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Higher Power, Brain Power:
An Interpretive Phenomenological Analysis of the Spiritual and Religious Characteristics of
12-Step Recovery Programs in the Context of the Brain Disease Model of Addiction

By

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Doctor of Philosophy

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Abstract

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An inverse relationship between spirituality and substance abuse consistently characterizes research findings on recovery from substance use disorders. Studies across medical and social sciences evaluate treatment strategies and efficacy measuring spiritual and religious (S/R) characteristics, but many employ simplistic single-item measures, and almost none engage scholarship in theology or religion. Growing public interest in and increasing research funding for brain disease models of addiction (BDMA) represent a significant shift in the medical and popular discourse on addiction. No investigations explore the impact of this shift on S/R characteristics of recovery. This oversight leads to further fragmentation and reduction of addiction research into isolated components that too often fail to attend to the lived experiences of people living with addictions.

This qualitative study uses interpretive phenomenological analysis to investigate the experiences of six North American adults, each with at least three years of recovery from addiction. In-depth key informant interviews track constructions of their experiences and etiologies of addiction. Through an analysis of these interviews, this project identifies two distinctive characteristics in such constructions. First, the cultural authority of neuroscience, regardless of the lack of medical agreement on or evidence supporting the BDMA, is a significant force in constructing the meanings of addiction for many seeking to recover because it engenders an increasingly mechanistic, agential, and mind-centered sense of self, resulting in changed conditions of belief for those in recovery. Second, the insights of Harvard philosopher Charles Taylor on secularity, particularly his notion of the buffered self, offer significant resources for understanding the functions of spirituality and religion in participants' recovery from addiction by providing a conceptual framework sufficient to understand a wide variety of spiritual/religious beliefs and practices ranging from orthodox Christianity to agnosticism.

Spiritual and religious characteristics of recovery persist, but an increasingly buffered model of the self necessitates different strategies in recovering from addiction. The findings describe innovations and paradoxical tensions within participant accounts. Attending to critical interventions impacting individuals in recovery, including their journeys of making meaning of experiences of addiction, reveals complex language and concepts required to describe the meanings of addiction and recovery.

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Dedication

To God, of so many understandings,
and to all who struggle with addiction.

“The roads to recovery are many.”

— Alcoholics Anonymous co-founder Bill Wilson, 1944

“You see, ‘alcohol’ in Latin is *spiritus*, and you use the same word for the highest religious
experience as well as for the most depraving poison.

The helpful formula therefore is: *spiritus contra spiritum*.”

— C.G. Jung, 30 January 1961, in personal letter to Bill Wilson

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List of Tables

Table 1. Participant Characteristics and Demographics	xx
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List of Abbreviations

A.A.	Alcoholics Anonymous
BDMA	Brain disease model of addiction
IPA	Interpretive Phenomenological Analysis
N.A.	Narcotics Anonymous
NCEA	National Committee for Education on Alcoholism
NIH	National Institutes of Health
NIAAA	National Institute on Alcohol Abuse and Alcoholism
NIDA	National Institute on Drug Abuse
SUD	Substance Use Disorder
S/R	Spiritual/Religious
S1, S2, S3	Secularity 1, 2, 3

Table of Contents

Abstract.....	i
Dedication.....	vi
Acknowledgements.....	vii
List of Tables	ix
List of Abbreviations	x
Chapter 1: Introduction to the Study.....	1
Background.....	1
Overview of the U.S. history of alcoholism and Alcoholics Anonymous.....	1
The neuro-turn and “brainhood” as the context for emergence of BDMA.....	5
Concurrence of S/R characteristics and addiction across research findings.....	7
Problem Statement.....	7
Research Questions.....	12
Purpose of the Study.....	13
Project Overview	13
Chapter 2: Literature Review.....	16
Research on Alcoholics Anonymous (A.A.) and other 12-step programs.....	16
Criticism of 12-step programs	17
History of conceptual constructions of “addiction”	21
Mutability of addiction.	22
Contemporary social scientific definition of addiction.....	24
Disease concept of alcoholism.....	25

BDMA: neuroscience-based theories and concepts of addiction.	31
Changes and challenges in defining “spirituality”	36
Research on the role of S/R characteristics in 12-step recovery.....	38
Implicit deployments of S/R components and metaphors in addiction etiologies within neuroscience and psychoanalysis.....	42
Omissions and reductions of S/R characteristics in addiction and recovery literature.....	43
Contributions from Religious Studies and Theology.....	46
Charles Taylor’s theories of secularity	49
Sean Daniels and “The White Chip”	50
Chapter 3: Research Methodology.....	53
Nature of Study.....	53
Rationale for Choosing Interpretive Phenomenological Analysis (IPA).....	53
Methodological Conceptual Framework of IPA.....	54
Idiographic	57
Inductive	57
Interrogative.....	58
Role of the Investigator.....	58
Sampling and Participant Selection Logic	59
Instrumentation	63
Interview 1.	64
Interview 2.	65
Data Analysis Plan.....	66
Chapter 4: Findings.....	68

Participants.....	69
Finding #1: Necessity of surrender to a higher power	71
Connie and Karl: no struggle with the “God part” of Higher Power.....	71
Navarro and Barry: release previous theological concepts before surrendering to new understanding of Higher Power.	75
Sean and Ursula: atheists who struggled with any transcendent belief	78
Finding #2: Higher valuing and use of the BDMA in younger participants.....	89
Sean: “My higher power is: Science. It’s my faith in Science that keeps me sober.”	90
Ursula: Medical and spiritual models are separate, but are mutually reinforcing rather than in conflict.	94
Barry: “My prefrontal cortex” had to “heal,” “but you don’t hear about it in the Big Book.”	98
Finding #3: Lower valuing and use of neuro-turn concepts in older participants	101
Navarro: “My prayer and meditation” to deal with “my factory settings”.....	102
Karl: My “allergy” is the struggle between me, God, and “the demons”.....	104
Connie: “Don’t get too burnt out” about “defining alcoholism” or “God stuff”	105
Chapter 5: Discussion	109
Analysis: BDMA engenders a more buffered account of the self than the disease model, “and it matters”	109
Charles Taylor’s theory of buffered self as it relates to addiction and recovery.	110
BDMA as a more buffered account than the disease model of addiction.....	113
Context of the BDMA changes conditions of belief for those in recovery	117
Conclusion	122

Limitations	123
Recommendations: examples of promising further research trajectories	124
References	127
APPENDIX A: Emory IRB Expedited Approval Letter	149
APPENDIX B: Emory IRB SHB Participant Information Sheet	151
APPENDIX C: Introductory Email/Letter.....	153
APPENDIX D: Data Collection Instrument	158

Chapter 1: Introduction to the Study

Background

The use of the term “spirituality” has grown dramatically in the literature of the medical and social sciences over the past three decades. In particular, the increased deployment of the term is notable among clinicians and researchers attending to the etiology and treatment of substance use disorders (SUDs) (Cook, 2004, 540). As shorthand, *addiction* will serve as an umbrella term in this project, referencing the full range of SUDs (Miller, 2016, 92).

Over its 80-year history, Alcoholics Anonymous (A.A.) and subsequent 12-step program variations have been the subject of significant research across disciplines. The central emphasis in every 12-step program of a metaphysical claim – surrendering to a Higher Power of the addict’s understanding -- is perhaps the most significant distinguishing feature separating 12-step methods from other recovery pathways. In the last several decades, variations of the 12-step model have diversified widely (White, 2014; Flaherty et al., 2014). Most research on 12-step programs has investigated their embedded beliefs and tenets, considering the wide-ranging implications of insisting that the individual seeking recovery from addiction profess faith in a Higher Power as a requisite of sobriety. Several such monographs have also sought to showcase questions of efficacy, a notoriously difficult measurement for care providers, policy makers, and researchers alike. Further exploration of this research will follow in the literature review below (Chapter 2).

Overview of U.S. history of alcoholism and Alcoholics Anonymous. The use of alcohol (ethanol) extends back to the beginning of recorded human history. As early as the fifth century B.C., references by Herodotus of “drunkenness as a body and soul sickness” may be found, as

well as even earlier references to “drink madness” from ancient Egypt and Greece (Crothers, 1893). However, the emergence of medical-style concepts of alcohol-related problems (alcoholism, alcohol abuse) are Western social developments of the past 200 years (Roman, 2007, p. 116). Understanding 12-step programs necessitates reviewing the history of Alcoholics Anonymous, a 20th century phenomenon, itself descended from a complex theological and socio-political heritage of the temperance movements that cycled through the entire history of the United States (Blocker, 1989). Indeed, prior to the unprecedented reform agitation of the temperance movement in the 1800’s, “a few people abstained from alcoholic drink, but almost nobody tried to convert the general public to do likewise,” (Fahey, 2001, p. 266). As a term, “alcoholism” emerged, along with other similar terms, in the first half of the 19th century, though inebriety was the preferred term for many decades. The heritage of Prohibition in the U.S. is also an important component, powered as it was by the Protestant revivalism of the second and third great awakenings. Historian George M. Thomas notes, “The greater prevalence of revival religion within a population, the greater support for the Prohibition parties within that population” (1989, p. 65). The rhetorical strategies of the temperance movement evoked Christian theologies of sin and salvation, linking alcohol abuse and the major social depravities of the day, while also weaving with politically progressive efforts to end poverty. When the 18th amendment was ratified, evangelist Billy Sunday proclaimed, “The slums will soon be only a memory. We will turn our prisons into factories and our jails into storehouses and corncribs” (Smith, 1983, p. 400). The reasons for the repeal of Prohibition in 1933 are complex, but many scholars point to the medicalization of alcohol abuse – as a “disease” suffered by some drinkers – as playing a crucial role in ending Prohibition (Roman, 2007; Jellinek, 1960; Akers & Heffington, 2000; Keane, 2002).

Prohibition was repealed just two years before the date often cited as the origin of Alcoholics Anonymous, the chance meeting between its co-founders, New York businessman William “Bill W.” Wilson and Ohio surgeon Robert “Dr. Bob.” Smith (Roizen, 2003). As a self-help organization, A.A. was a response to the dearth of self-help organizations following the repeal of Prohibition (Blocker, 2003, p. 118). As a spiritual fellowship, A.A. was the offspring of the Oxford Group, an explicitly Christian evangelical organization from which Alcoholics Anonymous emerged. The “religion” of the Oxford Group fell away from A.A., but Wilson insisted on the necessarily “spiritual” nature of the program, based in part on his transformative spiritual experience that took place in 1934 when he was hospitalized at Towns Hospital in New York City for yet another round of detox. Observing the way in which he was destroying his family, career, and health, Wilson reported: “[F]inally it seemed to me as though I were at the bottom of the pit. I still gagged badly on the notion of a Power greater than myself, but finally, just for the moment, the last vestige of my proud obstinacy was crushed. All at once I found myself crying out, ‘If there is a God, let Him show Himself! I am ready to do anything, anything!’” (Kurtz, 1980, p. 20). From this “rock bottom” experience, Wilson remained committed throughout his life to the importance of surrendering to a Higher Power of some sort. In fact, Wilson described alcoholism itself as a spiritual malady, “a vain attempt to drink God out of a bottle” (Nelson, 2004). Indeed, Ernest Kurtz’s widely-respected history of A.A. is appropriately titled *Not-God* (1980), because “Not-God” and “You are not God” are what Kurtz names as the single most prominent message of the 12-step programs. The core of A.A. is found in its first two steps:¹ unless alcoholics are willing to admit powerlessness over alcoholism and

¹ A.A. Step One is “We admitted we were powerless over alcohol—that our lives had become unmanageable,” and Step Two is “Came to believe that a Power greater than ourselves could restore us to sanity.”

accept that only a Power greater than themselves can restore them to “sanity,” they cannot reach recovery. Several familiar 12-step slogans reflect the centrality of this premise:

“E.G.O. is Edging God Out.”

“The only thing that I need to know about God is that I'm not it.”

“If God is your copilot, switch seats.”

“Is your program powered by Will Power or Higher Power?”

In 1939, *Alcoholics Anonymous* was published, known later as the “Big Book” of A.A., and it included a preface called “The doctor’s opinion.” During his 1934 hospitalization, Dr. William Silkworth had presented his concept of alcoholism to Wilson in terms of physical allergy, obsession, and compulsion (White et al., 2001). Silkworth’s words were included in the Big Book:

We believe...that the action of alcohol on these chronic alcoholics is a manifestation of an allergy; that the phenomenon of craving is limited to this class and never occurs in the average temperate drinker. These allergic types can never safely use alcohol in any form at all... (p. xxvi)

The word “disease” first appears on page 64 of the Big Book: “From it stems all forms of spiritual disease, for we have been not only mentally and physically ill, we have been spiritually sick” (1939). As will be detailed in Chapter 2, the disease concept of alcoholism permeated A.A. culture and practices as fellowships expanded and the decades progressed. Around the same time A.A. was founded and growing, biostatistician and physiologist E. M. Jellinek and the Yale Summer School on Alcohol Studies were developing a more medicalized model, with explicit understanding of alcoholism as a disease with a progressive character, rather than as a moral failing. As will be detailed further in Chapter 2, the medically modeled disease concept of alcoholism flourished in the twentieth century, in a complex dance of partnership and rivalry

with A.A. By the late 1990's, the most recent shift in addiction modeling emerged: the brain disease model of addiction (BDMA).

The neuro-turn and "brainhood" as the context for emergence of BDMA. A critical background element of this study is the dominating presence of "brainhood" in contemporary discourse, in which the modern self operates principally as a "cerebral subject," thanks to a belief in "brain-self consubstantiality" that is arguably so widespread as to be undisputed and self-evident (Vidal, 2009). In the years following President George H.W. Bush's 1990 Proclamation 6158, officially designating the 1990's as the "Decade of the Brain," unprecedented government funding shifted to research on neurological disorders and, more broadly, on the scientific understanding of the human brain. As Jeremy Carrette (2002) notes, if the 20th century began with "the decades of the unconscious," it closed with the "decade of the brain" (p. xlix). Powerful neuroimaging tools soon led to colorful fMRI brain images splashed across both scholarly journals and the popular media. In what many are calling the "neurological turn" (or "neuro-turn"),² many humanities and social science scholars began incorporating neuroscientific insights into their literary, political, philosophical, and theoretical work (Littlefield & Johnson, 2012; De Vos & Pluth, 2016). Scholars of religion and theology have been no exception, participating in the neuro-turn with various engagements of neuropsychological explorations of religious experience (Bulkeley, 2005; Doehring, 2010; Hogue, 2010; Jones, 2016; Peterson, 2003).

² In *The New Yorker*, Adam Gopnik glibly defined the neuro-turn as "what the 'cultural' turn was a few decades ago: the all-purpose non-explanation explanation of everything...Neuroscience can often answer the obvious questions but rarely the interesting ones...asserting that an emotion is really real because you can somehow see it happening in the brain adds nothing to our understanding." (2013)

However, despite what Jan De Vos (2016, p. 26) describes as “the situation of the colourful brain scan engendering an oh-my-god-is-this-what-I-am subject,” Vidal and others argue that the cerebral subject is *not* a new offspring of late 20th century Western neuroscience, as popular understandings might suggest. Instead, the evolved Western ideology of brainhood propelled (rather than being produced by) the positive feedback loops by which neuroscientific investigation has been powered, which Vidal traces to 17th-century concepts of selfhood (2009, p. 7), and which Taylor (2008) traces back even further, to late medieval and early modern movements which laid the groundwork for the “buffered self” that dominates today. The landscape of the neuro-turn and these coinciding ideologies of “brainhood” will be reviewed in further depth in Chapter 2.

If such notions of selfhood – e.g. “brainhood” and “cerebral subject” – provoke examination of the shifting tectonic plates of Western modernity, then notions of addiction sit on many of those fault lines, tied as they are to medical rationality, to particular notions of the unique and autonomous individual, and (persistently and inconveniently) to meaning-making beyond immanent frames (spiritual and religious beliefs). Helen Keane quotes Marc Redfield’s proposition that ““addiction returns us to the West’s most ancient topics and texts only to confront us with some of the most prosaic, specific, and in certain cases disastrous characteristics of our own modernity””(2002, p. 6). A recent and highly popular *New York Times* opinion piece, "Can You Get Over an Addiction?" (Szalavitz, 2016) sums up the ascendant prevalence of BDMA as an explanatory narrative in popular understandings of addiction: "[A]ddiction is neither a sin nor a progressive disease, just different brain wiring." If consumer demand for such explanations is any indicator, then book sales tell the story of high interest in neuroscience-based etiologies of addiction and recovery, with a flood of popular press titles similar to *The addicted*

brain: why we abuse drugs, alcohol, and nicotine (Kuhar, 2012), already in its eleventh printing. An overview of such titles is included in the literature review (chapter 2).

Concurrence of S/R characteristics and addiction across research findings. In social science, the pairing of spirituality and addiction as research components is more recent. Geppert et al. (2007), Cook (2004), Swora (2004), and Dermatis & Galanter (2016) survey the instances in English-language research and scholarship in which spirituality, in the context of addiction, is defined, interpreted, explained, or dismissed. Cook's heavily cited study (2004) surveys how spirituality is understood in the context of clinical and research examinations of addiction. Cook discovered that across the literature of medical and social sciences, before 1981, no publications linked addiction and spirituality (p. 542). Following Cook's review, Geppert et al. (2007) built a similar study that included not only medical and social science literature, but ATLA Religion databases as well. Geppert et al. located a total of 1,353 items on spirituality and addictions, as compared with 265 items in Cook's study. Across all this literature, 12-step programs feature prominently. The following chapter includes broader explorations of research on the role of S/R characteristics in addiction research, as well as the changes and challenges in defining "spirituality" within this literature. Several particularities in this body of research present various questions and challenges to be addressed.

Problem Statement

Notably, an inverse relationship between spirituality and substance abuse consistently characterizes the research findings in addiction studies overall (Dermatis & Galanter, 2016;

Geppert, 2007; Cook, 2004). Furthermore, Alcoholics Anonymous, and program variations derived from it, explicitly consider themselves to be “spiritual fellowships,”³ and such programs are vastly more available to (both geographically and financially) and more utilized by North Americans struggling with addiction than all other treatment methods combined (White, 2014, p. 427). Despite this, the spiritual and/or religious aspects of recovery from substance use disorders are largely absent in national policies and addiction research and unevenly present in public conversations. In the United States, substance abuse policies and discussions of addiction in popular media are largely drawn from two sources: (1) addiction pathology, and (2) the experiences of brief professional intervention (a narrow slice of experience of those seeking recovery from substance use disorders) (White, 2014, p. 474). In comparison to these pathology and intervention paradigms, the complex and paradoxical experiences of those in long-term recovery is far less documented, researched, or referenced. Thus, experiences of the spiritual/religious components of the various recovery pathways by those in long-term recovery from addiction are worthy of investigation.

With a few exceptions (the recent study by Flaherty, Kurtz, White, and Larson [2014] is a good example), the vast majority of research on the spiritual and religious aspects of recovery from substance use disorders have been quantitative in their methodological approach. Even for those studies that have been qualitative, nearly all have relied upon measurements featuring dichotomies (e.g. “spiritual” or not), closed questions, classification systems (e.g. spiritual, religious, both, neither), standardized scales, and/or single continuous dimensions (e.g. more or less spiritual, on a scale from 1 to 5) (Dermatis & Galanter, 2016). In studying the

³ Wallace (1996) notes the inappropriateness of the phrase “12-step treatment” since “AA is not a treatment program and those treatment programs that do nothing but teach the steps and traditions of AA are not treatment programs either” (p. 13).

spiritual/religious components of long-term recovery from addiction, such studies have value. However, it seems appropriate to also employ qualitative methods suited to illuminate the subjective variances of experiences of those in recovery from addiction. In contrast to studies that rely heavily upon participants to choose from a discrete number of labels, structures, and containers for describing the experiences of their inner worlds, more phenomenologically-oriented qualitative methodologies seek to discover the underlying structures differently. By most any measure, experiences of addiction and recovery are complex and intense, and the nature of religious experience varies enormously between any two individuals. An in-depth interview, though it disallows for easy comparisons across populations and data sets, does allow for the participant to volunteer a preferred language, symbols, metaphors, and narrative structure in interpreting experience and offers a rich array of accounts unavailable through even the most considered and sensitive of standardized scales or closed questions.

Such in-depth accounts of addiction and recovery help address a gap in the research: nuanced accounts of how those in recovery construct their own experience of addiction, and what language they use to describe the etiology of addiction. As will be explored below, several scholars (Keane, 2002; Campbell, 2007; Klingemann, 2011) have noted the importance of attending to the constructions of meaning generated by people in recovery about their experience of addiction.

With some notable exceptions (e.g. Higher Power Project at the University of Chester [U.K.], Dossett [2013]), scholars of religion and theology have been mostly absent from meaningful involvement in the design or interpretation of the various social scientific/empirical studies of the spiritual or religious aspects of recovery programs. Very few such studies show up in the scholarly journals of theology and religion (Sremac & Ganzevoort, 2013; Sørensen et al.,

2015; Stewart, 2004). Though not involved in empirical studies, several theologians have contributed insights about the S/R characteristics of recovery (Clinebell, 1998; Mercadante, 1996, 1998, 2009; McDonough, 2012; Rohr, 2011; Nelson, 2007; May, 2007; Cook, 2006; Dunnington, 2011). Several recent contributions in the field are enormously helpful in thinking through the questions involved with exploring the S/R characteristics of recovery from addiction, such as Bregman (2014), which is peerless in its exhaustive look at the ways in which “spirituality” is engaged, particularly in the context of Western health care. Also, Carrette (2002), Bulkeley (2005), and Jones (2015) all offer help in seeking more complex, less reductionistic understandings of S/R characteristics in the context of human health, particularly in the neuro-turn. All of this work, of course, stands on the shoulders of work like Lapsley (1972), one of many theologians who noted the changing contours of religiosity, and what it meant, for Christian theology, that the concept of salvation was being conflated with a view of health, or Rizzuto (1979) who delved into the function of religious belief for human health, and who illuminated how “It is not possible to tease apart religious belief or unbelief from the fabric of the self” (2002, p. 433). And behind all of these contributions, insofar as Western Christian theology and notions of human health and addiction are concerned, stands William James’ concept of the “educational variety” of religious experience, referred to in the “Spiritual Experience” appendix of the AA *Big Book* (1955, p. 567).⁴

However, across the scope of historical and contemporary theological and religious scholarly contributions to understanding human health, a few are particularly illuminating in considering addiction and recovery. Charles Taylor’s *A Secular Age* (2007) was considered by

⁴ James’ “educational variety” of spiritual transformation was voluntarily quoted directly by two of the six participants in this study.

many to be a pivotal work⁵, not as a causal account of the spread of unbelief, but as an account of the secular age as an ironic product of wide arching reform movements *within* Western Christianity, and as a scene-setter for *both* belief and unbelief. Taylor's insights on secularity, particularly his notion of the buffered self, offer rich resources for illuminating how individuals in recovery make meaning of their experience of addiction, both in relation to spirituality and religion, and in relation to the cultural turn to neuroscience. The account of the buffered self tells the story of a profound anthropocentric turn to a highly agential self that is now radically reflexive, disciplining (as subject) its own passions (as objects). Taylor's theoretical framework has limitations and weaknesses, but it is at least a helpful lens for seeing how it is we arrive in a place in which spiritual and religious characteristics of recovery from addiction remain important, yet many find it challenging to imagine belief in a transcendent agential power, external to themselves.

In summary: across the vast landscape of addiction studies, given the widely cited inverse relationship between spirituality and addiction, there is a need for qualitative research on meaning making in addiction recovery, engaging the resources of scholarship in theology and religious studies. Existing research is only recently beginning to note the effect of the neurological turn, with its attendant "brainhood" accounts of the self, on experiences of religious belief. Contemporary Western experiences of addiction take place against a backdrop of increasingly dominant of the BDMA (briefly described above), both in popular discourse and in research funding.

Thus, an investigation of the spiritual and religious characteristics of recovery from addiction, with particular attention to the effects/context of the ascendance of the brain disease

⁵ Not long before his death, Robert N. Bellah wrote of *A Secular Age*, "...one of the most important books to be written in my lifetime. Taylor succeeds in no less than recasting the entire debate about secularism" (2007).

model of addiction, engaging the insights of Taylor's notion of the buffered self, is a needed contribution.

Research Questions

The research questions guiding this study presented here were explicitly broad, open, and exploratory (rather than explanatory), grounded in a phenomenological epistemological position, detailed below in Chapter 3. These intentionally broad questions reflect the inductive orientation of this study and the shift in focus as the study evolved. While there is specificity (the spiritual and religious characteristics of recovery from addiction), these questions were designed to elicit a broad set of data from a small number of participants. As such, the data provide depth in relation to the meanings that those interviewed have created in regard to addiction but the data are by no means generalizable.

RQ1. How do various persons in recovery from addiction experience the role of spiritual and religious (S/R) characteristics within their recovery?

RQ2. What understandings do they construct about S/R characteristics?

RQ3. What role does the context of the neuro-turn play in each participant's constructed meaning of the etiology of addiction? In other words, to what extent do participants'

experiences of recovery reflect the ascendant prevalence of "brain chemistry" as an explanatory narrative in popular etiologies of addiction?

RQ4. How does each participant manage the common contradictions/paradoxes of addiction? What is her/his etiology of addiction?

RQ5. What elements of theological complexity are evident but unrepresented in discourse within clinical, research or policy discourse?

Purpose of the Study

These questions reflect the primary purpose of this study: to execute an interpretive phenomenological analysis of the spiritual and religious characteristics across various recovery pathways, with particular attention to the impact of the contemporary context of the BDMA. As described in Chapter 3, this study is based on findings and analysis from key informant semi-structured interviews with six participants, employing the methodology of interpretive phenomenological analysis detailed below.

Project Overview

With some background elements, the problem statement, research questions, and study purpose established, the contours of this project proceed through four basic sections. First, in

Chapter 2, a review of the relevant literature is considered. Research on 12-step programs (including the substantial critiques of their common practices and premises) is explored, with particular attention to the study of the spiritual and religious characteristics of 12-step recovery fellowships. More broadly, the literature review includes a history of the conceptual constructions of addiction, particularly in the last century in North America. The contemporary social scientific definitions of addiction, the medicalization of deviance underpinning the disease concept of alcoholism, and the emergence of the BDMA is considered. Additionally, the omissions, reductions, and implicit deployments of spiritual and religious components and metaphors within various addiction etiologies and models is reviewed including contributions from the fields of religious studies and theology, with special attention given to Charles Taylor's theories of secularity. Finally, an overview of the play, "The White Chip," staged in Boston in 2016 by Sean Daniels, is considered, given its particular relevance to nearly all the questions investigated by this study.

The second section (Chapter 3) is an articulation of the research methodology of this project, including a deeper explanation of the interpretive phenomenological analysis (IPA) method, its conceptual framework, and a rationale for its employment as an appropriate set of tools and strategies for the study. The methodology behind sampling and participant selection, as well as instrumentation and data analysis strategies, is also presented.

The findings of this study are captured within the third section (Chapter 4). The participants are briefly described. The three major findings of the study, the themes that emerged through the course of analysis, are detailed, along with the minor themes and patterns observed. In the final section (Chapter 5), the discussion and conclusion portions of this project are presented. Following the analysis and conclusion, the discussion moves to a presentation of

the study's limitations and implications for further research, teaching pedagogy, and practices of care.

Chapter 2: Literature Review

Research on Alcoholics Anonymous (A.A.) and other 12-step programs

Historical, sociological, and other types of research on Alcoholics Anonymous (and other 12-step program variations formed thereafter) have been conducted for more than fifty years (Kurtz, 2008, p. 1). Several components of 12-step programs make rigorous empirical study difficult, particularly in evaluating efficacy. Examples of such obstacles include its principle of anonymity, its lack of professional practitioners, its practice of not collecting the sort of data pertinent to efficacy studies, and its understanding of recovery as a lifelong process, rather than having a clear end-point. Wallace (1996) notes that the “literature of Alcoholics Anonymous (AA), from which all 12-step programs have been derived, does not lend itself to unambiguous interpretation” (p. 13). In particular, the explicitly spiritual elements of 12-step programs make research on them even more challenging than evaluation of (secular) behavior modification programs. As discussed below, defining “spiritual” and “religious” is itself, for a start, a contentious and difficult task. Even when appropriate and broadly useful definitions are discerned, parsing and measuring the effects of spiritual and religious components, as opposed to various and complex social and psychological factors, is particularly difficult. Swora (2004) describes the loose yet regimented nature of A.A.’s structure (and those of other 12-step programs): “As a social organization, AA can best be described as ephemeral, existing in and through local meetings and the interpersonal relationships between members.” Wallace (1996) suggests that the term “social movement” is most appropriate for A.A., particularly since “[A.A.] does not conduct assessments, arrive at diagnoses, dispense medications, write treatment plans, provide case management, or do group or individual therapy” (p. 13). Opinions differ about

whether such obstacles prohibit meaningful research findings. Despite complaints about 12-step programs' refusal to cooperate with researchers (McAdams, 2013, p.322n21), the Alcoholics Anonymous' statement about research (2010) clearly expresses founder Bill Wilson's repeated encouragement of such research on alcoholism, while protecting the values and structure of A.A. fellowships (Miller, 1998, p. 986). Moreover, as is reviewed below, large numbers of studies have focused on the 12 Steps. A.A.'s statement advises researchers to start at the individual and local levels, rather than the national office, when seeking research opportunities and participants.

