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DEGREE OF DOCTOR OF PHILOSOPHY IN PSYCHOLOGY**

BY
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A study of Psycho-spiritual approach to addiction treatment within the
controlled environment

Declaration

*I do hereby attest that I am the sole author of this project/thesis and that its contents are only the result of the readings and research I have done.
Permission has been obtained from persons and institutions mentioned to include their interviews and their case studies.*

Acknowledgements

First, I would like to express my gratitude to the creator and sustainer for granting me with meaningful opportunities to accompany many patients for the past 17 years in my work.

Many living human documents who taught me to patience, empathy and commitment 'stay back' with their deeply disturbing experiences.

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Abstract

Background:

It was in 2016, I first became fully aware of my genuine sense of interest, compassion and passion to contribute to those in addiction recovery program when I started associating with Promise Clinic in Singapore. Eventually I had many close encounters with many who struggled to 'move beyond the 'the controlled environment', I saw them battling with growing sense of shame and guilt an increasing their craving from the rising of the sun to the place where it sets. Addiction is a condition in which the body must have a drug to avoid physical and psychological withdrawal symptoms. Addiction's first stage is dependence, during which the search for a drug dominates an individual's life. An addict eventually develops tolerance, which forces the person to consume larger and larger doses of the drug to get the same effect. Addiction exerts a long and powerful influence on the brain that manifests in three distinct ways: craving for the object of addiction, loss of control over its use, and continuing involvement with it despite adverse consequences.

In the 1930s, when researchers first began to investigate the causes of addictive behaviour, they believed that people who developed addictions were somehow morally flawed or lacking in willpower. Overcoming addiction, they thought, involved punishing miscreants or, alternately, encouraging them to muster the will to break a habit.

The scientific consensus however has changed since then. Today we recognize addiction as a chronic disease that changes both brain structure and function. Just as cardiovascular disease damages the heart and diabetes impairs the pancreas, addiction hijacks the brain. This happens as the brain goes through a series of changes, beginning with recognition of pleasure and ending with a drive toward compulsive behaviour.

The behavioural manifestations and complications of addiction, due to impaired control, can include Impaired Control and Judgement Problems, Cognitive Changes & Emotional changes. I struggled well to convince myself of the title of the thesis. The quest in me to understand 'sense of God- awareness 'in every day life. I started my spiritual journey within the Anglican communion of my faith, while I found 'sense of direction' in my formative experience; I was not content with my 'gut experience'. I thought there was more to my orientation of faith and practice. This study in some way is a response to my growing debate of the deficiency of the traditional faith in addressing mental suffering as they came across to me. However, a new direction with an open heart, open mind and open door can be the beginning of therapeutic connection with a caregiver and the possibility of the meeting point between psychology and spirituality, which I believe, can bring about some harmony.

In my work with addicts, I have seen addicts going through the pleasure of addiction to the on going battle with 'fractured self to the loss of self respect to complete catastrophe. I have observed two serious conditions that mutilates them mentally, emotionally and spiritually. A deep sense of shame and guilt that overcrowd their vision. The primary objective of this study is to explore the efficacy of psycho-spiritual intervention to lift the addicts out of their stagnancy to walk through their recovery path.

I am curious and eager to understand the patterns of those in recovery, the masks they wear, many challenges and essential interventions required to break many barriers on the road to sober living. I aim to evaluate, reflect upon integrative therapeutic models and spiritual dimensions of psychotherapy, which I have incorporated into therapeutic work with those who had been through treatment program. I am drawing my insights, observations and learnings from those who had been under my direct care at the Rehab in South Africa and a relevant case study from Riverbend Counseling & Wellness, Winnipeg, Canada. I have conducted extensive telephonic discussions with Gerry, the senior Clinician who carried out the treatment and for whom I have been assigned to offer Clinical Supervision by the College of Registered Psychotherapists of Ontario, Canada for the recorded case study.

