery groups, having access to key workers and sponsors, the presence of spirituality and the support of family and friends in relation to recovery, as shared by participants, will be further discussed in detail.

4.1a Meaning of recovery

Throughout the interviews, the participants attributed varied meanings to recovery. Some perceived being in recovery to be a phase where they attempted to stop using substances, whilst also taking prescribed medication; for others, recovery meant complete abstinence, without the consumption of prescribed medication. Some emphasized the prominence of viewing themselves to be 'recovered', whilst others stressed the need to 'be in continuous recovery'. For instance, for Tom it has been apparent that he believes that he is not in recovery anymore. In various parts of the interview, he claimed to feel this way as he was confident living in the world without having to depend on the continuous use of drugs and alcohol. Despite being 'recovered', he acknowledged the risk of falling back into using substances, however during the interview, he rejected seeing himself as someone who has not been able to put the use of alcohol and drugs behind him. Also, for him, the concept of being recovered has been closely related to the notion of 'being an addict'. He shared that despite being abstinent, various organisations still tend to perceive him to be an addict, thus limiting and reducing his identity solely to his past substance using behaviour. Such approach is not something that he seems to agree with and he feels that this perception only holds him back from being able live a fulfilling life and seeing himself recovered.

"All these organisations are very clear that you know, even if I'm clean for five years, I'm an addict, I'm an addict, this whole thing that that is you and you must always be vigilant about this thing. I'm not like that, you know maybe in the future I will be an addict again, but at this the point, now I don't want to carry this like a big stone on my back like I'm an addict." (Tom)

In contrast with Tom, Yan does not see himself as recovered, but having a constant feeling of being 'in recovery' has been paramount for him. Throughout the interview, he

highlighted the need to view recovery as an ongoing process that requires continuous attention.

"I'm not recovered, I'm in recovery in a sense, it's continual, in the same way it's maybe with people with mental health needs, continue doing things to stay well, if they stop doing that then they will relapse and that it's like that for me." (Yan)

As compared to the other participants, at the time of the data collection, Helena has been at the very early stages of leaving the use of substances behind. She has not been using drugs or alcohol only for six months, and therefore one would argue that her experience of recovery could be very different from those who stopped using substances for several years. An exploration of the notion of recovery revealed that recovery, for her, entails the presence of a sense of clarity about her feelings and thoughts. However, acquiring such clarity has not necessarily been an easy process. She experienced a new self, as if 'she was a teenager again', a self that is unfamiliar and calls for further discovery.

"Everything is becoming clearer with what I'm thinking and feeling, finding myself again basically, because there is eight years where, crazy, I did not know myself, so it's all kind of coming back now, so it's quite difficult, so it's like going through being a teenager again I guess, yeah, everything is kind of new to me, like my hormones, my period is just like, oh I'm feeling like that because I'm due on, whereas before I did not know that because I was always using, so everything is really new to me again, which is weird." (Helena)

For some participants, the meaning of recovery has also been closely related to the ways in which they attempted to maintain their psychological well-being. At an individual level, meditation, being in the present moment and continuously aware of one's own lifestyle, and the importance of being passionate about interests and hobbies have been recognised to be crucial to recovery. On a social level, helping others, removing oneself from the presence of substance using friends, and seeking professional support came to the forefront of data analysis as important contributors to the maintenance of recovery and psychological well-being. For instance, Yan passionately spoke of his commitment to the maintenance of his psychological well-being.

“By the time I was finished with the drugs I hated it, I never wanted to return again and I still feel the same today, this is 14 years on and I want nothing to do with that, I never want to return to that again, just want to stay alive, enjoy whatever time I have got left and make the best of it. I don't want to be just drug free, I want to be completely free from addiction, I want to be at peace, just to enjoy my life as other people.” (Yan)

For Yan, recovery cannot be reduced to just living a life without substances. Being at peace, being able to make the most of his life and enjoying himself has been viewed to be crucial to the maintenance of his recovery.

4.1b Markers of recovery

Whilst conveying the personal meaning of recovery, the participants also shared significant contributions to being able to stop the unhelpful use of substances. Some named attending counselling, being part of recovery groups and having a key worker and a sponsor to be such markers.

Within the counselling sessions, the participants expressed that through being listened to, and being provided with the attention and time to explore and give voice to their inner thoughts and feelings allowed them take an explorative stance towards themselves and their past. Also, being in a professional relationship with a therapist helped some of them to come to terms with the past difficulties, reaching acceptance of such events and of self. Tom and Yan voiced these in the following way

“You know, gave me a chance to talk about all like things of the past, it gave me a chance to look in myself and see, like certain aspects of my behaviour and why, kind of like why I was like that.” (Tom)

“I have looked a lot at that stuff, I have had a lot of counselling over the years and I have spent a lot of time trying to be at peace with this horrific past that I had you know, I 'm trying my best anyway to accept it and just to live with it, or move on from it, or not to be held back by it, not to be affected by it anymore.” (Yan)

Being a part of various recovery groups, for instance, Alcoholics Anonymous (AA) or Narcotics Anonymous (NA) was also an important contributor to recovery. Such experiences enabled the participants to have shared experiences with others, doing things with others

that did not involve the use of alcohol and drugs, which in turn, contributed to the reduction of unhelpful substance consumption. Through these encounters, the participants also felt that they were able to relate to others, learn new ways of being, give and receive support, which in turn, enhanced their recovery.

“All these things helped me to meet other people in similar situations and then to understand that I was not so unique, you know, even though all my past and history and stuff was not same as everyone else’s, we relate you know and help each other, support each other, and also get used to like being in a group of people doing an activity together that isn’t like taking drugs or buying drugs.” (Tom)

On their recovery journeys, the participants also acknowledged the prominence of key workers and sponsors. Tom felt that the key workers’ belief in his ability to recover, their positive attitude and hopefulness towards him, faith in him, as well as the caring and compassionate way of being towards him was paramount. Through these encounters, similar to the recovery groups and counselling, he also received techniques to enhance his well-being, which helped him reach an understanding of his own addiction.

The usefulness of a sponsor has been accentuated by Yan. Through having a sponsor, Yan felt re-parented, started to trust others and instead of living alone and being closed off from the outside world, it slowly enabled him to share things about himself. Through the presence of such a relationship, he felt accepted and came not only to accept himself but also care for himself. Having someone in his life with similar experiences that was further along on their recovery journey, like Tom, it allowed Yan to learn sobriety techniques from this person, and embark on the development of positive well-being.

“Well, I wasn’t used to opening up and letting people in, I kept in all, I think for opening up to somebody and sharing anything and by them accepting you, I came to learn to accept myself as well, I think like I say, I’m not saying it’s that same thing but I haven’t been parented properly, as small boy and I ran away, I didn’t know how to accept myself, how to care for myself and all of that because I haven’t learnt it, so I’m learning from somebody else who knows that, maybe, as well as learning all the things you learn to stay sober and not to pick up an old habit, so somebody I knew who came from the same background as me, but they have found a solution to their problems so they were further ahead in their recovery so I could learn from their experience, so from that point of view that was really important.” (Yan)

Beyond attending counselling, being part of the recovery groups and having access to key workers and sponsors, spirituality and the support of family and friends was also described by the participants as a marker of recovery.

Spirituality, for some participants, was the need for the presence of something 'greater than own power' to stop using substances, and the necessity to live for something that was much 'bigger than just addiction'.

"I needed something greater than my own power to stay clean, will power alone wasn't enough so I needed to tap into something else. It's hard to explain, but it had to be something spiritual and I guess what takes me to places like mountains and nature as well, allows me to contact with something greater than me, you know, yeah and maybe in a way I want to live for something bigger than just addiction, because addiction is about me getting drugs, so I had to, well I wanted to live for something more than that." (Yan)

For Yan, battling with addiction all on his own has not been enough to recover and he therefore found spirituality as a supporting factor through nature. For others, it was Buddhism that helped them to reach a sense of control over their own lives, and learn that they have a choice in the ways in which they respond to things that happen to them. Through Buddhism, some also had access to a supportive community, which brought with it the opportunity to develop friendships and meaningful relationships, eventually allowing them to break away from a substance using community.

Tom explains

"When I became Buddhist then suddenly opens up to this whole world of people, all this huge Buddhist community that really like genuinely care about all the members. Before all the people I knew were drug users, so when I cleaned up then you know the few friends I had [location removed] I had to cut off relationship with them, because it was too risky to you know to go around with them, but then I started to go to these Buddhist meetings, then straight away there was one guy who lives two roads from me and another guy who lives nearby and like, all the time they are coming around to my house, chanting together, I'm going to theirs, they are teaching me Buddhist philosophy, talking with me." (Tom)

Other participants, through Buddhism, got in touch with Buddhist leaders who helped them explore their own qualities, and helped them raise their awareness to their ability to change their lives. Within Buddhism, some also encountered meditation, which encouraged them to be in the present moment, helping them to achieve internal stability, and attain self-acceptance, which in turn, had a positive influence on their recovery.

“Meditation puts you into the present moment in a sense, you don't have to dwell on things too much or worry about things, it gives you space, you know, be relaxed about whatever is going on and through meditation realising, and come to accept certain things about you, just accept yourself a bit and not be so worried about things and upset about everything, just, it just stabilised me a bit, you know.” (Brian D.)

Another contributing factor to recovery, as shared by some participants, was the presence of family and friends. Some acknowledged re-gaining the trust of their family members to be crucial, whilst others valued the provision of practical support to greater level. The value of connecting with wider family members and having the knowledge that they are not in isolation, but a part of a bigger family was named by Yan. At the time of the interview, he had been married for two weeks and spoke with enthusiasm of the importance of feeling connected to and to share his life with another person.

“Obviously it's a big deal for me to share my life with somebody, and to be really closely connected, she is now my next of kin, because I never put down a next of kin on a sheet of paper, that was always a difficulty for me, because I never really had such a thing, and the person who was legally closest to me, it was somebody who abused me, so I didn't want them to be my next of kin, but suddenly I have got a next of kin that I do want.” (Yan)

Alongside the importance of feeling connected with their family members, some participants also named the significance of friends as an important contributor to the maintenance of recovery and psychological well-being. For instance, Tom recognised the value of the care of his friends in his recovery:

“They would always like for about two years they would call on the phone and I wouldn't answer, I wouldn't answer but they kept trying to call, like very couple of weeks I would get a call, just from these two guys, even if I didn't speak to them eventually they called me from like another number and I answered, I had to speak to them and stuff, but just that they didn't give up

you know, they kept calling, you know even though I didn't answer for months and months and months they kept calling, so just that I had people who cared about me, you know.” (Tom)

The purpose of the first super-ordinate theme was offering an insight into the participants' understandings of the meaning of recovery and the ways in which they perceived recovery to take place in their lives.

From the data analysis, the themes of the positive effects of climbing on physical, psychological and social well-being emerged. The participants also expressed the potential of climbing as a therapeutic intervention.

4.2 Recovering through climbing

Ospray, Brian D., Yan, Rebel, Tom and Helena (pseudonyms) shared how climbing and the outdoors were present in their lives at varying degrees. Ospray came into contact with climbing as he grew up in a physically active family that put him in close touch with the outdoors. Later on, whilst working for a recovery organisation, he applied climbing as a therapeutic intervention to aid the recovery of those who sought to give up the use of substances. Brian D. enjoyed climbing trees from a young age; however, it was not until he joined a climbing club with the purpose of wanting to change his drug and alcohol using behaviour that he had the opportunity to climb. Yan, throughout the interview, expressed his 'inbuilt love for nature' and considered it to have a substantial role in his life. For Rebel, the connection with nature and outdoors was not always present. He had been brought up in a city and did not have a great affinity towards the countryside. When participation in hill-running and membership of a walking group was offered to him, he felt that he re-connected with 'something that has been lost in the past'. Tom tried climbing in his teenage years, but only started practicing it regularly whilst in recovery from substance dependence. Climbing was introduced to Helena at a young age by her mother. However, she only started climbing regularly and working in a climbing centre when she reached adulthood.

4.2a Climbing and one's physical and psychological well-being

The participants shared that climbing had an overarching positive influence on their physical well-being, which in turn, affirmatively impacted their recovery from dependence and substance misuse. According to their accounts, climbing allowed them to move away from a sedentary lifestyle and towards physical activity and engagement, thus contributing to improved physical health. This influence has been noticeable through the presence of an increased physical strength and improved ability to climb and apply technique. However, according to their accounts, the physical benefits of climbing could not be separated from the psychological influences. Within climbing, through the satisfaction of a successfully completed climb, they achieved a sense of being 'high', an emotional and physical state that was similar to the physical reward of taking substances.

"It's when they achieve that sense of satisfaction they become very attracted to it, because it helped them break through and you know they want to feel that satisfaction again, which is a bit like you know the reward of taking a drug."(Ospray)

Throughout the interviews, this sense of satisfaction and 'being high' has also been articulated as receiving a sense of 'buzz'. This feeling has been described to be 'even better' and 'more real' than the feelings gained from chemical substances, since such feelings have been perceived to be naturally obtained, brought on by self and not achieved through external substances.

"You get a big buzz if you did it and probably it's better actually, you know compared to the one that you get from other substances."(Brian D.)

For some participants within climbing, the provision of 'a sense of a buzz' also replaced the use of substances. For instance, for Helena, climbing, in comparison to a drug like ketamine, has become present in her life as an addiction itself but of course without the all-encompassing detrimental consequences.

"It has definitely replaced it, hundred percent, it seems to, that's exactly what happened. So obviously climbing is not a bad thing to replace, a way of, so yeah, because it gives you that kind of buzz, not the same buzz as ketamine does, but a better one." (Helena)

Whilst exploring the psychological and emotional contributions of climbing, the participants also conveyed that during climbing, they often felt a sense of enjoyment and satisfaction,

which has been accompanied by feelings of improvement and progression. According to their accounts, the sense of enjoyment, satisfaction, improvement and progression has often been achieved through climbing being a physically challenging activity. Whilst climbing, the participants encountered various difficulties and overcoming those difficulties allowed them to appreciate their own physical strength and power, which in turn, contributed to the achievement of such positive emotional states.

"You see a real sense that you are getting better because you can do these grades and stuff, a good feeling because at the start, these really tiny holes I couldn't even think how I could do them but eventually after time you have strength in your fingers and then it's like, just realized wooo, I climbed on this little chip of rock you know and I did it and you know it's like a real victory you know, maybe you don't make it the first few times, but then you keep doing it and you do make it and you know you can experience this kind of real joy of achievement." (Tom)

Similarly to Tom, Ospray also voiced the presence of feelings of enjoyment, achievement and progression whilst climbing and reaching ones' physical limitations.

"I enjoyed the activity, the sort of strenuous nature of the activity, I suppose being on the edge of not being able to do it you know, and then being able to do it, it's a sense of achievement, people overcoming obstacles and doing things that are more difficult than they were doing last week, so it's progress." (Ospray)

Beyond the sense of achievement, progression and feelings of satisfaction, other participants found climbing, similar to hill walking, to be an uplifting and spiritual activity, contributing to the presence of feelings of safety and security.

"When I was actually up there, I felt secure, that kind of feeling that I'm safe anyway, it's like the feeling that I would have when I walk to the top of the mountain, there is a beautiful feeling when you are around on the top of the mountains and that almost feels spiritual, uplifting awesome, and I just had the same feeling hanging on the side of this hill, so there was something really inspiring about it." (Yan)

An exploration of the psychological benefits of climbing also revealed climbing to be a mindful activity, encouraging the participants to be in the present moment. As climbing requires focus and concentration, it helped them to take their mind off the things that

concerned them, and instead of dwelling on their difficulties, it enabled them to stay in the present moment, and focus on climbing and technique.

"It requires a lot of focus so you are not distracted all the time and you are not thinking about how you really are, you are thinking about how do I get from here to there, you know do I need to pull in some more rope, so brings it all into a very sharp focus for people, you have to focus, I think because it takes a lot of focus, a lot of energy and a lot of concentration, I think I found it, I suppose it took my mind off other things." (Ospray)

Alongside Ospray, Helena also talked about the need to focus and be present in climbing, which for her gave, rise to some 'unexplainable' and 'amazing' feelings.

"When I'm climbing, everything goes, just I don't care about anything, when trying to get to the top, finish the climb and having to focus rather than, you know focusing on whatever else, just having to focus on everything, focusing your whole body, the way it is moving, I guess and the feeling it gives me is kind of unexplainable really, but it's amazing." (Helena)

During the exploration of a mindful attention in climbing, some participants found it difficult express these experiences in words. Some viewed mindfulness and meditation in climbing to take place through the presence of flow, where they are not only moved away mentally and physically from their daily concerns, but also the connection of their body and mind taking place.

"Climbing was more like meditative, when it comes together, you get that flow of things, I use that meditative feeling that you get, when it comes together, body and mind connect a bit, you get a thing where it's quite an experience you get totally absorbed in the whole thing, it's timeless too, you can say it's like meditation, it's mindfulness, you have got to be mindful in a sense, you cannot be thinking about all kinds of things, it takes concentration, it's good, it connects your mind and body I guess, something good about the whole thing that comes together." (Brian D.)

Throughout the exploration of the emotional and psychological contributions of climbing, some participants also talked about their experience of giving up the use of substances. Some described this process to provoke fear and anxiety in them. According to their accounts, during these times they have to be able to manage a wide range of difficult emotions without the use of drugs. As in the past, the management of such emotions in

their lives required use of substances, as managing such emotions for some can be particularly challenging. Furthermore, whilst exploring the phase of giving up the use of substances, some participants also conveyed the need to be honest about themselves and their own feelings and having to leave behind a life that was 'full of lies'.

Some participants drew a parallel between the processes involved in detoxing, leaving substances behind and climbing, sharing that the emotional demands of detoxing can also be present in climbing. For instance, climbing as it is a dangerous and challenging activity, can expose the individuals to a wide range of difficult emotions, where they are required to take responsibility for such emotions and learn to manage them. Ospray explains his encounter with this as follows:

"In climbing it is illustrated what they need to do in detox, and I felt that it was incredibly useful with particular respect to people with being confronted with genuine fear and anxiety and going beyond their capability." (Ospray)

Experiencing anxiety and fear whilst climbing and an improvement in one's ability to manage such emotions has also been shared by Helena through looking at her management of her emotions in the past and comparing this with the abilities that she possesses in the present.

"I would look at the bolts and I was like, all I could think about, because I was so paranoid, all I could think about is that they would come out and I wouldn't be able to stay up there, because I was thinking that the bolts are going to come out and just things are going to snap and I used to be really scared of heights and that has got so much better." (Helena)

As presented above, beyond the management of difficult emotions, the participants also conveyed that whilst detoxing, there is a need to be honest towards oneself as well as others, and make a commitment to live a more truthful life. Some participants voiced that such processes are supported by climbing, since one's competencies can become exposed, which may allow them to better understand themselves, learn about their own physical and psychological limitations and capabilities, start to be open about their own capabilities and potentially reach self-acceptance.

"It's honesty, you are climbing as hard as you climb and if you are not very good, you have to accept that you are not very good and just keep doing it"

until you get better, you cannot like bluff your way through it and I think, you know climbing helped me to kind of develop this confidence to, you know, not to be ashamed of who I'm and not try to hide it or do something like that." (Tom)

4.2b Lifestyle and social effects of climbing

As presented above, the participants conveyed climbing to have a positive effect on their physical and psychological well-being, which in turn contributed to their recovery from the misuse and dependence of various substances. Beyond such benefits, the participants also shared climbing to have a favourable influence on their lifestyle, positively contributing to the development and maintenance of social relationships.

According to participants' accounts, climbing provided them the opportunity to try out new things, 'stepping up to something new', offering a passion and hobby that has been perceived to be sustainable, healthy and manageable. Through climbing, some participants also seemed to find a new career. For instance, Helena has been committed to giving up the use of substances for climbing, becoming a climbing instructor with the aspiration of sharing with others the benefits of this activity.