Criticism of 12-step programs

Throughout their history, Alcoholics Anonymous and subsequent 12-step programs have been the focus of criticism, often notably vitriolic. Dossett (2013) summarizes the four arguments that feature most commonly in critiques of 12-step programs as follows:

- 1) That 12-step spirituality is a thin veneer for what is in fact religion.
- 2) That 12-step spirituality is inherently disempowering for women.
- 3) That 12-step spirituality is inherently exclusive to non-Judeo-Christian or post-Christian views of the world.
- 4) That the casting of the problem as a 'spiritual illness with a spiritual solution' is to a) further judge and stigmatize the alcoholic or addict, or b) to perpetuate the sense of powerlessness over the problem, thus allowing it to remain in place (p. 9-10).

The first and third critiques – that 12-step spirituality is poorly concealed religious doctrine – has several components. The assessments of Alcoholics Anonymous and subsequent 12-step groups as “coercive, pietistic, and even cultic (Bufe 1991; Chappel, 1992; Peele, 1992)” (Swora, 2004, p. 205-206) seem reflective of, among other things, high cultural suspicions of (and declining levels of literacy about) religious institutions. Perhaps the most recent loud critique in the popular media was from *Atlantic Monthly* (March 2015), which published Gabrielle Glaser's

“The Irrationality of Alcoholics Anonymous”, an article that accused the 12-step method of “bad science” and “false gospel.” Dodes (1990, 1996, 2014) is another familiar voice and message in critiques of 12-step, with a book aptly titled, *The Sober Truth: Debunking the Bad Science Behind 12-Step Programs and the Rehab Industry*. The “bad science” critiques seem founded in the controversies over the medicalization of deviance that persists at the root of the disease concept of alcoholism and addiction, along with the lack of empirical evidence the BDMA (see section below). The “false gospel” accusation, however, has several facets. The word “Irrationality” in Glaser’s title is an illustration of how highly prized rationality is in discussions about addiction more broadly. While some argue that the decision to abuse substances has elements of rational choice (Heyman 2009, Flanagan 2014), many agree that *irrationality* is deeply intrinsic to the choice to repeatedly self-poison, regardless of the consequences or stakes. More importantly, many elements of religious and spiritual practices and beliefs are not rational, and irrational healing practices or health solutions are increasingly counter-cultural.

From within the spheres of religious communities and scholarship on religion, this critique of the badly masked nature of 12-step spirituality persists. Pastoral theologian Linda Mercadante (1996, 1998, 2009) accuses Alcoholics Anonymous and subsequent 12-step groups of concealing their Oxford Group classist and evangelical Christian roots. Mercadante calls the connection “troublesome” to AA, which would want to be revealed to be “a derivative Christian program” and “an embarrassment to many people, including those in the church” (2009, p. 97). Consciously or not, the founders of AA built their diagnosis of addiction and their prescription for recovery on the Oxford Group’s clear-cut stress on sin and conversion, according to Mercadante (p. 104). Moreover, the Oxford Group was caricatured as a “Salvation Army for snobs,” given that “unlike traditional evangelism, which often sought out the marginalized or

deprived, the Oxford Group focused especially on the well off and well connected” (p. 100). Public health researcher and theologian John Blevins joins Mercadante in bringing to light the incriminating shadow cast by the Oxford Group, noting, “In 1936 Reinhold Niebuhr stridently criticized Frank Buchman, leader of the Oxford Group, for Buchman’s support of Hitler” (2009). While AA never declared formal affiliation with the Oxford Group, the shadow lingers. More obvious to any attendee of a contemporary 12-step program are the traditions of prayer – often the Serenity Prayer, and even practice of standing, holding hands, and reciting the Lord’s Prayer as a group. Such an explicitly Christian practice, like the many variations found in 12-step meetings, are regionally dependent, and frequently discussed at higher levels of governance within AA and related 12-step organizations. When the co-founders of AA made the decision, in the late 1930’s, to form a group that was explicitly *not* religious, and *merely* spiritual, they pushed against the grain of current cultural mores. More than eight decades later, cultural resistance to any element of S/R characteristics is reflective of many elements of our era. Nevertheless, critiques of the thinly veiled religious (or derivatively Christian) nature of 12-step practices have validity and should not be discounted.

The second common complaint that Dossett notes, that “12-step spirituality is inherently disempowering for women,” might be better amended as, “for persons from any oppressed population.” Blevins (2009) cites several psychologists who propose “recovery is not possible until a person begins to feel a sense of self-efficacy.” When it comes to any socially and systematically disempowered group (women, people of color, etc.), the demand that the addict confess powerlessness and/or surrender agency seems ineffective at best, unethically abusive at worst. In 1990, syndicated columnist Ellen Goodman voiced an increasingly loud critique from feminist scholars when she wrote about Kitty Dukakis' autobiography, which opens with the line,

“I’m Kitty Dukakis and I’m a drug addict and an alcoholic.” While she commended the “fierce honesty of the book, Goodman lamented this self-description which collapses the complex personality she had once known and admired into a mere disease entity” (Jacobsen, 1995, p. 175). Finally, Dossett aptly summarizes another key concern particular to women’s experience of 12-step practices:

For many women the experience of addiction is associated with experience of abuse, from childhood, and or in the context of their substance use, and the baseline experience of womanhood is one of relative disempowerment. Thus to be told that they must yet again be powerless, surrender and become dependent on something outside of themselves is perceived as perpetuating their victimhood, and felt to be anti-feminist. (2013, p. 10-11)

As Dossett and others have noted, such critique is powerful, but fails to account for the paradoxical yet profound empowerment at the core of sustained recovery within the 12-step framework, for persons in both over-empowered and disempowered populations.

Closely related to the “disempowerment” aspect of the second critique is the fourth critique, “that the casting of the problem as a ‘spiritual illness with a spiritual solution’ is to a) further judge and stigmatize the alcoholic or addict, or b) to perpetuate the sense of powerlessness over the problem, thus allowing it to remain in place.” Perhaps the most pronounced field-wide opposition to the aspects of the 12-step program they view as “profession of powerlessness” or “perpetuation of stigma” comes from cognitive behavioralism, where building up the addict’s fragile self-esteem, fortifying the addict’s will power, and in short, changing behavior is privileged. Certainly, there are strengths to this model, many of them seemingly mirrored in the 12-step focus on the actions of sobriety above all else. However, many clinicians and researchers argue that “getting ahold of one’s self” is quite precisely the problem; the person struggling to recover has been seeking to accomplish exactly this task, and is mistakenly convinced they *can* do it without significant assistance from resources beyond

themselves. Brown (1985) describes the high rates of failure when therapists and patients both participate in myth of “controlled drinking.” She quotes the usual adages: ““Only alcoholics must quit altogether because alcoholics have lost control”” and ““labeling patient alcoholic is an awful thing to do’...such a label must be avoided at all costs because a diagnosis of alcoholism is an acknowledgment of a shameful and embarrassing failure”” (p. 13-14). The flaw with these critiques is that the laudable goal of seeking to lift crippling stigma from those struggling to recover is contorted into participating in what many experience as the ultimate lie of addiction: that the person struggling to recover can somehow empower themselves to finally get control of themselves. As will be explored below in Chapter 5, the high cultural value granted to self-governance is writ large in these critiques of the “disempowerment” of 12-step programs.

Pointed critiques of the spiritual aspects of 12-step have led to communities of Rational Recovery and other 12-step adaptations and alternatives to spiritually-based models, like Intuitive Recovery, AA Agnostica, Smart Recovery, and Secular Organizations for Sobriety (S.O.S.) (Rotgers et al. 1996). Some proponents of A.A. and the traditions of 12-step programs argue that such alternative recovery programs remove the most critical (and difficult) piece of recovery: surrender to a Higher Power. Others applaud any road to sobriety, citing cultural shifts that make difficult the task of confessing faith in a Higher Power (no matter how flexible).

History of conceptual constructions of “addiction”

Exploring the conceptual construction of spirituality in the context of recovery from addiction necessitates surveying the conceptual constructions of addiction and recovery across

the literature. Although, as noted above, the abuse of alcohol (ethanol) reaches back to the earliest recorded histories of human community, notions of addiction are more recent and shifting. While no single understanding or etiology of addiction has yet integrated enough levels of analysis to achieve either universal acceptance or endurance (Campbell, 2007, p. 6), some patterns and defining features persist throughout popular culture, medicine, and scholarship. For the purposes of understanding the conditions in which those seeking to recover from addiction must hold the spiritual and religious characteristics of recovery, the history of the conceptual changes of addiction is important to note.

Mutability of addiction. In addition to a history of the constructions and transformations of various conceptions of addiction, the volatility and controversy around the seemingly mutable term is noteworthy. Leading voices within addiction studies have critiqued the field for its “conceptual chaos” and “crisis of categories” (Shaffer, 1985, p. 66; 1997). Keane’s provocative and insightful book *What’s Wrong with Addiction?* (2002) notes the dramatic reliance on metaphor in nearly all discussions of addiction in both popular and specialist texts, and the mixing of metaphors to support different understandings of the phenomena.

Is addiction like diabetes or high blood pressure (a chronic disease)? Is it like hunger or thirst (a visceral drive)? Is it like enjoying opera (an acquired taste incomprehensible to the non-enthusiasts)? Is it like watching TV in the evening (a routine habit)? Is it like falling in love (an irrational attachment)? (p. 9).

Keane challenges the notion of addiction as a universal feature of human existence. Rather, she suggests that it is “a historically and culturally specific way of understanding, classifying, and regulating particular problems of individual conduct. It is tied to modernity, medical rationality,

and a particular notion of the unique and autonomous individual” (2002, p.6)⁷. Indeed, several scholars note the importance of the shift to understanding addiction, particularly alcoholism, as a disease. The reflexivity encouraged by Keane’s insights is perhaps her greatest contribution to investigations of addiction. As with Taylor’s project on Western Christianity, Keane seeks to intervene in our collective self-understandings of addiction, to reveal how our particular understandings are imaginable only as the products of long histories and complex social, historical, and ethical matrices.

A similarly important contribution in this conversation is Campbell’s insightful history of substance abuse research (2007). Campbell illuminates the important twists and turns in addiction research within Western medicine, particularly in the last half of the twentieth century, posing questions similar to Keane’s:

Calling something a ‘disease’ appeals to scientific conventions and clinical vocabularies but generates a cascade of questions: Is it curable or incurable? Does it mark its victims? Is it a metabolic disease, an infectious disease, a brain disease, a social contagion, a biochemical imbalance, a disease of the will, a disease of desire, a disease of stress? Is it chronic, lifelong, or episodic? Is it more like diabetes or allergy? Is it genetic? (p. 1-2)

Campbell also notes how science offers specialized vocabularies that fuse with popular vernaculars: — “the fix,” “the rush,” “getting high,” “hitting bottom,” or “kicking the habit” — through which people describe their innermost sensation. She observes that “Expressive argots recursively feed into science: scientific theories affect how people interpret drug experiences, and users’ reports in turn become research material” (p. 1). From a constructivist perspective like Campbell’s and Keane’s, the metaphors and language employed to describe the experience of

⁷ Another example of reflexivity in understanding of addiction and substance “abuse” as culturally-particular uses caffeine as an illustrative counterpoint: “perhaps [no substance] has touched so many lives as the regularly consumed, legal drug caffeine, perhaps because coffee drinking is considered very normal and acceptable, even necessary, in everyday life. However, we must ask whether there is a level of caffeine use that is abuse — or perhaps self-abuse. Surely we do not want to throw caffeine use on this list of substance abuses and addictions. Still, a collection on addiction would not be complete without at least touching on this matter.” (Browne-Miller, 2009, p. xiii-xiv)

suffering from an addiction, and/or recovering from an addiction, whether in medicine, popular media, or various scholarly disciplines, should be of great interest to anyone seeking to understand the phenomena and varying cultural meanings of “addiction.”

A qualitative Polish study by Klingemann (2011) found that “lack of recognition of lay concepts of addiction by treatment providers may weaken help-seeking and increase drop-out rates” (p. 266). In their analysis, Klingemann’s team makes use of the theory of medical sociologist Eliot Freidson, whose work stresses the strength and importance of lay beliefs when coping with disease.

During the last three decades, there has been an increased interest within medical sociology in what lay people have to offer by way of knowledge on health and illness...we live in a world of smart people: Ordinary people are aware of the complexity of dependence and factors facilitating and impeding processes of change and are aware of felt and experienced stigma. (p. 267)

Other research has shown that patients of addiction services tend to adopt the ideologies of the institutions in which they are treated (Koski-Jännes, 2004). Given these findings and analyses, this project seeks to understand how study participants construct their own experience of addiction, and what language they use to describe the etiology of addiction.

Contemporary social scientific definition of addiction. “Addiction,” as defined in a recent edition of the *International Encyclopedia of Social Science*, represents the generally accepted understanding of the term across disciplines: “The term addiction, as applied to substance use, denotes an advanced level of dependence on a substance, marked by a compulsive need to obtain and consume it despite negative consequences. Dependency may consist of physical dependency, psychological dependency, or both” (Frazese 2008, p. 19). The entry concludes with a note about the necessity of interdisciplinary study, since addiction is “a

phenomenon with social, medical, and legal dimensions. A multifaceted public health problem, its treatment and prevention require contributions from multiple disciplines. Medical scholars, legal scholars, sociologists, psychologists, and policymakers are all needed if progress is to be made” (p. 21). The definition reflects the neuro-turn of recent years: "research on addiction has shifted from the domain of sociologists and psychologists to that of geneticists and neurobiologists" (19). Only seven sources are references for this encyclopedia entry, reflecting where authority tends to lie for defining such a culturally malleable concept: the DSM, a federally-funded research source, a sociological source regarding parenting, and four sources from neuroscience and pharmacology. Thus, the portrait of addiction, as a social concept, is characterized by the recognized lack of consensus around terms, and the preference for biological explanations and medicalized understandings. What follows here is a necessarily brief conceptual history of addiction, which tells the story of how this contemporary social scientific definition evolved to its present form.

Disease concept of alcoholism. A brief history of alcoholism in the U.S. was outlined above in Chapter 1, including how the rhetorical strategies of the temperance movement that evoked Christian theologies of sin and salvation, linking alcohol abuse and the major social depravities of the day. The emergence of “spiritual malady” and “allergy” in the founding of Alcoholics Anonymous was also presented. The rise of the Western understanding of alcoholism as a body illness – a disease – is critically important backdrop to any phenomenological investigation of modern experiences of addiction and recovery.

The history of the creation of the disease concept of alcoholism (eventually more broadly inclusive of addiction) in North America is perhaps best framed in four major eras, the first three

being the “sin” era of addiction (temperance movement, Prohibition), the “spiritual malady” and “allergy” era of alcoholism (the creation of Alcoholics Anonymous), followed closely by (and overlapping) the era of the “disease concept of alcoholism.” The most recent era is the one in which the brain disease model of addiction (BDMA) dominates as an explanatory discourse, as is explored in the sub-section below.

Another helpful framework is the literature emerging within sociology in the 20th century examining the medicalization of deviance. This work is often overlooked in histories of addiction by historians, and by most scholars of religion and theology. The social construction of alcoholism is an excellent illustration of the process by which non-normative or morally condemned conduct comes under medical jurisdiction (Horwitz, 2012; Conrad, 1992; Illich, 1982). The larger context of the medicalization of deviance is that “The tendency to see badness – whether immoral, sinful, or criminal – as illness is part of a broader historical trend from overtly punitive to ostensibly more humanitarian responses to deviance” (McGann and Conrad 2007, p. 1110). Akers and Heffington (2000) sum up the sociological understanding of the term alcoholism as:

[A] tautological (and therefore untestable) explanation for the behavior of people diagnosed as alcoholic...The concept preferred by these authors and by other sociologists is one that refers only to observable behavior and drinking problems. The term alcoholism then is nothing more than a label attached to a pattern of drinking that is characterized by personal and social dysfunctions (p. 97).

Consideration of the ways in which deviant uses of alcohol (destructive and/or anti-social behaviors, failures to perform expected social roles) evolved into medicalized notions is an illuminating thread to hold alongside the history of the disease concept of alcoholism.

As noted in Chapter 1, until the first decades of the 20th century, the medicalization of alcoholism, as a bodily disease, was much less prominent in the U.S. than the moralistic forces of

the temperance movement and Prohibition. In the ten years following the repeal of Prohibition, the disease concept of alcoholism began to take root once again. As noted above, A.A. sought to promote the severity of what it called a “spiritual malady.” The most specific definition of alcoholism in the “Big Book” of A.A. appears on p. 44, at the conclusion of the first paragraph of the “We Agnostics” chapter, asserting that alcoholism “is an illness which only a spiritual experience will conquer.” However, in many histories of alcoholism and addiction, A.A. is mistakenly credited (or blamed) with authorship of the disease model, such as this description:

In cooperation with other agencies, AA succeeded in popularizing the concept of alcoholism as a disease. Success in this endeavor was crucial in the creation of the modern network of treatment programs supported by corporate, state, and federal funding. In addition, AA’s twelve-step model for recovery has been widely adopted to treat a broad range of habits and afflictions (Blocker, 2003, p. 118)

The mistake made by this generalization is that of conflating several complex social movements and industries. While “disease” eventually grew to be a core concept in A.A. and other 12-step fellowship models, Kurtz and others point out that A.A. was not the originator of the idea.

The core idea of Alcoholics Anonymous was primarily the concept of the hopelessness of the condition of alcoholism. That most people in mid-twentieth century America found this hopelessness most understandable couched in terms of “disease,” “illness,” or “malady” derived from the historical context and revealed more about the culture than about Alcoholics Anonymous. (Kurtz, 1980, p. 34)

A.A. itself was not often helpful in clarifying the matter of whether it should be blamed or credited with the disease concept of alcoholism. A.A. co-founder Wilson, overseeing the massive expansion of A.A., was often queried about the matter of the disease concept.

[A] reply Wilson gave when specifically asked about alcoholism as disease after he had addressed the annual meeting of the National [Catholic] Clergy Conference on Alcoholism in 1961: “We have never called alcoholism a disease because, technically speaking, it is not a disease entity. For example, there is no such thing as heart disease. Instead there are many separate heart ailments, or combinations of them. It is something like that with alcoholism. Therefore we did not wish to get in wrong with the medical profession by pronouncing alcoholism a disease entity. Therefore we always called it an illness, or a malady is a far safer term for us to use.” (Kurtz, 2002)

In other moments and contexts, however, Wilson promoted the term “disease” quite freely, likely a reflection of the fraught efforts in popular culture and medical communities to understand the nature of alcoholism and addiction throughout the 20th century.

Outside of A.A., Kurtz and others (Lewis, 2015, p. 13; Roizen, 2003, p. 119) have noted that concurrent to the creation of A.A., in that first decade following the repeal of Prohibition, E. M. Jellinek and others were hard at work on a medicalized model of alcoholism as disease. For Jellinek, the enemy was theological and temperance movement views of alcohol as sinful. Jellinek and his associates at the Yale Center for Alcohol Studies sought to convince the public and the medical community of the scientific understanding of drinking, to free alcoholics from the burden of public shame, and perhaps most importantly, to capture funding for alcoholism treatment and research (Keane, 2002, p. 21). Though Jellinek’s research and advocacy are regularly cited in even the briefest of histories of the disease concept of alcoholism, the significant contributions of Marty Mann are often minimized. Mann, the daughter of a wealthy and socially prominent Chicago family, suffered years of heavy drinking in the mid-1930s, which at times threatened her life. Her psychiatrist gave her a manuscript of the *A.A. Big Book*, and connected her with an A.A. meeting (at the time there were only two groups in the U.S.).⁸ Jellinek hired Mann to assist with public relations at the Yale Center on Alcohol Studies, and eventually, Mann published the five core ideas of the newly launched National Committee for Education on Alcoholism (NCEA):

1. Alcoholism is a disease.
2. The alcoholic, therefore, is a sick person.
3. The alcoholic can be helped.

⁸ Eventually, Mann authored the chapter, “Women Suffer Too” that was included in the *A.A. Big Book* (second, third, and fourth editions). While Mann was not, as is often mistakenly claimed, the first woman to seek help from A.A., she was the first lesbian member (Brown & Brown, 2001, p. 72, 217).

4. The alcoholic is worth helping.
5. Alcoholism is our No. 4 public health problem, and our public responsibility. (Mann, 1944, p. 354)

Mann's advocacy was focused on public opinion of alcoholism, and the destructive effects of shame. In 1948, she published "The Alcoholic in the General Hospital" in *Southern Hospitals*, noting the rising numbers of deaths related to alcoholism. Mann noted that "the general hospital is the proper place for alcoholics in the acute stage of their illness," and blames public opinion, rather than the medical community, for ignorance to the contrary. In 1950, she published, *Primer on Alcoholism*, which emphasized the way in which alcoholism holds hostage the will of its victim:

The alcoholic, who is aptly known as a "compulsive drinker" does not choose. He has lost the power of choice in the matter of drinking, and that is precisely the nature of his disease, alcoholism. (Mann, 1950, p. 8)

Behind the scenes, notes historian Ron Roizen, Jellinek and his colleagues were "hoping that Mann's new campaign would provide grassroots support for the expansion of alcoholism treatment and the promotion of scientific research," just as the American Cancer Society had done for the cancer research industry. In the same way, "Jellinek doubtless looked forward to the expansion of AA as an ever growing source of members interested in scientific inquiry" (Roizen, 2007, p. 117). Whatever the case, the post-Prohibition enterprises of A.A., Mann's NCEA (eventually the National Council on Alcoholism and Drug Dependence), and Jellinek's Yale Center on Alcohol Studies all variously colluded and competed for public confidence in a more medicalized notion of alcoholism.

By the 1950's, institutional recognition and clinical implementation of the disease concept of alcoholism, and also addiction, took hold. Narcotics Anonymous (N.A.) was founded in 1953, and around that same time, the American Medical Association, American Hospital

Association, and the American Psychiatric Association passed formal resolutions advocating more medicalized approaches to the problem of alcoholism (White et al., 2001). With the rapid expansion of Hazelden's "Minnesota Model" in the late 1950's, the era of treatment centers began. As Lewis (2015) aptly describes, treatment centers, as an industry, were, and continue to be, deeply dependent on the understanding of alcoholism and addiction as disease, a view endorsed by the medical and scientific communities and most Western governments.

The disease model is excellent news for the owners and managers of the more than fifteen thousand drug and alcohol rehab centers operating in the United States and Canada, because it means *We know what your problem is, and we're the ones to fix it...* [it] also is a way of explaining what goes wrong when treatment doesn't work. Because no doctor, nurse, or shrink will ever tell you that they can fix you for sure. All they can say is that they'll try. And if you end up not getting fixed, well, that's the way it is with diseases. (p. 19)

Concurrent with the growth of treatment centers, the disease concept of alcoholism continued to grow, and transform. In 1958, an *A.A. Grapevine* article entitled, "Alcoholism is a Disease: The Essence of A.A." baldly opened with, "Alcoholism is a disease. A.A. was the first to give me this bit of information" (p. 13, quoted by White et al., 2001). Kurtz notes that this marked the movement of the disease concept from the periphery of A.A. thought to its center. By the time Jellinek published his landmark book, *The Disease Concept of Alcoholism* in 1960, the concept was controversial, but increasingly familiar within public discourse. By the late 1960's, debate intensified, rising to the highest levels of U.S. governing bodies. In 1966, the Narcotic Addiction Rehabilitation Act was passed, the first major federal expression of the resurgence of medical perspectives on addiction (Gerstein & Harwood, 1990). On New Year's Eve, 1970, President Richard M. Nixon signed into law the creation of the U.S. National Institute on Alcohol Abuse and Alcoholism (NIAAA), seen by many as a "crowning achievement of the modern alcoholism movement" (Roizen, 2003, p. 119). However, among the dramatic cultural shifts in American

culture through the close of the 1960s and the beginning of the 1970s were the rise of theories such as “addiction culture” and “addiction careers”, set forth as alternatives to disease etiologies of opiate addiction. According to Kurtz, at the moment of Wilson’s death in 1971, over 50% of American still thought of alcoholics as “weak, unhappy, neurotic” (1980, p. 9). Critics of the disease concept published in popular and medical publications, with critiques like T. Szasz’s “Bad habits are not diseases: a refutation of the claim that alcoholism is a disease” in *The Lancet Psychiatry*:

...the view that alcoholism is a disease is false; and the programmes sponsored by the State and supported by tax moneys to ‘cure’ it are immoral and inconsistent with our political commitment to individual freedom and responsibility. (1972, p. 83)

Despite controversy and critique, the disease concept of alcoholism, and also addiction, continued to take root at popular and institutional levels, and the treatment center industry continued to grow.

BDMA: neuroscience-based theories and concepts of addiction. The brain disease model of addiction (BDMA) is the latest shift in addiction discourse, with an immense hold on popular and medical discourse, and on research funding. This section will briefly sketch the historical contours of the emergence of the BDMA. As with the disease concept of alcoholism (and addiction), the BDMA cannot be traced back to a particular group of scientists, or common thread of articles or research findings. The best pivot point for the growth of the BDMA is the former Director of the U.S. National Institute on Drug Abuse (NIDA) Alan Leshner’s landmark 1997 *Science* cover story, “Addiction is a brain disease, and it matters.” In that essay, he argues that addictive drugs “hijack the reward centers of the brain” (p. 45). Within several months of Leshner’s article, Bill Moyers used the phrase “hijacked the brain” in 1998 on a PBS television

series on addiction, citing Leshner (Lewis, 2015, p. 17). Several historians and researchers of addiction have noted the way in which “hijack” stayed in the vocabulary of addiction for many years after that. In formulating his “self-medication” theory of addiction, E. Khantzian pointed out that

[But]... it can just as well be argued that drugs of abuse “hijack the emotional brain”. Any theory or explanation of addiction that does not address what it is in the workings of the mind (i.e., the inner psychological terrain) and a person to predispose and cause them to repeatedly relapse to addictive drugs is incomplete” (2003, p. 8).

But weaving complex behavioral or social constructs seemed to lack the rhetorical power of the brain scan images that soon accompanied the BDMA arguments of a “hijacked” brain.

The travels of the hijacking metaphor — and its staying power — forcefully convey how neuroscience remade the social worlds of substance abuse research with the claim that addiction was a chronic relapsing brain disorder. The implication was that the elusive secrets of this ‘disease of the will’ would now yield to the powerful force of brain science. (Campbell, 2007, p. 201)

If the publishing industry is any indicator, the BDMA has a definite hold on public understandings of addiction. Recent popular titles that make use of the BDMA (often without substantial scientific training or credibility for doing so) include *Rewire: Change Your Brain to Break Bad Habits, Overcome Addictions, Conquer Self-Destructive Behavior* (O’Connor, 2015), *Recovery Mind Training: A Neuroscientific Approach to Treating Addiction* (Earley, 2017), *Unbroken Brain: A Revolutionary New Way of Understanding Addiction* (Szalavitz, 2016), *Rewired: A Bold New Approach To Addiction and Recovery* (Spiegelman, 2015), *The Biology of Desire: Why Addiction Is Not a Disease* (Lewis, 2016). In terms of funding, it is widely observed that the BDMA has continued to exert notable influence. As several researchers note, “a number of social scientists have dubbed [the BDMA] the ‘NIDA paradigm’” (Dunbar, Kushner & Vrecko, 2010, p. 3). In 2014, the National Institute on Drug Abuse (NIDA) devoted 41% of its funding to basic neuroscience, a further 17% to the development of novel

pharmacotherapies based on this neuroscience, yet only 24% to epidemiology, health services, and prevention research (Field, 2015).