This study also discusses direct and indirect interaction among the disciplines such as the human suffering, study of unconsciousness, collective unconsciousness, archetypal materials, transpersonal mileages and reservoirs of spirituality. While enquiring various aspects of psycho-spiritual approach toward addiction treatment as an exploratory and supplementary path in recovery program, there is a conscious effort not to absolutize spiritual solutions for those who are suffering addiction, here by underlying my fundamental thinking that affirmation of one thing many not at the extreme cost of the denial of others. The final chapter comprises of a psycho-spiritual treatment planner in conjunction with the DSM V, which again has been an integral part of my philosophical approach in therapy and universally expected structure of therapeutic work with patients. In addition to treatment plan, I have included combination of relapse prevention plan and self-mental care tool for recovering addict with concurrent conditions can practice while progressing their treatment within any controlled environment.

In conclusion, this work aims to outline the fundamental need of self-awareness and personal growth for those are involved in treating addiction-related trauma. Healing of the past trauma must be integral part of the clinical training. I personally benefited from such an evolutionary approach in my training at the Christian Medical College & Hospital, Vellore, India and the residency program at the Blanton-Peale Clinic in New York founded by Norman Vincent Peale, the author of The Power of Positive Thinking. However, it is not mandatory to operate from morally and psychologically immune space in therapy, but an on going personal therapy and clinical supervision can come handy to deal with 'transference', which tends to hijack therapeutic alliance and obstruct recovery process of patient and the wellbeing of the therapist alike.

Hypothesis:

Drug and alcohol abuse blocks innate capacity for psychological and spiritual healing. Critical understanding and decoding of inner voices of shame and guilt for those battling for change.

Purpose of the Study:

This research will shed light on multifaceted framework of spirituality in clinical practice for sustainable recovery for addicts and their families. This research will also will discuss various theoretical formulations and treatment models.

Methodology:

The material for this thesis includes combination of literature reviews on spirituality and psychotherapy, direct observations of patients, reflection on the activities, both individually and collectively, casework evaluation of a fellow clinician and interviews of recovery coaches; open-ended questioner was used for the purpose. Key consideration are openness in which spiritual dimensions are generated which do or do not represent theoretical section. In particular, I am open to struggle consciously and unconsciously about the efficacy of the study and application psycho-spiritual approach toward treating addicts.

Introduction

What is addiction?

Addiction has had many descriptions over the years:

Chemical dependency - Learned behavior - Disease Health behavior Problem Substance use disorder. Many researchers, thinkers and clinicians have come to believe addiction is also spiritual disease. In my understanding, spirituality in clinical practice is not be compartmentalised, but to be viewed as an integral part of the recovery, hence I would like to work on the concept of psycho-spiritual intervention in addiction treatment.

In the DSM – 5, under the classification of mental health disorders, addiction is referred to as substance use disorder and addictive disorder. I have interacted with substance users since my days at the Christian Medical College & Hospital, Vellore, India, but addiction did not seem like 'life-break down for me those days, as an intern my focus was mainly on HIV conditions. Dual diagnosis was not a subject matter, but my first encounter with addiction as complex trauma terrified me during my tenure within the Psychiatry unit at the Vancouver General Hospital. I believe I have grown sufficiently to experience and relate to the trauma of addiction relatively better. It opened my eyes and generated passion towards the complex trauma of individuals, their family members and other stakeholders. I have created the diagram below based on my first hand experience with those who are fighting the battle of addiction and related conditions. In my initial assessment for admission, diagnosis and treatment plan with many addicts uncovered the history of their complex trauma as I sat there to pick up many broken pieces.