"Hopefully in the same way it helped me, just enjoying something so much, wanting something so much, you want it so much, yeah, you give up that addiction that you have in your life for it, so that what it did for me, maybe giving them something that they are interested in, giving them a hobby, giving them something to live for. I just would really like to show and give that to people who are in recovery or have drug problems, what it has done for me basically." (Helena)

Through climbing, whilst embarking on a new lifestyle, some participants also felt that they did not have to stay within the limits of such an activity, but try out other health and well-being enhancing activities. This has been perceived by Rebel to be something specific to climbing

"Enough people pick up on and think about what else they need to do, and they start to walk just where they are, they might get on their bike, they might go to a gym. Actually invites people with very unhealthy or previously unhealthy physical lives to actually appreciate that physical exercise can make you feel better and you can never invite people into that space if they

are stuck inside, inside a therapy meeting or counselling session, they come in the mountains.” (Rebel)

In addition to the lifestyle benefits, climbing also offered the participants with a space to socialize and spend time with others without the use of substances. Friendships and relationships developed, thus giving rise to feelings of engagement and belonging. Within these relationships, the participants have also been able to move away from isolation to connectedness and have experienced bonding with others. Through these connections the participants also received a non-judgemental, welcoming, and caring approach. For instance, Helena voiced feelings of being listened to and cared for in these encounters, which she perceived to be crucial in her time of abstinence

“The climbers that I met, they are my good friends now and they are amazing people who supported me through my recovery, they are very easy to talk to and just the most amazing people I have met to be honest, people I’m with now, they are involving me in things, so just, listening, not judging me, be my friend, being there.” (Helena)

Helena also added that

“it’s amazing, the climbers they are just really amazing people, all seem to have their bit of a weird background as well I guess, doesn’t seem like the normal people”

Hereby potentially referring to ‘normal people’ who are less supportive and understanding than those encountered in a climbing environment. Similarly to Helena, the other participants also elaborated on the notion of normality and the ways in which this is present in climbing. Some perceived normality to be something ‘mainstream’ which can be at times frightening to those with a substance misusing background, as individuals may feel that they cannot fit in such environments. In contrast to other activities such as football, climbing has been described by some participants to be a non-mainstream activity, where those with experience of dependence and substance misuse can meet others with ‘unusual backgrounds’ and feel related to them. This would allow them to still be part of the society, but also separate from it, without having to conform. Tom elaborated on this

“Climbing specifically I think is good, because it’s this kind of, a bit away from mainstream, you know, so people who haven’t been part of society can still go, don’t have to conform. The people you meet usually everyone has got

a story, something about them like, the guy I used to climb with was really into this, what do they call it, like, ecology, you know self-sufficient living and you know buy some land and build a self-sufficient little community for himself you know, which is against mainstream and even though I was not into these things, we found a common ground in the fact that we didn't kind of fit in with the society.” (Tom)

In the above quotation, Tom shared how he almost felt relieved meeting others with unusual and ‘different’ backgrounds. Through this difference, he found similarity, which enabled him to connect to others and feel less isolated. Ospray also gave an insight into the ‘non-mainstream’, ‘non-normal’ world of those who misuse substances, portraying climbing to be a space where such individuals with their often ‘chaotic worlds’ are non-identifiable, accepted and also welcomed.

“The world of problematic drug and alcohol user isn't normality and people are afraid going to some normal environments and they go somewhere like at the climbing centre, nobody is looking at them, they are all looking up, holding the rope or, it's about acceptance, so you are not isolated and identifiable. They are just looking at the climb, doing what they are doing, nobody is making judgements.” (Ospray)

Other participants viewed this non-mainstream nature of climbing offering a door to normality, a transitional space from ‘abnormal substance use’ to helping individuals learn to be in new environments and live in the society again. Some also viewed climbing to be a metaphor for change, supporting them to learn to take responsibility for themselves and others, begin to trust others and equipment, start to follow instructions and professional advice. For instance, Ospray believed that through climbing this can take place within a very short period of time and can also be applied to other areas of a person’s life.

“You learn to trust others, trust treatment, trust equipment, you know, the prescriptions that they use, you learn to use things properly and do what you are told and you have to learn to look beyond you know what is happening next, what do I need to do to get from here to there, what are the steps, how do I make it work, how do I make it safe, they are all things you would naturally be thinking about in climbing, so I just, you know I would use the world metaphor again, I think it works on every level as a sort of very powerful metaphor for the transition that people go through, that metaphor is absolutely centrally important, it helps people realize they are changing and I don't mean over six weeks, I mean two hours, it demonstrates that you

are changing, it shows, two weeks ago you couldn't possibly have got up that wall, you couldn't when you started, you came here today and two hours on you get up the wall, you know, and you know what you are doing, you are competent.” (Ospray)

Like Ospray Rebel also highlighted the presence of a metaphor for transition in the domain of climbing, emphasising the change taking place within climbing to be transferrable to other areas of individuals' lives.

“I think if people can actually psychologically just get up and can do this, they can do that in other aspects of their life.” (Rebel)

Climbing has been described by the participants to be an activity that entailed personally life-changing attributes, which in turn, enhanced recovery from substance dependence. Beyond the positive benefits described above, some participants also shared the potential application of climbing as a therapeutic intervention for those grappled with addiction and mental health problems.

4.2c Climbing as therapy

Some participants strongly believed that as an activity, climbing does not have to be limited to its positive benefits, but can be taken further and be applied as a purposeful therapeutic intervention on its own right. The participants, such as Ospray, articulated the therapeutic benefits of the activity, emphasising the importance of purposefully applying climbing as a therapeutic intervention.

“It's a therapeutic context, that's what I mean, it isn't just about going climbing, it's about using climbing in a particular way, and I think, I mean I suppose that's my belief that actually it has a significant therapeutic value that is not actually recognised and I think we should use it, we should go there with therapeutic motive to help people. ” (Ospray)

Yan also valued the therapeutic and healing properties of climbing, arguing that such activity, with the added benefit of getting to spend time in nature, can be specifically valuable to those who encounter mental health difficulties and/or addiction.

“I think it is really healing, and for people that have got maybe mental health problems, maybe addiction problems, maybe being nature is great. And I just

think you can't go wrong, if you are in nature, you are outdoors, it has got to be good for you, I really believe in that and maybe if people had more access to things like climbing or walking in mountains, that is really therapeutic I think.” (Yan)

Whilst considering climbing as a therapeutic intervention, some participants claimed that it can also be set up as a voluntary and/or peer-led climbing group for individuals in recovery, carrying the potential to have an abundant influence on the partakers’ well-being. Also, as climbing often takes place in nature and in the outdoors, some participants felt that it could offer a natural, ‘organic space’, where the individuals can feel comfortable talking about their everyday problems and support each other without the presence of the ‘sterility of a professional environment’.

“Of course in the mountains, they instantly have an informal physical environment, so suddenly the whole engagement in the process with other people is much more warm and accepting because it's actually the physical environment we are doing it is so much more informal.” (Rebel)

Ospray also expressed that climbing, as a therapeutic intervention, can be easily available and accessible to a wide range of people. Through its availability and accessibility, it is also sustainable, with little financial investment required from those participating in it.

“Climbing centre is in the middle of a city, you know it's easy to get to, it's not terribly expensive, something people could do with each other, they don't need a drug project or somebody to take them, they can go and do it themselves, it's there, it is accessible.” (Ospray)

The purpose of the second super-ordinate theme was to provide an elaborate description of the ways in which the participants experienced an activity such as climbing, contributing to the recovery journeys from substance dependence. Through the quotations, it has been aimed to present the voices of the participants who expressed climbing positively influencing their physical, psychological and social well-being, which in turn, contributed to the development and maintenance of recovery and psychological well-being. This theme also entailed the participants’ views on the potential application of climbing as a therapeutic intervention. In the following section the findings are discussed in relation to the relevant literature, and lines of enquiry.

CHAPTER V: DISCUSSION

5.1 The meaning of recovery

As the present study is concerned with the notion of recovery (Betty Ford Institute Consensus Panel, 2007; UK Drug Policy Commission, 2007), aiming to move from pathology, illness and symptoms to exploring individuals' strengths (Department of Health, 2009) and factors contributing to the sustenance of recovery, throughout the interviews, the participants' felt experience of the meaning of recovery were elaborately discussed. Some participants attributed the notion of recovery to a phase where they attempted to stop using substances, whilst also taking prescribed medication. For others, recovery meant complete abstinence, without any prescribed medication. Some highlighted the need to view themselves to be 'recovered', whilst others stressed the importance of understanding self as 'being in continuous recovery'.

Despite the fact that some researchers warn against substitute prescribing (i.e. Bloor et al., 2008; Centre for Social Justice, 2013; Duffy & Baldwin, 2012; United Kingdom Focal Point, 2012), some participants in the study felt that this has been beneficial to their recovery. This supports the argument that although substitute prescribing has never lived up to the early claims of its efficacy (Yale Law Journal, 1969), it can be of value, at least in the short term (Campbell et al., 2011), having a proven role in stabilizing chaotic drug use (Livingston et al., 2011). Some participants in the study who claimed to be taking maintenance medication in the past, alongside this, also received various types of support. This substantiates the views of Law (2017), who argued that medication alone is never a wise way to cope with addiction, especially while in treatment (except when immediately life- saving) and this must be combined with further treatment as part of a comprehensive programme to aid recovery.

As noted above, the participants have taken different positions on the meaning of being 'recovered' and/or being 'in recovery'. Some felt that viewing the self as a someone in

recovery is potentially damaging, which underlines Yates's (2014) position, who claims that when services warn the substance users and their partners to be continually on their guard against relapse, and maintain constant vigilance for signs of the imminent return of their 'disease' (referring to addiction), they give rise to negative attitudes towards recovery in those who wish to overcome substance misuse. In contrast with this, other participants felt that being abstinent and viewing addiction as a chronic and incurable disease which never goes away (Fisher & Harrison, 2005) positively contributed to their recovery process, encouraging them to be continuously vigilant about relapse. These accounts underline Logan's proposition, which highlights that "the path to recovery is an individual one, but it is rarely done alone or in isolation for the rest of someone's life. Individuals will go through similar stages and require the same types of support; the pace of progress and intensity of support will of course vary, and this is why we need flexible, responsive support" (Logan, 2011, p. 99).

In the present study, for the participants, the meaning of recovery has also been closely related to the ways in which they attempted to maintain their psychological well-being. On an individual level some claimed meditation, being in the present moment and continuously aware of own lifestyle, but also the importance of being passionate about their own interests and hobbies to be paramount. At a social level, some found it essential to help others, and remove oneself from substance using social networks in order to maintain recovery.

Research has demonstrated that being engaged in meaningful activities is a key factor in maintaining recovery goals (Best et al., 2008b; Cook, 1985; Day et al., 2008; Hood, 2003; McKeganey et al., 2008). In line with this is the Community Reinforcement Approach (CRA), which employs environmental contingencies to prevent drinking and drug use (Meyers & Squires, 2001), aiming to increase the individuals' feelings of pleasure from sober activities, and project sober life as a more rewarding way to live than the one which is characterized by the use of substances (Siporin & Baron, 2012). In support of this, researchers found an inverse relationship between substance use and engagement in non-drug-related social activities, highlighting that participating in non-drug-related activities may have the potential to help individuals to maintain abstinence and prevent relapse (Rogers et al., 2008). Engagement in meaningful activities has also been found to act as a positive

reinforcer and facilitate abstinence (Landale & Roderick, 2013). Furthermore, engagement in meaningful activities has also been proven to have social and mental health benefits, contributing to the presence of emotion regulation, identity development, provision of a sense of connectedness to the community, enhancement of the employment capacity, but also offering routine and structure (Dingle, Brander, Ballantyne, & Baker, 2012). From the findings above, one can approve the claims of researchers who substantiate that meaningful activities taking place in the community can be crucial in resolving alcohol and drug problems (Granfield & Cloud, 2001), that treatment is one discrete aspect to recovery, and that sustained recovery is often influenced by an individual's interaction with others within a social context (Venner et al., 2006).

Alongside following one's passion and interest and engagement in personally meaningful activities, some participants in the present study also highlighted helping others to be crucial on their paths to recovery. The helper therapy principle, where an individual takes on a role centred on helping others facing similar experiences as them, was conceptualised by Reissman (1965). This role may occur naturally in settings shared by people with substance misuse problems, or may be formally constructed within a recovery community. It involves the helper using experiences that they may previously have viewed negatively, to be key in helping others (Best, Bird, & Hunton, 2015). Through this process, the helper also becomes a role model of recovery, and by doing so, transforms their own experience into something positive (*ibid.*), shaping their own sense of identity and personal narrative (Maruna, 2001), reinforcing their own learning and strengthening positive attitudes, values, and skills (Gartner & Reissman, 1979). Also, through publicly acknowledging recovery activities, the individual challenges stigma and social exclusion (Best, Bird, & Hunton, 2015).

Another aspect of recovery emphasised by the participants is the need to remove oneself from substance using friends and community. Substance use and early recovery can be characterized by individuals struggling with the perception of being accepted by, and identifying with wider sober communities (Livingston et al., 2011). Individuals, in order to maintain recovery, have to leave their old drinking and substance using networks behind; therefore, communities play a crucial role in an individual's sense of belonging (*ibid.*). Furthermore, some researchers, such as Best et al. (2008) argue that factors associated with maintaining abstinence are linked more often to social networks, including moving away

from heroin-using friends and relying on support from non-substance using peers. The research area into the importance of the types of social connections also underlines this. For instance, according to Rosenquist et al. (2010) those who consume alcohol are 50% more likely to drink heavily if a person they are directly connected to drinks heavily. The chance of drinking heavily reduces to 36% at two degrees of separation and to 15% at three degrees of separation. Also, individuals are 29% more likely to abstain from drinking if someone they are directly connected to is an abstainer and this effect is 21% at two degrees of separation and 5% at three degrees of separation (ibid.). Furthermore, Zywiak et al. (2009) also found that those individuals with problems relating to cocaine use with the strongest social connections had the best outcomes, particularly with social groups whose norms were not supportive of continued substance use. Also, the frequency of contact with a recovery-oriented social network has been found to be important in determining exposure to both recovery values and processes (Longabaugh et al., 2010; Moos, 2007), creating a social environment in which an emerging sense of self as “non-using” or “in recovery” can be nurtured and shaped by the norms, values and expectations of the group (Best et al., 2008, 2012).

Biernacki (1986) was the first to claim that identity change is central to recovery. He argued that in order to achieve recovery, “addicts must fashion new identities, perspectives and social world involvements wherein the addict identity is excluded or dramatically depreciated” (Biernacki, 1986, p. 141). Advocates of the social identity model of recovery (SIMOR) (Best et al., 2016) view recovery as a process of social identity change, in which an individual’s identity shifts from being defined by membership of a group whose norms and values revolve around substance abuse, to being defined by membership of a group whose principles and norms encourage recovery. This emerging sense of self is shared with others in recovery, thus strengthening the individual’s sense of belonging within recovery oriented groups. This developing social identity becomes increasingly internalised, so that the individual comes to represent the norms, values, and beliefs of that group. This, in turn, helps the individual shape and make sense of changes in substance-related behaviour (Best et al., 2016) and substance-related outcomes, such as the initiation and maintenance of substance use (Hawkins, Catalano, & Miller, 1992), attrition from treatment (Dobkin, Civita, Paraherakis, & Gill, 2002), as well as risk of relapse following alcohol and substance

dependence treatment (Hser, Grella, Hsieh, Anglin, & Brown, 1999). Within this model, rather than locating recovery solely in individual processes, recovery is seen as a socially embedded process, reinforced by transitions in social network composition that includes the addition of new recovery-oriented groups, where such groups are perceived as attractive, beneficial and significant (Jetten et al., 2014).

Research evidence shows that even a single positive group experience, in the face of multiple negative ones, can provide the necessary support to help excluded and vulnerable individuals to search for meaningful groups and supportive networks (Cruwys et al. 2014; Cruwys, Haslam, et al. 2014), in support of a social identity model of recovery. Therefore, this model of recovery views group therapy for addiction as a vehicle through which to promote a positive recovery-based identity that members can draw on in negotiating their lifestyle (Best et al., 2016). Its advocates argue that in order to better understand recovery, professionals need to move away from the view that recovery is “simply an individualised personal journey and see it instead as a socially embedded process of successful social identity transition” (Best et al., 2016, p. 120). The model also offers a complementary approach to specialist alcohol treatment, targeting social and contextual factors that are often “inadequately addressed by pharmacotherapies and many psychological interventions” (Best et al., 2016, p. 119). Furthermore, conceptualising recovery as a process of social identity change highlights the need for policy makers to promote social engagement strategies that can help initiate and sustain recovery-supportive lifestyles in the community, both during and after formal treatment (ibid.).

Advocates of the model also emphasize the importance of informal, non-using groups beyond formal treatment, arguing that membership in such groups can result in similar positive recovery outcomes to structured groups. As informal groups can be formed and based on any shared experience, preference, goal, or activity, informal groups offer a greater variety in experiences, compared to those of formal groups, allowing multiple sources of support to be present in the recovery transition (Best et al., 2016).

5.2 Markers of recovery

Whilst conveying the personal meaning of recovery, the participants also shared significant contributors to being able to stop the unhelpful use of substances. Some identified the process of attending counselling, being part of recovery groups and having a key worker and a sponsor to be such markers.

Through counselling, participants have been able to explore and give voice to their inner thoughts and feelings, allowing them to take an explorative stance towards themselves as well as their past, come to terms with the past difficulties and reach acceptance of self and of the events that may have contributed to substance misuse. Being a part of recovery groups supported individuals to participate in substance-use-free activities, having the opportunity to relate to others, learn new ways of existing, giving and receiving support, thereby reducing feelings of loneliness and isolation. Through having a keyworker and sponsor, some participants received an accepting, positive, caring and compassionate approach, with the belief in one's ability to recover. The development of trust also took place in these relationships, which provided a safe base from which the individuals learnt new techniques to enhance and maintain their well-being. Similarly to counselling, some individuals in these relationships also acquired an understanding of their substance use and sense that change is possible.

There is research evidence that individuals with substance misuse and dependence difficulties who participate in self-help groups, and or receive professional treatment have better overall outcomes in comparison to those who do not (Miller et al., 2001; Moos & Moos, 2005). Despite various studies (i.e. Capuzzi & Stauffer, 2012; Miller et al., 2003 ;) finding numerous therapeutic approaches to be effective in the treatment of drug and alcohol dependence, the National Institute for Health and Care Excellence (2011) still concludes that even with the most effective current treatment such as cognitive behavioural therapies and social network and environment-based therapies, the treatment effects are merely modest and at best, the treatments are not effective for everyone. However, the participants' experiences in the present study provide supporting evidence to the findings of research studies which assert that therapy, self-help groups and the provision of professional support can be influential to individuals' recovery. Within the provision of formal support, the most common thing emphasized on by the participants is the importance of receiving a non-judgemental, supportive and caring approach, which allows

the development of trust to take place. The significance of such relationships has been stressed by various researchers, and it has been found that a key contributing factor in an individual's successful recovery journey is the quality of the relationships that they build with the ones offering help and support (Najavits, Crits-Christoph, & Dierberger, 2000; Project Match Research Group, 1999; White, 2008b). Furthermore, Malloch's (2011) proposition that the process of supporting each other and strengthening one's own recovery by sharing and learning from personal experience is apparent in mutual-aid societies and is considered to be a key element for enhancing recovery, also substantiates key change-initiating properties of self-help groups, as described by participants. Humphreys and Lembke's (2013) findings are in line with these observations; they advocate that peer-models are successful because they provide the personal direction, encouragement and role modelling necessary to initiate engagement and change.