As noted in Chapter 1, the epistemological framing particular to the context of the neuro-turn is an illuminating body of literature for the purposes of this study. The small clutch of conversations engaging the effect of neuro-turn sensibilities on understandings of addiction are happening within the smaller guilds of neuroethics, neurophilosophy, and critical neuroscience, among a handful of scholars (Flanagan, 2011, 2013; Carter et al., 2012; Banja, 2015; Hardcastle, 2015). Despite cultural perception (or even relatively accepted accounts like Kuhar's) of broad agreement between neuroscientific studies, the accounts of various neuroscientific teams differ on critically important issues, such as which neuromechanisms are relevant for understanding addiction, and even how such mechanisms operate (c.f. Koob & Le Moal, 2006, p. 18-19; Kime 2015b). About such discord between scientists as to the neuroscientific aspects of addiction, Campbell points out that "Neuroscience is a high stakes interpretive game" (2010, p. 90). In response, Lende calls for a neuroanthropological theory of addiction rather than a "brain-driven" theory:

Chemical imbalances and hard-wired pleasure circuits have been prominent public explanations advanced by some biologists for addiction. But the real story is more complex, even at the level of neurobiology. Addiction is not simply a chemistry experiment gone wrong, some poor sap in the 'laboratory of the street' mixing the wrong substances inside his brain. The parts of the brain where addiction happens are not single, isolated circuits — rather, these areas handle emotions, memory, and choice, and are complexly interwoven to manage the inherent difficulty of being a social self in a dynamic world. (2012, p. 342)

Along with Lende, others have pointed to the problems with the BDMA as a premise for research and/or public understanding of addiction. A fascinating chain of conversations published in the prestigious journal *Lancet Psychiatry* makes public the debates between leaders of various "camps" in debates about the validity and value of the brain disease model of

addiction.⁹ Lewis (2015) points to a preface by Volkow in one NIDA publication (2014) as illustrative of NIDA's love affair with neuroscientific accounts of addiction:

As a result of scientific research, we know that addiction is a disease that affects both the brain and behavior. We have identified many of the biological and environmental factors and are beginning to search for the genetic variations that contribute to the development and progression of the disease. (Volkow, 2014)

When challenged on the lack of conclusive evidence for the BDMA, Volkow's chief defense is a pragmatic one: that the BDMA frees those suffering from addiction from the shame of morality models of addiction that continue to linger. In this way, we might hear an echo of Mann's advocacy movement of the 1940s, which prioritized the lowering of social stigma surrounding alcoholism above all other concerns. The loudest response to this argument comes from neuroscientists and others who argue for something along the lines of a "learning disorder" model of addiction. Marc Lewis, a neuroscientist who struggled with drug addiction in his 20s, argues that "the disease idea is wrong...Medical researchers are correct that the brain changes with addiction, but the *way* it changes has to do with learning and development -- not disease" (2015, p. xi). Similarly, Szalavitz (2016a, 2016b) is a former addict, now journalist and one of the "leading thinkers on addiction," who allies herself with Lewis and with Satel and Lilienfeld (2013, 2014). In her popular *New York Times* opinion piece, Szalavitz wrote,

"Addiction is not a sin or a choice. But it's not a chronic, progressive brain disease like Alzheimer's, either. Instead, addiction is a developmental disorder — a problem involving timing and learning, more similar to autism, attention deficit hyperactivity disorder (ADHD), and dyslexia than it is to mumps or cancer. This is clear both from abundant data and from the lived experience of people with addictions." (2016a, p. 3)

Notably, Szalavitz admits she believes that 12-step programs saved her life, but argues nonetheless that

⁹ Hall et al. (2015a) "BDMA: supported by evidence?" then Trojuls' response (2015), then Volkow and Koob's response (2015), then Hall et al. (2015b) "BDMA: misplaced priorities?"

“From the problems I’ve seen in 12-step-based treatment, I think spirituality and medicine need to be kept separate, and that the current addiction treatment system needs to be completely overhauled. But I also believe that 12-step programs don’t get everything wrong. They have simply been misused and asked to take a role that they should never have played in professional care.” (2016b, p. 216)

Research conducted on the popularity of the BDMA among the public is built upon a larger body of research on the impact of neuroscientific findings in general. Many studies have highlighted the weight attributed to neuroscience findings in defining how people see themselves, focusing on “the implications of transfer of neuroscience knowledge to society given the substantial and authoritative weight ascribed to neuroscience knowledge in defining who we are” (Racine, Waldman, Rosenberg, & Illes, 2010, p. 725). When it came to looking specifically at how addiction-related neuroscientific findings are portrayed, the results were grim.

It was found that headlines are vague in their portrayal of addiction and provide little content value. In contrast, full articles link addiction with criminal responsibility and create a duality of subject positions with the addict on the one hand and a person of some power on the other. (Robillard & Illes, 2012, p. 215)

In other words, it seems the dualisms from which the BDMA was meant to free us end up reifying those same binaries.

Along with Lende’s proposal for a neuroanthropological theory of addiction, some of the most relevant critiques involving neuroscientific accounts of addiction build upon histories of addiction modeling (e.g. Campbell, 2007) and employ insights of critical neuroscience. Critical neuroscience¹⁰ urges a reflexive turn toward the practices, institutions, social contexts, and philosophical assumptions upon which neuroscience and popular interpretations of neuroscience

¹⁰ Vidal rightly challenges some of the supposedly “critical” voices, like those in neuroethics in the following passage: “Inflated claims and a revolutionary rhetoric have an obvious self-serving function, sustaining the cerebral subject ideology, and reinforcing the alliance between the norms and ideals of individualistic autonomy and self-reliance on the one hand, and on the other hand the prestige of the advanced technology supposed to demonstrate that we are our brains. Neuroethics provide a good example . . . neuroethicists seem to consider the sciences as *having* ‘social implications’ or an ‘impact’ on society, rather than *being* themselves intrinsically social activities that prosper largely through strategies embedded in the social fabric; this view reproduces the belief that humans have a biological self on which culture and intersubjectivity are somehow tacked.” (Vidal, 2009, p. 10)

are built (Campbell, 2010; Littlefield & Johnson, 2012; Carter et al, 2012; Viney et al., 2015; Fitzgerald et al., 2014; Choudhury & Slaby, 2016). Scholarly conversations show promise for illuminating the ways in which neuroscientific accounts offer generative perspectives and insights into the deeply subjective experiences of addiction and recovery, and the ways in which such accounts merely extend the Western legacy of the medicalization of deviance and, as will be explored in Chapter 5, the buffering of the self.

Changes and challenges in defining “spirituality”

If most researchers within the field of addiction studies concur that a universal definition of addiction is a troublesome challenge, then certainly most scholars within the field of religion and theology will agree similarly about the difficulty in (and futility of) precisely and universally defining spirituality, or even religion. Bregman’s *The Ecology of Spirituality: Meaning, Virtues, and Practices in a Post-Religious Age* (2014) is the best attempt to capture the contours of the term “spirituality” as it emerges in the English-speaking contemporary West. Bregman wisely eschews any illusion of a universal definition: “[W]hat we cannot do is offer once and for all a clear, comprehensive, and authoritative definition of spirituality that will be relevant today...no such precise entity as spirituality really exists” (p. 3). Cook (2004) argues that such imprecision is not workable within medical models: “the use of an undefined term in scientific research is highly problematic” (p. 540). To illustrate, Bregman (2014) presents the work of three Canadian occupational therapists who published an article in 2002, responding directly to an official statement from the Canadian Association of Occupational Therapists (CAOT) “that claimed ‘spirituality’ lay at the core of their profession, so that it was therefore vitally important to

integrate spirituality into the daily work of occupational therapy.” Perplexed, the therapists reported to have found 92 definitions for spirituality, which they present as evidence of the unworkability of such a model (Bregman 2014, p. 4, 19-25). Whether spirituality should be an allowable term in models of clinical practice, and whether the term can or should be tightly circumscribed, Bregman and Cook agree that three options are available to scholars and researchers faced with needing to define spirituality. First, they may simply leave “spirituality” undefined. Second, they may choose an existing or “working” definition of some sort. Third, they may allow spirituality to be subjectively defined by the population or individuals being studied. Both Cook and Bregman agree that specificity of understanding is best achieved via the third method; still, Cook proposes what he calls a “working definition” of spirituality (p. 548-9). In the end, the literature suggests that while “spirituality” is impossible to define in a universal way (like so many other elements of language), it is still valuable to seek an accurate description of all that is intended by the individual employing the term.

Separate from the importance of understanding how individuals define “spirituality” in the context of recovery is the matter of how medical and social science literature employs the term. There is widespread agreement, across models, that spirituality and religion are *not* interchangeable terms. Differences erupt in discerning whether they are closely related, overlapping terms, or “virtually antithetical” (Cook, 2004, p. 548).¹¹

¹¹ Cook distills 13 conceptual components of the definitions and descriptions of spirituality in medical and social science literature. The “not-God” attribute of 12-step does not seem present, except perhaps partially represented in #3, 4, and 8. In order of frequency:

1. Relatedness: interpersonal relationships
2. Transcendence: recognition of a transcendent dimension to life
3. Humanity: the distinctiveness of humanity
4. Core/force/soul: the inner ‘core’, ‘force’ or ‘soul’ of a person
5. Meaning/purpose: meaning and purpose in life
6. Authenticity/truth: authenticity and truth
7. Values: values, importance and worth
8. Non-materiality: opposition of the spiritual to the material

Research on the role of S/R characteristics in 12-step recovery

Among the studies on the spiritual aspects of 12-step programs, some leading projects stand out. Dermatis and Galanter (2016) recently published a relatively comprehensive review of “empirical studies conducted on the role of spirituality and religiosity (S/R) characteristics in 12-step recovery” (p. 510). This survey is, by far, the most comprehensive accounting of all the measurement tools that have been employed in the service of researching spirituality and 12-step programs. Makela (1996) published a cross-cultural sociological ethnography that remains the most reputable, cross-referenced and methodologically sound examination of some non-Western employments of 12-step programs. In a Greek study, Katsogianni and Kleftaras (2015) found “the association between spirituality, meaning in life, drug addiction and depressive symptoms was statistically significant.” Mason et al. (2009) sought “to extend prior findings by exploring the relationship between spirituality, religiosity, and self-efficacy with ‘cravings’” (p. 1928); they found that as spirituality increased, “cravings” decreased. A careful defining of terms (craving, religiosity, spirituality, self-efficacy) was included in the study’s discussion. Unterrainer (2013), which explores the extent to which religious/spiritual well-being patients is generally more compromised than a healthy, non-addicted control group, and Heinz (2010), which examines beliefs about the role of spirituality in recovery and its appropriateness in formal treatment, are further strong examples of studies that typify the field.

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9. (Non)religiousness: opposition of spirituality to, or identity with, religion
 10. Wholeness: holistic wellness, wholeness or health
 11. Self-knowledge: self-knowledge and self-actualization
 12. Creativity: creativity of the human agent
 13. Consciousness: consciousness and awareness” (Cook, 2004, p. 543).

Of particular note is the study conducted by Flaherty et al. (2014), a qualitative research project led by several leading clinicians and scholars in the field of addiction studies, published in *Addiction Treatment Quarterly*, a leading peer-reviewed journal in the field. Given that many of the methodological decisions of this project echo, or deliberately stray from, those of the Flaherty project, a more detailed description of the study follows.

Flaherty and his colleagues interviewed six respondents representing six different recovery pathways, and found that three categories -- “organizing frameworks” (Flaherty et al., 2014, p. 341) – emerged: secular, spiritual, and religious pathways. More broadly, beyond discovering a fitting set of categories for recovery pathways, the investigators’ aim was to discover the common and distinct features of various recovery pathways, such as the progressive stages (pre-recovery, recovery initiation, early recovery stabilization, and long-term recovery maintenance). A major research priority, named elsewhere by one of the co-investigators (White, 1998), is to shift the focus of addiction studies toward recovery as an organizing concept (Clark, 2007). Flaherty and his colleagues sought a richer, more nuanced description of the subjective interpretation of a small number of participants’ experience of recovery from addiction, and they chose IPA as the best method for achieving this end. This choice is the biggest similarity between Flaherty’s study and the study proposed herein. The original design of this study more heavily revolved around the three categories (spiritual, secular, religious) identified by Flaherty’s study -- religious mutual-help communities, explicitly secular mutual-help communities, and traditional 12-step spiritual fellowships. Midway through the process of interviews, these categories diminished in helpfulness, because such demarcations proved less distinct for participants, and because the complex tangles of neurological mechanism and theological worldview quickly arose as notable findings.

Brown et al. (2006) was perhaps the only other, besides Flaherty, to distinguish between three “competing recovery principles” (p. 654): A.A. (“spiritual”), Rational Recovery (“nonspiritual”), and Celebrate Recovery (“religious”). Another major influence on the original design of this project was the methods employed by Klingemann (2011), a qualitative Polish investigation of the tensions and conflicts between lay and professional concepts of alcohol dependence. Klingemann’s methodology included the following component: “During the in-depth personal life history interview, respondents were treated as addiction experts and the opening question – what do you think dependence is – facilitated the storytelling atmosphere of interview” (p. 268).

Surveying his forty years of experience in addiction research, W. R. Miller¹² (1998, 2016) scolds addiction researchers for neglecting 12-step/spirituality components of recovery, whether due to prejudice or lack of training, and for not including spirituality in measurement tools, even though many such tools developed in spiritual contexts: “Although not widely known in scientific circles, there is a large and well-developed psychometric literature on the measurement of spiritual and religious constructs (Spilka, Hood & Gorsuch, 1985; Richards & Bergin, 1997). If the measurement of spiritual constructs has been rare in addiction research, it is not for lack of reliable instrumentation” (1998, p. 980).” Tonigan et al. (2010) are critical of “assumptions” about and “embrace” of religious/spiritual paradigms in addiction recovery, because “Empirical findings suggest that the influence of religious/spiritual beliefs and practices in recovery are complex and poorly understood” (201, p. 1217).¹³

¹² Neuroscientist Marc Lewis refers to White as a “current rehab expert” who is “controversial” but has “poked large and small holes in the scientific foundation of the disease model, often citing the counterintuitive finding that most addictions end spontaneously – that is, without treatment” (2015, p. 21).

¹³ Despite (or as a result of?) their critiques, Tonigan et al. (2013, a different team configuration than 2010) were subsequently funded by the NIH to investigate “spiritual growth as a change mechanism in 12-step programs.”

Nearly all the studies noted above appear in journals unrelated to the field of religion or theology. In terms of the empirical research investigating the S/R characteristics of recovery within the scholarship of religion and theology (e.g. *The Archive for Religion and Psychology*, *American Journal of Pastoral Counseling*, *Religions*), a few studies emerge. A study by Sremac and Ganzevoort (2013) analyzes conversion and addiction testimonies in two European contexts (Serbia and the Netherlands). The study finds that participants “employ elements from their personal and family histories, their ethnic and religious heritages, and their larger cultural and historical context to create a meaningful conversion narrative,” which is important work, but largely confirms an already broad set of literature on the power of narrative in religious testimony. A study by Stewart (2004) measured spirituality and religiousness in addiction treatment, with inconclusive results, and with a seemingly low awareness of the related existing body of research. By contrast, the study conducted by Sørensen et al. (2015) engaged an explorative qualitative design, investigating S/R characteristics in treatment centers “founded on religious values in a Norwegian context” (p. 94). Like Klingemann (2011) in Poland, Katsogianni & Kleftaras (2015) in Greece, Sremac and Ganzevoort (2013) in Serbia and the Netherlands, and Mäkelä (1996) in Mexico, Finland, and elsewhere, Sørensen et al. (2015) is one of a small number of studies of S/R characteristics in recovery outside of North America. These are valuable windows into the way 12-step recovery fellowships are spreading rapidly, but that, as Sørensen notes, in regards to “the significance of religion and spirituality as meaning-making in substance misuse services...the international research literature shows limited knowledge, especially when studies of the 12-step program (Alcoholics Anonymous) and studies from America are excluded” (p. 94).

Tonigan’s team found that spiritual change, as measured by the Religious Background and Behavior (RBB) self-report questionnaire, was indeed “predictive of increased abstinence and decreased drinking intensity” (p. 1161).

Implicit deployments of S/R components and metaphors in addiction etiologies within neuroscience and psychoanalysis

Curiously, across the vast landscape of addiction studies literature, spiritual and theological terms and metaphors emerge across disciplines outside of religion and theology, even when spirituality or religiosity is explicitly excluded from the research findings or piece of scholarship. As in Franzese (2008), the majority of contemporary definitions of addiction omit any theories about or gestures toward the importance of spirituality, either in understanding addiction, or methods of recovery. However, even the most cursory review of the current principal recovery methods inevitably includes 12-step recovery fellowships, and at least mention that 12-step programs are considered spiritually based. One fascinating instance is found in neuropharmacologist Michael Kuhar's *The Addicted Brain* (2012)¹⁴. Lauded for being both scientifically authoritative and accessible to popular audiences, Kuhar narrates how addiction happens: chronic drug use alters chemical neurotransmission and cellular signaling, and such changes persist in the brain for a very long time. A revealing aspect of Kuhar's book is his description of corrupted neurological components as agential "demons." On the second page of the book, Kuhar writes:

Different drugs, some legal and others illegal, release powerful demons in our brains. Surprisingly, the demons—the chemicals and nerve cells in our brains—are already there, working in an important but much smaller way that is essential for our functioning. Drugs create the demons by disrupting the chemicals and nerve cells so that they get out of control and wreak havoc in many people. Decades of scientific research have revealed how this happens. The demons behave as expected. Once unleashed and in power, they don't go away easily. Even after we stop taking drugs, they influence our actions for a long time, for many months or even years. They want you to continue to feed them by taking more and more drugs. (xii)

¹⁴ Kuhar's book is now in its eleventh printing.

In seeking to make plain the meaning of neuroscientific findings about addiction and the brain, Kuhar chose metaphoric language that, presumably, he expects to resonate with popular audiences, based on his decades of work in substance abuse. Most clinicians and researchers, when presenting their findings to the general public or clinical care receivers, might not choose “demons” as a way to convey the neuroscientific mechanics of addiction, not only because of its non-rational “folk medicine” connotations, but because of its religio-spiritual connotations. Clinician Dapice (2009) appears to be employing moral development theory with claims like, “In the case of addiction, the substance or behavior can belong to the *god value* that exercises enormous power in people’s lives, allowing people to behave in ways that otherwise they might not” (p. 81, emphasis added). Other examples include Sweet (2003, 2013) and Director (2002, 2005). Respected for their innovative psychoanalytic innovations in care practices for persons suffering from addictive disorders, Sweet and Director (for different reasons) have little or no use for the spiritual aspect of 12-step programs, but seem unaware of the ways that implicit spiritual aspects feature in their own methodological propositions: the necessity of the addict moving from delusion of omnipotence to accepting his/her limitations and existential location.

Omissions and reductions of S/R characteristics in addiction and recovery literature

Elsewhere, the nature and importance of spiritual components of 12-step programs are reduced, or explained as functioning in other ways. Sociologist and medical anthropologist Swora (2004) catalogs examples of the bad translations of theological principles into psychosocial phenomena, noting how notoriously difficult spirituality is to “define and operationalize” (p. 188). As this study has sought to establish, an operating presumption of this

project is that addiction, and recovery from addiction, is more enormously complex than any single explanatory system has, heretofore, adequately contained. Nearly all addiction researchers propose *non*-spiritual functions at work when participation in a 12-step program seems to aid an addicted individual in maintaining stable and extended sobriety. While researchers like Groh, Jason, and Keys (2008) propose that social support (mutuality), coping, and self-efficacy (p. 431) are the reasons an addict in a 12-step program is motivated to surrender agency as a means to sobriety, this project seeks not to counter such claims, but to offer qualitative description and analysis for such researchers to better understand the breadth, depth, diversity, and changing conditions of S/R characteristics of recovery from addiction, as experienced by those in the program.

Broadly speaking, “it’s the social part” and “it’s the relationships” are the most frequent ways in which success of 12-step practices are accounted for by those less interested (or even hostile to) the S/R characteristics of recovery, or of 12-step practices specifically.

A classic example of stripping transcendent characteristics or any recognition of metaphysics from understandings of spirituality is found in the findings of Greene and Nguyen (2012): “We will suggest connectedness as an integral component in defining spirituality and demonstrate that in twelve-step recovery, spirituality can be defined as gaining knowledge through connectedness to others” (p. 179).

Even researchers who are focused particularly on the positive role that spirituality plays in 12-step recovery experiences offer surprisingly clumsy or ill-informed proposals about the functions of spirituality. Galanter (2006) frames a conflated history of religion and spirituality in the Western world, with statements like “Spirituality offers people a way to avoid uncertainty” (287) and “Evidence is emerging for the localization of spiritually related experiences in specific

brain sites” (287) which grossly misrepresent cognitive science of religion findings overall. In fairness, it should be noted that Galanter is an accomplished and highly regarded psychiatrist and leader in addiction scholarship, who perhaps should not be expected to bring the same capacities and perspectives as a scholar in religion and theology.¹⁵ Similarly, psychiatrist Khantzian, renowned for coining the term “self-medicate” in his research on addiction treatment methods, seemingly stumbles into rather reductive theological constructions when he distinguishes between “higher” and “lower” ways of belief:

God as a governing force within an individual may take various forms. For some, religion and religious ideas serve childish and ego-centric purposes, where God or religious beliefs or acts are felt to offer magical protection, or the religious system serves as a rigid and restrictive system of beliefs and practices. For others, the power and awe engendered by the outside universe and our humble place in it instills a sense of force or power greater than ourselves. The spiritual dimension of AA helps to move a person from a less mature, childish self-centeredness toward a more mature form of object love (Khantzian and Mack, 1999 p. 414).

For Khantzian, Mack, and so many other clinicians and researchers, the Higher Power is merely the self-object (to use psychoanalytic terms) to aid the addict’s transition from self-love to object-love, and to manage the narcissistic wounds for which addictive behavior is a maladapted coping mechanism. Or, to use cognitive behaviorist terms, the Higher Power is merely a form of social support, a profound sense of connectedness with others in the group. None of these theories is far-fetched – in fact, they are quite useful in understanding how the addict’s sense of omnipotence is finally broken. But such theories may be incomplete, failing to engage the complexity and vastness of religious experience as it pertains to recovery from addiction. More

¹⁵ Despite this, Galanter and several colleagues (2016) published their findings from their fMRI study of the “neural correlates of prayer” of A.A. members, claiming “AA members’ prayer was associated with a relative reduction in self-reported craving and with concomitant engagement of neural mechanisms that reflect control of attention and emotion. These findings suggest neural processes underlying the apparent effectiveness of AA prayer” (p. 92).

importantly, they may not reflect the subjective experience of the person in recovery from addiction.

Contributions from Religious Studies and Theology

A review of the literature on the understandings and findings regarding the aspect of spirituality in 12-step programs illuminates a lack of participation, on the part of theologians and scholars of religion, across nearly all such social scientific and medical explorations. One apt illustration: Swora (2004) notes the findings of Snow et al. (1994), a group of behavioral psychologists seeking to understand the processes of change used by long-term members of A.A. Snow et al. express frustration with A.A. members' resistance to citing any non-spiritual process as a means to their recovery. Snow concludes, "Illuminating the role of spirituality in addiction change represents a major task that will require the input of behavioral scientists, theologians and AA participants" (Snow et al., 1994, p. 369). This project seeks to contribute precisely such "input."

Of course, scholars of religion and theology *have* contributed to research on the spiritual aspect of 12-step programs. Overall, these contributions tend to gravitate around a few themes. Most prevalent is praise: that 12-step presents the Christian church with the keys for reorientation and reinvigoration in a time of institutional decline, because it enacts more successful or orthodox practices around sin, grace, testimony, etc. A second theme is critique: that 12-step programs are some of the worst aspects of Christianity in disguise (further disempowerment of the already-disempowered, etc.), or, conversely, that 12-steps are a betrayal of Christian theology, encouraging non-Christian theisms. A third theme, less directly related to

explorations of the spiritual aspects of 12-step recovery programs, seeks to show how Christian theology solves (or transcends) current controversies about defining addiction. Finally, a handful of contributions from religion and theology offer guidance and wisdom on the basics of providing spiritual care to individuals, and their families, affected by addiction.

A review of some of the leading voices in the explicitly theological literature investigating spirituality, addiction, and 12-step programs includes Ernest Kurtz (1993, 1998, 2008), who is respected for writing the authoritative history of A.A., as well as further midrases of spirituality¹⁶ as it is frequently described in 12-step programs. As noted above in the section attending to criticism of 12-step programs, Mercadante (1996, 1998, 2009) accuses Alcoholics Anonymous and subsequent 12-step groups of concealing their Oxford Group classist and evangelical Christian roots. Additionally, Blevins (2009) cites psychological research that concludes self-efficacy is both critical to recovery from addiction, and in particularly scarce supply for socially and systematically disempowered populations, thus making 12-step practices highly ineffective, if not psychologically disastrous, for many individuals seeking help. Gerald May, a physician who claims no theological expertise, wrote several influential pieces on understanding addiction as sin (2007). Like Kurtz and May (but contra Mercadante), theologian McDonough (2012) sees 12-step programs as offering the potential to bring back appropriately complex notions of sin to popular discourse and Christian theology; Lund (2016) makes similar claims. Franciscan friar and popular author Richard Rohr has written theological reflections on the 12 steps as showcasing the essence of Christian theology, and is quoted as saying that 12-step fellowships are "America's unique contribution to the history of spirituality" (Carr, 1995). As

¹⁶ *The Spirituality of Imperfection* (1992) is a popular press book, based on the traditions and literature of Alcoholics Anonymous, which pulls from wisdom literature across various traditions along themes such as hope in the midst of suffering and discomfort, and the premise that "trying to be perfect is the most tragic human mistake" (p. 5).

noted above, Swora (2004), though not a theologian, has offered a method of employing the anthropology of religious healing to interpret the twelve steps (2004) that is a complex and helpful contribution.¹⁷ James Nelson, a theologian who became alcoholic late in life and recovered through Alcoholics Anonymous, wrote a moving memoir with a robust explication of the theological underpinnings of 12-step program, similar to the work of Rohr. Particularly helpful, for the purposes of this project, is Nelson's 5-part "Sin-Disease Continuum" which describes various theological approaches to understanding addiction and recovery (2007, p. 42).¹⁸

Another strand of theological engagement of the spiritual aspect of recovery from addictive disorders comes in the form of theologians showing how Christian doctrine overcomes the contemporary dichotomies of addiction etiologies. Similar to McDonough (2012), Dunnington (2011) argues that Christian theology, via more nuanced understandings of virtue and sin, can propel research beyond the limiting dualities of disease and choice that pervade most addiction models. Cook (2006) proposes that, based on the writings of St. Paul the Apostle and Augustine of Hippo, Christian ethics can move research on addictive disorders toward a more serious consideration of the agony of addiction, and reintroduce a "moral model" which has been rejected as outmoded. However, Cook's interpretation of Augustinian divided will is not representative of the most recent and respected scholarship on the matter, and his interpretation

¹⁷ Alongside fields like health humanities and narrative medicine, Swora proposes engaging conceptual tools from the anthropology of religious healing, distinguishing between the meanings of illness and disease in the service of better understanding the spirituality of addiction recovery methods.

¹⁸ Nelson's continuum: "1. 'It's purely sin.' 2. 'It begins as sin and becomes disease.' 3. 'Addiction is sin and disease all mixed together.' 4. 'Addiction is disease resulting from sin, but that sin is outside a person's responsibility.' 5. 'Addiction is purely disease; sin is not a factor.' ...Those on one end of the continuum believe alcoholism is purely sin — a failure of the will, weak moral character, and deeply habituated bad actions. On the other end are those who say it is clearly a disease with all the medical criteria, including identifiable causes (biological programming and brain changes), prognosis, and symptoms" (2007, p. 42).

of the “I do not do what I want” passage from Paul’s letter to the Romans ignores the paradigm-changing scholarship of Krister Stendahl that revealed how Paul is not confessing contrition (Kime 2015a).

An small but important set of contributions within the scholarship of religion and theology are best practices for pastoral care approaches to those dealing with addiction – both the individuals, and the subsequently affected families and communities. Clinebell’s text (1998) has served as the standard in introductory seminary instruction in pastoral care for decades, though Doehring (2006) and others offer more updated approaches in the form of single chapters on addiction within larger introductory pastoral care texts. A gap exists, however, of material that provides ministerial practitioners with overview of the landscape of 12-step spiritual fellowships, and the particular challenges and opportunities that accompany caregiving for those struggling to recover from addiction.