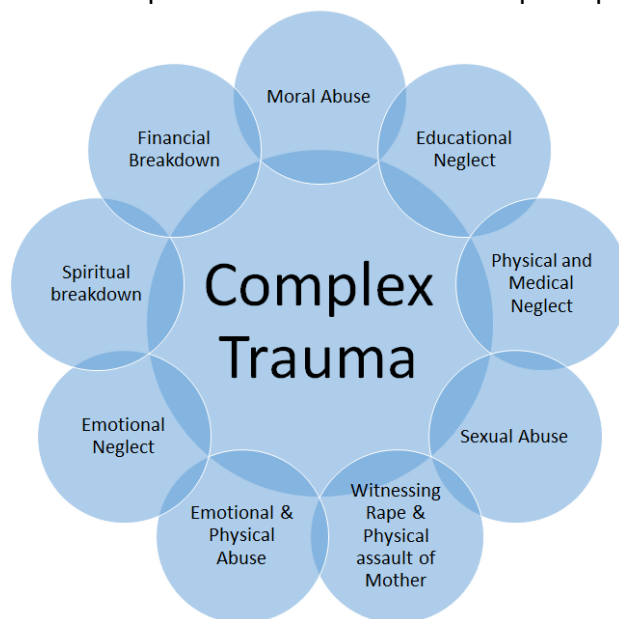


Figure 1 Complex Human Trauma

Why call addiction a disease?

Medically speaking, if you have disorders in the structure of the chemistry of the brain it can be described as a “neurological disorder” which is a brain disease. Alcohol and drugs have a temporary effect to brain chemistry. When drugs and alcohol are used over a long time, they can change both the chemistry and the structure of the brain.

A Scottish doctor Thomas Trotter, who treated alcoholics over 200 years ago, is thought to be the first person who viewed addiction as disease. The literature of Narcotics Anonymous (NA) and Alcoholics Anonymous (AA) discuss “the disease of addiction. Alcoholics Anonymous and Narcotics Anonymous are two groups that use the philosophy of the ‘12 Steps’ to overcome addictions. Prior to AA, there was very little solid advice directly relating to chronic alcoholics. Bill Wilson and Dr. Bob in the State of Ohio founded AA in 1935. Both were self – described “hopeless alcoholics”.

The first edition of the Big Book used by AA members was published in 1939. Since then, the AA has grown into the largest recovery network in the world, with thousands of meetings happening every week across the globe. Bill had been a member of the Oxford Group, where people shared experiences in open forums on how they were spiritually feeling. Bill thought this experience was a valuable addition to him remaining sober and wanted to adopt this method in his self -help group. He felt that alcoholism / addiction was a spiritual disease and therefore only spiritual cure could help an addict awaken from the use of drink or drugs. This is why the program of AA and NA is referred to as a spiritual program.

NA is the second largest 12 Step group, it was founded in 1953 by Jimmy Kinnon. Jimmy was a drug addict who sought help from an AA member to get clean. Although drugs and alcohol share vast similarities, they can be culturally very different. Many alcoholics have never taken any drugs in their lives and vice versa. This has been substantially verified in my experience in three different rehabs in three countries. I will be shedding some light in the review of literature certain broad criticisms about ‘12 Step’ program.

In 1972, the National Council on Alcoholism and Drug Dependence convened a group of Researchers and clinicians to propose a broad working definition of alcoholism. They came up With the following:

“Alcoholism is a primary, chronic disease with genetic, psychosocial, and environmental factors influencing its development and manifestations. The disease is often progressive and fatal. It is characterized by impaired control over drinking, preoccupation with the drug alcohol, use of alcohol despite adverse consequences, and distortions in thinking, most notably denial. Each of these symptoms may be continuous or periodic”

(Journal of the American Medical Association 268, no. 8 [1972]: 1012–13).

This statement encompasses several aspects of the disorder of alcoholism, and applies to drug addiction. The two key elements that will constitute our working definition of addiction are

- (1) *Loss of control* over the use of the substance, and
- (2) Continued use *despite negative consequences*.

Defining addiction in the abstract is hard enough.

This study an attempt to review some popular theoretical formulations, treatment models and spirituality as process-oriented subject matter in the context of therapeutic setting based on the clinical involvement of the researcher. Spirituality in clinical practice may not indulge in correction system, but can contribute to diagnosis and interventions within addiction recovery program.