Beyond attending counselling, the participants also described being a part of recovery groups and having access to key workers and sponsors, spirituality and the support of family and friends as markers of recovery. Within spirituality, the need for something 'greater than own power' to stop using substances has been revealed, as well as the need to live for something 'bigger than just addiction', which are the key components of recovery for those attending Alcoholics Anonymous (Fisher & Harrison, 2005). Through Buddhism, some participants received a sense of control and choice and practiced meditation, which enabled them to be present in the moment, become more 'stable', and self-accepting. Buddhism, similar to climbing, offered individuals access to a supportive community, where they developed friendships and meaningful relationships, breaking away from substance using connections in the process. The literature on the beneficial effects of mindfulness reveals that similarities have been found between secure attachment experiences and Buddhist forms of mindfulness in terms of accessing mental representations of security (Shaver et al., 2007). As Buddhist practice can involve accessing representations of acceptance by a loving Buddha, this can be similar to attachment theory's notions of a secure base, and a safe haven, provided by security-enhancing attachment figures (ibid.). Through these practices, the individuals may be able to internalise such attachment styles, and potentially be able to benefit from the well-documented, overarching positive benefits that secure attachment

has to offer (Ainsworth & Marvin, 1995; Bowlby, 1969; Bretherton, 1992), which in turn, may enhance individual recovery from substance dependence.

The significance of family and friends in recovery from addiction has been noted by some participants through the presence of re-gaining the trust of the family members, and also re-connecting with long-forgotten relatives. The family- focused interventions developed in the substance misuse field, such as Social Behaviour Network Therapy (Copello et al., 2002) was designed for the UK Alcohol Treatment Trial (UKATT Research Team, 2005), and is based on the idea that the best chance of a positive outcome can be derived from providing the individuals with the opportunity to access a social network supportive of change. The supportive network typically involves family members as allies in the recovery process, and emphasises that treatment can tap into positive supports and influences in the existing social networks of those struggling with addiction difficulties (Best, Bird, & Hunton, 2015). Staying in line with this approach, the findings of Gyarmathy and Latkin (2008) underline the support of peers and families to be particularly beneficial while sustaining recovery. Similarly, Campbell et al. (2011) also reported that individuals with an addiction past who have access to a relative, partner, or friend, who has been with them through “thick and thin”, and is still offering love and acceptance, can make a great progress in their recovery. Therefore, one can reasonably argue that families have a key role to play in enabling and sustaining recovery pathways (Best, Bird, & Hunton, 2015, p.12), and that problems, solutions, and resources associated with improved futures do not lie purely in individuals, as consistent with a client-blaming diagnostic approach to drink and drug use, but rather complex individual, family and community relationships (White, 2009).

5.3 Recovering through climbing

The main purpose of the present research study is to explore the ways in which the participants perceived climbing to influence their recovery. Under the second super-ordinate theme recovering through climbing with its physical, psychological, lifestyle and social effects and also climbing as a therapeutic intervention, sub-ordinate themes emerged.

Participants shared that climbing had a positive influence on their physical well-being, which in turn beneficially impacted their recovery from dependence and substance misuse.

Climbing helped the participants to move away from a sedentary lifestyle and towards physical activity and engagement, thus contributing to an improved physical health. The improved physical health has been witnessed in increased physical strength and an improved ability to climb and apply technique. The participants also talked about experiencing a sense of 'high' whilst climbing, a physical, but also emotional state similar to the physical reward of taking substances, which at times, for some participant replaced such feelings obtained from various substances.

The participants' accounts of the positive and beneficial physical effects of an activity, such as climbing, are in line with the findings of studies that investigate the physical benefits of exercise, outdoor recreational activities and climbing. Researchers advocate exercise to have the potential of positively influencing physical health (Daley, 2002), reducing one's chances of early mortality due to physical inactivity (National Research Council and Institute of Medicine, 2009; Parks et al., 2006). The findings are also consistent with Gathright et al. (2006), Frances (2006), McCreesh (2001), King (2000), and Palmer's (1995) research results, who claim that interaction with natural surroundings encourages better health and enhances the overall well-being, and outdoor recreational activities do have biological benefits.

The physical sensations of feeling 'high' and receiving a sense of 'buzz' as described by the participants, has also been reported by Willig (2008) who looked at the meaning of engagement in physically challenging and risky 'extreme sports', such as bungee-jumping, sky-diving, skate- and snow-boarding, surfing, paragliding and rock-climbing. The author found that individuals engaging in such activities do report feeling 'high', and the presence of 'adrenaline buzz', which is often characterized by excitement. In the present study, some participants felt that such feelings may be able to replace the sensations obtained from various substances. Some individuals taking part in Willig's (2008) study also claimed 'experiencing high' while climbing a mountain -compared feeling that could draw parallels with the pleasures obtained from the effects of taking substances, such as cocaine.

The psychological values of climbing described by the participants entailed experiences of challenges and overcoming challenges, which in turn contributed to the presence of positive emotional states, such as a sense of enjoyment and satisfaction, feelings of

improvement and progression, but also an appreciation of own strength and power. Despite the fact that climbing can be dangerous, it has also been described by some participants as an uplifting and spiritual activity, which contributes to the presence of feelings of safety and security. Some participants also talked about how climbing was a mindful exercise, enabling them to be present in the moment. Similar to mindfulness and meditation, whilst climbing, the participants also experienced a presence of flow, a connection with their body and mind taking place, where they moved away mentally and physically from their everyday concerns and worries.

The positive emotional states described by the participants have also been reported by Willig (2008) among extreme sport practicing individuals. The author describes that whilst participating in extreme sports, individuals can enter a situation which is physically and mentally challenging, providing an opportunity to put one's limits to test. Rising to the challenge, and reaching success generates a sense of achievement, satisfaction, reward, and pride. One may also experience intense feelings of joy and pleasure, and these feelings are unlike those generated by any other activity. Furthermore, in line with the findings of the present study, the author (*ibid.*) also found the experience of a contrast whilst practicing extreme sports, such as climbing. In the view of the author, individuals report experiences of paradoxical quality in that it combines apparently contradictory feelings and sensations such as pleasure and pain, calmness and arousal, feeling at risk and feeling safe, all at the same time. According to the author, the presence of these contrasts contributes to its exceptional quality and to the sense that it is an experience out of the ordinary and not available in daily life.

Similarly to the finding of the present study, Willig (2008) too, reported that whilst practicing extreme sports, the opportunity arises to just be in the present moment, in a calming, relaxing and 'meditative state'. During these times, the partakers can lose themselves and be momentarily freed from the concerns and responsibilities associated with their everyday lives. Willig (2008) concludes that the reduction of stress levels is indicative of the fact that such experiences have a therapeutic quality.

In the literature, the ability to be in the present moment is often noted alongside and/or within mindfulness. Mindfulness can be viewed as a psychological trait, which is measured

through the presence of one's ability to be non-reacting and non-judgmental, acting with awareness and being able to observe and describe (Baer et al., 2006). It can be defined as a particular state of awareness (Germer, Siegel, & Fulton, 2013), a distinctive state of consciousness compared to typical cognitive processing (Brown, Ryan, & Creswell, 2007), where deliberate self-regulation of attention, and non-evaluative acceptance of one's immediate experiences (Kabat-Zinn, 1994) takes place. Researchers assert that mindfulness has a positive influence on the mental, emotional, and physical health, evoking various positive psychological effects, such as increased subjective well-being, reduced psychological symptoms, reduced emotional reactivity and stress levels (Carmody & Baer, 2008; Farb et al., 2010; Ortner et al., 2007;), and improved behavioural regulation (Keng, Smoski, & Robins, 2011). It has also been found that those who practice mindfulness may be able to achieve a sense of compassion and kindness for oneself as well as for others (Neff, 2012). A sense of compassion and kindness for oneself and others is also strongly associated with psychological well-being and increased feelings of happiness, optimism, curiosity and connectedness, as well as decreased anxiety, depression, rumination and a fear of failure (Neff, 2009). Furthermore, self-compassion is also associated with greater personal initiative to make the necessary changes in one's life (Neff, 2009). Such 'by-products of climbing' may be of particular relevance to individuals who are recovering from substance dependence.

Perhaps in contrast with mindfulness are the notions of worry and rumination. In the research area of worry, rumination, substance use and addiction, it was found that worry is associated with alcohol use in problem drinkers (Smith & Book, 2010) and that rumination increases cravings in alcohol dependent drinkers and also prospectively predicts drinking status in problem drinkers (Caselli et al., 2010). Also, amongst those with nicotine addiction, research claims that rumination predicts quit attempt failures (Dvorak, Simons, & Wray, 2011). From these findings, it could be potentially argued that a focus on the present moment, taking place in climbing, may act as a protective factor in the process of recovery from substance dependence.

Described by the participants in the present study, similar to the concept of mindfulness and being able to be in the 'present moment', is the experience of 'flow'. The presence of flow whilst practicing extreme sports has been noted by various authors (i.e. Le Breton, 2000;

Chang, 2017; Csikszentmihalyi, 1975). According to Csikszentmihalyi (1975), during this flow experience, the individuals sense a unity of self, world and activity as a result of total absorption in an activity or situation. Such state has the potential to evoke general feelings of well-being, an altered sense of time, a merging of action and awareness, clarity as well as the manageability of limits (Indiana University, 1996). It can also entail an integration of mind and body, where individuals understand their 'true self' (ibid.). Also, during this state, the everyday worries and concerns lose their significance, and individuals are become unaware of any gap between 'what is and what ought to be'. People in the flow state also feel that they are in control of their actions, even if it is something potentially dangerous that they are engaged with (ibid.). Csikszentmihalyi argues that experiencing flow can be a strong motivator for many individuals and can be a potentially effective alternative to substance use (Indiana University, 1996).

Within the psychological values of climbing, some individuals taking part in the study also viewed the experiences encountered within climbing to be similar to the phase of giving up substances. Similar to embarking on the road of substance-free life, although climbing can be, at times, a dangerous, risky and challenging activity, it can also expose individuals to a wide range of difficult emotions, such as the anxiety, fear and a constant feeling of one's abilities being uncovered. During climbing, according to the participants' accounts, partakers are required to take responsibility for such emotions and learn to manage them. The participants shared that through experiencing such emotional states, they learn about their own physical and psychological limitations and capabilities and reach an understanding of self. Some also reported the process of engaging with being open and honest about own capabilities and backgrounds, thereby potentially attaining self-acceptance. In literature, experiencing anxiety and fear whilst participating in extreme sports has been documented by Brymer and Schweitzer (2012), who revealed that partakers in extreme sports do experience intense fear, but this is often a meaningful and constructive event, with potentially transformative qualities (Ibid.). Similar to this position, Livingston et al. (2011) also advocate that individuals learn well in the margins of discomfort and that taking risks does promote growth. The personal growth that some of the participants claimed to have gone through whilst climbing for instance, becoming open and honest about oneself, and reaching self-acceptance could be a crucial element of recovery from substance addiction.

Research asserts that stigma is a major problem for addiction, and illicit drug dependence is the most stigmatised health condition in the world (Kelly & Westerhoff, 2010). Substance users are more stigmatised both when they are active users and when in recovery, suggesting that stigma persists to exist even when active addiction is left behind (Phillips & Shaw, 2013). Non-substance misusing individuals find it difficult to differentiate between active addiction and recovery, and often deny that addicted individuals can truly recover from substance use problems (Best, Bird, & Hunton, 2015).

Furthermore, stigma has been demonstrated to have a damaging impact on the efforts by individuals to tackle their alcohol and drug problems, as well as on their families, and also adversely affect policy aimed at tackling substance misuse problems (Social Inclusion Action Research Group, 2013). Stigma has also been found to be damaging to self-esteem and the perceived possibility of recovery, thereby hindering one's willingness to access treatment and support, resulting in increased alienation (ibid.). Furthermore, Jones et al. (2012) underlined the fact that those who hide a potentially stigmatising condition are more vulnerable to the negative views that the mainstream society holds because it limits their ability to develop a collective coping response. Therefore, it is reasonable to trust the findings of Best, Bird, & Hunton (2015), who report that individuals with substance misuse and addiction difficulties are anxious about disclosing their recovery status for fear of discrimination and adverse consequences for them and their family. It can be concluded that there is a possibility that through climbing, individuals may be able to reach self-acceptance and practice self-disclosure, which can be paramount to a successful recovery.

Within the second super-ordinate theme, the participants shared the lifestyles and social benefits of climbing. According to their accounts, climbing provided them with the opportunity to try out a new activity, providing them a passion, a hobby to nurture, and a healthier and more manageable lifestyle. Climbing also allowed them to broaden their interests, and explore other health promoting activities. The participants also shared that for some climbing offered a new career and employment.

Whilst the importance of the presence of meaningful activities in the process of recovery has been explored, the literature on the role of employment and volunteering in the field of recovery from substance addiction claims that the most successful community rehabilitation

programs should ideally be inclusive of employment/training or voluntary work as a key performance indicator (Logan, 2011). According to the research findings, employment can help sustain recovery (Campbell et al., 2011) and volunteering is associated with reduced mortality (Ayalon, 2008) and higher levels of reported wellbeing (Morrow-Howell et al., 2003). However, those with a substance misuse background can be at disadvantage by prejudice against their past, which may include a criminal record and long gaps in employment history, if there is any history at all (Campbell et al., 2011). Craig (2008) argues that even if the employers were aware of the employability of substance misusing individuals, “the stresses and strains of work often lead them to revert to familiar coping mechanisms” (Craig, 2008, p.13). Because of this, the author highlights the need for the presence of support networks and particularly for long-term support in order to maintain recovery.

The role of communities, being part of groups and having meaningful relationships is also highly accentuated in the literature of recovery from substance misuse. According to Best (2012), the solution to the problems of addiction lie not merely in pharmacotherapy and counselling, but also in engagement with the lived community. Similarly, Campbell et al. (2011) also raise the importance of strengthening individual recovery through community development, and stress that social and community support following treatment, is an important resource for sustaining recovery. In line with these findings, the research into the importance of social relationships advocates that participation in groups is associated with less psychological distress (Ellaway & MacIntyre, 2007), as group membership provides social support, which results in positive effects on health and wellbeing (Jetten et al., 2009). It has also been found that “individuals with adequate social relationships have a 50% greater likelihood of survival, compared to those with poor or insufficient social relationships” (Holt-Lunstad et al., 2010, p.14). Furthermore, stronger support networks have also been linked to better access to community resources (McKnight & Block, 2010).

Although the role of the community and social support in the maintenance of recovery from substance dependence is paramount, in the view of Ashton (2008), substance users can be ‘multiply excluded and widely despised’. In order to reduce this, in continued recovery simple relationships with a non-judgemental approach are crucial (Nordfjaern, Rundmo, & Holi, 2010), as this allows substance-dependent individuals to move away from substance

using link and find supportive, non-using recovery networks to maintain recovery (Best et al., 2008a; Davis & Jason, 2005). Through the creation of such networks, the individuals may be able to develop a sense of identity and belonging within which they have a value and a positive image often denied to them in their daily lives (Livingston et al., 2011).

The above findings support the experiences of the participants participating in the study of the ways in which climbing through its social benefits encouraged individual recovery. The participants shared that climbing allowed them to spend time with others without the use of substances. It also carried the opportunity to develop friendships and close relationships, which in turn, gave rise to feelings of engagement and belonging. Through receiving a non-judgemental, welcoming, caring and accepting approach, participants also reported a shift in feelings of isolation and loneliness, to connectedness and bonding. Climbing also allowed them to meet others with 'unusual backgrounds', providing feelings of relatedness. Through this, individuals also experienced feelings of being part of the society, but also separate from it, without the need to conform.

Considering the overarching benefits of climbing presented above, the development of the final sub-ordinate theme, the application of climbing as a potential therapeutic intervention, may not be surprising. Some participants shared that climbing, as an activity, does not have to be limited to its positive benefits, but can be taken further, and be applied as a purposeful therapeutic intervention on its own right to those who struggle with mental health difficulties and/or addiction problems. Participants expressed that this could take place through setting up a peer-facilitated climbing group, offering availability and accessibility to many different individuals. Such intervention would be able to provide a natural, 'organic space', where the individuals can feel comfortable talking about their everyday problems and support each other without the presence of the 'sterility of a professional environment'. However, according to Kidd (2011), the narrow scope of service user groups is the product of a risk-averse system, with a great deal of fear surrounding things that may go wrong with peer-lead groups and activities, particularly when they involve activities, such as climbing. The author also found that in mental health services, the health care professionals fail to take service-user led groups seriously, and see little merit in any activity not facilitated by trained professionals.

Despite the negative attitudes towards peer-facilitated activities, in line with the research findings claiming that sport and physical activity have important benefits in promoting substance misuse prevention strategies (Flint et al., 2010), various self-supporting groups were formed to support recovery from substance dependence. For instance, the Calton Athletic Group is a self-supporting group formed to support physical and fitness activities, as well as recovery (Faulkner & Taylor, 2005). The Calton Athletic Group's connection of physical and recovery group activity is a great example of how combined approaches are applied in supporting recovery from addiction (Roth & Best, 2013). The aim of the group is to bring recovery into the community and support and sustain recovery from drug and alcohol problems, run by and for individuals recovering from addiction. The group has been helping individuals through a unique abstinence based programme, which involves weekly recovery meetings, as well as various physical activities, both of which are seen to be integral and substantial in the quest of achieving and sustaining long term recovery (Calton Athletic Recovery Group, 2017), providing a focus for achievement and a productive use of time (Malloch, 2011). The emphasis was given to physical activity as a main focus since change is seen to be a key component of the group program in supporting the individuals transform themselves physically and mentally, and develop a sense of fellowship (ibid.). Malloch (2011) reported that while physical activities were seen to be crucial by the individuals in developing a healthy lifestyle and managing a 'racing mind', friendship, companionship, the meetings and ongoing contact among the group members can be viewed as equal, and in some cases, more important than engagement in the actual physical activity.

Another example of a peer-led, informal, recovery-orientated mountaineering group is the Drug and Alcohol Recovery Expeditions (DARE) group, based in North Wales, focused around activities such as scrambling, caving and climbing, with the aim to support individuals from 'anything' that they wish to recover from. The group is financially independent, and the members have collective ownership through voluntary participation. According to Livingston et al. (2011), the inherent principle of ownership and inclusion arguably underlines any successful recovery. This is present within the group through an inclusive and embracing community, where a positive sense of belonging and achievement is nurtured (ibid.) Whilst carrying out activities such as climbing and caving, the individuals provide each other

informal, instrumental, emotional, as well as affiliated support, thereby creating a responsive and caring space to accommodate individual personal recovery journey (ibid.) During the walks, individuals also build both an inner strength and a wider community resource of support (Livingston et al., 2011). To conclude, based on the case study design and narrative discourse, Livingston et al. (2011) stress that the actual activity- the outdoor experience- is cathartic; participation in the group leads to changes in thought process, perception and ability. Members of the group can regularly be seen progressing from 'chaos to stability, and eventually achieving a broader societal engagement, such as employment, volunteering, and education allied to long-term abstinence. The authors recommend that any activity towards which a group feels passionate "could be adopted as the core of recovery due to the broader point that it is about involvement, control, acting together, and creating communities of both interest and proximity—in all, promoting a purposeful sense of inclusion. " (Livingston et al., 2011, p.184).

5.4 Implications of the study for the profession of Counselling Psychology

5.4.1 Implications for Counselling Psychologists working with clients individually

In the literature, there is research evidence that individuals with substance misuse and dependence difficulties who participate in self-help groups, and or receive professional treatment have better outcomes in comparison to those who do not (Miller et al., 2001; Moos & Moos, 2005). The participants' experiences in the present study provide further supporting evidence to the findings of the research studies, which assert that therapeutic support, self-help groups and the provision of professional support can indeed influence individuals' recovery.