Charles Taylor’s theories of secularity

Theories of secularity have changed dramatically over the past few decades, and Charles Taylor’s *A Secular Age* (2007) represents an important shift in the field. By thinking historically about the kind of pre-reflective self-conceptions that stage our human experience as Western moderns, Taylor uses his theory of the “buffered self” to interrogate the religiosity-secularity dualism. The practices of 12-step programs emerge as both resisting and enforcing the bounded, anthropocentric self. In a profound sense, the pre-ontological context of anyone living

in Western modernity, regardless of beliefs or principles, includes the expectation that one should, and may hope to, master one's inner experience, including one's desires, an expectation which in the context of addiction is charged with theological significance.

Such value of self-mastery has dramatic implications for modern Western understandings of addiction. Since the buffered self is expected to master its own desires, it follows quite naturally that one should be able to govern and manage one's sensations, feelings, and emotional states with any available tools and strategies, including substances. Within this frame, addiction may only be sensibly comprehended in two ways: (1) as (moral) failure, on the part of the buffered self, to adequately master one's desires; and/or (2) as disease, which although (like desire) as a force internal but not identical to the self, is an organic "chemical" problem over which the addict is understandably powerless (and not responsible). Further engagement of these elements of Taylor's theories of secularity will be found in the analysis section of Chapter 5.

Sean Daniels and "The White Chip"

A recent live theatre performance offered an embodiment of the complexity of S/R characteristics as they appear in recovery narratives and addiction in the context of the neuro-turn. In January 2016, a new comedic play, "The White Chip," premiered at Merrimac Repertory Theatre, outside of Boston, Massachusetts. Written by Sean Daniels, the play dramatizes Daniels' own near demise from alcoholism, and his experience of recovery.¹⁹ The play's title is based on the Alcoholics Anonymous tradition of giving a white chip (The Anonymous Press, n.d.), one of many types of A.A. sobriety coins, to "anyone who has 24 hours

¹⁹ Daniels does not play "himself" (Sean) or any other role in the performance.

or a desire to stop drinking” (Daniels, 2016, p. 56). The white chip is notorious as a symbol of both success and failure for those struggling with relapses, since it symbolizes getting back “on the wagon,” but also the confession that one has relapsed, and has abused the substance of addiction. The play’s narrative includes details of Sean’s spiritual history: traumatic incidents within his Mormon community as an adolescent, and disillusionment with institutionalized religion. When Sean “hits bottom,” after dozens of white chips, he has destroyed his career, his marriage, his health, and nearly lost his life while driving drunk. He enters a rehabilitation facility. Sean’s counselor and sponsor is “an ex-Air force tough-talker” Baptist named Britt who demands that Sean find a Higher Power if he is ever going to have sobriety. Sean protests, but in another scene, alone in the rehab clinic, trying to resist painful cravings to sneak out of the facility for alcohol, Sean attempts prayer.

I decide to, ugh, pray. I'm not a pray-er, but I was told, when this happens, you have to pray. So, I do. Old school. On my knees. First time since I was 15? 16? I pray the prayer I was taught - and the whole time I'm having a Meta snob moment - who are you praying to Sean? You don't actually believe in anything. But I pray. I pray, then I eat, then I shower, then I pray, and I eat again... and then I stop sweating. Suddenly I realize I haven't thought about a drink in a few minutes. Then I realize 10 minutes have passed. And then I am fine. I am proud, and worried about when the voices in my head will return. (Daniels, 2016, p. 85)

For Sean, and so many of those struggling with addiction, spiritual and religious beliefs carry a burden particular to the legacy of 12-step programs and centuries of Christian theologies of shame and discipline. In the pivot point of the play, Sean pleads with Britt:

BRITT: Your god thing is just a problem with authority.

SEAN: No. I just can't "surrender and let Jesus take the wheel" - that's not me not wanting to change, that's me wanting to be honest with you... Look, I only have four days left, and if this doesn't fix me, I'm screwed, you and I both know, I walk out like this, I'm not gonna make it.

BRITT: That's it, fine, I thought it may come to this, you're just gonna have to get sober with the Jews. (Daniels, 2016, p. 90-91)

The next scene comically moves to Sean entering an A.A. meeting that is led and primarily attended by those identifying as culturally and/or religiously Jewish. Sean notes that unlike his previous A.A. encounters, these recovering alcoholics “have a sense of humor” – but more importantly, they proclaim to Sean that what he really needs is “Science,” and to understand the chemicals in his brain. The word “brain” occurs 17 times following this scene. In a line that seemingly summarizes Sean’s success in finding sobriety, he says: “People ask me, why did it stick that time? I believed in something larger than myself. My higher power is: science. It’s my faith in science that keeps me sober” (Daniels, 2016, p. 97). Sean’s higher power is the neuromechanisms (“science”) of his own “brain”, which ostensibly has more power than he does, and “wants the best” for him (Kime, 2017).

Existing literature has noted the common practice within 12-step communities, for those new to recovery and uncomfortable with professing faith in a Higher Power, of proclaiming their Higher Power to be “the program” or “the group.” Sometimes this has been noted in conjunction with explicit or implicit critiques of 12-step as being primarily or entirely social in its strategies and successes. However, not only has this phenomena (constructing a Higher Power based on social experience of the spiritual fellowship) been underrepresented in any scholarship within religious studies or theology, the sort of Higher Power construction presented in “The White Chip” seems nonexistent. At a minimum, recovery narratives like Sean’s are worth investigating: in what ways might a contemporary North American need to theologically contort, in order to construct an authentic spiritual and/or religious experience? What can we learn about the S/R characteristics of recovery from a story like Sean’s?

Chapter 3: Research Methodology

Nature of Study

For this qualitative study, I chose to use the guidelines and intentions of interpretive phenomenological analysis (IPA), and utilize key informant semi-structured interviews to investigate the spiritual/religious characteristics of recovery from SUD. The research sample consisted of six individuals, and the selection of these participants, as well as other features of this project, was based on the recent findings and methodological choices of Flaherty et al. (2014).

Rationale for Choosing Interpretive Phenomenological Analysis (IPA)

As noted in the literature review above, many research teams have investigated the spiritual and religious characteristics of recovery pathways, especially in the last few decades. However, the vast majority, when engaging qualitative methods, tend to employ tools that rely upon measurements featuring dichotomies (e.g. “spiritual” or not), closed questions, classification systems (e.g. spiritual, religious, both, neither), standardized scales, and/or single continuous dimensions (e.g. more or less spiritual, on a scale from 1 to 5) (Dermatis & Galanter, 2016). When William R. Miller, a clinical psychologist and one of the world's most highly cited scientists,²⁰ reflected recently on his 40 years in addiction research and treatment, he lamented to his peers that “We are no better than chance at predicting which treatment approach will be best for our clients...Clinical research should move away from simplistic horse race trials toward identifying what actually promotes change” (2016, p. 104). Among his top recommendations

²⁰ A credential bestowed by the Institute for Scientific Information.

was that, given that “studies do support an inverse relationship between spiritual/religious factors and addiction” (p. 103), treatment and research programs must place far higher priority on understanding this phenomenon.

At the heart of the research questions guiding this project lies the goal of better understanding the subjective experience of recovery from addiction as interpreted by those who experience it, particularly the spiritual and religious characteristics of such experiences. The methodology most suited to such pursuit is a method first implemented in the field of health psychology by Jonathan A. Smith: interpretive phenomenological analysis (IPA). In order to explicate IPA and why it is the most appropriate methodology for the research subject and goals of this study, I offer the following brief description of the broad elements of IPA and the three characteristic features of IPA: idiographic, inductive, and interrogative.

Methodological Conceptual Framework of IPA

A broad range of philosophies, approaches, techniques, and assumptions fall within the category of qualitative research. The distinctive shared feature common to all is the identification of issues from the perspective of study participants, and a focus on understanding of meanings and interpretations that participants give to behavior, events, or objects (Hennink et al., 2011, p. 9). The features that distinguish IPA from other methods include its epistemological position, and the philosophical traditions from which it draws.

Phenomenology, as a method, is built upon philosophical premises associated with Husserl (1970), which prioritizes the experience itself, and how experiencing something is transformed into consciousness. Rather than attempting to produce any objective statement of

the object of study (a person or event), phenomenological methods seek to understand essences and underlying structures. Working from the assumption that there is an essence or essences to shared experience, the researcher whose method is phenomenological faces the task “to depict the essence or basic structure of the experience” (Merriam, 2009, p. 25). Max Van Manen names the dual nature of the method in its two sorts of description: “Phenomenology is, on the one hand, description of the lived-through quality of lived experience, and on the other hand, description of meaning of the expression of lived experience” (1990, p. 25). These characteristics make a phenomenological approach well-suited to research that explores the dimensions of human experience that are momentous, often intense, and affective. Reflexivity is also an innate philosophical underpinning of the phenomenological approach. As Husserl notes, “Focusing our experiencing gaze on our own psychic life necessarily takes place as reflection, as a turning about of a glance which had previously been directed elsewhere” (Husserl, 1999, p. 323). An explicit awareness of the inevitably retrospective and reflexive nature of any person making meaning of personal recovery from SUD seems foundational to a qualitative description of such experience. Thus, for multiple reasons, a phenomenological approach aligns nicely with the aims of this study: to describe and analyze the spiritual and religious characteristics of recovery from SUD.

Within the context of research methodologies, the term “interpretive” is slippery, and on its face, not necessarily very instructive in sorting all the methodologies that fall under the broad of umbrella of “qualitative.” As Merriam points out, “*all* qualitative search is interpretive” (2009, p. 22). However, Miles et al. (2001, p. 9), Merriam, and others generally describe methodologies as “interpretive” in as much as they seek the understanding of phenomena, and

their meaning for participants. Even within that subset, some approaches (e.g. grounded theory, ethnographic) are interpretive and qualitative, but not fitting for this study.

Within the sprawling map of various research methodologies, Smith (1996) positions IPA between social cognition and discourse analysis. Whereas social cognition methodologies, broadly speaking, assume a direct reflection (or at minimum, an easy relation) between verbal reports and underlying cognition, discourse analysis challenges this assumption. IPA was devised as an answer to what many in the health psychology field deemed a problematic assumption: “that people think about their bodies and that what they have to say about these bodies in some way relates to those thoughts” (Smith, 1996, p. 264). This methodological premise fails to allow for exploration of the myriad ways in which experience, cognition, and verbal response do not link together cleanly and consistently. As will be further detailed in the Data Analysis section below, IPA’s thematic analysis encourages the identification of implied and explicit contradictions and paradoxes within the interpretive accounts of participants. In this way, IPA seems a promising method for the task of illuminating how various subjects might hold the inevitable contradictions and paradoxes of addiction and recovery (e.g. making sense of apparently self-destructive desires and actions; holding simultaneously one’s agency and lack of agency/powerlessness in the face of addictive desires). At the core of Husserl’s phenomenology was his famous call to researchers to “go back to the things themselves” (1999) – rather than falling prey to our natural predilection for order, which might lead to pre-emptively sorting elements of participant experiences into pre-existing categories. In this way, IPA encourages the kind of “mess holding” necessary for receiving the contradictions and irrationalities that often characterize addiction narratives.

Idiographic. Smith describes IPA as “strongly idiographic” (2004, p. 41), linking the methodology to the Kantian binary of idiographic and nomothetic approaches to knowledge. As opposed to a nomothetic method, which seeks to generalize and to derive laws that explain objective phenomena, an idiographic method seeks to specify and to understand the meaning of contingent, unique, subjective phenomena. For this reason, most IPA studies involve a small number of participants. Smith describes such logic as deriving from critique of the nomothetic nature of most psychology, “which is concerned with making claims at the group or population level, and with establishing general laws of human behavior” (2009, p. 29). It is not the case that idiographic approaches or IPA necessarily eschew generalizations; rather, such generalizations are garnered in a different way. A deep exploration into the particularities of the spiritual/religious characteristics of the recovery experiences of a small number of persons seems a valuable contribution in the search for more complex understandings of the phenomena.

Inductive. In order to allow for the capacity to respond with flexibility in the analysis stage, IPA is more inductive than deductive. Rather than beginning with firm hypotheses to be proven or not by the data, IPA encourages broad research questions, resulting in broad sets of data from a few participants. Of course, inductive emphasis has long been an important component of qualitative methods, in various ways and to varying degrees. Furthermore, in the actual practice of qualitative research, most would agree with Smith: “the research process involves interplay between induction and deduction” (2004, p. 43). In that interplay, IPA generally leans to the side of induction. As with the other components and characteristics, an inductive orientation is suitable for the broad nature of the questions guiding this study – the spiritual and religious characteristics of recovery from addiction have specificity, but still are

likely to elicit a broad set of data from participants. Unlike a more deductive approach, this study does not begin with a firm hypothesis about the nature of those characteristics.

Interrogative. In its stance between research findings, and the conversations within field and extant literature, IPA seeks a constructive dialogue approach. IPA is not strictly adherent to the methodologies and conclusions of previous research, nor does it seek to pose its research results as unconnected to findings and conversations that have preceded it. At its best, Smith proposes that IPA contributes to its field “through interrogating or illuminating existing research” (2004, p. 43). Likewise, the intention behind this research is to join helpfully in a complex conversation about the nature of addiction and recovery that commenced long ago.

Smith notes, “IPA studies usually deal with significant existential issues of considerable moment to the participants and the researchers” (2004, p. 49). Its phenomenological theoretical position, its generally inductive and highly idiographic approach, its interrogatively-intentioned stance towards existing literature and the relevant fields of research: all components assemble to offer a methodology well-suited to the goals and research questions of this study.

Role of the Investigator

As the investigator of this research project, my disciplinary location is as a scholar of theology and religious studies, with additional doctoral-level training in psychoanalytic theory, as well as neuroethics and critical neuroscience. I bring years of field experience with various recovery communities, sometimes as a participant and sometimes as an observer-researcher. I have never been diagnosed with an SUD, nor have I sought recovery from any process or substance addiction. Having experienced the effects of alcoholism and other SUDs within my

family-of-origin, I participate in Al-Anon Family Groups, a spiritual fellowship based on Alcoholics Anonymous in which participants practice the 12 steps in recognition of addiction as a “family illness.” As a researcher, I have attended many, many open meetings of recovery communities in Atlanta (and elsewhere) for several years, both for the pursuit of my research questions, and for the purpose of facilitating educational experiences for the seminary students I instruct. As an ordained religious professional who led and counseled those within my faith community for many years, I have witnessed the devastation wrought by addiction upon individuals, families, and communities, as well as the potential social and spiritual gifts of those in recovery. I find the pervasiveness, complexity, gifts, and limitations of 12-step programs, and subsequent adaptations thereof, to be of enormous interest as a religious professional and scholar.

In the sense that I am both the research investigator, as well as an individual who has participated within recovery communities, I functioned as an interviewer-participant in this phenomenological research project. I understood it to be my responsibility to record the context and content of the interpreted lived-experiences of the participants in this study. Furthermore, I sought to keep at the forefront of my awareness, as an interviewer-participant, the double hermeneutic always present in human research: the participant is always trying to make sense of his or her personal and social world, and the researcher is trying to make sense of the participant trying to make sense of the personal and social world (Smith, 2004, p. 40).

Sampling and Participant Selection Logic

As explained above, this study inductively approached understanding how various persons in recovery from addiction experienced, or do not experience, the role of spiritual and religious (S/R) characteristics within their recovery, given the context of the BDMA, utilizing the method of IPA.

Sample size is best determined by the research questions guiding the study, the risks and benefits involved, what constitutes credibility, and the limitations of available time and resources (Patton, 2002, p. 244). The research sample for this study consisted of six individuals, a sample size based upon the standard participation in phenomenological research of one to 10 persons (Starks & Trinidad, 2007), guidance for appropriate sample sizes of IPA studies (Smith, 2009, p. 51), and the time and resources available for the completion of this project.

This study did not seek to represent any population: various racial or ethnic identities, particular regions of the U.S., age groups, gender, levels of education, class identities, or life phases. As Smith notes, “Participants (in IPA) are selected on the basis that they can grant us access to a particular perspective on the phenomena under study. That is, they ‘represent’ a perspective, rather than a population” (2009, p. 49). This study does not claim representation of any population (e.g. the S/R characteristics of the recovery experience of all white men in Atlanta, at least five years sober, participating in a secular recovery program). However, in identifying themes, similarities, and differences in the S/R characteristics across the recovery experiences of the interviewed subjects, the study operates on the hope that the findings and analysis might point to future research trajectories and the potential for the contributions of religious studies scholarship to increased understanding of addiction recovery.

As noted above, the limitations of this study preclude the ability to *represent* any racial or ethnic population, particular regions of the U.S., age groups, gender, levels of education, class

identities, or life phases. However, diversity was sought in participant selection, as detailed below in the sampling outreach method. Some homogeneity will be assumed: this study was limited to North America and to those with strong facility with the English language. Because this study is interested in gathering and analyzing the experiences of those who have been in recovery for what is broadly considered by caregivers, clinicians, and researchers to be a stabilized length of time, participants in this study identified as having uninterrupted sobriety/abstinence for at least four years.

As with most qualitative research, non-probabilistic sampling was most appropriate for this study, since generalization, in a statistical sense, was not a goal. Purposeful sampling (the most common form of non-probabilistic methods) best matches the aims and questions of this study, since it assumes a research goal of discovering, understanding, and gaining insight (Merriam, 2009, p. 77). Miles et al. note that some sampling strategies, particularly opportunistic or snowball sampling, are of particular benefit to inductive analysis (2014, p. 32). This study utilized a strategic combination of opportunistic and snowball approaches.

The first stage of recruitment was opportunistic. As investigator, I contacted three individuals who, in the context of my presence and participation in the field of recovery communities, had contacted me after having heard from others that I was a doctoral student at Emory University researching 12-step programs. See Appendix C for the introductory email I sent to each of these individuals in this first stage of recruitment. Any ambiguity was resolved through additional written or verbal correspondence.

In the second stage of recruitment, I sought participants using the snowball method. The definition of snowball recruitment provided by Hennink et al. (2011, p. 100) identifies the reasons that make this sampling approach appropriate for finding a small number of participants

in recovery from SUD: “Snowball recruitment...is a method of recruitment particularly suitable for identifying study participants with very specific characteristics, rare experiences or ‘hidden’ population groups (e.g. drug users) who may be difficult to identify with other recruitment methods.” As noted above, one well-known obstacle in researching the experiences of participants in 12-step programs is the aspect of anonymity. For many reasons, anonymity is highly prized within the traditions and practices of Alcoholics Anonymous and subsequent adaptations. However, in my experience with those participants with many years of sobriety, there is a tradition and aspect within 12-step programs even more pronounced than respect for anonymity: a deep understanding of the importance of “service.”²¹ Similarly, when I have approached those in recovery about speaking to my students, “service” is inevitably a word they say when I repeatedly thank them for their time and willingness to share their “experience, strength, and hope.” In essence, not only is the sharing of one’s story a well-accounted for practice across existing research and within 12-step literature; sharing one’s story is considered service, and serving others is considered a part of maintaining one’s own sobriety, beyond the other altruistic or evangelistic benefits.

As a researcher, educator, and participant with experience in the field of 12-step programs, I did not expect to experience many obstacles in finding individuals willing to be participants in this study. Indeed, I experienced far more challenge in avoiding the gathering of an unmanageable amount of data, given the depth with which I interviewed each participant.

²¹ One individual embodied this practice in our first brief introductory interaction. When I asked if I might contact him in the future about participating in my research, he nodded, and found a piece of paper. He wrote only his first name (in line with the 12-step tradition of not revealing one’s last name), and his email address, and said, “when asked to serve, the answer is always ‘yes,’ right?”

This study was submitted to, reviewed by, and approved by the Emory University Institutional Review Board (IRB). After being CITI²² certified, and submitting my full study design, including protocols, methods, risk and benefit analysis, and plans for data analysis, I received expedited approval (see Appendix A).

See Appendix D for a template of my snowball method outreach to various contacts within 12-step communities. Any ambiguity was resolved through additional written or verbal correspondence.

If upon first contact, a potential participant expressed interest in participating, I sent him/her Emory University's IRB "SHB Participant Information Sheet" (see Appendix B). Due to the personal and sensitive nature of the information collected, each participant was informed that s/he had choice to participate or refuse to take part in the study, or agree to participate and later change his/her mind, or to completely stop participation at any point in the process.

Instrumentation

As noted above, key informant semi-structured in-depth interviews were the instrumentation of this study: two interviews were conducted with each participant (see Appendix D). Participants were sent the interview questions 24 hours in advance of their first interview, to allow time for consideration. Following the first interview, each participant was permitted to see a transcript of the first interview, so that they might feel comfortable with the way they had represented their reflections and their story of recovery, building further trust between investigator and participant. The time allowed for each interview for each participant

²² Collaborative Institutional Training Initiative

was 60-90 minutes. It was expected, per the guidance of IPA, that the interview process might be iterative, allowing the researcher to shift the interview template based on insights gained from a previous interview. In the original design of the study, a second interview was planned as an opportunity to continue unexplored items from the first interview, particularly if the participant felt limited by the 90-minute time constraint. However, for all six of the participants, one interview yielded more than enough satisfactory material for the purposes of this study. This method of two key informant in-depth interviews, with interview questions shared in advance, and a transcription of each interview shared with the participant for their consent, was adapted based on the methodological conceptual framework described above, and the success of this method as engaged by the Flaherty study.

Each interview was recorded and transcribed. Audio recordings were used to insure accuracy; participants were fully informed of and consented to this protocol. A hand-held recording device was used to capture the data at each interview session. Immediately following each session, I engaged in extensive journaling to capture initial impressions of each interview, before transcription of the interviews.

Interview 1. See Appendix D. The interview schedule was amended from Flaherty et al. (2014, p. 340), and followed the guidelines for key informant semi-structured in-depth interviews of IPA (Smith, 2009, p. 59) and for responsible, successful qualitative in-depth interviews overall (Merriam, 2009, p. 89; Hennink et al., 2011, p. 108). The questions were highly narrative and employed open-ended prompts, designed to avoid manipulation or unnecessary leading of responses. Given the tradition within 12-step fellowships of sharing one's recovery narrative in multiple contexts, the first questions were designed to mirror what is expected to feel familiar to any participant. The next questions approached the participant as an

expert, following the methodological assumptions described above. Answering the first three questions, indeed, had the potential to fill an entire 90-minute session. Question 4 was designed to explore any conflicting narratives or etiologies the participant might have about addiction, based on how s/he might explain it differently in different contexts. Questions 5-10 were asked, only if such topics were not volunteered by the participant in Questions 1-4. Notably, the words “religion” or “spirituality” were not suggested/spoken by the interviewer until Question 11-12. When the participant reviewed the interview questions 24 hours in advance of Interview #1, s/he saw these questions as 2 of 21 questions, positioned two-thirds into the list. Although the participant would have seen “spiritual and religious characteristics” in the title and purpose of the study as described in the initial email contact and the information sheet, the intent of this methodology is to allow, as much as possible, for the participant to volunteer the ways in which S/R characteristics have/have not functioned for him/her through his/her recovery experience. Questions 13-21, where time allowed, were prompts for further conversation and areas not previously covered.

Interview 2. See Appendix D. As described above, the second interview was not necessary for any participant. The intent of Question 4 of Interview 2 was to provide the opportunity to reflect explicitly on the context of the neuro-turn, if the subject had not arisen already. In practice, however, this element was volunteered by five of the six participants, and in the case of the sixth (Connie), the subject arose naturally in the concluding segments of the interview conversation.

Data Analysis Plan

The goal of the phenomenologically-oriented method of this research project is to discover and understand the lived experiences of participants; therefore, an iterative and deductive cycle rather than pre-established coding was used to select segments of data for organization into common themes. Although this study is grounded in the broader themes and findings of the recent literature, and the common premises and subjects that might lend themselves to *a priori* coding, my desire was to refrain from preconceived expectations, allowing the data, rather than the researcher (myself) to form commonalities before the data are collected. Following each interview, careful notes were made so as to capture immediate observations. Next, each interview was transcribed.

In analyzing the data collected via the key informant semi-structured in-depth interviews of participants, an iterative and inductive cycle was implemented. The major analytic moves, per IPA, are best outlined as follows:

1. Reading and re-reading. Close, line-by-line analysis of the experiential claims, concerns, and understandings of each participant.
2. Initial annotation. Free textual-analysis. Often the most time-consuming.
 - Make descriptive comments.
 - Make linguistic comments.
 - Make conceptual comments.
3. Review notes. Identification of emergent patterns (themes).
4. Developing of dialogue between the researcher, the coded data, the relevant existing literature, cycling in a more interpretive account. Searching for connections across emergent themes.

5. Repeat with each case.
6. Development of a structure, frame, or *gestalt* illustrating the relationship between themes.
7. Development of full narrative, evidence by a detailed commentary on data extracts, which take the reader through this interpretation theme-by-theme, possibly engaging visual guides (Smith, 2009, p. 80, 82-101).

Although predetermined coding tools were not useful to meeting the research goals or following the methodology of this project, such tools were considered²³, based on the existing literature that investigates religious and spiritual characteristics on addiction and recovery.

A well-detailed audit chain (i.e., detailed writing) was maintained: records were sequentially organized so that another researcher could trace conclusions and findings through the documentation of the data and analysis, and preconceptions, methodological rationale, and the theoretical interpretation of the data was documented in the study notes (Smith, 2011).

²³ Among those tools considered for measurement and/or analysis were the Multidimensional Measurement of Religiousness/Spirituality for Use in Health Research (Fetzer Institute, 2003), the Religious and Spiritual Coping Scale (Keefe et al., 2001), and Cook's 13 conceptual components of the definitions and descriptions of spirituality in medical and social science literature (2004, p. 543).

Chapter 4: Findings

The central overall findings of this study were related to the complex ways in which neurological terms and metaphors, entangled with theological worldviews, feature in accounts of addiction and recovery.

All participants told moving, deeply thoughtful narrations of their recovery from addiction. All participants were quite familiar with the practice of naming aloud their experience of moving from active alcoholism (and for two of them, also abuse of narcotics) to sobriety. All participants were willing participants, several of them noting that they saw the task of sharing their story of sobriety with a researcher to be another form of “service” as understood in 12-step spiritual fellowships. However, even though all had experience sharing their recovery story, all participants found the exercise emotionally taxing.

Three major findings emerged from this study, within which several minor themes and patterns were observed. The first finding was the consistent reports from all participants as to the necessity of surrender to a Higher Power in order to sustain sobriety. Three patterns within this finding included a) Connie’s and Karl’s lack of struggle with the “God part” of Higher Power, b) the need for both Navarro and Barry to release previous theological concepts before surrendering to new understandings of Higher Power, and c) the way in which, Sean and Ursula, as atheists, struggled with transcendent belief of any kind as they worked to construct a sense of Higher Power to which they might surrender. The second and third findings revolve around the most pronounced division within the six participants: the younger three participants placed high value on and devoted significant effort and imagination to integrating neuroscientific theories of addiction and recovery (neuro-turn concepts) along with their spiritual experiences and

understanding of recovery. The older three participants did not show nearly the amount of concern or interest in terms like “my brain chemistry” and “prefrontal cortex” and “neuropathways” as did the three younger participants. For the three older participants, medical-model addiction etiologies certainly arose, but with far fewer references to “brain chemistry” or neuroscience. Instead, the traditional disease concept of alcoholism and addiction featured more prominently.

In this chapter, a brief description of the participants will be followed by a more detailed account of the three central findings of this study, as well as other themes and patterns that arose within.

Participants

Of the six participants, all of them were adults with several years of sobriety (minimum 4 years). Table 1 shows each participant’s pseudonym, gender, age, ethnicity, sobriety, religious identity, and recovery program involvement. Four participants were male, and two were female. Half the participants identified as white, the other half were of other ethnicities: African American, Palestinian-Filipino American, and Mexican. The average age of the six participants was 48, with a wide spread between the youngest participant (24 years old) and the oldest (72 years old). All participants identified as alcoholics and had experience, and at least some success, with Alcoholics Anonymous (A.A.). Two participants also identified as drug addicts and have participated in Narcotics Anonymous (N.A.).