Dr. Gabor Mate – Winner of the 2009 Hubert Evans Non-Fiction Prize
'In the Realm of Hungry Ghosts: Close Encounters with Addiction', said

"Drug addicts are often dismissed and discounted as unworthy of empathy and respect. In telling their stories, my intent is to help their voices to be heard and to shed light on the origins and nature of their ill-fated struggle to overcome suffering through substance use. Both in their flaws and in their virtues they share much in common with the society that ostracizes them. If they have chosen a path to nowhere, they still have much to teach the rest of us. In the dark mirror of their lives we can trace outlines of our own"

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Chapter 1 – Spiritual Dimension: Review of Literature

Healing the Spirit and rediscovering God-awareness

I have divided the literature review into three parts to with an attempt to gain multifaceted approach for the framework of spirituality in psychotherapy with those in recovery program. Firstly, it is contextually relevant to review and ponder over the work of John Dubay from *integral recovery: A revolutionary approach to the treatment of Alcoholism and addiction*, based on the transpersonal approach of American Philosopher Ken Wilber. Secondly, I will reflect on Abraham Maslow's hierarchy theory, which is all time relevant. Thirdly, I would review the spiritual dimensions envisaged in the 12-step program and fourthly, Robert Enright's work on the Process Model of Forgiveness will supplement literature review for this study.

1: 1 Healing the Spirit: Integral Recovery

The main thrust in this chapter is healing the spirit of the individual who is addicted, in other words healing of the soul in recovery. This may be very interesting, attractive to some, and repellent to others, depending on what your experience and history have been up to this point in your life. So, let us start by defining our terms. In Integral Recovery terms, spirituality deals with the most fundamental questions of life. Is there a God? Is there life after death? Is there a meaning and a purpose to life and the universe? Is there a personal purpose to my life that I must find? These are profound human questions, which confront us all, whether we choose to address them or not. They are a river we all have to cross, if we live long enough. This book invites us to given an opportunity to face these questions.

Addressing the great existential questions of human existence involves looking beyond mere exteriors into the ground of being. It involves a profound inner journey, where we confront and, in some sense, overcome the sources of our dysfunction and suffering. This work can be framed in traditional religious terms or in secular ways. In the end, it probably does not matter. The quest itself is what produces the results.

The author does not point in any direction for searching dogmas to fit into the context of spiritual practices, but an invitation to embrace open -ended questions, which are essentially helpful in addiction recovery program. The author's suggestion to undergo a paradigm shift is note worthy — in that, you make up a new set of assumptions and beliefs about the nature of reality. But in the sense that you follow an injunction to practice using new techniques and technologies, which will provide you with new data that will shift and transform the way you understand reality. "The promise of spirituality is that when you do, you will find that your deepest self is your truest self and that this true self is what your heart and soul have always been seeking", the author adds (p. 159)

As Mickey Gilley sang, "You've been looking for love in all the wrong places."

An important understanding that Integral Recovery brings to this spiritual practice, or injunction, is based on the work of Abraham Maslow, one of the great twentieth-century pioneers of both humanistic and transpersonal psychology. One of the many contributions that Maslow made was to observe that most of Western psychology up to that point had been

based on the study of pathology, in other words, sick people. Maslow asked what would happen if we turned that on its ear and studied healthy people, to see if we could come up with any commonalities among them that we could learn. Maslow proceeded to do just that and found a common denominator in these human exemplars or role models. He found that they all shared what he called a “peak experience.” Sometimes it had only happened once, but in many cases it had happened more than once, if not often.

These peak experiences were characterized by intense, joyful feelings of peace and connectedness, and, in a very real but often mysterious way, a deep knowing that fundamentally things were okay, even if the observable data indicated otherwise. Now “peak” experience is just a secular, non-religious way of saying “spiritual” experience. Maslow found that these peak experiences (or what are sometimes called “unitive” experiences) are necessary. Almost like essential psychic nutrients, for a whole, healthy, and creative human being. Many of us have had these experiences in our lives already, facilitated by being in nature, music, making love, art, literature, seeing a newborn baby, and so on.