The findings of the study also emphasize the broad support requirements of individuals seeking therapeutic support for substance dependence. Counselling Psychologists working with such group of clients need to be aware that such individuals can come from challenging and disadvantaged backgrounds, and experience complex difficulties (at times above and beyond addiction), which may be the result of early family relationships, current or historical traumatic events, and/or the consequence of various misused substances. Therefore, whenever deemed necessary, Counselling Psychologists need to be willing to provide long-term support, aiming to meet the wide spectrum of support needs of such

individuals. Also, in treatment approaches, where they are required to follow professional guidelines, at times, Counselling Psychologists may need to defer from these and be willing to not solely focus on addiction, but be flexible and attend the particular needs of each individual.

In the present study, some participants claimed the beneficial effects that substitute prescribing had on their recovery. Some Counselling Psychologists refrain from the medicalisation of mental health (The British Psychological Society, 2014), and emphasise its detrimental effects on recovery (The British Psychological Society, 2012). However, based on the findings of the present study, one can argue that regardless of their personal and therapeutic stance, Counselling Psychologists need to be able to promote whatever it is that their clients find supportive in their recovery.

As stigma, marginalisation and demonization of being an addict (i.e. Best, Bird, & Hunton, 2015; Kelly & Westerhoff, 2010; Phillips & Shaw, 2013) is commonly experienced by those accessing support for dependence, an accepting, empowering, welcoming and non-judgemental approach may be even more paramount with this client group than with clients who do not experience such difficulties. Therefore, the Counselling Psychologists working in relational psychotherapy, emphasising the importance of a therapeutic relationship, are well placed to offer and develop a secure base with individuals with the help of which, individual recovery from such experiences can take place.

Beyond the beneficial effects of climbing, participants in the present study also claimed a number of other factors that further contributed to their recovery. Therefore, Counselling Psychologists engaging with such a client group need to be knowledgeable of the wider support services available in the community, so that the appropriate referrals can be put in place, whenever necessary and appropriate.

Participants in the study highlighted the importance of family and friends in the process of their recovery. Whilst engaging with this client group, Counselling Psychologists, in their approach, may need to shift from the one-to-one form of therapy, and be open to involve family and friends in the process of recovery.

Cooper (2009) accentuates that the Counselling Psychology's role is to welcome the other and engage with the 'unengageable' in a genuinely valuing and respectful manner. In order for this to take place, the profession needs to offer free or low cost therapy services, so that potentially hard to reach groups, such as those facing addiction, also have access to such services.

5.4.2 Moving beyond the practice of one-to-one therapy

In the last three decades, prescriptions of psychiatric medication have been increasing, both for adults and children, above the rates of growth of the population (Harper, 2016). There has also been a large increase in the amount of individual psychological therapy received (Harper, 2017). However, "individual psychotherapy is available to a small number only" (Albee, 1999, p.133), and whilst it might be effective on an individual level, it will never be available to all those who need it (Harper, 2016). McLellan (1999) reasons that traditional psychotherapy has been created by privileged white males, and practitioners of it, consciously or unconsciously work to maintain the status quo. Created by the mainstream, to serve the mainstream, therapy can fail the marginalised and disempowered groups in essential ways. Through focusing narrowly on the personal and individual, such approaches fail to address oppression and power issues in people's lives - the cause of most emotional and psychological distress (McLellan, 1999). The use of individual therapy and medication to relieve psychological suffering can also be a reactive, rather than a preventative measure, assuming that causes and remedies lie within the individual rather than in structural conditions (Harper, 2016). Because of these, Johnstone (2017), Friedli (2009) and Pilgrim (2017) argue for the need to locate and formulate mental distress within its wider social contexts. However, despite the presence of substantial evidence for socio-cultural influences on distress (e.g. Friedli, 2009; Psychologists Against Austerity, 2015; Wilkinson & Pickett, 2009), there is often insufficient regard paid to psycho-social and relational issues bearing on illness and recovery (Rustin, 2015). Additionally, psychologists also tend to be comfortable with looking at the proximal origins of suffering and feel apprehensive about examining the detrimental distal influences on well-being (Harper, 2017). Kinderman (2014) goes further, questioning the appropriateness of the continued dominance of a medical approach to mental health, and advocates the placing of psychologists in local authorities,

also encouraging a psychosocial approach to public mental health. According to Brodsky (2016), community psychology can “be a strong voice for ecologically grounded research and action that promotes positive outcomes for all individuals and their communities, particularly those who are most vulnerable and lacking in power” (Brodsky, 2016, p.286). Also, community psychology - ‘a science with a conscience’ (Brodsky, 2016) - is able to explicitly focus on fairness and justice (Brodsky, 2016), addressing and privileging the needs and desires of the most marginalized communities (Nelson & Prilleltensky, 2010). Therefore, the findings of the present study argue for a more community-based approach to working with individuals with substance dependence difficulties. Furthermore, as far as Counselling Psychologists are concerned, the present study also stresses the importance of practices beyond individual therapy, and the application of social approaches in the treatment of dependence. Such approaches highlight the significance of substance users’ social environment in recovery, assisting individuals to build social networks supportive of change (Copello et al., 2002; The British Psychological Society & The Royal College of Psychiatrists, 2011), whilst also encouraging problematic substance users to pursue activities that do not promote alcohol use (Hunt & Azrin, 1973; Meyers & Miller, 2001; Sisson & Azrin, 1989), as the solutions to addiction problems lay not merely in pharmacotherapy and counselling, but also in engagement with the lived community (Best et al., 2012).

Based on the findings of the present study, a final recommendation for the profession of Counselling Psychology is that Counselling Psychologists need to be aware that recovery is a personal journey, and that individuals may find healing in other forms of activities - for instance, climbing. When clients seem to withdraw themselves from counselling services, instead of trying to be persuasive of the effectiveness of traditional therapy, practitioners may need to be encouraging of their clients’ commitment to resources other than therapy, so that individuals may find personally influential aids to their recovery.

5.5 Limitations of the present study

Although the present study produced a variety of rich and detailed material concerning the individuals’ experiences of recovering from substance addiction, the limitations of the study

need to be acknowledged. Methodological limitations relating to the approach, the sample, sampling and validity will each be discussed in turn below.

Generalisation is not a meaningful goal for qualitative research; the knowledge generated in qualitative research from an interest in the detail of the phenomenon being explored is context-bound (Johnson, 1997; Schofield, 1993). However, some researchers (Sandelowskis, 2004; Stephens, 1982) claim that qualitative research results are potentially generalisable, just not in the same way as quantitative results are. As Yardley (2008) notes, “there would be little point in doing research if every situation was totally unique, and the results in one study had no relevance to any other situation” (Yardley, 2008, p. 238). IPA is an idiographic approach; it does not seek to find definitive or positivist answers but tries to provide an in-depth insight into the prominent themes of the participants’ experiences. The aim of the present study was theoretical transferability (Lincoln & Guba, 1985), rather than empirical generalisation: that is, this study should enable the reader to evaluate its transferability to people in similar contexts, to link the findings and their own personal and professional experiences in the context of the existing literature (Smith, Flowers, & Larkin, 2009). Therefore, the aim is not to make claims for all professionals working in the field of substance addiction, but to shed some light on the broader context, so that subsequent studies might add to this and perhaps enable more general claims to be made, where applicable or helpful. Correspondingly, in the present study, every attempt has been made, through a reflexive interview and the use of supervision, to put aside the researcher’s own repertoires of knowledge, beliefs, values and experiences, in order to accurately describe participants’ life experiences. However, in qualitative studies, the researcher is the primary instrument for data collection and analysis, and the findings are mediated through this human instrument (Chan et al., 2013), with the researcher inevitably influencing the research process and the knowledge produced (Yardley, 2008). Furthermore, according to Dowling (2006, p.15) “achieving reflexivity is not a straightforward endeavour,” and Crotty (1996) argues that it is not humanly possible for qualitative researchers to completely bracket their own experiences and be fully objective. With this in mind, one potential limitation of the present study is the presence of biases that the researcher brought to the research project. For instance, positive experiences of climbing and a felt need to research positive outcomes and factors that contribute to sustaining recovery could be considered as

potential sources of bias. These have been evident in the data collection process, in the form of interview questions which lacked explicit exploration of negative or neutral experiences of climbing, thus limiting the theoretical transferability of the findings.

Another limitation of the present study might be that the researcher may have made certain assumptions from their experiences of climbing more salient to participants via the participant information sheet and consent form, which may have induced a response bias, in the form of socially desirable responses. This may have led participants to mainly present the positive aspects of climbing, avoiding sharing its drawbacks. Despite that the disclosure of such information may have made participants feel more comfortable about sharing their experiences, future researchers need to be aware about self-disclosure and its influence on the data being collected.

A further limitation of the present study that should be considered is the potential selection bias (Mantica, 2011), as those choosing to participate were likely to have somewhat different experiences to those who decided not to take part in the present study. Also, participants taking part in the study all expressed positive perceptions and experiences of climbing. Future research studies could potentially explore the experiences of those who tried climbing but did not pursue the activity, or perhaps research novice climbers who do not have extended experience of the activity. Moreover, in the present study there was homogeneity in terms of gender and nationality among participants, with only one female participant and the participants mainly identifying as white British. Williams (2000) argues that gender-related differences are apparent in the way in which males and females respond to issues, and it is likely that the experiences of males are different to those of females when climbing.

The sample group in the present study also has some further limitations. The selection criteria asked the participants to be over 18 years of age, be in recovery or have had an experience of recovery from alcohol and/or other drugs and have experience of climbing formally or informally. The broad nature of selection criteria has been applied to reach the required number of participants; however one could argue that different types of addiction and different types of climbing practiced could lead to very varied experiences.

A further potential limitation of the present study lies in the validity of the findings. During the process of data collection, the participants were asked to convey their wish to review their transcripts prior to data analysis and only two participants asked for their transcript, one requesting certain information to be removed in order to protect the anonymity of the individual. In the literature, there is a continuing debate regarding the usefulness of the participants' validation as a method of establishing the credibility of the findings (Angen, 2000). Whilst it is suggested that it is a useful method to check the researcher's understandings and to ensure that the participants' views are not distorted (Elliott, Fisher, & Rennie, 1999; Yardley, 2008), some argue that this may very likely lead to confusion, as the participants may have changed their minds about an issue, may not have understood the interpretations made, and may not feel at ease to remark upon the researcher's interpretations (Angen, 2000; Mantica, 2011; Yardley, 2008). This method also relies upon the assumption that there is a fixed truth or reality against which the accounts can be measured, therefore continuing the positivistic assumption of an independently existing external reality (Angen, 2000; Mantica, 2011). Owing to this, it has been decided that the use of participants' validation would not be appropriate for this study, as the interpretative element of the analysis could have made it difficult for participants to relate to the analysis. However, as with any decision taken in research, there are losses in abandoning participants' validation (Mantica, 2011): the study could be seen as less collaborative and also the information given by the participants on the interpretations could have been an additional important source for expansion of the researcher's understanding of the phenomenon.

5.6 Recommendations for future research

In order to have a richer texture of the individuals' experiences, alongside interviews, future studies may apply, for instance, other qualitative methods, such as researcher-directed diaries (Holliday, 1999; Thompson & Holland, 2005) in an attempt to answer some qualitative questions, such as the one that the present study is concerned with. Also, given that the experiences of recovery may change over time, future research studies could also take a longitudinal approach (Torregrosa et al., 2015), whereby participants would be

interviewed at regular intervals about their recovery journeys in order to provide a more comprehensive understanding of the process of recovery.

The present study explored the individuals' experiences of recovery from various types of substance addiction while practicing climbing, which involves a wide number of practices. Limiting the type of addiction experienced by the participants and the type of climbing practiced, future studies could elicit potentially even more specific and nuanced experiences.

5.7 Quality in qualitative research

When considering quality in qualitative research, Yardley (2000, 2008) developed a set of four theoretically neutral validity principles that could be applied to experiential qualitative research, such as IPA. According to the author, each set of criteria can be interpreted and demonstrated in different ways, in appropriation to the methods used and "it is not necessary or even possible for any single study to exhibit all these qualities" (Yardley, 2008, p. 248). According to Braun and Clarke (2013), Yardley's criteria are open and flexible and represent one of the most successful attempts to develop theoretically neutral quality criteria.

Yardley's (2000) open-ended and flexible principles for judging the quality of the qualitative studies are as follows: sensitivity to context, commitment and rigour, transparency and coherence and impact and importance. In the present study, the researcher aimed at proving sensitivity to context through various avenues. Firstly, sensitivity to context was achieved by contextualising the research in relation to the relevant literature. Secondly, this was achieved through being sensitive to the participants' perspectives and socio-cultural context, and asking open ended questions that encourage participants to talk about what is important to them. Finally, sensitivity to context has also been achieved by taking care that my own meanings are not imposed on the data and being open to alternative interpretations as well as complexities in the results.

In order to ensure quality in the process, commitment and rigour has been present in the study through thorough recruitment and sampling, and also evidenced in conducting semi-structured interviews, paying particular attention to detail, but also utilising counselling

skills, during data collection, to know when to further elicit information from participants and when to step back from material that would include inappropriate levels of distress. Transparency and coherence are evidenced in the write-up of the research, into a coherent account of the research process, describing sampling strategies, the interview schedule and the steps engaged in the analysis.

Impact and importance according to Yardley (2000) “can only be assessed in relation to the objectives of the analysis, the application it was intended for, and the community for whom the results were deemed relevant” (Yardley, 2000, p.223). If the research can increase the reader’s knowledge of the topic under exploration and help create some new understanding, it can be said that its primary purpose has been achieved.

CHAPTER VI: CONCLUSION

The participants’ experiences in the present study provide further evidence to the findings of research studies (i.e. Miller et al., 2001; Moos & Moos, 2005) which assert that the provision of professional services can be positively influential to individuals’ recovery. However, according to the participants’ accounts, aspects of professional treatment influential to substance dependence recovery is not necessarily unique to formal support, and is likely to be present in an exercise activity, such as climbing. According to participants’ accounts, engagement in a leisure and personally meaningful activity, such as climbing, had a positive influence on their physical, psychological, as well as social well-being, which in turn positively contributed to their recovery from substance dependence. The psychological values of climbing particularly entailed experiencing a sense of ‘high’ whilst climbing: a physical, but also emotional state similar to the physical reward of taking substances. Such sensations present in climbing, for some, replaced similar feelings obtained from various substances. Furthermore, individuals also expressed whilst climbing the presence of the management of anxiety or fear. Whilst climbing, the provision of the opportunity to learn about own physical limitations and capabilities also took place, contributing to the achievement of self-understanding. According participants’ accounts, these experiences, for some individuals, may be necessary for giving up substances; therefore, climbing potentially contributing uniquely to the process of achieving abstinence.

A further benefit of climbing described by participants has been the opportunity to receive a non-judgemental, welcoming, caring and accepting approach from others, whilst also offering the chance to spend time with others without the use of substances. According to participants' accounts, such encounters contributed to a shift in feelings of isolation and loneliness, and to the manifestation of emotions of connectedness and bonding, giving rise to a sense of engagement and belonging. These findings support the claims of studies which argue the importance of simple relationships with a non-judgemental approach (Nordfjaern, Rundmo, & Holi, 2010) in order to allow substance-dependent individuals to move away from substance using links and find supportive, non-using networks to maintain recovery (Best et al., 2008a; Davis & Jason, 2005). Through the creation of such networks, substance using individuals may be able to develop a sense of identity and belonging within which they have a valued and a positive image often denied to them in their daily lives (Livingston et al., 2011). Such social benefits of climbing emphasize the need to potentially move away from traditional one-to-one treatment of substance dependence and claim the importance of social approaches applied in the treatment of dependence. For instance, social network and environment-based therapies focus on and take into consideration individuals' social environment in order to help achieve abstinence or controlled drinking (The British Psychological Society & The Royal College of Psychiatrists, 2011), assisting substance users to build social networks supportive of change (Copello et al., 2002).

The findings of the present study also stress the importance of maintaining abstinence through the development of activities that do not promote alcohol use, for instance, social and recreational activities, a crucial element of the community reinforcement approach (Hunt & Azrin, 1973; Meyers & Miller, 2001; Sisson & Azrin, 1989) applied in the treatment of substance dependence.

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APPENDICES

Appendix A: Interview topic guide

Interview topic guide for

“Recovering from addiction through climbing: an Interpretive Phenomenological Analysis study”

We have about an hour for the interview; please elaborate on your answers as best as you can

- Tell me something about yourself
- Could you tell me about your personal experience of addiction?
- What does recovery mean to you?
- What does climbing mean to you in relation to your recovery from substance misuse?
- How does climbing contribute to your psychological well-being?
- Is there anything specific about climbing that contributed to your recovery? If there is what is it? Could you elaborate on this?
- Is there any other form of exercise that you feel that has a central role in your recovery?
- What type of formal or informal support have you received in the past or are currently receiving that influences your recovery?
- Anything else that you would like to add or follow up?
- Any final thoughts?

Appendix B: Participant information sheet and informed consent



Information sheet and informed consent

Recovering from addiction through climbing: an Interpretive Phenomenological Analysis study

WHO AM I?

I am a climber myself and also a trainee Counselling Psychologist at the University of the West of England.

WHAT IS THE PURPOSE OF MY STUDY?

The aim of my Doctoral research is to explore individuals' personal experiences of substance addiction and climbing. The project is supervised by Dr Zoe Thomas. It has been approved by University of the West of England's Ethics Board.

WHO CAN TAKE PART IN MY STUDY?

- Individuals above 18 years of age
- With experience of being in recovery or have experience of recovery in the past from substance addiction (for instance drug, alcohol)
- Have experience of climbing formally or informally

WHAT WILL HAPPEN IF YOU WANT TO TAKE PART IN MY STUDY?

I would like to invite you to an interview, lasting about 60 minutes, which will contain several open-ended questions and will give you the opportunity to reflect on your personal experience of substance addiction and climbing. Interviews with your approval will be recorded and transcribed. Interviews can take place at the University of the West of England's Health and Social Sciences department, but also potentially at allocated recovery

and/or climbing centres. If you are unable to commit to a face-to-face interview, you can share your experience through Skype.

WHAT HAPPENS ONCE THE DATA IS COLLECTED? WILL IT BE CONFIDENTIAL?

After the interviews I would transcribe and analyse our interview, however after the interview you have the opportunity to review my analysis and also add your comments and feedback to it. After the final data analysis and write-up the results of the study will be written up in a Thesis/Dissertation format, may be presented at conferences or other presentations and/or published in peer reviewed journals.

In order to ensure that your identity remains confidential and that your views and experiences are reported anonymously within the research, prior to conducting the interviews you will be asked to name a pseudonym that you wish to be used in the data presentation. All information obtained from the interview will be available only to the researcher and research supervisor and will be treated in the strictest confidence.

WHAT IF I CHANGE MY MIND ABOUT TAKING PART IN THE STUDY?

You have the right to withdraw at any point from the study, even after the data collection.

WHAT ARE THE BENEFITS OF TAKING PART IN THE STUDY?

Taking part in the research is voluntary and you will not receive reward for your participation. You may choose not to take part, or you may withdraw from the study at any time. Before you decide to take part or not, please take as much time as you need to ask questions.

During the interviews you will have the opportunity to share your experience. Information and learning derived from this study will be used for the benefits of those with experience of substance addiction through exploring factors such as climbing as potential contributors

to recovery. The researcher also hopes that through the collected data the Counselling Psychology's profession's knowledge base will also be enhanced.

WHO SHOULD I CONTACT TO TAKE PART IN THE STUDY?

If you have any further questions or you are interested in the research, please contact me, the main researcher, or the research supervisor through email or phone

Main Researcher's E-mail:

Research Supervisor's Tel:

Research Supervisor's email:

Consent statement

I agree to take part in this research, and I am aware that I am free to withdraw at any point. I understand that the information I provide will be treated in confidence by the researcher and that my identity will be protected in the publication of any findings.