Table 1

Participant Characteristics and Demographics

Pseudonym	Gender	Age	Ethnicity	Sobriety	Relig. Identity	Recovery programs
Ursula	F	24	White American	4 years	Spiritual/New Age, SBNR	A.A.
Barry	M	38	Palestinian-Filipino American	4 years	Catholic	A.A., N.A.
Sean*	M	44	White American	5 years	Agnostic, SBNR	A.A. (some), Rational Recovery, Right Turn
Navarro	M	52	Mexican	5.5 years	Former Catholic, SBNR	A.A.
Karl	M	58	African American	27 years	Christian	N.A., A.A.
Connie	F	72	White American	37 years	Protestant	A.A.

* Given public disclosure of his addiction narrative in *“The White Chip,”* Sean declined to have his identity masked by a pseudonym, or otherwise anonymized.

All participants described experiencing at least two of the following consequences as a result of their alcoholism or addiction: homelessness, loss of custody of children, destroyed marriages/serious relationships, loss of job, suicidal ideation/attempts, imprisonment, and/or serious health problems (in addition to alcoholism/addiction). Five of the six participants were raised within a Christian denomination, with varying degrees of frequency in religious practice and levels of education in religious doctrine. Half of the participants identify as “spiritual but not religious.” Four of the six participants had been treated at least once in a rehabilitation facility as a part of his/her recovery. Five of the six have experienced psychotherapeutic treatment of some sort in the course of recovery. At the time of the interview, all participants were employed or otherwise economically secure.

Finding #1: Necessity of surrender to a higher power

The most consistent finding among all six participants was the expression of a necessity of some sort of spiritual surrender to a Higher Power in order for sobriety to be sustained. Three notable patterns emerged within this finding. In Connie's and Karl's experiences of recovery from addiction, neither participant reported any struggle with belief in a Higher Power. For Navarro and Barry, significant effort was necessary to release previous theological orientations before constructing belief in a Higher Power to whom they each would surrender. Sean and Ursula, both identifying as atheists at the time of their "rock bottom" and early recovery, experienced significant struggle in transcendent belief of any kind, and thus in any sort of Higher Power.

Connie and Karl: no struggle with the "God part" of Higher Power. For Connie and Karl, the two oldest participants, belief in God (the term both of them used to describe their Higher Power) was not an enormous stumbling block of the beginning of their recovery, nor throughout their decades of recovery since that time. Both Connie's and Karl's narrations of their experiences of "rock bottom", the last years and months of their abuse of substances, then the first few months and years of their recovery, are similar to many other narratives.

Connie recalls her primary struggle centering around her inability to imagine how to function without alcohol, but also knowing "I was out of excuses." Despite her enormous desire to stop drinking, Connie remembers clearly, and with some tears: "I just couldn't – I just almost died thinking I could do it myself. Because I knew my life was in shambles, and you know, my

children...” Most of Connie’s memories of struggle and transformation from her first months of recovery relate to her surrender: admitting to herself the severity of her problem, that she could not fix her alcoholism without help, an idea of herself without alcohol, and the relational and social aspects of her treatment center experience and her first months of A.A. meetings. Though the act of surrender itself was enormously difficult and critically important, Connie does not report the idea of a Higher Power as a stumbling block in her recovery,

I wasn't worried about a Higher Power, at the time. I was worried about, "I don't know what else to do." And then when I got around people, the Higher Power – I don't really even know when all of that – I'd been in church all my life, and I'd had some moments of a real connection with God, in my mind. But I'd always drink, and then, you know, you get separated again, right? And I don't know when the idea of a true meaningful God of my understanding came about.

Like Connie, Karl does not recall difficulty with assenting to the concept of a transcendent force.

Karl uses the word “God” in referring to his Higher Power, and repeatedly returned to theological concepts in order to describe the nature of addiction and the process of recovery.

It’s like my life has completely changed. I wouldn't – you know, I don't like the idea of being called a Holy Roller, but I do – God is somehow or other the center of my life. He is. It's the only way I could – I don't think – see, how I look at is that (a) we're alcoholic, (b) no human power could restore us from our alcoholism, and (c) God could and would if he were sought. That's it: God could or would if he were sought. And if I sought him, and he did it, so he can do the rest. 'Cause I'm still uncomfortable in my skin. I'm still not sure what my place is in this world, what my goal, what my position, what I'm supposed to do. I'm still unsure of all of that.²⁴

In addition to the centrality of God in his (or anyone’s) recovery from addiction, Karl understands the act of turning toward God (critical to recovery) to be a move away from “self-centeredness”:

You just gotta keep moving. God will – if I – it talks in the book about selfishness and self-centeredness. See, if I get away from my selfishness and self-centeredness and just turn my head toward – and it's somewhere. They say all you gotta do is just turn towards it...

²⁴ Karl often spoke in first-person plural, echoing the style of the “Big Book” of A.A.

Karl is also comfortable with theological language like “grace,” which he used many times to describe the dynamic of unmerited favor.

I'm not worthy, you know? And the deal is it's not really about worthy. It's about grace. It's about grace. And the only way – I know all of this stuff has been said in the church...All of this, to me, is just part of the grace of the program, with the 12-step program, that you start with step 1 that says, "I'm powerless over alcohol and my life is unmanageable." And I take the alcohol out and I start to become restored to sanity 'cause I see this stuff happen in my life and I get all mad at it at first, and then I have to stop, because I can't drink, and really face it and then find the truth in it, find the sanity in it, the truth in it, and then trust God to move forward – that made a decision to turn our will and my life over to the care of God and trust God to move forward with, no matter what happens in those circumstances.

In the A.A. circles in which I observed him, Karl is clearly a beloved and respected veteran, active in “the rooms” and a sponsor to many. When asked about how he responds to those who are in the first months of recovery and struggling to assent to any idea of a Higher Power, Karl invoked the famous “door knob” phrase common to 12-step programs:

Understand that there's gotta be something else out there, and I don't care what you call it. They always say, “We don't care what you call it. You can call it God. You can call it a doorknob. You can call it whatever it is.”

For Karl, surrender to a Higher Power is an absolutely unavoidable task for anyone in the grips of addiction who wants to find sobriety.

Connie and Karl were alike in their affection and respect for 12-step programs, in their lack of difficulty in having belief in a Higher Power, and in their generally positive experiences with the institutions of the Christian church previous to their recovery. Also, unlike the other four participants, neither Connie nor Karl felt compelled to explain to me the difference between religious and spiritual. They differed, however, in their feelings toward and interest in church involvement. Connie was frank about her sense that A.A. meetings fulfilled any needs that might be met if she attended church. “Right now, I go to 10 or 12 meetings a week, because I

love it!” Connie also inferred that A.A. allowed her to know something more about God than she would through church: “I remember hearing this old priest say, in one of my groups in Knoxville, he said, ‘I knew all about God, but I didn't know God, until I came to AA.’” For Connie, the relational aspect of spiritual fellowship is where she locates much of her experience of her Higher Power.

I never feel God's presence any stronger than when one human being is honestly and unafraid talking to another human being. God's presence is there, you know, there's a bond there, that you just can't find at the local book club. *[Laughs]* And that's a huge part of our program, is sharing honestly and openly with another human being.

Another comment that revealed how Connie's sense of the spiritual and the social are deeply intertwined was her description of her relationships with several men in the program:

I find that I have such sweet male relationships in the program, that I don't need that physical – to me, the intimacy is in sharing, you know? And, okay, there's a guy that's probably 50, and he will call and say – and it's nothing, I mean, he's got family, it's nothing sexual about it – “I just had to tell you, because I knew you'd be interested.” You can't buy that, “I just wanted to tell you, because I knew you would be happy for me, I knew you would be interested.” And tell me personal – nothing sexual, again, but just personal stuff, “I am so afraid, right now, I don't know what to do, and I knew that I had to hear your voice.” That is spiritual. That's about as vulnerable and spiritual as you can be, so, you know, that feeds my soul.

Connie clearly pinpoints her spiritual nourishment within the social relationships and fellowship of A.A. More than nourishing, though, Connie sees the social dynamics of 12-step as essential for counteracting the “disease of loneliness” that the illogical and self-destructive thinking of alcoholism breeds:

You can't fix a problem till you let it come to the surface, period, I think. And as long as I'm having to be alone – it's a disease of loneliness, oh my god – as long as I'm alone, and protecting, and lying about it, I keep rationalizing it, because I have to be able to live with myself.

Karl is similarly active in “the rooms” of A.A. and N.A., but as with his comments about “grace” and being a “Holy Roller,” he was the person least opposed to church involvement, among the six participants.

Overall, Connie and Karl, like all the other participants, very clearly named spiritual surrender to a Higher Power as a crucially important step in a time when their lives were at stake. Connie and Karl differed from the other four, however, in that they did not experience enormous opposition to the idea of a Higher Power.

Navarro and Barry: release previous theological concepts before surrendering to new understanding of Higher Power. Overall, Navarro and Barry both described their experiences of surrender to a Higher Power in ways similar to Connie and Karl: all four used the term “God,” and all four credited the God of their understanding with their ability to maintain sobriety, to some extent. However, both Navarro and Barry clearly articulated a stumbling block that Connie and Karl did not: the need to release “old ideas” of God from their childhood exposure to Catholic theology.

Barry described feeling hindered by his own sense of mastery over Catholic doctrine, given his high level of achievement as a student in a Catholic school:

I was born and raised with a concept of God. Funny enough that not the Catholic part, but being so religiously trained actually made it more difficult for me I think in hindsight. I came from a good school and college prep high school that was Catholic. So I was good at being studious. I could regurgitate the book to you. I could do all this and that and look good, but it wasn't sinking into me until I really just had to wipe the slate clean and ask myself who God is to me and trust that this God, you know, wants... trust that this Higher Power, however I define him, needs to be that if anything I can't play God. I have to stop playing God.

Knowledge of doctrine seemed to morph into a sense of God as a known and dominated entity for Barry, rather than an entity with which he could feel vulnerable, much less surrender his

agency. Barry went so far as to report that “I knew atheists who were grasping the Higher Power concept easier than I could...they came from a clear slate.” Such a distortion of self and God, for Barry, was a key part of what allowed him to slide into active alcoholism in the first place. He reported that for the twenty years of destructive drinking, he was “willpower run riot. It was definitely ‘Barry’s will be done’ for a long time, and it was not working, obviously.” Barry describes his “spiritual realignment” as a long and arduous process. “I did that one, two, three waltz,” said Barry, a 12-step quip that refers to a tendency to work the first three steps, and avoid the fourth step, making “a searching and fearless moral inventory of ourselves.” For Barry, admitting the wreckage of his actions was connected to a more subterranean admission that he could no longer “play God.” Finally, after many rounds of “restarting the steps” and seeking to “Stop making myself the power because it’s keeping me locked in this,” Barry reports, “I felt I was met with a divine answer. A bush didn’t come down and talk to me, but over time I started to experience what I call God in a different way.”

Similar to Barry, Catholicism was the religious context in which Navarro experienced theological formation as a child and adolescent. Born and raised in Mexico, Navarro detailed the sequence of events in his early teens that led to his first rejection of church, beginning with memories of his father (to his mother’s deep dismay) allowing Navarro and his siblings to choose sports activities over church attendance. “Once we split that... hierarchy or whatever you want to call it, I never went back to church,” Navarro said. Distinct from Barry, who sees his sense of doctrinal mastery as the stumbling block to developing his sense of a Higher Power to whom he could surrender, Navarro sees an illogically vindictive image of God he experienced in church as his stumbling block when he entered A.A.:

I had a problem with God when I came in [to A.A.], because I grew up with a God that was very punishing. I mean, I – a lot of the concepts don't make sense. I'm a biochemical

engineer by trade, so I need to... I need facts. I don't believe in faith, or I didn't believe in faith... And what they [the Catholic church] told you was if you don't go to church, you're going to hell and I'm going, "Okay." And then, on the other hand, they tell you that you are made to his image, and that we are his kids, and I'm thinking, "Well, I have kids. I wouldn't send my kids – if I had the power, I wouldn't send my kids to hell because they didn't come to see me on Sunday." I mean, it's like that makes no sense.

Like Barry, Navarro described his long process of growth and “working the steps” that necessarily preceded his sense of God he now experiences.

When I came [to A.A.] I was – every time they talk about God, it was like, "Okay, here we go again." But I have cornered myself into a situation that whatever I was learning wasn't working, and I needed help. And that's what kept me coming back to the rooms, and I didn't want to be an alcoholic. I didn't want to be there. I wasn't sure that the 12 Steps were going to work, but I didn't have an answer.

Eventually, Navarro’s experience of a Higher Power transformed. Notably, it was his observation of and reflection upon the vulnerability and brokenness of other people caught in the trap of addiction that shaped Navarro’s sense of God as paternal, loving, and forgiving:

I truly believe a lot of people with addiction are good kids, are good guys, and they mean well. It's just that they get in trouble because of that addiction, because they can't help themselves. And that helped me create a Higher Power that is forgiving and that is helpful; is there when you need him; supportive; like a father. Like a – I don't know, I suppose like the father should be in those Hallmark movies. And that helped me a lot. That helped me open my mind to religion and spirituality.

Like Barry, Ursula, and Sean, Navarro found it important to distinguish between religion and spirituality:

Now I understand the difference between the spirituality and religion, but back then it was all the same. When I was drinking, it was all the same. Religion is organized. The spirituality – and they are processes, while, spirituality can be anything. I mean, it can be – you can organize it in a way that is convenient to you and do it as often or as far apart as you decided to do. And there's not that structure, which works better for me, and it works with a lot of people in recovery. Especially in AA. We say that you can tell an alcoholic, you just can't tell him much.

Navarro expressed his conviction that the flexibility of Higher Power concepts, paired with the insistence that those in recovery surrender to a power greater than themselves, are indispensable

components of recovery. “[My girlfriend] is very religious and spiritual, and that's something I need,” said Navarro. “I mean, I truly believe that without that, you cannot remain away [from drinking]. You cannot remain in recovery.” Similarly, Barry said, “To recover, a person has to believe in something besides their own thinking.” Like Connie and Karl, both Barry and Navarro referred to the “door knob” concept, that one can surrender to any power or entity outside of one’s self (the group, the Universe, an object), but what Barry refers to as “a spiritual realignment” is indeed crucial to recovery.

Sean and Ursula: atheists who struggled with any transcendent belief. While Karl and Connie experienced no difficulty in assenting to the concept of a Higher Power, and Barry and Navarro had some “old tapes” of religious belief to re-write before reconstructing their sense of Higher Power, Sean and Ursula report laboring more intensely to budge open a door of belief, given what both describe as their identities (in pre-recovery and early recovery) as atheists. Both Sean and Ursula describe their first attempts at prayer during their moments at “rock bottom” when each of them felt as though death might be the only alternative.

In many ways, Sean’s experience overlaps with the experience described by Navarro and Barry: the need to unravel experiences of disillusionment and hurt in the context of the church in which each man was raised. Sean’s entire family was very active in the Church of Latter Day Saints, until Sean’s late adolescence when his parents departed from the church.

My father was a contract sports attorney, so his job was...to go through the details and find them, and [he] just found all these details that he couldn’t just agree with in the Gospels... The tricky thing that I think [is true] with any religion is that my parents really believed 80 percent of it so true and wanted those things to be great...[T]here’s a part in the Book of Mormon where God turns people’s skin dark for being evil. There’s just some stuff that is hard to embrace, and [my parents] are just not the type of people that can believe 80 percent and think that’s enough to be able to do it, especially when it came

to women and women's roles in the church and the idea that you can't even get into Heaven unless your husband does well.

Sean recalled a great deal of emotional tumult within nearly all the relationships and community surrounding his family during this time. Following his family's departure from the LDS church, Sean reported, "I never really found any religion after that." Sean speculated that perhaps his closed attitude towards religion was related to a lack of understanding of other faiths.

When you're a kid, you don't even realize that there's options. It's just kind of what you are, and only later on, you're like, "Wow. Other people aren't this." So I think that really laid the groundwork there for me just to be not a fan of religion.

Sean suggested a symbolic connection between his religious upbringing and his identity as an alcoholic: at age thirteen, Sean had his first drink at a friend's house, which happened to be the same day he was baptized for the dead, an LDS practice of proxy performance of the ordinance of baptism. By the time Sean was in his early thirties, beginning to admit to himself the destructive effect of his drinking on his health, his career as a theater director, and his marriage and other relationships, he attended his first few A.A. meetings, but was intoxicated when he did so.

I would go to AA meetings drunk, because there was on some level, I thought if I was absorbing it, it would still make me better somehow. I don't know. Looking back, I don't totally even understand what I was thinking.

Like many alcoholics, Sean found it hard to conceive of himself as an artist, or even a human being who experiences joy, without alcohol: "I was like, 'What do you do for fun? How do you have sex with people?'" Sean remembers feeling some affinity toward aspects of 12-step programs, but always seeking a reason to reject the model:

Being a theatre person, I loved the ritual of it all [A.A.]. I loved the community part of it all. I was looking for something to not like to then reject the whole thing. I would wait for one person to talk, and if they said something wrong, I would be like, "Nope. See, exactly. That's why I can't do this."

To some extent, Sean's attitude (a common protective coping mechanism in pre-recovery and early recovery stages) followed him to his experience in rehabilitation. Even more than his experiences in A.A., Sean experienced a barely veiled Christian agenda behind all his encounters in recovery services:

Even all through rehab, I couldn't get it. I just couldn't...because rehab is actually more religious than just your standard AA meeting. It's really people believing in the power of God...It's like almost everybody I encountered who works in recovery services is very Christian and very conservative. Almost all Republicans. So that, for me, was also the tricky part of it, like, "We don't agree on anything. Our belief systems are so different." [But] even when I was like, "I don't know if I believe any of that," they were like, "Well, this is a faith based program. This is what we're here for." I got in all these fights with my counselor [Britt] just because I felt like what they were saying was, "You don't have to believe in Jesus. You can pick anything." But everybody, eventually, believes in Jesus. So I felt like they were just stalling us up until this moment when you'd eventually come around.

Unlike Connie, Karl, Navarro and Barry, Sean found the "door knob" concept of A.A. to be disingenuous, and more importantly, unworkable. A close confidante of Sean's suggested a "workaround" Higher Power concept that functioned for him:

I have a great friend [in rehab] who I was talking to during it, and he said...he picked "the ocean" as his thing, because the ocean is bigger and more powerful than him. But I just felt like I didn't know. I'm giving up my power to the ocean? I just couldn't wrap my head around any of it.

In his play, Sean relates much of these struggles through the frame of his relationship with his counselor and sponsor, "a real tough recovering cocaine addict former Air Force officer turned Preacher and Addiction Specialist, named Britt" (Daniels, 2016, p. 80) who demands that if Sean wants any chance at sobriety, or even at continuing to live, he must find and surrender to a Higher Power.

I do remember, at one point, Britt telling me, "You have to remember we bury the smart ones all the time." Because I really felt that I was smart. I could figure this out. I had this

real pompous thing of this most meetings I was in, thinking I'm the smartest person in this room. So that didn't help me at all. It probably wasn't even true.²⁵

Perhaps most notable in Sean's story of surrender is that he did not see his inability to assent to any sense of a Higher Power as mere philosophical or theological discrepancy. In his play and in his interview as a participant in this study, Sean was very clear that he agreed with Britt: his life was at stake. He had entered rehabilitation after losing his spouse, his job, and then coming frighteningly close to attempting suicide. Sean describes his desperation on one day near the end of rehab:

I had this terrible day. It was Sunday, so we didn't have any sessions until the afternoon. I was crazy. I was literally like, my brain was racing and I was sweating and I was coming up with scenarios of how I could get out and how I could...the funny thing was even though I was a crazy person, I was still rationalizing it...I think I probably couldn't have convinced the front desk ladies to let me go, but I really believed I could if I tried, so I knew I had to not go try, because I thought if I did go try, I'll get out...I still had a whole plan about how I was going to drink, but then I was going to switch to beer, and I was going to eat a lot, so I was going to absorb the alcohol.

It is in this state, Sean said, that he prayed out of desperation, losing consciousness at one point, which seemed in itself to be an answer to his prayer.

We [Britt and I] had covered this in earlier sessions that week, this is what you do, so I couldn't think of anything else to do besides pray, and I did...I was praying and I was like, "What are you doing? You don't believe in this." This was a real moment of despair, because I was like, "Who are you praying to? You don't...this doesn't make any sense. You're trying to say, 'God help me,' and I don't believe in God. I don't believe in these things."...I'm just told it was because I was really out of options for what else happens....I prayed, and then I prayed some more, and I prayed a ton, and then I kind of passed out, and I woke up and I prayed some more. So in a sense, it [prayer] really did work.

As noted above in Chapter 2, Sean's dramatization of this critical moment in his play aligns relatively closely with how he narrated the moment in our interview:

I decide to, ugh, pray. I'm not a pray-er, but I was told, when this happens, you have to pray. So, I do. Old school. On my knees. First time since I was 15? 16? I pray the prayer I was taught - and the whole time I'm having a Meta snob moment - who are you praying

²⁵ "We bury the smart ones all the time" is an A.A. slogan also quoted by Navarro, Karl, and Barry.

to Sean? You don't actually believe in anything. But I pray. I pray, then I eat, then I shower, then I pray, and I eat again... and then I stop sweating. Suddenly I realize I haven't thought about a drink in a few minutes. Then I realize 10 minutes have passed. And then I am fine. I am proud, and worried about when the voices in my head will return. (Daniels, 2016, p. 85)

In the dramatization of the play, and in his experience of rehab, Sean saw his prayer as a failure, though it seems notable that he later reports how it did, in a sense, function to his benefit, insomuch as he was able to prevent himself from attempting to break out of rehab and finding alcohol to consume. He reflects further on the dynamics he retrospectively sees functioning in prayer:

I think what I know now about it [prayer] is that these moments of taking the focus off of myself and putting it on something else...I'm not a pray-er now, but I have to say that what the value of that to me would be to stop feeling sorry for myself. I stop thinking there are things out of my control. I calm my breathing. So I think that meditation or doing something nice for somebody else takes the focus off of you in that moment as opposed to over and over again, wishing harder and harder for your needs to come true. So I think that was a breakthrough, but I could never get into the religion thing.

Whatever the function of prayer in that particularly difficult moment, Sean's fear and desperation were not abated the next day as he faced the end of his rehab period.

Really, with only a couple days left to go, I knew I would die when I left. [Rehab] is the thing you do and then you come out a new person at the end. We don't know what happens when you're away...I had gotten to the end of my 28 days, and I was just like, "I'm not any different. I'm just exactly the same. I'm miserable. I've detoxed properly, but I haven't done really anything else."

Sean's report of his conversation during this time with Britt follows closely his dramatization of the conversation in his play:

BRITT: Your god thing is just a problem with authority.

SEAN: No. I just can't "surrender and let Jesus take the wheel" - that's not me not wanting to change, that's me wanting to be honest with you...Look, I only have four days left, and if this doesn't fix me, I'm screwed, you and I both know, I walk out like this, I'm not gonna make it.

BRITT: That's it, fine, I thought it may come to this, you're just gonna have to get sober with the Jews. (Daniels, 2016, p. 90-91)

As noted above, Britt's decision to introduce Sean to a particular A.A. group there in Jacksonville of predominantly Jewish men led to the inner experience/realization that Sean credits with saving his life.

Before moving to Sean's report of his successful A.A. experience, it is helpful to note Ursula's experience of prayer at her moment of rock bottom desperation, noting similarities and differences between the two participants' reports. Ursula, as opposed to the other five participants, became aware of her destructive alcoholic behavior while still in late adolescence. Similar to Sean, Ursula found herself unable to stop drinking by any method, facing homelessness and the destruction of many elements of her life and relationships.

So this is where my spiritual experience really starts, is because I prayed for the first time. I don't know why I prayed in that moment. I was an atheist. I don't pray, but I was like, "Dear God, help me," you know? I guess because – when I read this in The Big Book, it's the only reason that ever made sense. It's like, deep down in every man, woman, and child is the fundamental idea of God, you know? As a – as atheist as I was, theoretically and in my brain – like intellectually, I was like, "I'm atheist. I will fight you to the death. I will argue about it." Deep down, I knew that my human power was not enough, but it need – what was going on needed to change. So I prayed. And it could've been more of calling out to nothingness, but I did – like, but it did. And it wasn't some long, drawn out, like the Lord's Prayer. It was just like, "I need fucking help, God."

While the experience of inner division and firm atheistic beliefs is strikingly similar to Sean's experience, Ursula's framing of her prayer experience is markedly different from Sean's framing of his prayer experience.

Yeah, everything changed that day. Yeah, I think that it – that is – that's grace, you know? What I mean by grace is unmerited favor, like, I did nothing to deserve those ideas occurring in my brain. And they had never occurred before, so it wasn't like – it was something like spontaneous ideas coming from a place that was not normal within me, that was not normal Ursula thoughts or behaviors or – you know what I mean? It was very spontaneous, other – from outside of me – thoughts that were coming into my brain, you know? Like, "Pray," or, "He said you need help. He's right. Why don't you call that person who has been going to AA?" What?

For Ursula, divine agency is credited with putting ideas “into” her “brain” – which she then frames through a relatively sophisticated Christian theological lens of grace. Soon after her rock-bottom prayer experience, Ursula attended her first A.A. meeting. Her initial response to the 12-step model was starkly opposite to Sean’s response to his first meeting. Not only did Ursula report that she was immediately receptive to nearly all suggestions and precepts presented to her, but like prayer, she also retrospectively framed the experience in Christian theological terms.

So I went to my first meeting and things changed – [*snaps fingers*] – like this. I mean, that's how it happens, and I look back at it now and I see, like, that is the essence of a spiritual experience, you know? Immediately, all of my ideals and all of my motivations in life and all of my conceptions of what the world were, were immediately replaced with something else. So my ideas of, "I need to be getting drunk, I have to avoid myself, I have to avoid others, I can't trust myself or others," you know, those were my core beliefs – that's who I was – was immediately replaced with all of these things that I was learning in The Rooms like, "Go to meetings. Don't drink today. Get a sponsor. Call that sponsor. Read literature. Do all the things that it takes to stay sober." And I don't think I had the feeling, like faith, the feeling that I was having a spiritual experience, but now that I look back at it, that's what it was.

Despite the suddenness and immediacy Ursula retrospectively described her spiritual experience, she distinguished this from the “slow” pace of her development of a sense of her Higher Power, which she thinks began around the time she reached Step 4²⁶:

²⁶ In A.A. Big Book chapter 5, “How it Works,” the twelve steps are named as follows: “

1. We admitted we were powerless over alcohol—that our lives had become unmanageable.
2. Came to believe that a Power greater than ourselves could restore us to sanity.
3. Made a decision to turn our will and our lives over to the care of God as we understood Him.
4. Made a searching and fearless moral inventory of ourselves.
5. Admitted to God, to ourselves, and to another human being the exact nature of our wrongs.
6. Were entirely ready to have God remove all these defects of character.
7. Humbly asked Him to remove our shortcomings.
8. Made a list of all persons we had harmed, and became willing to make amends to them all.
9. Made direct amends to such people wherever possible, except when to do so would injure them or others.
10. Continued to take personal inventory and when we were wrong promptly admitted it.
11. Sought through prayer and meditation to improve our conscious contact with God as we understood Him, praying only for knowledge of His will for us and the power to carry that out.
12. Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics, and to practice these principles in all our affairs” (Alcoholics Anonymous, 1955, p. 59).

When I did my four step for the first time, I undid years and years of denial and lies that I had told myself, and slowly, in there, a Higher Power crept in. It wasn't something from me – I mean, like I said, my spiritual experience was like a very sudden thing. Suddenly, things had changed, but I didn't realize that that's what had happened, so it seemed more of a educational variety spiritual experience²⁷, and I did it the old-fashioned way by just working the steps and going to meetings and being of service and doing what I was told because I was so – you come at this program, if you're a real alcoholic and you really hit bottom, you come at the program like a – with all the desperation of a drowning man. You do everything that you're told to do 'cause it was that or kill myself, or I was gonna end up killing myself slowly with alcohol. So, slowly, a Higher Power crept in – and they say, "The great fact is just this." I've had – I have a God consciousness now that I know that a Higher Power has entered my life and does things, you know, helped me to be sober, helped me to get rid of so many bad, bad habits, character defects, and learned to live my life in a way that I would not have been able to do on my own... I had tried all the other things.

Ursula's report of her receptive attitude toward the people and precepts she encountered in her first A.A. meeting is similar to Sean's report of his immediate feeling of transformation in the A.A. group that he views as saving his life in the eleventh hour of his recovery. As noted above, many important elements distinguish the spiritual and religious characteristics of Sean's and Ursula's experiences of surrender to a Higher Power, most notably that Ursula retrospectively views her entire journey through the lens of spirituality (with some Christian theological constructs), while Sean retrospectively views his journey through relational, psycho-social, cognitive behavioral, and neuroscientific frames.