Many of us have also had peak experiences using mind-altering drugs, and it was the wonder of these experiences that led us to continue to use drugs. This resulted, however, not in liberation (maybe for a brief period) and higher growth, but in dependency, addiction, and eventually, total demoralization. For the addict, pursuing these types of experiences through drugs leads to a devastated life and a shameful death. Arrived at in the wrong way, these experiences are the equivalent of the sirens’ song, which promises everything but leads to destruction. Come by in the right way, these experiences can be both useful and instructive, and cumulatively they can metabolize into energy and inspiration for higher stage growth.

1: 2 Inclusion of Maslow’s hierarchy of needs.

Another aspect of Maslow’s work, which we would do well to heed, is his hierarchy of needs.

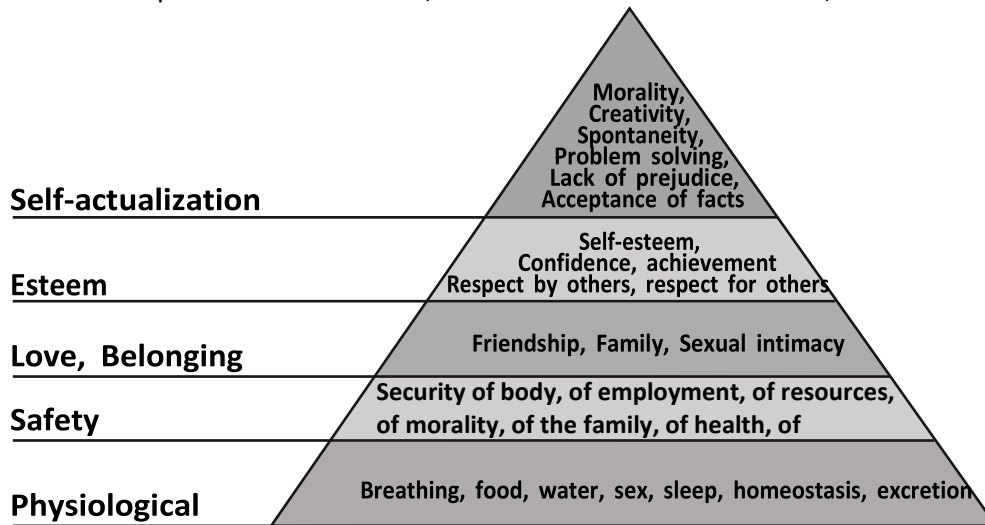


Figure 2: Maslow’s Hierarchy of Needs Pyramid

As you can see from the illustration, the first rung in the ladder starts at very foundational stuff and works its way up from there, from survival to self-actualization needs. This is important, because as we have said before, the goal of Integral Recovery is not just ceasing to ingest addictive substances, but optimal health in all four quadrants, and sustained growth in your essential lines through an ongoing lifetime inter- relational phase. What this means is that once the lower rung needs are addressed and sufficiently satisfied, from the physiological to safety, from love and belonging to esteem, the question in life shifts radically from “What can I get?” to “What can I give?”

Some critics have pointed out, quite rightly, that this process is not as sequential as Maslow’s model indicates. We can still be haunted by questions of higher meaning when our bills have not been paid, there is no money in the bank, and the refrigerator is empty. However, it is also clear that there *are* depths of meaning beyond mere materialistic survival needs, and the capacity of people to address these deep, existential questions is greatly increased when the lower rung needs have been satisfied. (That is why the Lower-Right quadrant supports growth in the Upper-Left quadrant.)

The goal of Integral Recovery is to help our students skillfully repair and fulfill the lower-rung needs, and to prepare a strong foundation in all four quadrants so that the individual can more fully address the essential soul queries, “What can I give?” “How can I serve my people?” “Who are my people?” “What are my unique gifts that I am here to give?” “What kind of discipline and sacrifice will it take for me to do this?” When these questions arise, and they will as the Integral Recovery journey of healing and growth unfolds, you will be ready to embrace them and you will know you have come a long way from the narcissistic addict-self that lived by the creed that all that matters is “me” and getting high. There should not be any fantasy about recovery, but we must work on guidelines for recovery, but be advised that this is the eventual high ground you are headed for, which will emerge from your practice and your healing process.