If you give your permission for the interview to be audio-taped, please tick the box below:

☐

If you give your consent for the interview data to be used within any publications or presentations which arise from the study, please tick the box below:

☐

Please note that we will only be able to use your data within the study if you tick the above boxes.

The last statement is additional and you do not need to tick it for the researcher to be able to use your data in the research.

If you wish to review your interview transcript before using your interview data, please tick the box below:

☐

Participant's initials:.....

Participant's Signature and date:.....

Researcher's Name:.....

Researcher's Signature and date:

If you have any concern about any aspect of your participation or any other queries, please raise it with the researcher or with the main research supervisor.

Thank you for your interest, I am very grateful for it!

Appendix C: Participant demographic information sheet



Demographic Information

“Recovering from addiction through climbing: an Interpretive Phenomenological Analysis study”

Age	
Gender	
Sexuality	
Ethnic background	
Employment status	
Relationship status	
Type of substance addiction	
Length of substance addiction	
Type of formal and/or informal support received	
Types of climbing practiced/practicing	
Years of climbing	

Appendix D: Participant recruitment flyers in climbing centres and recovery centres



Recovering from addiction through climbing: an Interpretive Phenomenological Analysis study

My name is Szerenke Kovacs. I'm currently undertaking a Professional Doctorate in Counselling Psychology degree at the University of the West of England. My Doctoral research thesis aims to explore individuals' personal experiences of substance addiction and climbing.

In order to be able to take part in my study, you will need to:

- Be above 18 years of age
- Be in recovery or have experience of recovery from substance addiction (for instance drug, alcohol)
- Have experience of climbing formally or informally

You will be asked to take part in an interview, lasting about 60 minutes, which will contain several open-ended questions and will give you **the opportunity to reflect on your personal experience of substance addiction and climbing**. The interview will be audio-taped. All information obtained from the interview will be available only to the research team and will be treated in the strictest confidence.

Participation in the research is anonymous and during the data presentation pseudonyms chosen by you will be used to ensure that your views and opinions cannot be identified by others.

The project is supervised by Dr Zoe Thomas. It has been approved by the University's Ethics Board. Taking part in the research is voluntary and you will not receive reward for your participation. You may choose to take part in the study but you may withdraw at any time.

If you have any further questions or you are interested in the research, please contact the main researcher, Szerenke Kovacs or the research supervisor through email or phone

E-mail:

Research Supervisor's Tel:

Research Supervisor's email:

HAVE EXPERIENCE OF CLIMBING AND SUBSTANCE ABUSE? WILLING TO SHARE YOUR STORY?

Recovering from addiction through climbing: an Interpretive Phenomenological Analysis study

Who am I and what is the study about?

I am a climber myself and also a trainee Counselling Psychologist at the University of the West of England.

My Doctoral research project aims to explore individuals' personal experiences of substance addiction and climbing.

I would like to invite you to an interview, lasting about 60 minutes, which will contain several open-ended questions and will give you **the opportunity to reflect on your personal experience of substance addiction and climbing.**

Who can take part?

If you are

- Above 18 years of age
- In recovery or have experience of recovery from substance addiction (for instance drug, alcohol)
- Have experience of climbing formally or informally

For further information and willingness to participate, please contact me on

Email:

Researcher: Szerenke Kovacs

Appendix E: Ethical approval



**Faculty of Health, &
Applied
Sciences
Glenside Campus**

Tel:

UWE REC REF No: HAS/15/03/128

13th March 2015

Address

Dear Szerenke

**Application title: Recovering from addiction through climbing: an Interpretive
Phenomenological Analysis study**

Your ethics application was considered by the Faculty Research Ethics Committee and, based on the information provided, has been given ethical approval to proceed with the following conditions:

1. My only concern is with the selection of participants. In section 3 'None of the above' has been selected. However, given the correlation between drug/alcohol abuse and mental health either as cause or effect, as outlined in Section 1, and that the criteria for participation in the study include 'being in recovery or having

experience of recovery from alcohol and/or other drugs' clarification may be required as to how no 'adults with mental illness' will be included in the selection process.

If these conditions include providing further information please do not proceed with your research until you have full approval from the committee. You must notify the committee in advance if you wish to make any significant amendments to the original application using the amendment form at

<http://www1.uwe.ac.uk/hls/research/researchethicsandgovernance.aspx>.

Please note that any information sheets and consent forms should have the UWE logo.

Further guidance is available on the web:

<http://www1.uwe.ac.uk/aboutus/departmentsandservices/professionalservices/marketingandcommunications/resources.aspx>

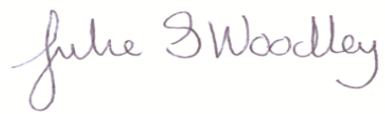
The following standards conditions also apply to all research given ethical approval by a UWE Research Ethics Committee:

1. You must notify the relevant UWE Research Ethics Committee in advance if you wish to make significant amendments to the original application: these include any changes to the study protocol which have an ethical dimension. Please note that any changes approved by an external research ethics committee must also be communicated to the relevant UWE committee.
2. You must notify the University Research Ethics Committee if you terminate your research before completion;
3. You must notify the University Research Ethics Committee if there are any serious events or developments in the research that have an ethical dimension.

Please note: The UREC is required to monitor and audit the ethical conduct of research involving human participants, data and tissue conducted by academic staff, students and researchers. Your project may be selected for audit from the research projects submitted to and approved by the UREC and its committees.

We wish you well with your research.

Yours sincerely

A handwritten signature in purple ink that reads "Julie Woodley". The signature is written in a cursive, flowing style.

Dr Julie Woodley

Chair

Faculty Research Ethics Committee

c.c. Zoe Thomas

Ethical approval confirmation

Hi Szerenke

The Committee has reviewed your response and has now given you full ethical approval.

Kind regards

Leigh

Leigh Taylor (Mrs)

Team Leader (Committee Services)

Research Administration

Research, Business, & Innovation

University of the West of England, Bristol

Appendix F: Research participant debriefing form



RESEARCH PARTICIPANT DEBRIEFING INFORMATION

Research project

Recovering from addiction through climbing: an Interpretive Phenomenological Analysis study

Thank you very much for participating in my study.

The aim of the present research has been to explore individuals' personal experiences of substance addiction and climbing.

The project is supervised by Dr Zoe Thomas. It has been approved by University of the West of England's Ethics Board.

Information and learning derived from this study will be used for the benefits of those with experience of substance addiction through exploring factors such as climbing as potential contributors to recovery. The researcher also hopes that through the collected data the Counselling Psychology's profession's knowledge base will also be enhanced.

I would like to remind you that your data are held securely and anonymously. If you wish to withdraw from the study at any time, please do not hesitate to contact us.

If you have a concern about any aspect of your participation or any other queries, please raise it with the researcher. However, if you would like to contact the main research supervisor, her details are the following:

Research Supervisor's Tel: Research Supervisor's email:

If you find that your participation in the interview has raised any challenging or painful issues that you need to discuss or explore further, consider contacting the MindLine or the Samaritans, the British Psychological Society (BPS), the UK Council for Psychotherapy (UKCP), the British Association for Counselling and Psychotherapy (BACP) to find a suitable counsellor or psychotherapist, if appropriate. Their telephone numbers are supplied below:

MindLine 0808 808 0330 The Samaritans 01850 60 9090 British Psychological Society 0116
227 1314 UKCP 020 7014 9955 BACP 01455 883316

Appendix G: Data analysis example

Interview	Initial analysis
Appendix G: Data analysis example interview data with 'Tom' Nature of the interview [00:31:28.06] Interviewee: that was, I mean at the time I didn't even think about it, a lot of this stuff, it's just kind of in reflection you know umm, because at the time I was just enjoying that I could go there and do that, you know Questioning about the usefulness of data Past of the participant; reasons for taking drugs: 20 years of addiction, clean for 5 years; use of drugs at the beginning to explore, recreational use; weed, party drugs, speed, ecstasy, heroin once when younger [00:15:22.07] Interviewee: um, I guess, it's kind of, it's kind of like, trying to think like when I was a kid, why did I like it, um, I was a very unhappy child, like father left and all these kind of things you know, that's why I left school when I was so young [00:15:51.10] Interviewee: I think drugs is, especially hard drugs like heroin and	Interview seen as reflection on the past Some background into the participant's life

stuff, you know, it's kind of, an extreme thing to do, it's kind of, you know, I think people get into that because they don't feel like they fit in with the mainstream society through various ways they end up on these drugs, I don't think it's like I don't fit in so I would take heroin	Reasons for taking drugs- not fitting into mainstream society
[00:16:58.19] Interviewee: well, I mean through counselling and stuff it kind of trace it all back to kind of childhood traumas really, you know I think that, so I understand all the problems you have as an adult using, started with some kind of trauma so various things, about my dad leaving, not being happy at school and not having friends	Counselling providing understanding
[00:17:21.11] Interviewee: all these kind of things, you know, lead to that, to that rebellion, rebellious	Reasons behind taking drugs/ background to the participant's life
[00:17:27.18] Interviewee: you know, because you know I was not happy, so I don't want any part of this mainstream world, you know	Prone for addiction? Not fitting into mainstream society, rebellion?
Participant's way of being and making sense of the world [00:52:30.29] Interviewee: yeah, I mean for	Not fitting in? not belonging, not wanting the mainstream world?

me, it's always like about a goal, you know I have to have a goal to work towards something, otherwise why, what am I doing you know, I don't wanna just work to get money, like to get money for what? To buy a tv or something, its kind of like mundane existence, you know , really like, really troubles me, you know and [00:52:58.24] Interviewer: living from day to day? [00:52:58.24] Interviewee: yeah, and like, all society, it really troubles and worries me, you know advertising, capitalism, corporates, I mean I don't want to get into all these stuff, but to, you know I feel if I can just go along and be part of that and it's kind of live an empty kind of existence you know, just being like a consumer [00:53:27.28] Interviewer: yeah [00:53:27.28] Interviewee: so something for me, I need a goal or something I am working towards you know, I need something to become better than I am [00:53:37.07] Interviewer: yeah [00:53:37.07] Interviewee: or do something or help in the world or something like that [00:53:41.14] Interviewer: yeah [00:53:41.23] Interviewee: is it fuller, richer life? [00:53:42.27] Interviewee: yeah, I mean, I have to, I have to be working towards this,	Need for a goal in life; troubled by mundane existence View on life???? Sense of purpose in life
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otherwise what's the point of being alive you know, so • Meaning of addiction [00:13:57.02] Interviewee: all these organisations are very clear that you know even if I'm clean for 5 years, I'm an addict, I'm an addict this whole thing that that that is you and you must always be vigilant about this thing, I'm not like that [00:14:18.27] Interviewee: you know maybe in the future I will be an addict again, but it's the point, now I don't want to carry this like a big stone on my back like I'm an addict, you know • Impact of using drugs: Loss of job a job with BBC as a trainee for a while, I did that for a few years and then my addiction and things you know, it all got too much and I stopped doing that, then I didn't do anything, just little bits and pieces for the next sort of 4, 6, 8 years I think	View on life Meaning of addiction for others Meaning of being an addict Studying, work, working hard defining self, view of self in a positive way, through success
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[00:08:46.09] Interviewee: sort of things so, you know eventually I stopped working there, I was on a sick leave for a while and just left and then my kind of drug use increased, you know, I would been smoking this stuff now for like 4 years, something like that, but they didn't work any more Psychological difficulties Psychosis, schizophrenia, paranoia [00:06:03.12] Interviewee: and just always this, this oppressive feeling, you know, something bad is going to happen, someone is gonna get me, something like that Positive impact of heroin and of experiencing difficulties: helping with studying to focus, making paranoia, schizophrenia disappear [00:06:03.12] Interviewee: and suddenly it was gone and it was great, I started to live my life, I met a new girlfriend and you know started you know to really enjoy, I got this job at BBC [00:50:00.12] Interviewee: I do try to remember back you know you are miserable and you would have done anything to escape from this hell you know and now you	No work, no structure? Use of drug increasing? IMPACT OF DRUGS- negative IMPACT OF DRUGS- positive Difficulties whilst using drugs gives a
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escaped and so you know enjoy, enjoy this time you know [00:51:21.28] Interviewee: more fully and you know live in the moment, appreciate things, I mean not all the time but, it's just you have to keep working at these things, you know appreciate people you know cos I'm Buddhist as well you know and every day I do chanting, I read Buddhist texts and stuff like that and all this life philosophy stuff, you know , really have to keep reminding myself, but it's like now I have the chance to do this you know and be more than I'm, that's why I'm studying now, to be an artist, you know every day challenging, more battles and things to always grow and improve and stuff like that Physical impact of drugs [00:06:40.06] Interviewee: because it's one drug, you know, you use it little bit on the weekends you know and then start to use it in the weekends and few days in the week and then it gets to a point where if you don't use it, you get withdrawal symptoms [00:09:05.16] Interviewee: yeah this was the heroin and didn't work any more smoking it,	perspective on one's life Use of drugs giving perspective on one's life; need to continue growing, improving through art, Buddhism Addictive nature of drugs
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so I started injecting it and it just changes everything when you started doing that [00:36:59.13] Interviewee: because you know for years of you know not looking after myself, also drinking alcohol, you put on weight, you know I was weak, you know all these kind of stuff and you know climbing, [00:49:02.24] Interviewee: before I always felt like that I wanted to be free, like somehow like a prisoner, because the fact that you have to, it's almost, I mean you don't have to but this thing like, you have to go and get money so you can get drugs, otherwise you get sick you know that was like the thing and you were almost held hostage by this thing, you could not move to another country, go on holiday or go somewhere or relax [00:49:27.22] Interviewer: yeah [00:49:27.22] Interviewee: you know, every morning you wake up and you have to do this thing to get this drug, otherwise you get sick, you know and then when I started medication, every day I have to go to chemist to get this medication, I could not go away or miss a day [00:49:40.22] Interviewer: yeah [00:49:41.18] Interviewee: on holiday or so	Body getting used to smoking heroin, not the same effect, needing to inject Negative IMPACT of drugs, alcohol Negative IMPACT of drugs on one's life
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it's like freedom, really, it's like freedom that, you know I can do, I want to go to France for a week, I can go to France for a week

[00:49:52.05] Interviewer: yeah

[00:49:52.10] Interviewee: I don't have to you know worry about that stuff

[00:49:56.20] Interviewer: so nothing and no one is holding you back?

[00:50:00.12] Interviewee: yeah, yeah, freedom, and the kind of like the misery of this realisation **when I was using like this thing that I'm trapped here, I don't know how to get out**, you know at the end of the day you can just stop using for 2 weeks and it leaves your system, but it's not as easy as just doing that you know cos it's always **this battle of relapse and it's constantly on your mind and stuff so really just this like desperation, misery, this like life state of hell you know, just constantly you know and yeah, just sucks up everything about you** and now I don't have that and so I need to keep reminding myself cos it's easy to get into normal life and you know and start to become unahappy about things that really don't matter too much you know, little, small things at home or going out, I have to keep reminding myself that this stuff doesn't matter, the small stuff doesn't matter you know

Negative IMPACT of drugs on one's life

Impact on lifestyle [00:07:21.05] Interviewee: after a job, you know searching the city to try and scot drugs and you know getting in all kinds of dangerous situations and stuff, all like buying big loads of this stuff before I went on a job [00:07:53.17] Interviewee: yeah and then I go to the point where I was not only using it outside of work, I started using it in work as well [00:10:23.24] Interviewee: yeah, I was, just kind of existing from day to day, you know nothing, like, nothing, I used to play music, I studied sound engineering, I was a dj and into music, stopped playing music slowly, stopped doing things that I did, you know, I used to read a lot, I used to play music, you know suddenly my room was not a lively place, my room was just a quiet place [00:10:52.03] Interviewer: yes [00:10:52.03] Interviewee: where I would sit and just sit and be high all the time [00:11:24.18] Interviewee: because of just the two of us, yeah, she had a job, she would	IMPACT OF DRUGS- negative Drugs taking over one's life Negative IMPACT OF DRUGS
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go to work every day, I would just be on my own, not on my own seeing any friends, just on my own, you know, just going out and around, trying to get money and things like that and trying to get you know hold of this stuff, but that went on I don't know like 4-5 years, just really miserable and then I am in this flat and there is like hole in the roof, there is rain coming in, there is, the heater is broken, all these things and it was about, it took me about 4 years to think like, why am I here, I came to London because, you know to get away from Bristol, to free myself from my problems, you know to expand my life, to go and study and to be big, famous sound engineer and now I'm sitting in this flat that is falling apart and I'm freezing cold and I don't have money and I wanna get high and all these stuff, so, you know, I was like, I said to L., you know let's go back to B.

[00:12:46.29] Interviewee: and just this like, the fact that the heating worked, and the roof was fixed, you know

[00:12:49.03] Interviewer: of course

[00:12:49.03] Interviewee: and just frees you up from worrying about these, you know, your day to day, cos it's like how do I survive today

NEGATIVE impact of drugs- isolation, main purpose of life- searching for drugs, feeling "miserable"; bad living conditions, loss of job, main focus of life- wanting to get high

[00:29:59.10] Interviewee: I mean in drugs group and with the counsellor or something you can be honest like that, but you are so used to putting on like, wearing a mask, you know like, if you live in a bad area or something like that you got to wear a mask, so people don't think you are weak and they will come and pray on you or rob you or something like that and you get so used to wearing that [00:30:18.25] Interviewer: so you had to be, to be quite just tough? [00:30:22.00] Interviewee: yeah, not like tough like, people don't mess with me, but some, it's like, I'm never, I'm not a violent person, I 'm not good at fighting or anything like that so I never behaved like this, so somehow just, it's almost like, oh, he looks, I don't know a kind of gaze you know that, they are not gonna get anything from me sort of thing Impact on social relationships [00:09:15.21] Interviewee: um, well just, smoking heroin with friends it was, I was an addict, but it was also a social thing, you know we would smoke, we would share and we would talk and then switch to, you know I split up with my girlfriend just before that,	Change of life circumstances- support from family, not having to focus on survival Use of drugs and risk of danger Protecting self from exploitation
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you know, friends, didn't see through many friends, so ended up mainly just me and one another guy who I lived with, just [00:09:41.01] Interviewer: just the 2 of you? [00:09:41.01] Interviewee: yeah, just the two of us [00:09:41.15] Interviewer: so isolated you? [00:09:44.25] Interviewee: very isolated, yeah and a lot of the times we would be in separate rooms as well, because when you are spending this much money on something and there is the two of you there and you are not working, it becomes this kind of, almost this kind of suspicion about each other, aw, did he get money, where did he get money, or if I buy something I better hide it, because he is gonna ask me for some [00:10:06.27] Interviewer: so becoming protective of your own stuff? [00:10:10.06] Interviewee: yeah, exactly, yeah, so in the end using just on my own, injecting all the time and [00:11:00.24] Interviewee: who was a, she was also addict as well and I have known her for years, but you know we met again together and we got together, it was , you know it was kind of love and gave me boost to my life, both still using drugs [00:11:15.16] Interviewer: okay [00:11:15.16] Interviewee: so, we ended up	Smoking heroin- social, with friends Injecting drugs- isolation, not with others, suspicion about each other, protecting own drugs, not wanting to share; financial strain
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getting a flat together and in the end I became even more isolated because [00:33:35.12] Interviewee: it was like, it was a bit difficult, because, yeah because coming out of addiction, especially in the beginning, I always felt like I needed to explain myself, you know like, to let people know that by the way I'm an addict and all of this, because I feel like I probably don't behave in a normal way, I probably did, but it's just like fears that you know they are gonna think that I 'm weird or something so I must justify why I'm weird by saying that I'm an ex addict and all of this • Introducing climbing into one's life [00:15:02.09] Interviewee: did a lot of groups and it was there where I went climbing [00:15:06.00] Interviewer: so how was that for you? [00:15:07.27] Interviewee: that was great, I mean I did actually climbing when I was at school when I was ten or something like that [00:15:13.21] Interviewer: okay, yes [00:15:13.21] Interviewee: our teacher took us to Avon Gorge and we did some climbing,	Finding love gives a “boost to life, but not enough to stop drugs; partner a drug user as well; potentially more difficult to change? Addiction giving a sense of isolation, losing the sense of normality, not being the same as others – negative IMACT of addiction Support: groups and CLIMBING BEING INTRODUCED
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a few times and I loved it, I really loved it [00:38:26.25] Interviewee: like, I guess about, I guess about 3, 3-4 years of climbing, first about 18 months really-really heavy climbing, then another year of once or twice a week and then a year of very spreaded on and then had a baby and I stopped, so • How climbing is experienced? [00:15:36.26] Interviewee: but climbing, as just kind of, you are on your own there, but I don't know, I can't remember too much [00:17:35.18] Interviewee: and climbing, I feel it's a bit like that in a way, because it's not a mainstream sport, it is quite a, it's a very safe sport, but it kind of feels like there is this element of danger, not like, not like adrenaline rush like a parachute jump or something, but it's kind of like, hmm, hard to describe it, you know it's kind of like, yeah, yeah, it's not mainstream sport, you know, it's something a bit different, it's kind of, it has got its own culture, you know like surfing or something like that, you now it's not like, you know, cos things like football, and these kind of team sports and these coming together to support a team, for me, I never really understood that, you know, in	When younger, climbed a few times, loved it CLIMBING length of climbing and reasons to stop CLIMBING and being alone
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fact I even find it quite repellent in a way that kind of the football mentality, the kind of tribal thing, all gathering together to support a team, so I never liked these kind of team sport and **climbing is a real, it's a real like, personal challenge, you know for yourself.** At the end of the day it's **you challenging yourself to overcome something**, which is