Sean's description of his first encounter of the Jewish men of the Jacksonville A.A. group generally mirrors his presentation in the play of these encounters.

They were just ... happened to be a bunch of Jewish guys who had started their own gathering of just men, and they traveled. They met twice a week. They traveled and had these huge meals at different places. It's Florida. I grew up in Florida, which is like southern New York. So they weren't particularly...that wasn't the doctrine of who they were. They were still an AA group. They were just a bunch of guys who happened to be Jewish. That really formed their way of going about it...So they would also have meetings at the rehab facility, people who had graduated would come back and talk. So

²⁷ A reference to William James, in the Big Book, also cited by Connie.

then they sat me down and they were so excited to explain all of the science aspect of it to me. So every time I would come, they would tell me more about science.

“Science” was the most salient term for Sean, referring to particular theories of neurochemical mechanisms as they relate to alcoholism. Sean incorporated the most important mechanisms into the script of his play, with characters “Lenny” and “Stuart” serving to tell the story of his most important conversations with members of the group:

LENNY: Here’s the truth - Dopamine is the chemical that when it’s released in your brain, you feel great. The drug that’s been in your brain since you were born.

STUART: Your brain is always trying to maintain balance, and therefore the more you drink, the less dopamine your brain releases.

LENNY: Your brain is with you all the times you snuck a drink, so when you say...

STUART: “I’m quitting, I really mean it this time...really!”

LENNY: Your brain doesn’t believe you. So, on Day 2 of sobriety you have no alcohol and no dopamine from your brain, because it’s sure the alcohol is coming.

STUART: So, you feel terrible.

LENNY: Your body is signaling you that it needs you to hold up your end of the current destructive bargain.

STUART: So terrible.

LENNY: That spiritual awakening most drunks feel around Day 90 when they look up and suddenly the sky is bluer and everything seems like it’s gonna work out, and they get on their knees and thank god -- that’s chemistry.

STUART: That’s your brain FINALLY believing you that you won’t drink and therefore it releases chemicals into your brain to maintain balance.

LENNY: Yes, you will walk out the door and suddenly feel light and notice trees and children and feel happy to be alive, and that MAY be god, but it is definitely chemistry. Just stop drinking for 90 days and let science save your life.

...LENNY: Don’t worry kid -- most people are dopamine junkies -- they just think it’s free will.

...LENNY: So, to stay sober, you have to fight your own brain. Fight chemistry with reason.

STUART: Train yourself to have healthy Pavlovian responses that follow your unhealthy Pavlovian responses.

SEAN: Oh. My. Fucking. God. Slash. Science. And I do. I think about science, a lot, a day at a time (sometimes an hour or minute at a time) and I make it to Day 71. And when in trouble I think about science some more, try to picture what is happening in my brain... (Daniels, 2016, p. 94-95)

Further observations and analysis about Sean’s employment of neuroscientific theories of addiction will follow in the next section. For the purposes of this section, the notable finding is

Sean's construction of Higher Power. In Sean's monologue near the end of the play, he names "Science" as his Higher Power, and proposes several reasons why this formulation of Higher Power allowed him to maintain sobriety when other methods had failed:

SEAN: People ask me, why did it stick that time? It was the first time it was chemistry and science and not shame and weakness. I believed in something larger than myself. My higher power is: science. It's my faith in science that keeps me sober. Though it seems to work for the vast majority, and I never try to talk anybody out of it -- ever ever ever - it does make you think, how many people are like me, and then don't make it because we lead with God and not with science? Does belief in one exclude the other? After years of Mormonism, I may never again be able to do organized religion... (Daniels, 2016, p. 97-98)

For Sean, "science" is sufficiently powerful, explanatory, and trustworthy. Now having access to a Higher Power of sorts, Sean feels freed from his negative experiences of organized religion, as well as the moral model of addiction by "science" in a way he was unable to find in any traditionally spiritual or social formulation of Higher Power. Notable also is Sean's suggestion that his construction of science as a Higher Power, and more traditionally theological constructions of Higher Power may not be mutually exclusive. This openness continues in the second half Sean's closing monologue:

SEAN:....but I have seen lame men walk and blind men see. There's a story in the bible that used to make angry, but now it's my favorite. After God tested Job, and punished him, and destroyed his friends and family – because Job never lost faith, God gave him everything back, not the same things and people he had before, but a new family and new friends and a new life. A better one we're told. Alcoholism is the same for me. If I don't drink, I can have it all back. Not the same. But I can have it all back. And it is a better one. (Daniels, 2016, p. 98)

At several junctures, Sean named social dynamics that were present with this Jewish A.A. men's group that were strikingly different than any of his previous experiences:

I went to the first meeting, and it was like straight out of central casting...first of all, there was tons of food, it was very funny, they had a sense of humor, there was a water buffalo hat that whoever was running the meeting had to wear like Fred Flintstone.

In addition to fun and food, Sean noted in the play that the men encouraged him to ask questions, to push back on their proposals, which he found deeply appealing. These descriptions contrast sharply with the “Republican” and “conservative Christian” people Sean reported meeting at all other junctures of his recovery. Sean connected his ability to surrender to a Higher Power with the example he felt the men presented him as fellow “successful business people,” allowing him to integrate his identity as a theatre director with his identity as an alcoholic needing to admit vulnerability:

I don’t even know that I fully understand it now, but the whole surrender to when, or the idea or once you admit that you’re defeated, then you can put it back together. I think I couldn’t wrap my head around that, and really not until I found other successful business people who were trying to get sober kind of clock into this, because I felt that being a director is so based on being in charge of the room and letting people know that you’re confident, and kind of faking these things. So the idea of admitting that I didn’t know what was going on or what it was beaten or that I couldn’t do this felt like really separate from the experience I was going through.

At the time of our interview, Sean had recently celebrated his fifth year of sobriety, and he noted some other transformations that seemed gradual and ongoing. Notably, Sean reported more distance from his former identity as an atheist, and more affinity for the position of Britt: “Over time, I guess I have fallen for Britt’s thing, because I’m not religious, but I am now agnostic, which is to say I don’t know.” In another moment, Sean volunteered even more “belief”:

I think I do believe in spirituality now, and I feel like there are things outside of my knowledge that I can’t fully comprehend, so it could be true, it could not be true... I think I’m much more tolerant and just like...and because I don’t really belong to any religion, I can pick the parts of it that I like and that I want to be.

This comment, offered almost as an amendment at the end of the interview, was Sean’s only description of what could be interpreted as overt, deliberate spiritual belief of some sort, though it is nevertheless notable.

In conclusion: all participants consistently reported the surrender to a higher authority, of some sort, was necessary in order for them to sustain their sobriety. Within this finding were three more minor patterns that differentiated the participants' accounts from one another: a) Connie's and Karl's lack of struggle with the "God part" of Higher Power, b) the need for both Navarro and Barry to release previous theological concepts before surrendering to new understanding of Higher Power, and c) the way in which, Sean and Ursula, as atheists, struggled with transcendent belief of any kind as they worked to construct a sense of Higher Power to which they might surrender.

Finding #2: Higher valuing and use of the BDMA in younger participants

The most surprising overall finding of this project was the high priority, as expressed by the three youngest participants (Sean, Barry, and Ursula), placed upon the task of integrating neuroscientific etiologies of addiction (the BDMA) alongside more traditional spiritual, moral-model, and older medical-model etiologies. Differences emerged between the reports of these three participants: the reasons why they directed so much attention toward what they all saw as a split in model types (internal desires versus external contextual pressures), the aspects they each found most important, the extent to which traditional "disease concept" 12-step models harmonized with more neuroscientific theories, and what etiological models and methods they recommended as helpful for those struggling with the first stages of recovery. But overall, a striking similarity remained that distinguished the younger half of the participants: the attention each of them devoted to the task of understanding medical models of addiction, and the BDMA.

Sean: "My higher power is: Science. It's my faith in Science that keeps me sober." In the previous section, description of the findings of Sean's construction of and surrender to the Higher Power of his understanding ("science") necessitated a basic sketch of Sean's experience integrating neuroscientific theory into his self-understanding of alcoholism. This section presents further findings about Sean's construction of multiplicity based on his experiences of inner division.

Sean's encounter with the Jewish men's A.A. group in Jacksonville was not his first encounter with medical models of addiction. When hospitalized, Sean recalled the physicians who treated him in the detox unit speaking frankly about the physical effects of his abuse of alcohol. However, Sean's experience of their approach and the data they presented to him were in stark opposition to his transformative experience later with the Jewish men's A.A. group.

When I was hospitalized, it was all based on, "We ran liver function tests, we did a brain scan, we did these things. You are starting to cause irreparable damage to your body. You've got stomach problems. So if you don't quit drinking, all of these things will get worse." Which was true, but I already knew that I had to stop drinking on some level...They were trying to scare me straight, and it was like, if I could have stopped, I would have. I could not. It only added to my, "Of course. I don't want to die. I don't want to cause brain damage."... I knew the damage it could do. That only made it worse, because I was a little unsure then how three days later, I was drinking again.

It seems that the depth of distortion that Sean reported about his thinking, entirely common for anyone approaching end-stage alcoholism, allowed him to reject the medical counsel he received when hospitalized, on the illogical premise that if he was physically capable of consuming alcohol, then the damage to his body could not be as grave as they suggested. Setting aside further analysis at this juncture, the finding to be observed here is the enormous difference Sean felt between the medical model counsel he received (pre-recovery) in the hospital, which he remembers as based on physiological and neurological damage, as opposed to the explanation of neurological mechanisms that he received (in early recovery, at the end of rehab) in the Jewish

men's A.A. group. In the play, Sean's character declares to the new group, "I have been to detox, 4 weeks of rehab, alcohol counseling, and hundreds of AA meeting -- and I have never EVER heard any of this mentioned before" (Daniels, 2016, p. 94). Similarly, Sean reported as a participant in this study:

But it wasn't framed [that way] until I met the Jewish guys, "Here's how your brain is operating. Here are the things that are out of your control." So for me, that was the key in terms of finding science...No one ever explained, "It's not in your control. This is the way that your brain is set up." So nobody had ever walked me through that...I had been to detox. I had been to countless meetings. I had taken alcohol training courses as required when you get an aggravated DUI in Kentucky. None of this had come up. It had always been religion. It had always been like if you had believed in God hard enough, you could do it.

Critical to the neuroscientific account, for Sean, was his release from a sense of failure.

Cognitive mechanism, for Sean, was not something for which he was at risk of failing to have, as was the case with adequate belief. Furthermore, cognitive mechanism (or "chemistry" as Sean often referred to it) was separate from his "will power," separate even from his personhood. "Chemistry" was something to understand and manage, which worked well with what Sean named as his identity as a theater director and his self-perception as someone capable of achieving success by learning more and trying harder:

I have to realize, "Oh, that's just chemistry. That's not like my self-will failing me. That's not me being not as strong as I am on other days when it didn't occur to me as much."...for the first time I didn't feel like a real failure, like I wasn't a personal letdown, that I had not been able to do these things, that it was chemical, that it was predisposed, that there were other things going on, not just that my self-will wasn't strong enough... At that point, I realized that, "Oh, my self-will was what I'd been counting on all this time." Every time that I got a couple days, I was like, "If I just try harder this time, I'll do it."...So when it didn't work out, I felt that much more that I'm a failure, because I was just relying on me. Everything else in my life up to that point, if I had put my mind to it, I had done it. I'm a very obsessive workhorse of a person.

Sean gave several examples of the way his perception of his actions and feelings transformed, affecting all parts of his life.

I began to read as much as I could and be a part of it. It was really easy to do. I still do this. Sometimes you wake up in the morning and you get in the shower, and you just feel like the world is against you, and then you're like, "Wait, actually, nothing happened to do that," and you're like, "I'm just chemically low on dopamine at this moment." So it's like, "Great. I know what that is." So I'm able to call it and name it.

Like most persons experiencing severe addiction of any kind, Sean felt bewildered and disturbed by the "not-me" aspect of his behaviors while in the throes of alcoholism:

I do remember all these times I was laying in bed, and then next thing I knew, I was putting on my clothes and going out, because I knew the liquor store closed at 2:00, and I probably didn't have enough to get through the evening and the next morning. It wasn't even like...I just felt like the next thing I knew, I was dressed and there...So you've rewired your brain to know we have to have enough alcohol in the house before 2:00 in the morning, because 2:00 to 10:00 is the one time in the day that we can't get it. I think like that made me feel so much better, just that I wasn't out of control and watching myself from afar.

Many of Sean's accounts revealed a dualistic construction of his self-agency in opposition to his "brain," an external yet internal, even alien, entity with agency, intention, goals, and beliefs all "its" own.

[Learning] about neuropathways, how your brain begins to learn your activities. So the example they used is you can get up in the morning and you can get dressed for work, and you can kind of make it to work, and really until some car pulls in front of you, you don't really wake up. Your brain goes on autopilot. Your brain wants the dopamine all the time. So the brain can actually rewire itself to make you do things that will eventually get it dopamine.

In addition to what "your brain wants," Sean offered many descriptions of the sorts of inner dialogue he experiences as himself in conflict with his "brain". In describing how confounded he previously felt by behavior and thinking that "didn't make any sense," Sean described how learning the way in which his "b-*-----rain equalizes dopamine experiences" offered him clarity:

...your brain doesn't believe you because your brain was always there every time you had a relapse. So you can say, "I'm stopping," and your brain says, "Sure." Really not until day 90 does your brain adjust its chemistry in any way, so it just sucks for the first 90 days... Your brain doesn't want to overload you with dopamine if more is coming. I

don't think about "should I have a drink?", and then remember "I was suicidal!" I think, "should I have a drink?" and I remember how much fun it was. That's instantly the thing my brain puts forward. I have to, then, right away force myself to remember how it was.

Even now, I'll get in a big fight with my wife, and I'll think, "I just want to drink to burn it all down." Then it's just like, "No, I'm just being self-destructive. I'm just thinking of the most self-destructive thing I can do," which isn't really... I'm not really close to drinking. My brain still flashes that in my mind as a thing that could work, but I kind of trained myself to have Pavlovian responses, so it's like I know that, then I'm like, "Nope. I don't. That's just my brain putting that there. I don't really have to do that."

Sometimes instead of "my brain" Sean would refer to his experience of the "not-me" yet still internal forces of addiction as "my body":

I was staying with my mom afterwards to try to get sober and try to stay sober, part of what the big thing was that I knew that every day around 4:00 to 6:00, which is happy hour time, I would get cravings really bad. So I could feel them, and that's a chemical reflex. That's just that my body has been trained to expect that around 4:00, it will get its daily dose. So I have to go walk her dog within an inch of its life.

The night preceding our interview, Sean experienced relapse dreams. He employs phrases like "my subconscious," "just a dream," and "just chemistry working in my brain," and "just anxiety":

So I think science for me, and I still think about it all the time in moments of stress or moments of whatever it is. Even to last night, I had two big relapse dreams, which I don't have that often anymore, but still somewhere in my subconscious, is... one dream was I had been drinking for a couple days, and I was hiding it, and then another dream was I had started drinking again, but I had stopped for a couple days and I was hiding it. So you wake up and you feel guilty, you feel weird, you feel sweaty. So when you realize it's just a dream, and I have to clock that as, that's just chemistry working in my brain. I can get through, that's just anxiety. My wife was trying to quit smoking, so I think that was just in the house.

As will be explored further in Chapter 5, Sean's experience is an interesting portrait of a conglomeration of anthropologies and self-understandings that comprise contemporary Western epistemologies. But more important than that, it is a picture of the wide variety of ways of self-understanding that might save the life of addict, as it did Sean.

Ursula: Medical and spiritual models are separate, but are mutually reinforcing rather than in conflict. While Sean experienced a generally internal motivation to reconcile or integrate spiritual and medical-model etiologies of addiction, Ursula and Barry felt more externally/contextually-related motivations for such tasks. For Ursula, medical-model and neuroscientific accounts of addiction did not emerge in our interview until she turned our conversation to her observations as an addiction counselor. Though, as noted earlier in this section, Ursula's understanding of both prayer and grace included multiple references to her "brain," Ursula's framing of the "how" and "why" of her addiction and recovery was almost entirely spiritual in terms of phrasing and epistemology. Following her account of her own story of recovery, Ursula first raised the issue of her sense of division between "spiritual malady" and "brain disease of your neural pathways" when I asked her about her personal view of the nature of addiction:

Well, have you ever heard people talk about it being a seeking? So it's like a fundamental lack of God, right, or of innate connectedness to others. Of fundamental emptiness that people – and it's beyond just drugs and alcohol. I mean, you can try to fill that fundamental emptiness with shopping or sex or gambling or overeating or over-exercising or anything, any obsession outside of yourself that will try to make you feel whole, but it's an incompleteness. Spiritual malady, I think, is really the innate thing that we all have in common. You know, working in the field, there's a lot of – I kind of have to separate my opinions out of what best practice and what science says is addiction, where it's like, "Okay, it's a brain disease of your neural pathways have developed in this certain way for your reward system to work," and I think of it more of a spiritual thing. I wouldn't say that to a client. I might – well, I might, depending on the situation. But I really think that's what it is, it's a – I feel like I was born into this world broken-hearted. You know, that term, "spiritual malady," I had a spiritual malady that I had to fix somehow, and for whatever reason, didn't fix it with the direct source, which is a Higher Power, but fixed it with the only best way I knew how, was to self-medicate myself with drugs and alcohol. Once I found it, it was like, "This is what I've been looking for."

In terms of Ursula's engagement of her clients, the treatment center in which she works has a "behavior-based" model, counseling its clients with a combination of cognitive behavioral models and 12-step meeting attendance. Such a model is generally representative of most North

American treatment and rehabilitative center models that are approved by insurance companies.

Ursula described how neuroscientific theories of addiction and recovery feature in her very first conversations with her clients:

I talk a lot about how we have neural pathways...because it's easy for me to understand and it's easy for them to understand, how if you have engrained a certain behavior over and over, that the nerves become stronger and more nerves in that one area, from, "I drive past this road, I get high, and then I get dopamine and I feel good," right? So then driving past this road is, then, therefore, a trigger because it leads to this because of your neural pathways. And then you're trying to work on a lighter neural pathway that's like, "I drive past this road, I call my sponsor."...And also, talking about how they have to work on creating the health of their brain because it's been damaged and they're not gonna have natural rewards that people get. You know, they've depleted all of that – the dopamine and serotonin, all that stuff in their brain, they've depleted it, and explaining that probably, because you're in early sobriety, you're a low spot.

It is notable, though perhaps not surprising, that neuroscientific etiologies of addiction are considered the safest, most understandable, and least controversial entryways into conversations with new clients. Ursula described the “hand model” she uses with clients. She held up her fist, thumb enclosed in her fingers, with the underside of her wrist facing forward. For the “brain stem,” she gestured towards her wrist, while other brain components were represented by different parts of her fist.

I also use a hand model a lot. So this is your prefrontal cortex, the frontal cortex, cortex, midbrain, brainstem here. So this is very reptilian brain that really just kind of – the midbrain – or the – excuse me, the brain stem is very survival stuff. Then the midbrain is very like, "This is good. This is bad." Pain and not pain. And then this is all rational thinking, and how we damage this part of our brain in our using – and especially like me and you used from so young, it's like, the time where this prefrontal cortex is supposed to be developing that's in charge of all rational thought, like thinking things through, showing up for places on – being an adult, really, lies here. You damage that so much and you really live in this good and bad area, the midbrain, that's a very – kind of like a dog, you know? Like punishment and reward. And you learn that drugs are the ultimate reward, and it goes, in the reptilian brain, even above things like food, water, shelter, sex. It's like, drugs. It's like, "I need this to survive," type of thing, because it releases the dopamine in your reward pathway that would be normally released for things like food, water, shelter, sex. All of that gets – I mean, you release so much dopamine from using that it's not even comparable to having a nice meal. It's not in the same ballpark. So it becomes the ultimate survival thing, where that reward pathway was developed for us to

survive, you know? And we've hijacked it. And so – *[sighs]* – slowly working on the midbrain, and also, developing that cortex in the pre – and kind of living in that prefrontal cortex of working with mindfulness and being grounded, connections with other people, and really just taking actions, do the right thing. "Do the next right thing."

In terms of models of selfhood, Ursula's neuroscientific account suggests that the damage effected by addiction diminishes one's humanness (in which rationality is prized), as well as echoing much of the narrative of dopamine and reward pathways to which Sean was attracted.

In terms of holding together potentially the conflicting etiologies of addiction (spiritual and medical), Ursula expressed clarity about four aspects. First, because of role appropriateness and because of varying client perspectives, Ursula strictly separates the models she presents as an addiction counselor as opposed to serving as an A.A. sponsor.

I'm not gonna tell somebody just coming in who's an atheist, as their addiction counselor, "You have a spiritual malady and you need God." I'll talk about, "Well, okay, so you're having these behaviors," and use – a modality I use often is called motivational interviewing and I'll try to see where they're at and if they have any desire or want or need to move forward and kind of work out of that and just kind of normalize and relate. It's different being a sponsor, because being a sponsor, I can say, "You need to pray." And as a counselor, it's more like, "You need to call your sponsor," who will then tell them they're gonna need to pray, hopefully, you know?... Like, the DSM doesn't talk about a spiritual malady in any way. It's [the DSM is] like, "These are the behaviors that you exhibit. It's these symptoms. Is it mild, moderate, or severe?"...So, coming at it from a very clinical way, I can't be like, "You have a spiritual malady and that is your diagnosis," you know? I don't diagnose people, but it's a fine line because I am an addiction counselor and not a sponsor, so how I would talk to a sponsee would be about the spiritual program of action and the spiritual malady that caused the alcoholism. And how I talk to a client would be more behavior-based and more life skills-based, more action-focused.

Ursula would see it as unhelpful and inappropriate to express her views of the spiritual characteristics of recovery to a client identifying as atheist. Moreover, even if a client identifies with more spiritual models of addiction and recovery, Ursula would still see telling a client to pray as inappropriate given her role as counselor. The second way in which Ursula is clear

about the division of medical models and spiritual models of addiction and recovery is her perspective that though the models are separate, they are not in conflict with one another.

They don't really clash because you find that all of the things that we've found with neuroscience of addiction and then the solutions to that, the behavioral solutions to that, are very in line with what we already intuitively do in AA. But I think the God piece is missing, you know? That's what's missing within a very scientific approach to addiction, is that, for me, I needed that God piece. I still do to this day.

For Ursula, the “neuroscience of addiction” explains why the methods of 12-step programs are effective. Thus, rather than conflicting with one another, the models use different, partially sufficient language to describe phenomena. For Ursula, the “scientific approach” is ultimately insufficiently explanatory, since it lacks what she refers to as the “God piece.” Despite this conviction, Ursula’s third clarity about the division of models is that she does not believe that a person recovering from addiction must necessarily understand addiction as spiritual brokenness in order to recover. However, she does believe “it’s easier for those of us” who “get” the spiritual aspects of addiction and recovery, because “on a spiritual plane,” the action steps of recovery do not seem as counter-intuitive as they will otherwise:

It's easier to take all the right actions and to do what you're told and to not struggle – like, to struggle with the ideas – if you're trying to intellectualize it a lot, you're gonna struggle in this program because it doesn't make – a lot of this stuff doesn't make sense intellectually. I mean, now they're starting to come up with the way that the brain works and lining up with it so you can – I can sometimes explain it intellectually, how it works, but most of the time, the way this program works – like, look at the 12 steps. You're like, "I'm addicted. You want me to do these things and then I'm gonna be better? Like, what the f – hell is that? What is that? That doesn't make any sense," intellectually. But on a spiritual plane, it makes perfect sense, like basic spiritual ideals. So I think people who are struggling with the idea of it being a spiritual thing or it needing a spiritual solution to a spiritual problem, people who struggle with that idea and who have to tackle it intellectually, it makes it harder because you're dealing with a lot of ambivalence and rationalization and justification in your brain, and for me, that makes it hard for me to take action when I'm in that state of change where I'm just like, "I don't know. Do I want to do this? Do I not want to do this? Why would it work?" When I'm asking myself all these questions, it paralyzes me from changing, from taking actions.

Ursula repeatedly distinguished between those of her clients who are able to operate on a “spiritual plane” and those “who have to tackle it intellectually.” Her fourth and final observation on the matter of this division of etiological models was Ursula’s clarity on the unhelpfulness of making addiction and recovery into “an issue of morality.” She named the damage such moral models of addiction have within the public sphere and judicial systems, and sees the supposed legitimizing of addiction as a “brain disease” vis-à-vis the DSM as a possible solution:

It's not an issue of morality. Because it comes up – it appears as though that it is an issue of morality. I mean, it's a brain disease, you know? And beyond that, if you go even further, it's a brain disease, but it's something that is seriously a psychological brokenness about a human being. It's a sad thing, and to try to bring in some empathy rather than it being a moral, "You are a bad person," very black and white, not empathetic way that we deal with addiction, especially in the judicial system which I think is – there's a movement toward that, but I think more just working with the science – the medical community and the judicial community to talk about the fact that it is a brain disease. Because I think a lot of the time – you would think that the newest science about how it is a brain disease, you know? It's in the DSM, I mean, come on, this is a disease – that medical professionals would know about that, but they don't. It's surprising that most medical – I mean, if you're not directly correlated to the field of addiction and – you're not gonna know about this stuff. You have no reason, really, to learn about it. You might have a couple hours in medical school learning about this, but...

It is worth noting that this perspective of Ursula’s is different from Sean’s observation that spiritual models of recovery are shame-based (at least in part), in that failure to recovery means one has failed to have adequate belief in God. Ursula’s and Sean’s perspectives overlap in the way in which “brain disease” releases the addict from “fault”, at least to some extent.

Barry: “My prefrontal cortex” had to “heal,” “but you don’t hear about it in the Big Book.” Like Ursula and Sean, Barry necessarily expended significant energy and attention in holding together understandings of addiction that were “scientific” versus “12-step oriented.” After several attempts to maintain sobriety, Barry found success after his near-death car crash

(flipped his car at 113 miles per hour) and his subsequent brief imprisonment and lengthy (498 hours) court-ordered outpatient treatment sentence. As noted above, Barry's etiology of addiction (like Ursula) is spiritually based:

This is just my opinion and belief...[addiction] exists in some degree or another in all of us as humans longing to fill a hole....I found myself latched onto, in this case, a substance both physically, which perpetuated itself because I was addicted physically but also mentally and spiritually because that's what was my landing ground for coping with everything else in life.

Also essential to Barry's understanding of addiction and recovery is a medical-model understanding with substantial helping of neuroscientific theory. Barry described how he was able to sustain sobriety because his "brain also healed":

But the coin didn't really flip until my brain also healed. You might have heard that how the prefrontal cortex gets all messed up from long term alcohol use. It doesn't really actually begin to heal, my understanding is until six months after the last drink. And funny enough that part is responsible for our sense of consequences and actions and all that.

Barry views himself as fortunate (rather than burdened by) the dual models he was presented with while in treatment:

Usually people just see one teacher or the other. Well, I had the best of both worlds. I had Dr. Jason Perry who had a doctorate in, I think it may be addiction studies or something, and [he] wasn't a 12-step person. Then I had Levi, who was a 12-step guy, 22 years over, from I guess crack cocaine. So the presentations were very different. One was from a very sometimes scientific from Dr. Perry. And the other was very 12-step oriented, behavioral type oriented. That's where I started to learn about the physiology and also understanding that my liver actually does literally process ethanol, which is alcohol that ethanol the drug differently and it breaks it down different chemically than the "normal liver"...for some reason when [alcoholics] take that first drink they are defenseless and the phenomenon of craving...becomes paramount to any other thing in life. For me, like from Dr. Perry's angle, I understood, began to understand that when alcohol my liver it breaks down in acetone types of sugars and things that in turn actually produce a new chemical or a type of amphetamine affect. And hence, you have the people who are "alcoholics" who when everyone else is passed out, they're like, "Let's keep going."²⁸

²⁸ Dr. Perry and Levi are pseudonyms.

Like Sean, Barry benefitted from instruction about how his physiology was “chemically different” from other “normal” people. Like Ursula, Barry saw the models (“presentations”) as distinct from one another, but not conflicting. At one point, Barry distinguished 12-step programs (“formal, moral psychology”) from medical model etiological components like “50% of it’s genetic” and “pre-frontal cortex”:

So when I’m armed with the facts about myself, both in how to arrest the process of addiction, the cycle, or put it in remission, but also understanding that bodily and mentally there are some differences. 50% of it’s genetic. That’s probably where I also learned about the prefrontal cortex. But I’m not by any means an expert. I’m just, that helped me understand. And you don’t hear about it in the big book because the 12-step program is focused on a formal, moral psychology in a sense that being the fastest way to buy someone time to heal, even though it’s funny in the big book they will make references to how this person is bodily and mentally different.