[00:18:55.02] Interviewee: **personal thing yeah and I think that kind of drew me to it, the fact that it's kind of, it's not it doesn't, it is not the mainstream thing**, it's kind of, I guess, it's that you **challenging yourself, to push yourself**, not for help your team or, you know for personal glory or anything like that, because you know I would climb and there is guys better than me, there is guys worse than me but in the end all that matter is me, getting on top of this thing and you know **developing my skills and becoming better at this route, or trying to do this thing that I couldn't do before, you know certain types of holds and hangs, overhangs and things like that**

[00:19:40.08] Interviewer: yes

[00:19:40.08] Interviewee: you know, so yeah, I think that's it, **maybe for heroin user,**

Climbing not being a mainstream sport-
danger, own culture, personal challenge

CLIMBING- challenging self, progression,
pushing self; doing it alone

cos when you are out on the streets using heroin it's kind of, you are kind of on your own really, you know you can have friends, but at the end of the day they will all rob you if they can, you know they only don't rob you, you know, there is some kind of respect and come and ride with me, but it you and you are you know battling for yourself, so I guess climbing as well, it's kind of you know, I mean that's not a nice way to battle with yourself, you know climbing is a nice way you know to challenge yourself and push yourself forward instead of sinking down you know	CLIMBING - Using heroin and being alone; battling with self in the world and battling alone whilst climbing
[00:20:42.03] Interviewee: yeah, I mean I was trying to remember the timeline, like the timeline, I started climbing when I was still using, still using heroin, but I was going to the drugs project and then I signed up and did an induction, so I got my, like licence or whatever	Use of drugs whilst still climbing
[00:21:00.28] Interviewee: to go on my own there, but I didn't go for ages, cos I didn't have anyone to go with, cos when we went on our day trip I went with a friend from the project and we were gonna go together and do the induction, but we both drug users and drug users are not reliable people, so on the day we were gonna both go for the	Needing to put effort into going climbing, taking time to get into it

induction he didn't come, so it was just me, so then I had my membership, but I didn't have anyone to go with so I think it was then a couple of years until I started going [00:21:46.29] Interviewee: I didn't really know about bouldering then, otherwise I could have gone on my own, this was just top rope climbing [00:22:02.10] Interviewee: oh, is just, you just say, I live in Bristol, I am looking for someone to climb with [00:24:02.02] Interviewee: yeah, couldn't keep up, cos I didn't have work and you know other people working and things like that and you know so going as much as I could, as much as could, just like, like I think I'm always quite, like to challenge myself, you know and get better at something and you know if I'm happy with myself for achieving something, then quickly I wanna do better you know, like I don't ever wanna, don't ever feel like I wanna beat someone, it's always myself [00:24:33.09] Interviewer: beating yourself? [00:24:33.09] Interviewee: yeah, beating myself, like that was good, but you can do better, you know you can do this climb or always the thought was I wanna do lead	Type of climbing: rope Use of social media to find partner Personality types for climbing? Need for challenge, need for progression
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climbing, I wanna do outdoor climbing, I gotta get good at doing this climbing [00:24:46.13] Interviewer: so the variety of climbing was a challenge and a good challenge as well? [00:24:51.09] Interviewee: yeah, yeah or that I was, I wanted to do it, I would see the guys doing the lead climbing and I didn't know how to do it, I would just do top rope, and I think I wanna do that, I would see when they do these things on the ceiling and stuff like that and I want to do that and so, I really, you know, just really pushed myself and in that period when I was just came off drugs and this kind of emptiness about life you know, climbing just really filled that cos just gave me such a focus, you know and I think it's not just climbing that can do this, I think anyone, you know, people can be passionate about like yoga or other kind of sports or running or martial arts or climbing or, like for me now it's art, which is to me art is now a personal struggle, cos always, it's the same for climbing, I do drawing, I am happy with it, but I can do better, I can better, always pushing you know, climbed the next route, so for me it's like that [00:25:50.08] Interviewer: yeah	CLIMBING Variety of climbing giving a sense of progression, further challenges CLIMBING Wanting to be better, climbing giving focus, sense of accomplishment
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[00:27:15.27] Interviewer: yeah [00:27:15.27] Interviewee: as much as that time, you know, whereas I think a lot of other sports, you don't have to, it's kind of like, you know, you are trying to break in into a tribe of people that all have similar views, but you don't have these views, football or something like that [00:27:33.07] Interviewer: yeah [00:27:33.07] Interviewee: and for an addict, they just wouldn't bother. Even if they like playing football, they wouldn't take that risk, you know cos the fear of people judging them and things like this, whereas climbing is like, it's I always felt anyway, it was very accepting and open community [00:27:53.02] Interviewer: yeah [00:27:53.02] Interviewee: so kind of go and do [00:27:56.24] Interviewer: so you felt a sense of belonging? or almost like, okay, I don't want to belong to the mainstream, but I actually somehow I can belong to somewhere? [00:28:08.00] Interviewee: yeah, I guess so. I mean didn't really get, I didn't really get into it kind of like too much socially as in like socializing with all the climbers there, usually I just would stay with my partner and climb with them, but I think I didn't, that's just me anyway, I'm not so much social person, but	Fear of being judged- in CLIMBING accepting, open community Not socializing a lot whilst climbing
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even if I didn't speak with them just being kind of part of this, you know knowing that everyone is there, because they want to push and challenge themselves you know, I mean I guess you do get climbers who who are very boastful and want you know, about glory, cos you get all kinds of people everywhere, but mostly I felt that it was, this thing about challenging and pushing yourself and at the end of the day it's like you know, it's you, hard to say, you can't really talk up your abilities to climb, because you climb and everyone can see how you climb, you know it's not, it's not something you know you cannot make excuses about that, you know it's, you can have a bad day or something, but at the end of the day it's about you, so there is kind of no, too much room to you know to be to be fake or dishonest about this, about the kind of stuff so that was, you know that was good as well I think	CLIMBING Having a shared goal
[00:29:33.02] Interviewer: so people, people could see you as you were [00:29:36.28] Interviewee: hmmm [00:29:36.28] Interviewer: in terms of climbing and so you could just be yourself? [00:29:40.03] Interviewee: yeah, yeah, yeah, exactly, I think in drugs as well there is a lot of dishonesty and you kind of almost you are dishonest all the time with so many	CLIMBING Challenging and pushing self CLIMBING and honesty, use of drugs and

people that that becomes you and it's hard to be completely honest [00:30:45.27] Interviewee: yeah, yeah, like not vulnerable, you know either because he looks too screwed up, he looks like he doesn't have money, or just like, just a look that, you know we are not gonna get, it's gonna be more trouble than it's worth, it's not like he is tough or, I don't know, just a feeling that, you know, yeah, and I guess climbing forced you to expose that, cos it's honesty [00:31:16.06] Interviewer: yeah [00:31:16.06] Interviewee: you are climbing as hard as you climb and if you are not very good, you have to accept that you are not very good and just keep doing it, until you get better, you cannot like bluff your way through it [00:31:55.01] Interviewee: yeah, routine was good, I think important as well is that is not a, there is no drugs or alcohol involved in the thing, it's like when I cleaned up, I kept drinking for a while and eventually I stopped drinking and as soon as I stopped drinking it's like socially there is not really	dishonesty- forcing the person to be honest CLIMBING and need to be honest CLIMBING and routine
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too much you can do in the UK, or or in our culture it's so engrained that socializing you go to the pub you know , this one to go and drink beer, you know, it's this whole, so the friends I had before I started using, they would go to the pub and I didn't want to go to the pub cos you know I didn't have problem with the alcohol, but I didn't want to sit there and people getting drunk, cos when people are getting drunk and you are not drunk and they are drunk, it's [00:32:44.26] Interviewer: it's not fun [00:32:44.26] Interviewee: yeah, it's not fun, so I think climbing as well, it was like, aww something to do socially that it doesn't revolve around drugs or alcohol, which was really missing in our culture here, you know obviously you can find it, but it's not accessible for everyone [00:33:01.25] Interviewer: yeah [00:33:02.06] Interviewee: there is not public space where we all go where people don't drink [00:33:06.24] Interviewer: yeah [00:33:06.24] Interviewee: so I think that was really important for me [00:35:30.09] Interviewee: so you know I'm, I kind of think if someone would take away my job for that, I don't want to work there	CLIMBING and doing something socially that doesn't involve drugs or alcohol – NEED FOR THIS
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anyway you know so and I think, you know climbing and these social interactions with people helped me to kind of develop this confidence to you know not to be ashamed of who I'm and not try to hide it or do something like that	CLIMBING- giving confidence, being honest, accepting addiction as one's past
[00:36:59.13] Interviewee: well, my fitness back, you know, really, [00:40:04.07] Interviewee: and then suddenly, and then I started to, cos this fear was building up, I started to like tell her let's not go climbing this week, cos I know she wants to go lead climbing and I just wanna top roping just for fun, so that was part of it, also other part of it is that I was doing other things with my life as well, you know when I was cleaned up climbing was my only focus, focus, focus focus	CLIMBING and physical fitness
[00:42:46.09] Interviewee: they don't really fit with me, where as climbing it did, you know so other sports, I'm sure other sports could get into if there is the right environment you know to start then, but I don't know, climbing is just, just this whole personal thing, you know, you are overcoming, you are battling with yourself all the time you know you are not relying on anyone, you know, I mean you rely on	CLIMBING giving focus, not doing other things in life- whilst when stopped addiction, not a lot to do- no job, no routine, having to face difficulties alone, without the support of drugs CLIMBING and not relying on others, relying on self

your partner to keep you safe, but you know, it's up to you to make this climb. You know in a way like, you know they don't wanna be with others, but at the end of the day in the world it's something, you have other people, you can rely on friends and they help you and support you, but the end of the day it's only you, you know, anything, if you are unhappy, it's up to you to change that, if you are struggling, it's up to you to change that, other people can help you do that, but they can't do it for you and I think a lot of misery in the world is because people rely on others or respond to others you know, now we have have new government here which is making a lot of people miserable cos they do a lot of bad things, but you know a lot of people get miserable about this you know, but in the end of the day it's for, you know it's how they feel inside[	Being in charge of own happiness
00:44:07.10] Interviewer: yeah [00:44:08.13] Interviewee: think, climbing is like this, cos it's such a personal battle like this, I think it is good for yeah [00:44:20.00] Interviewer: yeah, so you mentioned battle, a couple of, a few times and I wonder, if you wanted more water there is plenty, and what I'm thinking about is, what, so besides the challenge and	CLIMBING as a personal battle CLIMBING as challenging, getting better, improving

getting better and improving

[00:44:40.03] Interviewee: hm

[00:44:40.11] Interviewer: what battles did you have at climbing if you had any?

[00:44:44.24] Interviewee: okay, yeah, well, first, yeah, first there was just a, you know like the grading system, you know 4a, 4b, 5a, 5c as they get more difficult as they go up, so it's kind of like, when I started I can do like 5a climbs, okay I wanna do 5b and it's like I can do most of the 5 b except this one and then it's like 5c, you know, **these kind of challenges keep moving up, you see a real sense of that you are getting better because you can do these grades and stuff** and I remember one of the first times I went climbing the who came with me he was really very very experienced guy and he was just like helping me out you know and he did this like, it was like a 6a or something but to me like at the time a 6a climb was like wao, you know he just did it and did these, just these moves that I couldn't believe and I was like oh my, like these, you know high with his feet and doing all these like really crazy to me at the time it looked really crazy you know, **so then for me it's like a battle like I wanna do, I wanna do that, then eventually not much later I can do that and then I do the next one**, 6b and you know I can't remember this system, I think I did some 7a,

some 7b, you know like sometimes or like most of the time I would fall off or something, but just the few of them, **wao I did a 7a climb and that was like you know, yes, such a good feeling cos at the start these really tiny holes I couldn't even**

[00:46:28.07] Interviewer: touch them

[00:46:28.07] Interviewee: **couldn't even think how I could do them but eventually after time you have strength in your fingers and then it's like, just realized wao, I climbed on this little chip of rock you know and did it and you know it's like a real victory you know**

CLIMBING giving a sense of improvement

[00:47:14.23] Interviewee: battles, not specifically about climbing, but just this battle of being like sociable person, you know and getting on with people who I don't know so well, you know like

[00:47:31.02] Interviewer: yes

[00:47:32.01] Interviewee: yeah, like before, the life, drugs and everything into you know people you see the same people all the time so you can be comfortable with them

[00:47:46.06] Interviewer: yeah

[00:47:46.26] Interviewee: but then climbing, even like the guy who works in the

climbing centre, things, you know before like being a sociable person, having a conversation with someone, you know it's difficult [00:47:59.22] Interviewer: yeah [00:47:59.22] Interviewee: for me this is like a battle as well [00:48:03.14] Interviewer: yeah [00:48:03.14] Interviewee: not directly related to climbing, but doing all that stuff has given me the opportunity to challenge myself and be, you know more courage, you know [00:54:02.29] Interviewee: yeah, I think so, I think really, I didn't really think about it before, maybe just I'm talking kind of rubbish a bit, but you know, whatever is arising, but it's really it's kind of a metaphor for a lot of things in life, you know this, you know this goal I wanna get to the top of this wall and you know maybe you don't make it the first few times, but then you keep doing it and you do make it and you know you can experience this kind of real joy of achievement and then but then it's like you don't stop and think well I have done it now, you think oh, what's the next one, I have done this one, where is the next one	CLIMBING giving a sense of improvement Being sociable a personal difficulty Climbing giving an opportunity to challenge self, have more courage CLIMBING as a metaphor
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[00:54:44.16] Interviewer: yeah [00:54:44.16] Interviewee: and yeah always, always, you know you reach your goal and you make the next goal and then you make a bigger, aww one day I wanna climb you know Avon Gorge or something like that on my own or you know whatever, you know feel like go to another country and climb, you know, how do they call them like the Devils' teeth in Australia [00:55:06.26] Interviewer: okay [00:55:06.26] Interviewee: they have this tower of rocks and I have seen them in a few movies and stuff and always kind of like a dream, it's not like mountain climbing where you are up for week, it's just one, this big tower of rock there and I see people climbing it, so one day I wanna do that, you know [00:55:23.24] Interviewer: yeah [00:55:23.24] Interviewee: so kind of the long goal and the mid goal is like I wanna climb, I wanna master all these routes and then even closer goal is I wanna master this one route in front of me you know [00:56:08.01] Interviewee: I know people who aren't drawn to it, you know, my wife for instance, she did, went to BDP as well and they took her climbing and she really hated it cos she was really scared and you know not confident with herself and she got	CLIMBING giving goals Climbing and short and long-term goals CLIMBING not for everyone- need for confidence
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stuck half way up the wall, you know it was not a good experience for her [00:56:59.28] Interviewee: were more confident, confident, yeah, I don't know, also like trust as well, you need to trust that person belaying you, it's gonna keep you safe you know, um, so think you need to have, cos in some way you give away [00:58:07.20] Interviewee: yeah, I was saying this thing like you know, like I say it's battling yourself and everything, but you also giving your life in someone else's hands and really and you know which I think I think as well maybe people cannot do, cos they have to rely on this person, maybe they don't know this person too well Why giving up climbing? [00:39:22.06] Interviewee: and but then when I got to the point of doing lead climbing I became really fearful of it and because this fear of falling, you know cos obviously you are lead climbing you fall further and stuff and I used to go with this girl G., with this Polish girl she really wanted to do lead climbing all the time and I was just so scared of doing it, I mean really thought I was scared of it so I need to keep doing it, I need to keep doing it until I'm not scared	CLIMBING and need to trust others Battling with self, relying on others, giving power away Fear of falling as another reason to stop climbing
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and other climbers they said just fall a few times and you will stop and I did that a few times, I would go up and jump off and just to fall

[00:40:34.26] Interviewee: and then cos I started to get more comfortable with living life and you know live in the real world and stuff like that you know , I guess I went to college and some things and other commitments and stuff like that and just slowly started to let it slip and then kind of laziness creeps in you know, when you start something new, you give it, all your energy, but then it's to maintain that is like the hard work and I did 4 years or something, but

[00:41:04.21] Interviewer: quite a long time

[00:41:04.21] Interviewee: yeah, but towards the end it was like, it's just laziness I guess, which is yeah, which you know like talking now, I feel like I wanna go climbing again and hopefully this gives me you know the motivation to get back out there, cos I love it you know

- Danger of just giving up drugs and the importance of climbing

[00:22:07.14] Interviewee: find a partner, so

Having other commitments- family, child, other hobbies but also laziness

I found this site, by this time I stopped using, but I was at this really, at this point when you stop using drugs, it's kind of, this dangerous point, because you are clean, but you are suddenly in this world where you haven't got this support of this drug in your mind that comforts you all the time you know and it's quite scary, because suddenly it's like, you don't have work, don't really have too many hobbies or passion or interest but suddenly you got to face life without this drug and it's just really, it's really depressing, because you are just, yeah, you are just kind of, you know all the bad things about the world, all the bad feelings, all the things you are trying to escape from before suddenly you have to kind of face them and it's just this kind of grey dreary boredom of life without drugs you know	Stopped using drugs- danger of this period- psychological
[00:23:14.22] Interviewee: umm, so it's really dangerous time for addicts because a lot of time people think, I can't handle this, I will use again and often they go to use and something like heroin it's very easy to overdose, because your tolerance went way down but you just buy what you usually buy, use it [00:23:33.24] Interviewer: yeah	Dangerous period when stopped using drugs –physical danger; CLIMBING COMING INTO HIS LIFE AT A CRUCIAL TIME

[00:23:33.24] Interviewee: **and a lot of people, most people die from overdose like this, because they get clean and then they go back so it's really like a really dangerous time and it was at this time that I started climbing**

- The needs of people who struggle with addiction

[00:34:10.02] Interviewee: actually it was quite good for me, because also taught me to be honest with myself and accept that this is who I'm and as a result, you know it's really good, because the reaction I found was most people were not too bothered you know and I never met anyone who was, who, or no one who said to me anyway that that they disapproved or you know didn't like this behaviour or something like that or they didn't like me because of it you know, most people are like, well done for getting over it, you know and so it gave me confidence in people really

[00:34:46.11] Interviewer: really?

[00:34:46.11] Interviewee: you know, everywhere I go, I don't, I 'm never ashamed to admit what I did. Even when I was working as a teacher I told my boss, i told my

Need for supportive, non-judgemental attitude towards addicts

colleagues, I didn't tell my students, because they are teenagers and it's not appropriate [00:34:58.00] Interviewer: yeah [00:34:58.00] Interviewee: but you know some people could say ohh no, don't say anything, because you are a teacher and you could lose your job, or something and I, I kind of in myself I didn't really think about it too much, it's just, it was just normal for me to explain this stuff or if it comes up, to say it and nothing happens [00:35:23.05] Interviewer: yes [00:35:23.05] Interviewee: and in fact people are more supportive, colleagues are more supportive and more helpful because it is, I didn't lose my job, because I was an addict [00:36:21.04] Interviewee: and stuff and I'm sure some people are judgemental or think this and that, but you know that's fine, they can think that, but to my face no one has ever been nasty and if people avoid me because of that, then that's fine, because probably they are not the people I need to mix with • Addiction services	Society's response towards addiction? Supporting recovery? Positive reaction from others towards "being an ex- addict" Positive experiences with others
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[00:36:01.10] Interviewee: hm, because in the drugs project you are very open and honest, but everyone else has similar experience so it's not, so you know it's not till you say these stuff to other people outside who didn't have a drug history it's kind of a test to yourself, how do people, will they accept you • Role of further sport	At Drug Services- people open and honest Searching for acceptance – difficulties to encounter when given up addiction
[00:41:48.28] Interviewee: possibly, when I was in London, I used to go to a drugs project and they did yoga, there was a guy who came in to teach yoga and he was an ex-addict as well and he was now a yoga teacher and I really got a passion from that, you know I used to go every week to his yoga sessions for ages and ages, yoga every week, you know and and I really got into that, I think the reason I didn't continue it is because you know you go to a yoga class and it's mainly women who go there for fitness, you know which is cool, nothing wrong with that, but as an addict it's kind of, you feel a bit uncomfortable with this things, where as I was going with him was all of addicts, he was an ex-addict, he kind of felt like he was on the same wavelength you know, I got into that, but I didn't keep it up because you know the, the, the available places to go	Sameness of the yoga teacher- ex addict; gender differences, different goals- not keeping him in doing yoga

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Appendix H: Research article

Abstract

Currently, there is limited research on the ways in which an outdoor or indoor recreational activity, such as climbing may be able to promote recovery from substance dependence. The aim of the present study is to explore the ways in which individuals experience recovering from substance addiction through climbing, adopting a qualitative methodology, specifically Interpretive Phenomenological Analysis (IPA). A sample of six participants (five male and one female) were interviewed. According to the participants' accounts, climbing, as a recreational activity, has therapeutic benefits, with the potential to positively influence recovery from substance dependence through having a beneficial effect on the individuals' physical and psychological well-being, social relationships, and lifestyle.

Key words: climbing; outdoor recreational activities; exercise; mental health; addiction; substance misuse

Introduction

Substance misuse is a significant national and global public health problem (Centre for Social Justice, 2013; Wittchen et al., 2011; Zangeneh et al., 2007). In 2016, England and Wales were found to have a greater number of drug abusers than the European Union's average number of drug abusers. Of these, under one-third of adults were found to be cannabis users (Health and Social Care Information Centre, 2016). In England, in the year 2014/15, there were 8,149 hospital admissions with a primary diagnosis of drug-related mental health and behavioural disorder, and 1.1 million estimated admissions where an alcohol-related problem, injury or condition was the primary reason for admittance or a secondary diagnosis (National Statistics, 2016). Alcohol misuse costs the National Health Service (NHS) in England £3.5 billion every year (National Treatment Agency for Substance Misuse, 2011-12). Beyond the financial strains that substance misuse imposes, it can also have overarching and negative physical (NHS Inform, 2015; NHS Choices, 2017), psychological (Casadio et al., 2011) and social consequences (Capuzzi & Stauffer, 2012; Centre for Social Justice, 2013; NHS Inform, 2015). Despite these effects, the preventive measures for

substance misuse in the United Kingdom are considered to be not only poorly administered, but also seem to be ineffective (Centre for Social Justice, 2013). In schools, in the past few years, for example very little has been done to prevent young people from starting on a path to substance abuse. The only support that children received was the national campaign called FRANK, which has been considered to be inappropriate and ineffective, by some, as only one in ten children would call the FRANK helpline to talk about the use of substances (Centre for Social Justice, 2013; FRANK, 2017a).

For those who encounter substance addiction, various factors can prevent them from achieving a successful recovery. Internal, external (Xua et al., 2008) and social barriers (Centre for Social Justice, 2013) have been identified to exist, which adversely affect the number of individuals living substance-free lives. Stigma, depression, neuroticism, personal beliefs and attitudes about treatment have been found to be among the internal barriers to recovery (Xua et al., 2008). Also, time conflicts, addiction treatment accessibility, not understanding addiction treatment, entry difficulty and the cost of treatment are often viewed to be a few external barriers to recovery (Xua et al., 2008). Beyond such obstacles however, broad, societal barriers have also been claimed to exist. The Betty Ford Institute Consensus Panel (2007, p. 221) defines recovery as “voluntarily maintained lifestyle composed characterized by sobriety, personal health, and citizenship”. However, the way the term has been applied in documents has led to devastating confusion as not every individual who enters treatment achieves a substance-free life, and a lot of such people are not even given the chance to try in the first place (Centre for Social Justice, 2013). By not specifying that every person in treatment should be given the opportunity to learn about not using substances, a vacuum has been created. Rather than aspiring for a life free of substances, the definition of recovery can actually mean that the providers are able to discharge someone ‘in recovery’ even if they are known still to be using (ibid.). There have also been instances where the terminology and criteria for recovery have been applied as an excuse for withdrawing support from individuals with dire ongoing needs (Slade, 2010).

The treatment of substance dependence is often influenced by the various approaches and understandings that one takes towards its aetiology (West & Brown, 2013). The identification of issues to be addressed in treatment and recovery has been primarily defined by the disease model of alcoholism and has also been translated into a program of

recovery (Rhodes & Johnsons, 1994). According to the National Institute of Health and Care Excellence's (NICE) (2012) guidelines, evidence-based formal psychosocial interventions should be applied in the treatment of drug dependence. Those who are harmful drinkers and have a history of struggle with mild alcohol dependence should seek and receive psychological intervention, such as cognitive behavioural therapies, behavioural therapies or social network and environment-based therapies, focusing specifically on alcohol-related cognitions, behaviour, problems and social networks (National Institute for Health and Care Excellence, 2011). Psychological interventions are an important therapeutic option for individuals with alcohol-related problems, however, even with the most effective current treatments, the effects are modest at best and the treatment is not effective for everyone (The National Institute for Health and Care Excellence, 2011).

Residential rehabilitation is also known to be a particularly effective intervention for substance addiction (National Treatment Agency for Substance Abuse, 2012b). However, residential rehabilitation is received only by 2% of those in treatment, and in contrast with the suggestions of NICE Guidelines on the provision of medication and therapeutic support, 49% of those in treatment solely receive medication prescription as treatment. This lack of quality treatment received by many addicts struggling towards recovery could explain the reasons behind the national figures for leaving 'free of dependence' to be only at 11.5 % (National Treatment Agency, 2012b).

According to research findings, even without specific treatment, high percentages of spontaneous recovery rates are likely to occur (Morse, 2006; Lopez-Quintero et al., 2011; Blanco et al., 2013) and natural recovery from even the most severe episodes of addiction is widespread, perhaps even commonplace (Yates, 2014). Researchers also argue that recovery takes place at least as much in the community as it does in treatment settings (Groshkova & Best, 2011) and that treatment is one discrete aspect that can facilitate recovery. Sustained recovery is also often influenced by an individual's interaction with others within a social context (Venner et al., 2006). Meaningful activities taking place in the community have been emphasized by natural recovery researchers to possess the potential to resolve the problems of alcohol and substance misuse (Granfield & Cloud, 2001; Best et al., 2008; Rogers et al., 2008; Best et al., 2013; Correia et al., 2005; Dennis et al., 2004; Smith et al., 1998; Petry et al., 2001). Exercise, a potentially meaningful activity that often takes

place in the community, has been proven to have beneficial effects on individuals' psychological well-being (National Research Council and Institute of Medicine, 2009; Zschucke et al., 2013; Goodwin, 2003; Harvey et al., 2010; Ten Have, de Graaf & Monshouwer, 2010; Ströhle et al., 2007; Pasco et al., 2011). Exercise has also been reported to be likely to play a substantial role in the prevention and treatment of mental health difficulties (Callagan, 2004). In the treatment of substance misuse and dependence, the idea of exercise serving as an adjunct to substance misuse treatment has been and continues to be promoted widely (Ala-leppilampi, 2006; Zangeneh et al., 2007; Weinstock et al., 2008); This is based on research evidence which indicates that individuals who engaged in exercise-related activities can achieve longer durations of abstinence during treatment as compared to those who do not complete an exercise-related activity (Weinstock et al., 2008). For example various studies have shown that in comparison to the control groups, those attempting to quit smoking and who participate in physical activities, can have significantly higher abstinence rates than those who do not engage in such activities (Bock et al., 2012; Marcus et al., 1991; Marcus, 1999; Martin Kalfas & Patten, 1997; Ussher Taylor & Faulkner, 2014).

Outdoor recreational activities and their influence on physical well-being has been widely explored. Researchers assert that interaction with natural surroundings encourages better health and enhances individuals' well-being (Gathright et al., 2006). Also, outdoor recreation activities such as climbing, walking, hiking, orienteering and cycling, kayaking, canoeing and sailing have been shown to be bio-psycho-socially beneficial to mental health (Frances, 2006). The physiological benefits of such activities include improved blood pressure, pulse, vigour, energy and physical well-being (King, 2000; McCreesh, 2001; Palmer, 1995), whilst psychosocial benefits such as improvement in daily living skills and hobbies, increased self-esteem and confidence, development of a positive self-identity, increased decision-making power, improved communication skills, enjoyment of the natural habitat and increased self-awareness and motivation have been recorded (King, 2000; McCreesh, 2001; Mills, 1992; Raine & Ryan, 2002; Siegel Taylor & Evans-McGruder, 1996). Furthermore, improvement in mood and distraction from mental health problems, enhanced coping mechanisms, increased ability to overcome challenges, emotional maturity and increase self-acceptance have also been identified as some major emotional benefits of outdoor recreational

activities (King, 2000; Mc Creesh, 2001; Raine & Ryan, 2002; Siegel Taylor and Evans-McGruder, 1996).

Many climbing activities are outdoor activities, whilst others take place indoors with climbing walls designed specifically for the purpose. Some activities are usually carried out with ropes to help control the risk, whereas others such as bouldering and hill walking are invariably done without ropes. Rock climbing, traditional climbing, sport climbing, soloing, bouldering, ice climbing, competition climbing, hill walking, scrambling and mountaineering are the main activities that can be seen as climbing (British Mountaineering Council, 2014). Climbing, as a form of outdoor or indoor activity and exercise influencing psychological well-being, has limited research attention. A few studies looked at the health (Kuo & Taylor, 2004) and psychological benefits of climbing (Arbor, 2008; Oppezzo & Schwartz, 2014), some concluding that climbing can be a legitimate educational activity, encouraging the physical, mental, social and emotional growth of the participants (Cook et al., 2007).

In the current literature, there is a dearth of research studies which explore the individuals' experiences of the ways in which a meaningful activity and exercise, such as climbing may contribute to recovery from various forms of substance addiction. The aim of the present study is to address this gap and in line with the recovery approach (Betty Ford Institute Consensus Panel, 2007; UK Drug Policy Commission, 2007), moving from pathology, illness and symptoms to health, strengths and wellness (Department of Health, 2009) to focus on the positive outcomes and factors that contribute to sustained recovery.

The prime research question of the present study is 'What are climbers' experiences of recovering from substance addiction?'. The present study seeks to contribute to the research on addiction by exploring a topic of interest in rich detail by adopting a qualitative methodology, specifically Interpretive Phenomenological Analysis (IPA).

Method

Interpretive Phenomenological Analysis (IPA)

As the present study has been concerned with the lived experiences, the research study was approached through Interpretive Phenomenological Analysis (IPA). IPA was initially adopted within the domain of health psychology (Flowers et al., 1997; Osborn & Smith, 1998; Senior

et al., 2002; Smith, 1996), but it has found application in social and counselling psychology research (Coyle & Rafalin, 2000; Golsworthy & Coyle, 1999; Macran et al., 1999; Tourni & Coyle, 2002; Turner & Coyle, 2000), allowing scholars to explore individuals' experiences, cognitions and accounts (Willig, 2001). It is an approach to qualitative, experiential and psychological research which has been informed by phenomenology, hermeneutics and ideography. Phenomenology, which is a philosophical approach, is considered to be the study of experience, and focuses on what the experience of being human is like. Phenomenology provides a framework to psychologists about how to comprehend and examine lived experience (Smith, Flowers, & Larkin, 2009).

Within IPA the phenomenological inquiry is also an interpretive process, and the researchers are making sense of what is being said. Also, IPA is a 'double hermeneutic', as the researchers are making sense of the participants, who are also making sense of their experience. Within double hermeneutics, the researchers have a dual role: they are not participants and they only have access to what has been shared, perceiving the data through their own, experientially-informed lens (Smith & Osborn, 2003).

IPA, through the influence of idiography, is also committed to analysing the particular in depth and in detail. Idiography engages with single cases on their own right, but it can also attend to the process that moves from the analysis of a single case to general claims (Harre, 1979). From idiography, IPA researchers adopt analytic procedures, moving from single cases to more general statements, and at the same time retrieving particular claims for the individuals involved (Smith, Flowers, & Larkin, 2009).

Design

The participants in the study were invited to engage in approximately hour-long semi-structured interviews (Smith et al., 2009). Semi-structured, one-to-one interviews tend to be the preferred means for generating qualitative data in IPA. They are easily managed, allowing rapport to be developed and give the participants space to think, speak and be heard (Smith et al., 2009). Semi-structured interviews can also be applied flexibly, with the participants having an important stake in what is covered (Chang et al., 2013). Semi-structured interviews can be characterized by open-ended questions, and these have been developed in advance and prepared with probes and prompts (Morse & Richards, 2002).

The data analysis followed the ‘Stages of IPA Analysis’, aiming to be descriptive and interpretive, seeking deeper meaning about the ways in which the participants made sense of their experiences (Smith, Flowers, & Larkin, 2009).

Participants

According to Smith and Osborn (2007) there is no correct number of participants for a qualitative study. Smith et al. (2009) and Braun and Clarke (2013) highlight that three to six participants can be reasonable for a student project using IPA, therefore the present study aimed to reach the proposed number of participants. The criteria for participation were: over 18 years of age; being in recovery or having experience of recovery from substance misuse; participants to have experience of climbing formally or informally.

With the aim to generate an insight and understanding of the topic of interest, the present study adopted purposive (Patton, 2002) as well as snowball sampling methods (Coolican, 2004; Henry, 1990). The participants were recruited through flyers in climbing centres and recovery centres. The research was also advertised through social media to reach the required number of individuals.

Table 1 Participants’ demographic information

Pseudonym	Rebel	Helena	Brian D.	Yan	Ospray	Tom
Age	52	25	52	56	60	34
Gender	Soft male	Female	Male	Male	Male	Male
Ethnic background	Not identified	White British	White European	British	White British	White European
Employment status	Employed	Employed	Employed	Employed	Employed	Student
Relationship status	Married	Single	Divorced	Married	Living with partner	Married
Type of substance addiction	Poli-drug user	Ketamine, speed, party drugs	Alcohol and drugs	Heroin, crack cocaine and alcohol	Alcohol	Heroin
Length of substance addiction	38 years	9 years	28 years	29 years	40 years	10 years
Type of formal/informal support received	No drug or alcohol services; experience of triage appointments	Counselling	Spirituality-Buddhism and Alcoholic Anonymous	12-step fellowship and counselling	No involvement of services	Key worker and counselling
Types of climbing	Mountaineering, ice and rock	Indoor and outdoor	Traditional and sport	Outdoor and indoor	Indoor sport climbing	Top rope and lead

practicing/ practiced	climbing, free soloing, hill walking, field runner	sport climbing, bouldering, and traditional climbing	climbing	sport climbing, scrambling, hill walking		climbing
Years of climbing	31 years	6 months	31 years	8-9 years	10 years	4 years

The interviewing process

Whilst collecting the data through semi-structured interviews, the researcher aimed to keep the research question in mind, while encouraging participants to expand on anything that was felt to be relevant in relation to the topic (Josselson, 2013). In order to attain a well-prepared interview guide and encourage a reflexive stance, a pilot interview and a reflective interview was conducted with a colleague (Braun and Clarke, 2013). Seven, face-to-face, semi-structured research interviews were conducted with six participants. The need to conduct a second interview with one of the participants emerged because of allowing needed space for the participant to express and share thoughts, feelings and experiences. The interviews lasted approximately an hour. All the interviews were audio recorded and transcribed verbatim (Smith & Osborn, 2003).

Data analysis

The transcription and data analysis was conducted alongside interviewing. The analysis approach was interpretive, seeking deeper meaning (Smith, Flowers, & Larkin, 2009) around the way in which the participants experienced climbing during their recovery.

Ethical considerations

Ethical approval for the research was granted in March 2015 by the University of the West of England Faculty Research Ethics Committee (FREC). The Code of Ethics and Conduct published by The British Psychological Society has been followed throughout the study (The Ethics Committee of the British Psychological Society, 2009).

Findings and discussion

Interpretative Phenomenological Analysis (IPA) of the seven semi-structured interviews, conducted with six participants resulted in the development of two super-ordinate themes with five sub-ordinate themes.

Table 2 *Super-ordinate themes and sub-ordinate themes*

Super-ordinate themes	Sub-ordinate themes
1. Experiences of recovery	1a Meaning of recovery 1b Markers of recovery
2. Recovering through climbing	2a Climbing and one's physical and psychological well-being 2b Lifestyle and social effects of climbing 2c Climbing as therapy

The present article engages with the presentation and discussion of its key, second super-ordinate theme, of individuals' experiences of recovering from substance addiction through climbing, presenting the physical, psychological, lifestyle and social effects of climbing. It is recognised that these themes are one possible account of the experience of recovery and they do not cover all aspects of the participants' experience, and were selected due to their relevance to the research question. It is acknowledged that they are a subjective interpretation and it is likely that other researchers may have focused on different aspects of the accounts.

Physical and psychological values of climbing

The participants shared that climbing had an overarching positive influence on their physical well-being, which in turn affirmatively impacted their recovery from dependence and substance misuse. According to their accounts, climbing allowed them to move away from a sedentary lifestyle and towards physical activity and engagement, thus contributing to an improved physical health. This influence has been noticeable through the presence of increased physical strength and an improved ability to climb and apply technique.

The participants' accounts of the positive and beneficial physical effects of an activity, such as climbing, are in line with the findings of studies that investigate the physical benefits of exercise, outdoor recreational activities and climbing. Researchers advocate exercise to have the potential to positively influence physical health (Daley, 2002), reducing one's chances of early mortality due to physical inactivity (National Research Council and Institute of Medicine, 2009; Parks et al., 2006). The findings are also consistent with Gathright et al. (2006), Frances (2006), McCreesh (2001), King (2000), and Palmer's (1995) research results, who claim that interaction with natural surroundings encourages better health and enhances overall well-being, and that outdoor recreational activities have biological benefits.