It is worth noting that Barry associates the word “moral” with the 12-step model, in contrast with Ursula’s eschewing of the word “moral” and its attendant associations of shame. While Barry reported feeling deeply appreciative of his exposure to what he called “the best of both worlds” from his two types of “teachers” – a 12-step approach and an addiction science approach – Barry made a point of noting he thinks too much “science” is not helpful for a “newcomer” in the first stages of recovery:

Now I love getting into the other stuff...that gets into more of a chemistry lesson with how alcohol interacts with my liver and all that. But when you’re talking to a newcomer, all that stuff that’s going to turn into clouds...You have to reach down at a gut wrenching level, something that will get their attention because everything else is just knowledge that can’t really be used at that time.

In his framing of the “how” and “why” of addiction and recovery, Barry clearly valued being educated about relevant neurological and biological processes. Notably, “how alcohol interacts with my liver” is grouped with understanding that “my brain” and “pre-frontal cortex” needed to “get healed.” Barry’s perspective and experience contrast with those of Sean, who reported that information about neurological mechanism and the dynamics of dopamine as it relates to

alcoholism was entirely different and exponentially more critical to his ability to surrender and transform sufficiently to sustain sobriety.

From Ursula's "hand model" of the neurological aspects of addiction, to Sean's reports of inner multiplicity understood through a framing of his "brain" as a "not-me" aspect of himself, to Barry's integrating of his "two kinds of teachers" of 12-step and addiction science, all three of the younger participants of this study volunteered extensive reports of the importance of medical modeling of addiction etiologies in their own recovery. Ursula, Sean and Barry differed in the directions from which they felt compelled to such tasks of integration. For Sean, the pressure came from within; all other models felt inadequate, until he was introduced to a form of "science" to which he could surrender as his Higher Power. For Ursula and Barry, outer forces (Ursula's job as addiction counselor, Barry's court-mandated two types of counseling) introduced more contemporary neuroscientific theories of addiction and recovery. The three participants also differed in the extent to which they integrated the traditional "disease concept" 12-step models as in harmony with more neuroscientific theories, and in their recommendations for what is most helpful for those struggling through the first stages of recovery. Overall, however, the divide between the younger three and the older three participants is the most remarkable of findings.

Finding #3: Lower valuing and use of neuro-turn concepts in older participants

It is not the case that the three older participants did not mention medical-model addiction etiologies within their accounts of their recovery, but references to "brain chemistry" or neuroscience were far fewer and less pronounced. Instead, for Navarro, Connie and Karl, the

traditional disease concept of alcoholism and addiction featured more prominently than any references to neuroscientific theories. Furthermore, all three participants explicitly volunteered the importance of relinquishing the impossible project of resolving paradoxes of addiction and recovery, such as “spirituality and science.”

Navarro: “My prayer and meditation” to deal with “my factory settings”. For Navarro, a sense of internal mechanism persists through his descriptions of his experience and understanding of addiction and recovery, but distinguishing between “physical allergy,” “obsession,” “disease of the mind,” and “factory settings” was not a necessary task for Navarro. In describing how he speaks generally about alcoholism with peers or colleagues unfamiliar with its dynamics, Navarro uses “obsession” and “physical allergy”:

They [AA] tell me that it is a disease of the mind... I agree. I think that alcohol just makes it worse. I mean, there's a physical allergy, because one of the reasons I talk to people that are not in the program and we have friends that are trying to get sober. They drink too much, and people that haven't been addicted or haven't dealt with addiction, I hear them making comments like, “Why doesn't he just stop?” And I go, “Because he can't.” “What do you mean, they can't?” And I said, “You can't.” I said, “You have an obsession. You have a physical allergy,” I said, “but you have an obsession of the mind. You just have to have it....And they ask me, “How do you know that you're an alcoholic?” And I said, “Because I had that obsession.” I said, “I vividly remember having that obsession. I vividly remember looking at a bottle of red wine and salivating.”

For Navarro, the “obsession” he experiences is best described by a phrase he used many times in describing his experience of addiction and recovery: “factory settings.” He describes the ways in which his participation in 12-step programs revealed to him his tendency towards rigidity, and his difficulties with experiencing emotions:

I call 'em “factory settings,” where...somebody might come up with an idea, and my first reaction is to push back. Why? Because it wasn't my idea. It doesn't matter that it might be a good idea. It wasn't my idea. It's like, ‘No, I'm not doing that.’ But before, I used to actually react. I'd actually go and say, “No, I'm not doing that. That's ridiculous.” Now, in my head I'd go, “I'm not doing that,” but I don't say anything. I keep my mouth shut and

let it sink in, and then I start thinking about it...When I was actively drinking...there was a lot of emotion. I mean, my life was ruled by emotions; everything was emotion. You knew when I was pissed off. You knew when I was happy; when I was sad. I mean, that was it. There was no pulse. Now there's a pulse. Now... I was told by my sponsor and people in the program, "Those emotions are fine. It's fine to feel those emotions. It's fine to be happy. It's fine to be upset. What is not fine is to act out on them – that is what is not fine." But... I didn't have that pulse button before I entered recovery.

In addition to living a "life ruled by emotions" before recovery, Navarro described feeling amazed at the logic he remembers inventing to justify his irrational and destructive behavior while drinking. Similar to Sean, who described internal dialogue with his "brain" which attempted to generate logical arguments in the service of consuming alcohol, Navarro recalled how his "brain" rationalized his continuing drink, even in the moment he sat in jail, convicted of driving under the influence of alcohol.

I didn't think I had a problem, but I said, "This other guy has a problem. He has four [DUIs]. This is mine, and I was a borderline case." And you know how the brain starts to justify your behavior. A lot of the things that I didn't know until I came into recovery is just how we justify behavior; how selfish and self-centered we are.

Navarro spoke frequently about the dangerous habits of thought he experiences as part of his "factory settings." Similar to Connie, who used the word "insane" or "insanity" nine times in 70 minutes when describing thinking of herself and other alcoholics before recovery, Navarro sees such self-destructive irrationality as a defining component of alcoholism and addiction:

I have a girlfriend that I share sometimes what goes in between my ears. She lets me talk and then she turns around and she goes, "You tell yourself a lot of shit, don't you?" *[Laughter]* And I said, "And that is the problem. That right there is alcoholism, or addiction."

To manage the "lot of shit" that Navarro's "factory settings" will generate if left unattended, Navarro described the importance of attending 12-step meetings, and also his daily practice of morning prayer and meditation. Navarro reported that without the practice, he immediately

observes the return of unhelpful mental habits, because of how “conditioned” his “brain” and his “behavior” seem:

If I get up, I jump in the shower, get dressed, and walk out of the house, then by 10, 11 o'clock in the morning, I just feel like I'm reactionary again, like my factory settings are taking over and it's like, "What the heck?" And I go, "Oh, shoot, I didn't do my prayer and meditation today...I try to stay involved in the program as much as I can. It just keeps me in the mind. It keeps my factory settings away, which is the whole purpose of doing this, because when I allow the factory – I mean, they immediately go back. I mean, it's unbelievable how conditioned your behavior, your brain is, to think that way.

Clearly, terms like “brain” are important for Navarro’s self-understanding, but overall, as noted above, his etiology of addiction and recovery is based on a traditional mix of the disease concept of alcoholism and the spiritual approaches typical of 12-step programs.

Karl: My “allergy” is the struggle between me, God, and “the demons”. For Karl, neuroscientific theories of addiction and recovery featured even less prominently than for Navarro. “The biggest thing I've learned is the substance, it doesn't matter,” said Karl. “The substance is just what is used to comfort.” The physiological aspect of addiction is certainly real, but for Karl, “emotional state of mind” and “spiritual state of mind” are distinct from “physical,” which is like an allergy:

I think the physical part of [addiction] is just like anybody who's allergic to shrimp or who's allergic to strawberries or who's allergic to peanuts. There's something that happens when I put a substance – mind or mood altering substance – in my body that's physical; it's purely physical. The deal is, though, it's the emotional state of mind, it's my spiritual state of mind that allows me to pick that up. And as long as I'm working on that spiritual state of mind that allows me to pick that up, then I'm good. But if I stop working on that, then I slip. That's called a slip.

Identifying as an alcoholic and drug addict, with nearly three decades of sobriety and many dozens of sponsees, Karl spoke at length about the wreckage caused by addiction, and his experience with the hope and power of working the 12 steps. At one point, Karl described the

inner struggle with addiction as a pull between self, God, and the “demons” of addiction, all subjects with agency and power, as opposed to the substances themselves, which are mere objects.

[F]irst step, honesty; second step, hope; third step, faith, believing in God. The fourth step is courage, facing that stuff. It's facing it. So the faith moves me to courage, you know. It's not believing in me. It's believing in God, which says that if I really believe in God, I'm ready to challenge these demons. They're real demons. You know, alcohol and all is – alcohol and drugs is a substance; it's something that I am physically – physically have a reaction to. But the demons that lead me to 'em are the ones that I will eventually have to face. And I can't face those alone. I can trust God to get me through that. That's why they're demons.

In another moment, Karl shared a way in which he understands his inner experience of God, as well as his limitations and the limitations of others through the frame of a popular conception about typical neurological activity.

When I was growing up, I hung around with people who did stuff I did. Now I don't hang around with people who did stuff that I did, so I get different information. I like it like this. You know they say that we only use ten percent of our brain. There's a whole 'nother 90 percent that we don't use. To me, that's that God part to me. I don't know if God's in the brain or anything. He's probably not...But if I use my ten percent to the best of my ability, and then use somebody else's ten percent 'cause somebody else's ten percent might be just one percent different or nine percent different than mine – or something like that – in between the collective information of people trying to do the same thing, which is to stay sober, live a productive life, and be helpful and happy and all that, then I'm gonna get the information, and that will change me.

Other than these snippets, the experiences and perspectives Karl shared were completely devoid of terms like “brain” or references neurological mechanism of any kind.

Connie: “Don’t get too burnt out” about “defining alcoholism” or “God stuff”. In telling her own story of recovery and her understanding of addiction, Connie’s testimony echoed much of Karl’s testimony, in terms of the absence of neuro-turn terms. The predominant explanatory terms Connie used to describe alcoholism and addiction were “insane” and

“insanity” (as noted above), and also “it’s a mental illness” and “mental obsession.” She also noted genetic predisposition as an important aspect. Connie described first drinking in high school with a close-knit group of ten friends with whom she still keeps in contact. Connie noted that “it’s interesting to me” that of that group of ten “who drank steadily together, I was the only alcoholic.” She noted the mysterious but consistent physiological effect of alcohol:

I think once I put alcohol in my body, it triggers something. I don't understand exactly what it is, but it triggers something, it's like I have to have another one. And then another, and then another.... I don't know which comes first, the chicken or the egg.

At another point, Connie delineated between willpower and the “insanity” of alcoholism:

I think that it's not willpower, because I probably have more willpower than the average bird... there's some genetic predisposition – like I said, my father's alcoholic, my three brothers died as a result of alcohol in some way... And people say it's not how much you drink, it's not how often you drink, it's not what you drink, it's not who you drink with – it's what happens to you when you drink, right? And I know, in my heart of hearts, that no sane person would poison themselves the way I poisoned myself, and then the minute I was able to reach for another one, do it again. That's insane. That's insane.

In sharing her story of recovery, Connie recalled when she was hospitalized, and confronted by a doctor:

The doctor who treated me at the hospital was an alcoholic himself – he was recovered, of course – his name was Dr. Capps. When I had my discharge, whatever, consultation, he said, "Do you know what your blood alcohol content was when you came in here?" I said, "No." He said, "It was 3.85, and people die in gutters with that kind of blood alcohol. I don't know why your mind is still good – your body's in a hell of a shape, but I don't know why your mind is still good – your liver's awful, but it will recover if you let it. And if you're half as goddam serious as you act like you are, you will go to a minimum of 15 meetings of week." [Since then] I have never heard anybody tell anybody to go to 15 meetings a week! *[Laughs]*

Except for the possible use of the word “mind” above (though even here, she is quoting a physician, rather than herself), Connie was the only participant of this study who did not use any concepts related to neuroscientific theories of addiction, nor any neurological terms in describing her experience of herself, nor even the word “brain.” At the conclusion of our conversation, I

introduced the topic by beginning to describe a popular newspaper article, to which Connie quickly responded:

KGK (interviewer): In *The New York Times*, last summer, there was an article – it was in, like, the top ten most clicked-on articles in *The New York Times* online ...it basically said that, you know, all this stuff, everything we know about alcoholism and addiction, it can now be explained neuroscientifically. And I'm wondering what –

Connie: First thing I'd say is, "Bullshit." *[Laughs]* No, I mean, really, I just, I think that there is something in me that is genetic, some predisposition, right? But again, how are you going to define alcoholism?

Connie went on to describe examples of utterly illogical and self-destructive behavior, noting how “unexplainable” it was. This was a pragmatic point on which Karl, Connie, and Navarro were in clear agreement, both in terms of pursuing the “how” and “why” of addiction, and in terms of completely “getting” the “God stuff.” Connie shared how she typically responds to newcomers struggling with the concept of a Higher Power:

I tell people all the time, “Don't get too burnt out about this God stuff, at first, because it'll just drive you crazy that you're not good enough, right? Don't get all whooped up about that. Don't take all that stuff so seriously.” To me, the point is, “I can't do this by myself; I am not that powerful.”

Similarly, Karl reported that he advises newcomers to A.A. and N.A. who are struggling with the concept of Higher Power to focus on their actions, on the “next right thing”:

They say trust God, clean house, and help somebody... The only thing I tell people that I work with is don't drink, go to meetings, call somebody when you need to, keep in contact and keep close.

Navarro articulated a similarly pragmatic approach in response to medical models of addiction:

[I]n recovery, they talk about being born with it – if it was genetical or if you just - I don't know. I don't know that it matters. Once you have it, you have it. And if you don't do something about it, I do truly believe what you hear in the rooms is that you're either going to end up in an institution or you're going to end up dead.

For all three participants, it is the decision to surrender to a Higher Power and to work the steps that supersedes any other explanations or theoretical frameworks for addiction and recovery.

However, on this point of the working the steps, Karl was careful to distinguish between his “right actions” and the “grace of God”:

It's real simple. It's repetitive. It's real simple. But I have to do it every day. I have to do it every day because I've seen people – and it's not – you know, this is a – one thing I learned about is paradoxes. It's not – you know, they say, ‘I have to do this every day,’ but I've seen people do it every day and still go out. You know? Because it's God that keeps me sober one day at a time. I know I do these actions. I know right actions and all that. But right actions just are that: they're just that. But there's nothing above the grace of God. Nothing above the grace of God.

In summary, the findings of this study are that the older three participants did not show nearly the amount of concern or interest in terms like “my brain chemistry” and “prefrontal cortex” and “neuropathways” as were reported by the three younger participants. For the three older participants, medical-model addiction etiologies certainly arose, but with far fewer references to “brain chemistry” or neuroscience. Instead, the traditional disease concept of alcoholism and addiction featured more prominently.

Chapter 5: Discussion

The increasing prevalence of the brain disease model of addiction (BDMA) represents a significant shift in medical and popular discourse of addiction. In light of the findings of this interpretive phenomenological analysis, along with the relevant literature, it is the conclusion of this study that BDMA engenders a more buffered account of the self than the disease model of addiction. It is also evident from the study that the BDMA accounts for changed conditions of belief for those struggling with addiction who find it necessary to incorporate S/R characteristics into their recovery. The discussion of these findings is presented in three movements. The first movement is a discussion of Charles Taylor's theory of buffered self (and attending theoretical components) as it relates to addiction and recovery. The second movement is an analysis of BDMA as engendering a more buffered account of self than the disease model of addiction. The third movement is an explication of how those struggling to overcome addiction within the cultural context of BDMA's dominance, and who also find surrendering to a Higher Power (or other S/R characteristics) to be a necessary part of their recovery, face different conditions of belief.

Following these analytic movements, the discussion moves to the conclusion of this study, which is then followed by a presentation of the study's limitations, and implications for further research, teaching pedagogy, and practices of care.

Analysis: BDMA engenders a more buffered account of the self than the disease model, "and it matters"

Charles Taylor's theory of buffered self as it relates to addiction and recovery. Thinking historically about the kind of pre-reflective self-conceptions that stage our human experience as Western moderns, particularly via components of Charles Taylor's theories of secularity as they pertain to what he calls anthropomorphic shifts (2007, p. 221), illuminates how contemporary accounts of addiction are clustered around a dichotomy of moral failure and illness. In particular, buffered self—a guiding anthropology underlying Western experience in modernity—helps illuminate the fundamental dynamics that make a brain disease model of addiction attractive as a medical narrative and hence alter conditions of belief.

Taylor distinguishes his “sense” of secularity from previously identified theories of secularity, which he groups into two sorts of “senses.” A first sense (S1) of secularity involves the departure of religion from public spaces (politics, the marketplace, science, the arts) (Taylor, 2007, p. 2). A second sense (S2) of secularity is more personal, involving the inevitable waning of religious belief and practice as a consequence of modernity (Taylor, 2007, p. 3-4). In both of these senses, Taylor points to the ways in which they are actually “subtraction stories” which fail to account for how secularity is produced, not simply distilled, and which cannot account for the “very exigent demands of universal justice and benevolence which characterize modern humanism” (2007, p. 572). In contrast to “S1” and “S2” is Taylor's third “background” sense of the secular, referred to as “S3,” which creates particular *conditions of belief* and shared context of understanding, and which also shapes both belief and “unbelief.” Taylor sees us having shifted from a context in which belief in God is unchallenged and unproblematic, to a context in which such belief is understood as one of many options. Crucially, whether or not a person consciously identifies as holding a belief, it is a shared pre-ontological condition of life in our time to have awareness of the multiple *options* of belief. For Taylor, the primary features of S3

are the awareness that any belief is always one option among many and that exclusive humanism becomes an option. Exclusive humanism, a worldview that accounts for meaning and significance without any reference to transcendent entities, is “accepting no final goals beyond human flourishing, nor any allegiance to anything else beyond this flourishing” (Taylor, 2007, p. 18). Again, it is critical to note that Taylor is talking about the kind of pre-reflective self-conceptions that stage our human experience as Western moderns.

I want to emphasize that I am talking about our *sense* of things. I’m not talking about what people believe. Many still hold that the universe is created by God, that in some sense it is governed by his Providence. What I am talking about is the way the universe is spontaneously imagined, and therefore experienced. (Taylor, 2007, p. 325)

Taylor is not talking about a change in theories, or a shift in beliefs – but rather, our background assumptions, our “*feel*” of our world.

Taylor’s phenomenology of secularism includes a comprehensive historical construction of our “sensed context in which we develop our beliefs” (Taylor, 2007, p 549), showing that it did not emerge as “a force that assaulted religion from without; it did not suddenly appear from modernity; it was not contrived by Enlightenment rationalists; and it did not entirely happen willy-nilly as the result of capitalism. Its history is at least partly -- perhaps mostly -- a history of spiritual motives” (Warner, Van Antwerpen, & Calhoun, 2010). The resulting modern moral order, a distinctly Christian achievement, included “training in a disciplined, sober, industrious life,” imposed by elites of success “imposing the order they sought on themselves and society.” Thus, in a profound sense, at pre-ontological, non-optional level, the human experience of anyone living in Western modernity, regardless of beliefs or principles, includes the expectation that one should, and may hope to, master one’s inner experience, including one’s desires, now charged with theological significance. The capacity to stand outside of belief and “religion” is the result of long-standing projects and spiritual dilemmas (including questions of sin, will, and

agency) which Taylor links back to various reform movements within Western Christianity which gave rise to what he calls a *buffering of the self*.

No longer porous or vulnerable to the transcendent or the demonic, the ideal self is an anthropocentric agent, buffered from forces that seem to be outside the individual as well as forces that seem to be inside:

The buffered self is the agent who no longer fears demons, spirits, magic forces. More radically these no longer impinge; they don't exist for him; whatever threat or other meaning they proffer don't "get to" him. (Taylor, 2007, p. 135)

The self is now radically reflexive, disciplining (as subject) its own passions (as objects).

Disease, then, is an example of a force that is internal but not identical to the self: I have feelings, desires, sensations, and ailments, but I am separate from those entities. Furthermore, I may expect that I may have mastery over them. When I fail to sense mastery, I employ my agency to "go to new experts, therapists, and doctors, who exercise the kind of control that is appropriate over blind and compulsive mechanisms" (Taylor, 2007, p. 620).²⁹ Sin becomes sickness – an immense hermeneutical shift that pits "spiritual" against "therapeutic." Taylor proposes that what has changed is not whether there is a place for pathology; rather, "the issue is whether one can speak of pathology alone" (Taylor, 2007, p. 622). Taylor diagnoses us with a profound anthropocentric turn.

Thus, in a profound sense, the pre-reflective context of anyone living in Western modernity, *regardless of beliefs or principles*, includes the expectation that one may master one's inner experience, including one's *desires*. Our age is distinctive for its secularization of our desires and its prizing of self-governance as a high and treasured good. In disrupting our assumption that our inner life "feels" like the inner life of people in other eras, Taylor calls

²⁹ Taylor names this primacy of healing and self-fulfillment the "triumph of the therapeutic."

attention to the historicized nature of our innermost senses of self and notes how deeply embedded these senses are within larger Western theological constructions.

Such valuing of self-mastery has dramatic implications for modern Western understandings of addiction. As buffered selves, our way of being ourselves in the world means we conceive of ourselves as subject and object: the object on which we work, and the subject from which we do that work. Since the buffered self (subject) expects to master its own desires (objects), it follows quite naturally that one should be able to govern and manage one's sensations, feelings, and emotional states with any available tools and strategies, including *substances*. Within this frame, addiction may only be sensibly comprehended in two ways: (1) as (moral) failure, on the part of the buffered self, to adequately master one's desires; and/or (2) as disease, which, although (like desire) a force internal but not identical to the self, is an organic "chemical" problem over which the addict is understandably powerless, and not (or less) responsible. In proposing the concept of "buffered self," Taylor does not propose resolution to the mind-body problems, or take sides in the debates. Rather, "buffered self" is a genealogy of the mind-body problem and its terms, rather than an answer to it.

Thus, it is the case that Taylor's historicized, pre-reflective category of buffered self names the contours of an anthropocentric turn that produced clustered understandings of addiction (and thus recovery) around these two poles of moral failure and disease.

BDMA as a more buffered account than the disease model of addiction. The findings of this study together with the review of the literature, seem to suggest that the transitions over the last decade of the twentieth century until now, from a disease model of addiction to a BDMA, involved a further intensified buffering of self, as indicated within Taylor's conceptual framing.

As presented in Chapter 2, the dominant popular and clinical Western models of addiction moved from a generally moral model (addiction as sin and moral depravity) in the nineteenth century temperance movements and Prohibition, to more medicalized nomenclature in the early twentieth century. With the growth of Alcoholics Anonymous came phrases like “spiritual malady” and “like an allergy” as explanations and etiologies for alcoholism. The concept of alcoholism as biological deficit was built upon and popularized by E. M. Jellinek and other architects of research and treatment centers, so that by the mid-twentieth century, the disease concept of alcoholism, along with narcotics and other substances of abuse, was established in the popular and clinical imagination. The most recent macro-level shift in Western standard parlance regarding addiction began in the late 1980’s, typified by the “This Is Your Brain on Drugs” television and print campaign (Cardona, 1997, p. 44) and Bill Moyers using the phrase “hijacked the brain” in PBS television series on addiction, based on Leshner’s landmark 1997 *Science* cover story, “Addiction is a brain disease, and it matters,” in which he argues that addictive drugs “hijack the reward centers of the brain” (p. 45). For the last three decades, the BDMA has increasingly dominated all other models, most evident in measures like research funding and media coverage.

This dominance was evident in the widely differing opinions, between study participants, about whether the BDMA should be introduced to individuals in their first days of recovery. For Ursula, “neural pathways” is among her very first discussion topic with clients new to recovery, implying the low chance of disagreement, given the BDMA’s wide cultural acceptance, and “because it's easy for me to understand and it's easy for them to understand.” Similarly, Sean insisted several times, in his play and as a study participant, that if the hospital clinicians who counseled him during detox had explained about reward pathways and the dynamics of

dopamine, rather than merely naming the destruction he was doing to his brain, his recovery might have happened much sooner. But Satel and Lilienfeld argue that, given the hegemony of the brain disease model of addiction, not much has changed in public discourse:

The familiar “This is your brain on drugs” is still with us (this slogan was created in 1987 by an American drug-prevention charity. To illustrate how drugs affect the brain, an egg [representing the brain] was cracked on a sizzling frying pan [representing drugs]. Result: fried brain). Nowadays, however, the brain itself often substitutes for the fried egg. (Satel & Lilienfeld, 2013, p. 3)

For Sean, the sizzling egg image was inadequate, but neural pathway explanatory models worked. Thus, perhaps part of the power of the BDMA model is the way in which agency is paradoxically retained in the more recent manifestations (e.g. colorful brain images). After all, as a model, a brain is self-like, with ability to respond, while a raw egg lacks such capacities. Contrary to Sean, Barry said that he did not think “a chemistry lesson” would be helpful to those who are “newcomers” to recovery since such information would only “turn into clouds” for those in the earliest stages of recovery. Despite their apparent disagreement, these opinions reflect a shared sense of cultural potency accompanying the BDMA. Whether they thought the model would be generally clarifying and convincing, or rather confusing and distracting, the perspectives expressed by all participants implied that the brain disease model of addiction carries major cultural authority.

The move from broadly and conventionally theological modeling of addiction (addiction as sin) to the “spiritual malady” and “allergy” of A.A. to the disease concept is a clear medicalization of a complex human phenomenon and an example of the ontological shifts of the Western sense of self that Taylor describes as “buffered self.” What is less obvious, however, is the shift from the disease model to the BDMA. However, the more “mind-centric” aspects of BDMA, as seen in the literature and in findings from this study, clearly show how BDMA is a

more buffered model than that of the disease concept of addiction. It is important to note that evaluating BDMA as more buffered than preceding models is not necessarily a positive or negative evaluation; what matters is that it is *different*. Given the cultural and historical location of addicts here and now, BDMA accurately reflects, at least, some aspects of the felt experience. As noted above, Campbell points out in her history of addiction science that “Expressive argots recursively feed into science: scientific theories affect how people interpret drug experiences, and users' reports in turn become research material” (2007, p. 1). Like every medical narrative, BDMA is both a product and a perpetuator of its context.

To be porous, for Taylor, is to be open to an *outside*, whether that outside is benevolent (a grace, a blessing), or malevolent (a curse, a possession) (Smith, 2014, p. 29). Before, “in the enchanted world, the line between personal agency and impersonal force was not at all clearly drawn” (Taylor, 2007, p. 32), but in disenchantment, the now buffered self has a “mind-centered” view of the world. Sean’s relating of his inner dialogue, since recovering thanks to the BDMA, is a significant illustration of the “mind-centered” nature of an ultra-buffered self. Sean found unbearable the thought of “talking to God,” his self-described “meta-snob” attempt at prayer in an excruciating moment of recovery, a struggle typical of a buffered self, that will be further analyzed in the following section. Now, in his “post-BDMA” experience of life in recovery, Sean describes a dualistic construction of his self-agency in opposition to his “brain,” an external yet internal, even alien, entity with agency, intention, goals, and beliefs all “its” own:

Sometimes you wake up in the morning and you get in the shower, and you just feel like the world is against you, and then you’re like, “Wait, actually, nothing happened to do that,” and you’re like, “I’m just chemically low on dopamine at this moment.” So it’s like, “Great. I know what that is.” So I’m able to call it and name it.

In addition to felt senses being understood as neurochemical mechanism, and thus separated as forces that are internal but not identical to self, Sean described his experience of his “brain” as having voice and intention:

So you can say, “I’m stopping,” and your brain says, “Sure.” Really not until day 90 does your brain adjust its chemistry in any way, so it just sucks for the first 90 days... Your brain doesn’t want to overload you with dopamine if more is coming. I don’t think about “should I have a drink?” and then remember “I was suicidal!” I think, “should I have a drink?” and I remember how much fun it was. That’s instantly the thing my brain puts forward. I have to, then, right away force myself to remember how it was.

Sean’s internal agential force, his “brain,” is a component of his experience of his self, and a part of the critical step of his recovery – learning about the BDMA – which he describes as saving his life. The disease model of addiction, on the other hand, does not place agency in quite the same way. To have an “allergy” is quite different from having a part of your brain that is working against you, speaking to you, with agency of its own. Addiction-as-brain-problem is a more buffered anthropology than addiction-as-disease. Given the hegemony of “the belief in brain-self consubstantiality” (Vidal, 2009, p. 7), the “reducibility of self to an organ of the body” (Vidal, 2009, p. 11) does not translate, in the neuro-turn, to anything nearly as completely as it does the brain. For Sean, a “disease” explanation seemed to feel too distant from the “me-but-not-me” experience of addiction; rather, he needed an explanation of his failure to self-master, and giving “autonomous order” to one’s own life is of the utmost importance to the buffered self.

Context of the BDMA changes conditions of belief for those in recovery. The heading for this analysis section of this chapter includes the phrase “and it matters,” a reference to the landmark journal article “Addiction is a brain disease, and it matters” (Leshner, 1997), often cited as the central source that helped reframe addiction as a brain disease best investigated by

neuroscientific research. In this spirit, one might say, “it matters” that the BDMA depends upon and perpetuates a more buffered self than a disease model of addiction, as explored above. This also “matters” for the conditions of belief for those seeking recovery from addiction.

In gaining a critical perspective on the dynamics of the neuro-turn as they relate to addiction and recovery, many scholars and scientists helpfully offer tools and insights. Lewis (2015), a leading voice in arguing for addiction as a learning disorder, carefully rejects the dichotomy between addiction as a deliberate choice and as a “brain disease” (or any sort of disease). Raikhel suggests that the BDMA is an attempt to resolve the unsettling (and less marketable) “conceptual chaos” of addiction, but that instead of seeing such disagreement as chaotic, we may instead see “the potential for a vibrant ‘epistemic pluralism,’ encompassing not only different research styles in neurobiology and the biosciences but also distinct approaches to psychoactive substances and addiction in the social sciences” (2015, p. 391). Nadeau (2014) is one example of a common type of plea, from the perspective of a physician: that we might resist the devaluing of “the contributions of non-medical health professionals in the treatment of addictions” (p. 23), that interdisciplinary and non-medical teams are valuable, that addiction is not just brain disease, and that no one can yet claim victory over the complexities of addiction. All this is helpful reflexivity. But neither Raikhel’s “epistemic pluralism” nor Nadeau’s “interdisciplinarity” for addiction models include any recognition of S/R characteristics or the possibility of valuable contributions from theology or religious studies. Furthermore, though Lewis, Vidal, and Satel and Lilienfeld all contribute meaningfully to deeper understandings of reductionistic conceptions of self that are reified in the BDMA, none have any interest in noting the exclusion of religious and spiritual characteristics that persist through the medical and social scientific literature. Thus, Taylor’s account of the buffered self becomes a singularly powerful

lens for seeing how S/R characteristics are differently shaped in a BDMA context for those seeking to recover from addiction. It is not only the case that “brainhood” collapses the complexities of mind. By more firmly buffering the sense of self, an even more mechanistic universe is implied, in which we are “utterly unmoved by the aura of desire” which is merely a set of “functional passions” which we must manage through “an ethic of rational control” (Taylor, 2007, p. 135-6). The buffered self is the product of the secularization of desire.

Perhaps the single most important theological shift, in the medicalization of addiction and the rise of the disease model of addiction, was the practice initiated by Alcoholics Anonymous of naming a Higher Power. Of critical importance (and of great interest to the theologians and scholars of religion who have studied 12-step practices) is that A.A. maintained that one’s “Higher Power” and “God as we understood him” was to be self-defined by each member. As Karl describes, “We don’t care what you call it. You can call it God. You can call it a doorknob. You can call it whatever it is.” That we may all have “our own thing” (in terms of S/R identity) is all but taken for granted in contemporary Western discourse, but Taylor points to the way in which this pluralization (2007, p. 300) is a highly produced and historically novel orientation. Some examples of the processes and elements of Reform³⁰ that led to pluralization are: more inward and intense personal devotion, salvation as accessible to all by faith, and sanctification as an inner process (Taylor, 2007, p. 79). This pluralization has created both a greater fragility of belief, and also a homogenizing effect, until differences (such as how you define Higher Power, as compared to how I define Higher Power) seem less foreign, and eventually, seem less important.

³⁰ For Taylor, “Reform” is an umbrella term for three centuries (1450-1750) of late medieval/early modern movements he sees as the beginning of modernity (which built upon long-standing trajectories rooted in the so-called axial age): Renaissance humanism, the scientific revolution, the rise of the “police state,” and the Reformation.

Now, in the context of the neuro-turn, not only may we construct meaning and significance without any reference to the divine or transcendence, the sense of *geist-in-a-box* or “inner” spirituality may be mechanized; spirituality, much like “empathy” or “love,” might be neurochemically explained. It does not seem to much matter if science can yet find evidence for or explain such mechanisms – in the social imaginary, it is the *possibility* that matters. Thus, when (as previously noted in Chapter 4) a close confidante of Sean’s suggested a “workaround” Higher Power concept that functioned for him, Sean found the whole notion utterly untenable:

I have a great friend [in rehab] who I was talking to during it, and he said...he picked “the ocean” as his thing, because the ocean is bigger and more powerful than him. But I just felt like I didn’t know. I’m giving up my power to the ocean? I just couldn’t wrap my head around any of it.

In Sean’s moment of desperate prayer, it is notable that his buffering was so firm as to make it, even when faced with death, untenable and literally unimaginable (which, for Taylor, is arguably a more subterranean layer than “unbelievable”) to consent to the possibility of a force or entity beyond the immanent sphere. The inner dialogue Sean describes is similar to the inner dialogue he later refers to as being between himself and his “brain” when it is trying to convince him to pick up a drink.

I was praying and I was like, “What are you doing? You don’t believe in this.” This was a real moment of despair, because I was like, “Who are you praying to? You don’t...this doesn’t make any sense. You’re trying to say, ‘God help me,’ and I don’t believe in God. I don’t believe in these things.”

Instead, as has already been explored, Sean finds his Higher Power through the BDMA as explained by a particular A.A. fellowship he encountered in his last days of rehabilitation. The dialogue of Sean’s play quite perfectly illustrates the conditions of belief in the contemporary secular age: the constant awareness of unbelief that accompanies belief, and vice versa:

LENNY: That spiritual awakening most drunks feel around Day 90 when they look up and suddenly the sky is bluer and everything seems like it's gonna work out, and they get on their knees and thank god -- that's chemistry.

STUART: That's your brain FINALLY believing you that you won't drink and therefore it releases chemicals into your brain to maintain balance.

LENNY: Yes, you will walk out the door and suddenly feel light and notice trees and children and feel happy to be alive, and that MAY be god, but it is definitely chemistry. Just stop drinking for 90 days and let science save your life.

To believe it is "god" is also to know that it is possible to believe instead that it is "chemistry," with the reverse also being true. In this way, becoming porous is not the same as going "back" to a pre-buffered self. For Taylor, the "process of disenchantment is irreversible" (2011, p. 287), and becoming porous always carries a "haunting" of buffering.

It continues to be the case that surrender of some kind, to a higher power of some sort, persists as important for many people seeking to recover from addiction. Paradoxically, this practice is widely reported as empowering, rather than disempowering, for the person in recovery. Mullins (2010) published in a psychoanalytic studies journal about his own experience of the paradox of surrender, echoing the typical account: "I now know that the only person I can change is myself, and I can only do that with the help of my Higher Power...I now know that I am not compelled to do anything. I do things by choice, even though my choices may not always be best" (Mullins, 2010, p. 160). To experience surrender to a Higher Power as empowering is not a new development in the history of 12-step practices, but the increased intensity of the critiques that reduce the practice (Bufe & Peele, 1998; Dodes, 1990, 1996, 2014; Lewis, 2015; Glaser, 2015; Szalavitz, 2016) is a change that seems to have accompanied the rise of the BDMA. Thus, the change in the conditions of belief for those in recovery, in the context of the BDMA, includes broader suspicion of and more widespread reductionist understandings of what it means to surrender, and thus have belief in, a Higher Power of any kind. As the concept of spiritual/religious belief becomes less and less familiar, it seems unsurprising that the

complexities and paradoxes of what it means to surrender to a Higher Power also become less commonly understood.

Conclusion

My analysis of the findings of this qualitative study, alongside a sprawling expanse of literature, highlights the critical importance of attending to how people in recovery construct their experience of addiction, and what language they use to describe the etiology of addiction in general. Taylor's insights on secularity, particularly his notion of the buffered self, offer significant resources for illuminating how individuals in recovery make meaning of their experience of addiction, both in relation to spirituality and religion, and in relation to the cultural turn to neuroscience.

The shift from the disease model of addiction to the *brain* disease model of addiction matters for those in recovery, not only because it further medicalizes the experience of addiction, with little or no scientific consensus or evidence for doing so, but also because it even more firmly engenders a sense of buffered self, a model of a more mechanistic, agential, and mind-centered anthropology, in which the self is insulated from the transcendent and demonic, and also from one's own desires. When addiction is understood to be sourced in one's brain, along with many other emotions and affective experiences, the self is even further reduced to a sort of rational manager.

Attending to, even helping ignite, what individuals in recovery *imagine is possible* seems key in responding to addiction in the context of the neurological turn. Taylor's insights suggest that it may be increasingly difficult, given current trajectories, to imagine ourselves as porous, as

permeable and in-relation-with transcendent powers beyond ourselves. However, this does not necessarily mean a diminishment of the role S/R characteristics in experiences of recovery. To conclude that we are moving toward a post-religious future (or even that secular society is humanity-minus-religion) is to miss entirely the gifts of Taylor's insights, and the complex accounts of the experience of addiction from those in recovery. What seems to lie ahead is further fortified expectations, as buffered selves, that we may and should exert mastery over all our inner experiences, whether that be compassion, resentment, wonder or desire. This seems to be a recipe for disordered relationships with external substances that we might use to attempt to exert control over our affective states. But in the case of recovery from addiction, *imagining what is possible* might be more likely located in our mysterious-yet-partially-known neuromechanisms. For the buffered self, this imaginal leap, in regards to an external agential power, might be an example of the kind of spirituality that might save the life of someone struggling to experience or picture any force external to conflicting internal desires.

Limitations

This study inductively approached understanding how various persons in recovery from addiction experienced the role of spiritual and religious (S/R) characteristics within their recovery, given the context of the BDMA, utilizing the method of IPA. The chief methodological limitations of this study were in regards to data collection. For instance, all six participants had generally positive experiences (at one point or another) with 12-step programs. All named Christianity as the faith tradition with which they were most familiar, or in which they were

raised. While effective phenomenological studies have been completed with as few as three participants, a larger sample might have provided a more diverse pool of participants from which to gather data. Broadening the sample size to include, for instance, persons who consider themselves to be in long-term recovery, without ever confessing powerlessness or confessing faith in a Higher Power, would likely deepen understandings of the S/R characteristics in various recovery pathways.

Nevertheless, as noted above, this study did not seek to represent any population: various racial or ethnic identities, particular regions of the U.S., age groups, gender, levels of education, class identities, or life phases. While not opposing the value of general claims for larger populations, Smith and Osborn (2008) stated that IPA is concerned with complexity, process or novelty (p. 55), since this method employs an ideographic (rather than nomothetic) approach that "...is committed to the painstaking analysis of cases rather than jumping to generalizations" (p. 56). Additionally, the goal of this study was not meant to identify causal relationships, but to gain an in-depth understanding of how persons in recovery, in the contemporary context of the BDMA, make sense of their lived experience (Smith et al., 2009). The six participants engaged in this study make for an insufficient sample size to offer generalized findings.

Recommendations: examples of promising further research trajectories

Based on the findings and analysis of this study, many promising avenues for future research emerge in relationship to the S/R characteristics of recovery from addiction in the context of the BDMA. Given that the current prominence of the BDMA is necessarily accompanied by a more buffered account of the self than the previous disease model of

addiction, it seems likely that increasing (rather than decreasing) numbers of individuals seeking recovery from addiction via 12-step practices (the most geographically and financially available recovery pathway for North Americans) will find the “Higher Power” component to be insurmountable. Furthermore, as noted in the findings of this study, the 12-step approach of radical openness and flexibility as to how the person in recovery understands her/his Higher Power (“your Higher Power can be anything, the ocean, or even this doorknob”) has long been insufficient for some people struggling, like Sean did, to assent to belief in any sort of transcendent power.

An important example of a research trajectory built on the presumptions that “spirituality has a protective impact on addiction,” and that “mystical-neumatic and spiritually-induced experiences are helpful for dealing with addiction” but that “openness” to spirituality is an increasing problem (Ross, 2013), is the renaissance of studies on single-dose psilocybin-assisted treatment for alcohol dependence (Bogenschutz et al., 2015; Krebs & Johansen, 2012; Burdick & Adinoff, 2013). The use of psychedelics to treat addiction is an old concept receiving renewed interest and funding. Clinical use of psychedelic therapy for alcoholism began in Saskatchewan in 1953 (Bogenschutz, 2015) before that, the use of hallucinogens as a cure for alcoholism goes back at least as far as the Native American peyote cults and was reported by anthropologists as early as 1907 (Kurtz, 1999). Controversially, A.A. co-founder Bill Wilson experimented with LDS beginning in 1956, and strongly believed that LDS could serve as a useful tool within the context of AA for people who were having trouble establishing a spiritual experience (Bogenschutz, 2015; Cheever, 2004; Kurtz, 1999). In the 1960’s, following years of popularity and notoriety in the U.S., the chemical compound known as LSD was suppressed entirely, not only for use, but also for research of any kind. The all-encompassing federal research bans on

the compound and related entheogens marked an unprecedented level of taboo in modern science (Pollan 2015), betraying various cultural and political agendas that loomed at least as large as public concern about “bad trips.” The very recent resurgence of scientific research into and funding for entheogens and mystical experience evidences a notable turn. Exactly why and how such bans were loosened is a complex matter, but a major turning point came when Roland Griffiths, a leading researcher of drug-addiction and senior scholar in psychiatry and neuroscience, published in *Psychopharmacology* in 2006 the results of a landmark study, “Psilocybin can Occasion Mystical-Type Experiences Having Substantial and Sustained Personal Meaning and Spiritual Significance.” Since that time, Michael Bogenschutz (Professor of Psychiatry, NYU School of Medicine) and Steven Ross (also an NYU professor of psychiatry, as well as Director of the Division of Alcoholism and Drug Abuse at Bellevue Hospital) have been leaders in advocating for research into the ways in which psilocybin, as “a discrete pharmacologic event” might, in effect, help make more porous the worldviews and perceptions of self of those struggling with the S/R characteristics of the recovery pathways of 12-step programs. In conversations with Dr. Ross, it is clear the researchers are highly aware of the fraught, complex territory they face on many levels: how a drug-induced spiritual experience might be accepted, or not, by other members within 12-step communities, as a valid experience of another participant’s Higher Power; or how their colleagues in the field of addiction science, may or may not appreciate the use of psychedelics as an approach to managing alcohol dependence.

Such projects are worthwhile examples of the ways in which S/R characteristics, rather than being reduced to “only the social aspect” of 12-step fellowships, or otherwise explained away, are engaged as important aspects for many persons seeking to recover from addiction.

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APPENDIX A: Emory IRB Expedited Approval Letter

12/14/2016

<https://eresearch.emory.edu/Emory/Doc/0/NG4UTHBKA7K113644K8HGHA97/fromString.html>



EMORY
UNIVERSITY

Institutional Review Board

TO: Katharine Kime, M.Div.
Principal Investigator
GRS: Theology & College

DATE: December 14, 2016

RE: **Expedited Approval**

IRB00092298

Higher Power, Brain Power: An Interpretive Phenomenological Analysis of the Spiritual and Religious Characteristics Across Secular, Spiritual, and Religious 12-Step Recovery Models in the Context of the Neuro-Turn

Thank you for submitting a new application for this protocol. This research is eligible for expedited review under 45 CFR.46.110 and/or 21 CFR 56.110 because it poses minimal risk and fits the regulatory categories F[6] and [7] as set forth in the Federal Register. The Emory IRB reviewed it by expedited process on **12/10/2016** and granted approval effective from **12/13/2016** through **12/12/2017**. Thereafter, continuation of human subjects research activities requires the submission of a renewal application, which must be reviewed and approved by the IRB prior to the expiration date noted above. Please note carefully the following items with respect to this approval:

- A request to waive documentation of informed consent (i.e. signature) has been approved **AND**
- Please note that you are required to consent subjects with the verbal consent script approved with this submission, and document this consent process. Informed consent has not been waived; only the requirement for subject signature has been waived.

The following is a list of documents included in the IRB submission:

- Protocol Guidelines-Sociobehavioral KGKime v.2.docx
- KGKime SHB IRB Research Instrument.docx
- SHB-Patient-Information-Sheet KGKime v2.doc

Any reportable events (e.g., unanticipated problems involving risk to subjects or others, noncompliance, breaches of confidentiality, HIPAA violations, protocol deviations) must be reported to the IRB according to our Policies & Procedures at www.irb.emory.edu, immediately, promptly, or periodically. Be sure to check the reporting guidance and contact us if you have questions. Terms and conditions of sponsors, if any, also apply to reporting.

Before implementing any change to this protocol (including but not limited to sample size, informed consent, study design, you must submit an amendment request and secure IRB approval.

In future correspondence about this matter, please refer to the IRB file ID, name of the Principal Investigator, and study title. Thank you

12/14/2016

<https://eresearch.emory.edu/Emory/Doc/0/NG4UTHBKAF7K113644K8HGHA97/fromString.html>

[Anisha Easley](#)

Research Protocol Analyst

This letter has been digitally signed

CC: Kime Katharine GRS: Theology & College

There are no items to display

Emory University
1599 Clifton Road, 5th Floor - Atlanta, Georgia 30322
Tel: 404.712.0720 - Fax: 404.727.1358 - Email: irb@emory.edu - Web: <http://www.irb.emory.edu/>
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APPENDIX B: Emory IRB SHB Participant Information Sheet

Study No.: «ID»8

Emory University IRB
IRB use only

Document Approved On: «ApproveDate»

Emory University Research Study Information Sheet

Title: Higher Power, Brain Power: An Interpretive Phenomenological Analysis of the Spiritual and Religious Characteristics Across Secular, Spiritual, and Religious 12-Step Recovery Models in the Context of the Neuro-turn

Principal Investigator: Katharine (Katie) Givens Kime, M.Div., Graduate Division of Religion

Funding Source: N/A

Introduction

You are being asked to be in a research study. This form is designed to tell you everything you need to think about before you participate in the study. **It is entirely your choice. If you decide to take part, you can change your mind later on and withdraw from the research study.**

Before making your decision:

- Please carefully read this form or have it read to you.
- Please ask questions about anything that is not clear.

This information sheet is yours to keep. Feel free to take your time thinking about whether you would like to participate.

Study Overview

The purpose of this study is to explore the nature of the religious and spiritual characteristics of various recovery pathways of persons with substance use disorders.

Procedures

Each participant is interviewed twice by the principal investigator. Each semi-structured interview will last approximately 60-90 minutes.

Risks and Discomforts

The possible discomforts of participating in this study may be in recalling difficult past experiences as they relate to the participant's recovery journey. Each participant will already have some experience sharing his/her journey of recovery from addiction within the communities of care within which s/he participates, either in a group setting, and/or with a sponsor. The possible discomforts of this interview may be similar to such experiences.

Benefits

This study is not designed to benefit you directly. This study is designed to learn more about the experience of various recovery pathways. The study results may be used to help others in the future.

Compensation

You will not be offered payment for being in this study.

Other Options Outside this Study

If you decide not to enter this study, there is care available to you outside of this research. In being offered the opportunity to participate in this study, it is understood that you participate in a community of care in relation to your recovery. We will discuss additional care resources with you, should you wish to learn more.

Confidentiality

Certain offices and people other than the researchers may look at study records. Government agencies and Emory employees overseeing proper study conduct may look at your study records. These offices include the Office for Human Research Protections, the Emory Institutional Review Board, and the Emory Office of Research Compliance. Emory will keep any research records we create private to the extent we are required to do so by law. A study number rather than your name will be used on study records wherever possible. Your name and other facts that might point to you will not appear when we present this study or publish its results.

How will you protect my private information that you collect in this study?

Whenever possible, a study number, rather than your name, will be used on study records. Your name and other identifying information will not appear when we present or publish the study results.

Study records can be opened by court order. They also may be provided in response to a subpoena or a request for the production of documents.

Certain offices and people other than the researchers may look at study records, for example, Emory offices that are part of the Human Research Participant Protection Program and those that are involved in study administration. These include the IRB, Compliance Offices, and the Office for Clinical Research. Government agencies and study funders may also look at your study records.

Emory will keep any research records we create private to the extent we are required to do so by law. A study number rather than your name will be used on study records wherever possible. Your name and other facts that might point to you will not appear when we present this study or publish its results.

Voluntary Participation and Withdrawal from the Study

You have the right to leave a study at any time without penalty. You may refuse to answer any questions that you do not wish to answer. You may request that information you have provided not be used.

The researchers also have the right to stop your participation in this study without your consent if:

- They believe it is in your best interest;
- You were to object to any future changes that may be made in the study plan.

Contact Information

Contact Katie Givens Kime at 404-536-6314 or kkime@emory.edu.

- if you have any questions about this study or your part in it,
- if you have questions, concerns or complaints about the research

Contact the Emory Institutional Review Board at 404-712-0720 or 877-503-9797 or irb@emory.edu:

- if you have questions about your rights as a research participant.
- if you have questions, concerns or complaints about the research.
- You may also let the IRB know about your experience as a research participant through our Research Participant Survey at <http://www.surveymonkey.com/s/6ZDMW75>.

APPENDIX C: Introductory Email/Letter

Participant Recruitment Stage 1 (opportunistic method)

Template of email to be sent (individually) to Individuals #1 – 4

Greetings, [first name] :

I was pleased to meet you on [date, place, context], and I appreciated our brief conversation.

You inquired about the research project in which I am involved, and when I described it briefly, you suggested you might be interested in participating.

I invite you to take part in a research study of individuals in recovery from a substance use disorder, who have abstained from the substance of abuse for a minimum of five years, and meet the other criteria listed below.

The purpose of this study is to explore the nature of religious and spiritual characteristics in various recovery pathways of persons with substance use disorders. I am the researcher conducting this study, as a doctoral candidate at Emory University.

Any individual who meets all of the following criteria is invited to participate in this study:

- is in recovery from a substance use disorder (addiction to alcohol, narcotics, etc.)
- is five years sober/abstinent from the substance of abuse
- 18 years of age or older
- speaks English as a first language

- participates in a 12-step recovery fellowship of one (or more) of the following types:
 - a traditional spiritual 12-step fellowship, like Alcoholics Anonymous,
 - an explicitly religious 12-step fellowship, like Celebrate Recovery,
 - an explicitly secular 12-step fellowship, like S.O.S. or SMART Recovery.

If you agree to be in this study, you will be asked to:

- Meet with me (the researcher) for two individual interview sessions of 60 to 90 minutes each, during which your responses will be audio recorded
- Meet with me (the researcher) to confirm that the data collected in the interview process accurately conveys your experiences and the meanings you assign to them.

This study is voluntary. If you decide to join the study now, you can still change your mind during or after the study. You may stop at any time. There will be no payment for participation in this study.

Whether or not you are interested in the study, you are invited to pass this information to any individuals who fit these criteria and who you think might be interested in participating.

Any information you provide will be kept confidential. The researcher will not use your personal information for any purposes outside of this research project. The researcher will not include your name or anything else that could identify you in the study reports. You will be provided with an approved information sheet before any information will be requested.

I am happy to answer any questions you have; you may reply to this email, or you can call me at 404-536-6314.

Best Regards, Katie Givens Kime

Participant Recruitment Stage 2 (snowball method)

Template of email to be sent to individuals who have contacted me, interested in participating, having heard about my research through another recovery fellowship community member.

Greetings, [first name] :

Thank you for your email [or phone call]. I am glad [referral] connected us.

I invite you to take part in a research study of individuals in recovery from a substance use disorder, who have abstained from the substance of abuse for a minimum of five years, and meet the other criteria listed below.

The purpose of this study is to explore the nature of religious and spiritual characteristics in various recovery pathways of persons with substance use disorders. I am the researcher conducting this study, as a doctoral candidate at Emory University.

Any individual who meets all of the following criteria is invited to participate in this study:

- is in recovery from a substance use disorder (addiction to alcohol, narcotics, etc.)
- is five years sober/abstinent from the substance of abuse
- 18 years of age or older
- speaks English as a first language
- participates in a 12-step recovery fellowship of one (or more) of the following types:
 - a traditional spiritual 12-step fellowship, like Alcoholics Anonymous,
 - an explicitly religious 12-step fellowship, like Celebrate Recovery,
 - an explicitly secular 12-step fellowship, like S.O.S. or SMART Recovery.

If you agree to be in this study, you will be asked to:

- Meet with me (the researcher) for two individual interview sessions of 60 to 90 minutes each, during which your responses will be audio recorded
- Meet with me (the researcher) to confirm that the data collected in the interview process accurately conveys your experiences and the meanings you assign to them.

This study is voluntary. If you decide to join the study now, you can still change your mind during or after the study. You may stop at any time. There will be no payment for participation in this study.

Whether or not you are interested in the study, you are invited to pass this information to any individuals who fit these criteria and who you think might be interested in participating.

Any information you provide will be kept confidential. The researcher will not use your personal information for any purposes outside of this research project. The researcher will not include your name or anything else that could identify you in the study reports. You will be provided with an approved information sheet before any information will be requested.

I am happy to answer any questions you have; you may reply to this email, or you can call me at 404-536-6314.

Best Regards, Katie Givens Kime

APPENDIX D: Data Collection Instrument

SEMI-STRUCTURED INTERVIEW SCHEDULE #1³¹

(Adapted from Flaherty et. al. 2014, p. 340)

1. Please briefly share the story of your personal recovery from alcohol or other drug dependence.
2. Based on your own experience, how would you define addiction?
3. Based on your own experience, how would you define recovery?
4. Sometimes we use different words to describe something complicated, depending on the person to whom we are speaking.
 - a. How you might explain the nature of addiction and of recovery to your 7-year-old niece/nephew? What it is, what it feels like?
 - b. How you might explain the nature of addiction and of recovery to your primary physician? What it is, what it feels like?
 - c. How you might explain the nature of addiction and of recovery to a favorite elderly relative, perhaps a grandparent? What it is, what it feels like?
5. For you, when did recovery begin?
6. Were there specific moments, factors or acts that, for you, marked the beginning of your recovery?
7. What role, if any, did professional treatment or support play in your attaining recovery?
8. How have the relationships in your life changed as a result of your recovery?

³¹ Should Sean Daniels choose to participate, this interview would be amended to include questions about any differences between his “real-life” recovery and his recovery as dramatized in his play, as well as insights he gained when his play was performed for audiences of treatment facility patients in early stages of recovery from SUDs.

9. What role, if any, has helping others played in your recovery?
10. Have there been changes in the (kind or) frequency of your recovery support activities over the course of your recovery
11. Did “spirituality” play a role or importance in your recovery? If so, please share how or in what way.
12. Has the concept of a “Higher Power” been important to you? If so, how do you define Higher Power?
13. What has been most difficult for you in your recovery process?
14. What was most helpful to your beginning recovery?
15. What has been most helpful to you in maintaining your recovery?
16. Have there been recognizable stages within your recovery? If so, please describe them.
17. What role have others played in your recovery—positive or negative?
18. What things do you tell yourself that help you stay on track with your recovery?
19. What has been the response of other people (family, friends, coworkers, etc.) to your recovery and what have those responses meant to you?
20. What do you think everyone should know about addiction?
21. What do you think everyone should know about recovery?

SEMI-STRUCTURED INTERVIEW SCHEDULE #2

1. What was it like to look over that transcript of our last conversation?
2. Was there anything new you noticed about yourself or your recovery journey that you hadn't noticed before?
3. Anything you would like to change? Or add?
4. *If, up until this point, the concept of "my brain chemistry" or "neuroscience" or similar concepts/phrases have not been volunteered by the participant, then the interviewer will ask: have you heard in the news or from other people about neuroscientific discoveries possibly offering new insights about addiction? If yes, then: what are your thoughts on that?*
5. *Other follow-up questions as discerned by interviewer based on Interview #1.*