Throughout the interviews, when the physical effects of climbing were explored, the participants expressed experiencing a sense of a 'high' whilst climbing, which is a physical, but also emotional state, similar to the physical reward of taking substances. Ospray expressed it as:

"It's when they achieve that sense of satisfaction they become very attracted to it, because it helped them break through and you know they want to feel that satisfaction again, which is a bit like you know the reward of taking a drug."(Ospray)

Throughout the interviews, this sense of satisfaction and 'being high' has also been articulated as feeling a certain sort of 'buzz'. Such experiences, at times, for some replaced the feelings obtained from various substances.

"It has definitely replaced it, hundred percent, it seems to, that's exactly what happened. So obviously climbing is not a bad thing to replace, a way of, so yeah, because it gives you that kind of buzz, not the same buzz as ketamine does, but a better one." (Helena)

This feeling has been described to be 'even better' and 'more real' than the feelings achieved from the consumption of chemical substances, because such feelings have been perceived to be naturally obtained, brought on by self and not achieved through external substances.

"You get a big buzz if you did it and probably it's better actually, you know compared to the one that you get from other substances."(Brian D.)

The physical sensations of feeling 'high' and sensing a 'buzz', as described by the participants, has also been reported by Willig (2008); it was particularly found amongst individuals engaging in extreme sports. The author found that individuals engaging in such activities do report the experience of 'feeling high', and the presence of an 'adrenaline buzz', which is often characterized by excitement and is comparable to the pleasures obtained from the effects of taking substances, such as cocaine.

Whilst exploring the psychological and emotional contributions of climbing, the participants conveyed that during climbing, they often felt a sense of enjoyment and satisfaction, which has been accompanied by feelings of improvement and progression. According to the participants' accounts, these feelings have often been achieved through climbing being a physically challenging activity. Whilst climbing, the participants experienced difficulties, and overcoming these allowed them to appreciate their own physical strength and power, which in turn contributed to the development of positive emotional states.

"You see a real sense that you are getting better because you can do these grades and stuff, a good feeling because at the start, these really tiny holes I couldn't even think how I could do them but eventually after time you have strength in your fingers and then it's like, just realized wooo, I climbed on this little chip of rock you know and I did it and you know it's like a real victory you know, maybe you don't make it the first few times, but then you keep doing it and you do make it and you know you can experience this kind of real joy of achievement." (Tom)

Similarly to Tom, Ospray also voiced the presence of feelings of enjoyment, achievement and progression whilst climbing and reaching ones' physical limitations.

"I enjoyed the activity, the sort of strenuous nature of the activity, I suppose being on the edge of not being able to do it you know, and then being able to do it, it's a sense of achievement, people overcoming obstacles and doing things that are more difficult than they were doing last week, so it's progress." (Ospray)

The positive emotional states experienced during climbing have also been reported by Willig (2008) among individuals that practice extreme sports. The author found that whilst participating in extreme sports, individuals can enter a situation which is physically and mentally challenging, providing an opportunity to test one's limits. Rising to the challenge,

and reaching success generates a sense of achievement, satisfaction, reward, and pride. One may also experience intense feelings of joy and pleasure, and these feelings are unlike those generated by any other activity.

An exploration of the psychological benefits of climbing also revealed climbing to be a mindful activity, encouraging the participants to be in the present moment. As climbing requires focus and concentration, it helped them to take their mind off the things that concerned them, and instead of dwelling on their difficulties, it enabled them to stay in the present moment, and focus on climbing and technique.

"It requires a lot of focus so you are not distracted all the time and you are not thinking about how you really are, you are thinking about how do I get from here to there, you know do I need to pull in some more rope, so brings it all into a very sharp focus for people, you have to focus, I think because it takes a lot of focus, a lot of energy and a lot of concentration, I think I found it, I suppose it took my mind off other things."(Ospray)

Not only Ospray, but Helena also talked about the need to focus and be present in the climbing activity, which for her, gave rise to 'unexplainable', 'amazing' feelings.

"When I'm climbing, everything goes, just I don't care about anything, when trying to get to the top, finish the climb and having to focus rather than, you know focusing on whatever else, just having to focus on everything, focusing your whole body, the way it is moving, I guess and the feeling it gives me is kind of unexplainable really, but it's amazing." (Helena)

During the exploration of the presence of a mindful attention in climbing, some participants found it difficult express these experiences in words. Some viewed mindfulness and meditation in climbing to take place through the presence of flow, where they are not only moved away mentally and physically from their daily concerns, but also the connection of their body and mind taking place.

"Climbing was more like meditative, when it comes together, you get that flow of things, I use that meditative feeling that you get, when it comes together, body and mind connect a bit, you get a thing where it's quite an experience you get totally absorbed in the whole thing, it's timeless too, you can say it's like meditation, it's mindfulness, you have got to be mindful in a sense, you cannot be thinking about all kinds of things, it takes

concentration, it's good, it connects your mind and body I guess, something good about the whole thing that comes together.” (Brian D.)

Similarly to the finding of the present study, Willig (2008) too, reported that whilst practicing extreme sports, the opportunity arises to just be in the present moment, in a calming, relaxing and ‘meditative state’. During these times, the partakers can lose themselves and be momentarily freed from the concerns and responsibilities associated with their everyday lives. Willig (2008) highlights that the reduction of stress levels is indicative of the fact that such experiences have a therapeutic quality.

Described by the participants in the present study, similar to the concept of mindfulness and being able to be in the ‘present moment’, is the experience of ‘flow’. The presence of flow whilst practicing extreme sports has been noted by various authors (i.e. Le Breton, 2000; Chang, 2017; Csikszentmihalyi, 1975). According to Csikszentmihalyi (1975), during this flow experience, the individuals sense a unity of self, world and activity as a result of total absorption in an activity or situation. Such state has the potential to evoke general feelings of well-being, an altered sense of time, a merging of action and awareness, clarity as well as the manageability of limits (Indiana University, 1996). It can also entail an integration of mind and body, where individuals understand their ‘true self’ (ibid.). Also, during this state, the everyday worries and concerns lose their significance, and individuals are become unaware of any gap between ‘what is and what ought to be’. People in the flow state also feel that they are in control of their actions, even if it is something potentially dangerous that they are engaged with (ibid.). Csikszentmihalyi argues that experiencing flow can be a strong motivator for many individuals and can be a potentially effective alternative to substance use (Indiana University, 1996).

Researchers on mindfulness assert that it has a positive influence on the mental, emotional, and physical health, evoking various positive psychological effects, such as increased subjective well-being, reduced psychological symptoms, reduced emotional reactivity and stress levels (Farb et al., 2010; Ortner et al., 2007; Carmody & Baer, 2008), and improved behavioural regulation (Keng, Smoski, & Robins, 2011). It has also been found that those who practice mindfulness may be able to achieve a sense of compassion and kindness for oneself as well as for others (Neff, 2012). A sense of compassion and kindness for oneself and others is also strongly associated with psychological well-being and increased feelings of

happiness, optimism, curiosity and connectedness, as well as decreased anxiety, depression, rumination and a fear of failure (Neff, 2009). Furthermore, self-compassion is also associated with greater personal initiative to make the necessary changes in one's life (Neff, 2009). Such 'by-products of climbing' may be of particular relevance to individuals who are recovering from substance dependence.

It has been found that worry is associated with alcohol use in problem drinkers (Smith & Book, 2010) and that rumination increases cravings in alcohol dependent drinkers and also prospectively predicts drinking status in problem drinkers (Caselli et al., 2010). Also, amongst those with nicotine addiction, research claims that rumination predicts quit attempt failures (Dvorak, Simons, & Wray, 2011). From these findings, it could be potentially argued that a more mindful mental state taking place in climbing, may act as a protective factor in the process of recovery from substance dependence.

Throughout the interviews some participants drew a parallel between the processes involved in detoxing, leaving substances behind and climbing, sharing that the emotional demands of detoxing can also be present in climbing. For instance, climbing, as it is a dangerous and challenging activity, can expose the individuals to a wide range of difficult emotions, where they are required to take responsibility for such emotions and learn to manage them. Ospray explains his encounter with this as follows:

"In climbing it is illustrated what they need to do in detox, and I felt that it was incredibly useful with particular respect to people with being confronted with genuine fear and anxiety and going beyond their capability." (Ospray)

Experiencing anxiety and fear whilst climbing and an improvement in one's ability to manage such emotions has also been shared by Helena through looking at her management of her emotions in the past and comparing this with the abilities that she possesses in the present.

"I would look at the bolts and I was like, all I could think about, because I was so paranoid, all I could think about is that they would come out and I wouldn't be able to stay up there, because I was thinking that the bolts are going to come out and just things are going to snap and I used to be really scared of heights and that has got so much better." (Helena)

Beyond the management of difficult emotions, the participants also conveyed that whilst detoxing, there is a need to be honest towards oneself as well as others, and make a commitment to live a more truthful life. Some participants voiced that such processes are supported by climbing since one's competencies can become exposed, which may allow them to better understand themselves, learn about their own physical and psychological limitations and capabilities, start to be open about their own capabilities and potentially reach self-acceptance.

"It's honesty, you are climbing as hard as you climb and if you are not very good, you have to accept that you are not very good and just keep doing it until you get better, you cannot like bluff your way through it and I think, you know climbing helped me to kind of develop this confidence to, you know, not to be ashamed of who I'm and not try to hide it or do something like that." (Tom)

In literature, experiencing anxiety and fear whilst participating in extreme sports has been documented by Brymer and Schweitzer (2012), who revealed that partakers in extreme sports do experience intense fear, but this is often a meaningful and constructive event, with potentially transformative qualities (Ibid.). Similar to this position, Livingston et al. (2011) also advocate that individuals learn well in the margins of discomfort, and that taking risks does promote growth. The personal growth that some of the participants claimed to have gone through whilst climbing for instance, becoming open and honest about oneself, and reaching self-acceptance could be a crucial element of recovery from substance addiction.

Research asserts that stigma is a major problem for addiction, and illicit drug dependence is the most stigmatised health condition in the world (Kelly & Westerhoff, 2010). Substance users are more stigmatised both when they are active users and when in recovery, suggesting that stigma persists to exist even when active addiction is left behind (Phillips & Shaw, 2013). Non-substance misusing individuals find it difficult to differentiate between active addiction and recovery, and often deny that addicted individuals can truly recover from substance use problems (Best, Bird, & Hunton, 2015).

Furthermore, stigma has been demonstrated to have a damaging impact on the efforts by individuals to tackle their alcohol and drug problems, as well as on their families, and also

adversely affect policy aimed at tackling substance misuse problems (Social Inclusion Action Research Group, 2013). Stigma has also been found to be damaging to self-esteem and the perceived possibility of recovery, thereby hindering one's willingness to access treatment and support, resulting in increased alienation (ibid.). Furthermore, Jones et al. (2012) underlined the fact that those who hide a potentially stigmatising condition are more vulnerable to the negative views that the mainstream society holds because it limits their ability to develop a collective coping response. Therefore, it is reasonable to trust the findings of Best, Bird, & Hunton (2015), who report that individuals with substance misuse and addiction difficulties are anxious about disclosing their recovery status for fear of discrimination and adverse consequences for them and their family. It can be concluded that there is a possibility that through climbing, individuals may be able to reach self-acceptance and practice self-disclosure, which can be paramount to a successful recovery.

Lifestyle and social effects of climbing

According to participants' accounts, climbing provided them the opportunity to try out new things, 'stepping up to something new', offering a passion and hobby that has been perceived to be sustainable, healthy and manageable. Through climbing, some participants also seemed to find a new career. For instance, Helena has been committed to giving up the use of substances for climbing, becoming a climbing instructor with the aspiration of sharing with others the benefits of this activity.

"Hopefully in the same way it helped me, just enjoying something so much, wanting something so much, you want it so much, yeah, you give up that addiction that you have in your life for it, so that what it did for me, maybe giving them something that they are interested in, giving them a hobby, giving them something to live for. I just would really like to show and give that to people who are in recovery or have drug problems, what it has done for me basically." (Helena)

Through climbing, whilst embarking on a new lifestyle, some participants also felt that they did not have to stay within the limits of such an activity, but try out other health and well-being enhancing activities. This has been perceived by Rebel to be something specific to climbing

“Enough people pick up on that and they think about what else they need to do, and they start to walk just where they are, they might get on their bike, they might go to a gym. Actually invites people with very unhealthy or previously unhealthy physical lives to actually appreciate that physical exercise can make you feel better and you can never invite people into that space if they are stuck inside, inside a therapy meeting or counselling session, they come in the mountains.” (Rebel)

Research has demonstrated that being engaged in meaningful activities is a key factor in maintaining recovery goals (Hood, 2003; Cook, 1985; Best et al., 2008b; Day et al., 2008; McKeganey et al., 2008). In line with this is the Community Reinforcement Approach (CRA), which employs environmental contingencies to prevent drinking and drug use (Meyers & Squires, 2001), aiming to increase the individuals' feelings of pleasure from sober activities, and project sober life as a more rewarding way to live than the one which is characterized by the use of substances (Siporin & Baron, 2012).

In support of this, researchers found an inverse relationship between substance use and engagement in non-drug-related social activities, highlighting that participating in non-drug-related activities may have the potential to help individuals to maintain abstinence and prevent relapse (Rogers et al., 2008). Engagement in meaningful activities has also been found to act as a positive reinforcer and facilitate abstinence (Landale & Roderick, 2013). Furthermore, engagement in meaningful activities has also been proven to have social and mental health benefits, contributing to emotional regulation, identity development, the provision of a sense of connectedness to the community, and enhancement of employment capacity, while also offering routine and structure (Dingle, Brander, Ballantyne, & Baker, 2012).

Meaningful activities taking place in the community can be crucial to resolving alcohol and drug problems (Granfield & Cloud, 2001) as well. Amongst the various types of meaningful activities, employment and volunteering in the field of recovery from substance addiction is highlighted. It has been found that employment can help sustain recovery (Campbell et al., 2011) and volunteering is associated with reduced mortality (Ayala, 2008) and higher levels of reported wellbeing (Morrow-Howell et al., 2003). Therefore, climbing, as a meaningful activity, for some offering even employment opportunities, has the potential to positively contribute to the maintenance of recovery.

Apart from lifestyle benefits, climbing also provided participants with a space to socialize and spend time with others without using substances. Friendships and relationships developed, giving rise to feelings of engagement and belonging. Within these relationships, these individuals have also been able to move away from isolation to connectedness and to experience bonding with others. The participants also shared that through these connections they received a non-judgemental, welcoming, and caring approach. For instance, Helena voiced feelings of being listened to and cared for, which she perceived to be crucial in her abstinence.

“The climbers that I met, they are my good friends now and they are amazing people who supported me through my recovery, they are very easy to talk to and just the most amazing people I have met to be honest, people I’m with now, they are involving me in things, so just, listening, not judging me, be my friend, being there.” (Helena)

Helena also added that

“it’s amazing, the climbers they are just really amazing people, all seem to have their bit of a weird background as well I guess, doesn’t seem like normal people”

Hereby potentially referring to ‘normal people’ who are less supportive and understanding than those encountered in a climbing environment. Similarly to Helena, the other participants also elaborated on the notion of normality and the ways in which this is present in climbing. Some perceived normality to be something ‘mainstream’ which can be at times frightening to those with a substance misusing background, as individuals may feel that they cannot fit in such environments. In contrast to other activities such as football, climbing has been described by some participants to be a non-mainstream activity, where those with experience of dependence and substance misuse can meet others with ‘unusual backgrounds’ and feel related to them. This would allow them to still be part of the society, but also separate from it, without having to conform. Tom elaborated on this

“Climbing specifically I think is good, because it’s this kind of, a bit away from mainstream, you know, so people who haven’t been part of society can still go, don’t have to conform. The people you meet usually everyone has got a story, something about them like, the guy I used to climb with was really into this, what do they call it, like, ecology, you know self-sufficient living and you

know buy some land and build a self-sufficient little community for himself you know, which is against mainstream and even though I was not into these things, we found a common ground in the fact that we didn't kind of fit in with the society.” (Tom)

In the above quote, Tom shared how he almost found it a relief to meet others with a different background. Through this difference, he found similarity, which enabled him to connect and feel less isolated. Ospray also gave an insight into the ‘non-mainstream’, ‘non-normal’ world of those who misuse substances, portraying climbing to be a space where such individuals with their often ‘chaotic worlds’ are non-identifiable, accepted and welcomed.

“The world of problematic drug and alcohol user isn't normality and people are afraid going to some normal environments and they go somewhere like at the climbing centre, nobody is looking at them, they are all looking up, holding the rope or, it's about acceptance, so you are not isolated and identifiable. They are just looking at the climb, doing what they are doing, nobody is making judgements.” (Ospray)

Other participants viewed this non-mainstream nature of climbing offering a door to normality, a transitional space from ‘abnormal substance use’ to helping individuals learn to be in new environments and live in the society again. Some also viewed climbing to be a metaphor for change, supporting them to learn to take responsibility for themselves and others, begin to trust others and equipment, start to follow instructions and professional advice. For instance, Ospray believed that through climbing this can take place within a very short period of time and can also be applied to other areas of a person’s life.

“You learn to trust others, trust treatment, trust equipment, you know, the prescriptions that they use, you learn to use things properly and do what you are told and you have to learn to look beyond you know what is happening next, what do I need to do to get from here to there, what are the steps, how do I make it work, how do I make it safe, they are all things you would naturally be thinking about in climbing, so I just, you know I would use the world metaphor again, I think it works on every level as a sort of very powerful metaphor for the transition that people go through, that metaphor is absolutely centrally important, it helps people realize they are changing and I don't mean over six weeks, I mean two hours, it demonstrates that you are changing, it shows, two weeks ago you couldn't possibly have got up that wall, you couldn't when you started, you came here today and two hours on

you get up the wall, you know, and you know what you are doing, you are competent.” (Ospray)

Like Ospray Rebel also highlighted the presence of a metaphor for transition in the domain of climbing, emphasising the change taking place within climbing to be transferrable to other areas of individuals' lives.

“I think if people can actually psychologically just get up and can do this, they can do that in other aspects of their life.” (Rebel)

The role of communities, being part of groups and having meaningful relationships is also highly accentuated in the literature of recovery from substance misuse. According to Best (2012), the solution to addiction problems lies not merely in pharmacotherapy and counselling, but in engagement with the lived community. Similarly, Campbell et al. (2011) raise the importance of strengthening individual recovery through community development, and stress the fact that social and community support following treatment is an important resource for sustaining recovery. In line with these findings, the research into the importance of social relationships advocates that participation in groups is associated with less psychological distress (Ellaway & MacIntyre, 2007), as group membership provides social support, which results in positive effects on health and wellbeing (Jetten et al., 2009). It has also been found that “individuals with adequate social relationships have a 50% greater likelihood of survival, compared to those with poor or insufficient social relationships” (Holt-Lunstad et al., 2010, p.14). Furthermore, stronger support networks have also been found to be in relation with better access to community resources (McKnight and Block, 2010).

Although the role of community and social support in the maintenance of recovery from substance dependence is paramount, in the view of Ashton (2008), substance users can be ‘multiply excluded and widely despised’. In order to reduce this, what is crucial in continued recovery is simple relationships with non-judgemental approaches (Nordfjaern, Rundmo, & Holi, 2010), allowing substance-dependent individuals to move away from substance using link and find supportive, non-using recovery networks to maintain recovery (Best et al., 2008a; Davis & Jason, 2005). Through the creation of such networks, the individuals may be able to develop a sense of identity and belonging within which they have a value and a positive image which is otherwise often denied to them in their daily lives (Livingston et al., 2011).

Conclusion

Participants' experiences in the present study provide further supporting evidence that recovery is individual, and aspects that individuals find healing in therapy can also be found in other forms of activities, for instance in climbing.

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