However, remember the old adage in the recovery world, “First things first.” First, we create a safe environment for you away from the source and ability to get drugs and alcohol. Then we support you in detoxifying your body and restoring health and balance. At the same time, we establish emotional safety, and as the fog lifts and the mind begins to clear, we begin the work of transformation. In Integral Recovery terms, *transformation is positive change that lasts*.

Dr. Gary Nixon, a transpersonal psychologist on the faculty with the Addictions Counselling program at the University of Lethbridge, recently pointed out to me that addiction is “a counterfeit for the real quest for wholeness.” If that is the case, and I think that it is, what, specifically, is addiction the counterfeit for? As I see it, people are looking for when they begin to use drugs three essential things:

Escape from egoistic suffering: By egoist, I do not mean selfish. Rather, I mean the suffering that is an inherent part of being a separate self in a human body. This suffering can be physical, emotional, or spiritual, and derive from any number of causes, but for all of us, suffering is an

existential given. In addition, drugs offer a very effective, if temporary, way out of that suffering. The problem is, of course, that as dependency takes over and use increases, the suffering is multiplied exponentially. Life becomes a literal “hell on earth.”

Enhancement of pleasure: The desire to be more confident, more sensual, more intelligent, more creative, and so on. Again, there *is* often an experience of superior functioning, but it does not last. As the disease progresses, and the body, mind, and soul deteriorate, these temporary gains are lost.

Transcendence: One often experiences states of transcendence using mind-altering substances, where the body and the little mind are dropped temporarily, and one experiences a unitive state—a sense of expanded identity and consciousness. The problem is, as with all states, that they come and go. In the case of the drug user, this can often turn into a depressing letdown. Then one seeks the experience repeatedly through increased use of the drug, or trying new drugs or new combinations of drugs. However, the experience never lasts, and it is never quite as good as the first time. This is called “chasing the high” and is a downward spiral to insanity, addiction, and death.

The good news is that the quest for these qualities is not bad; in fact, it is dead on. Many of these drives are essential to realizing our highest aspirations as human beings; only the method is at fault, in this case drugs. Legitimate ways of achieving these goals involve practice. The recovering addict must learn that these goals are indeed legitimate and are achievable in ways that are a thousand times better than their counterfeit counterparts. It is essential for recovery that we realize this and begin to experience this very early on. If the choice is between addiction and depression, addiction will win almost every time.

1:3 Spirituality for Transformation

Spirituality is one of the essential lines we work with on our journey toward transformation, sobriety, and optimal health, because without a vital spiritual connection and the light and liberation it brings to our goal of Integral health, sobriety will not happen. The spiritual meditative experiences that we encounter in our daily practices actually have transformative effects in our healing ability, sobriety, and health. These experiences are not just fascinating and cool (which they definitely are) but are also an essential part of our ongoing healing and transformative process. The mystics have always known this, and science is beginning to understand this. Probably, this is not the spirituality you have heard in the church nor do you hear preachers preaching about on TV and radio. I am talking about using the eye of deep introspection to relax into your body and to relax into your thoughts and emotions in a systematic daily practice, aided by teachers who have themselves taken the plunge into their deepest selves. It is about committing to this process with heroic intent and singleness of purpose, which will allow you to achieve the results you are looking for.

Until One is Committed

Until one is committed, there is hesitancy, the chance to draw back, always ineffectiveness. Concerning all acts of initiative (and creation) there is one elementary truth, the ignorance of which kills countless ideas and splendid plans: that the moment that one definitely commits oneself, then Providence moves too. All sorts of things occur to help one that would never otherwise have occurred. A whole stream of events issues from the decision, raising in one's favor all manner of unforeseen incidents and meetings and material assistance, which no man could have dreamed could have come his way.

—William Hutchinson Murray

In Sanskrit, there is the phrase “neti, neti,” which means “not this, not this.” It well describes the first stage in meditation, when we no longer identify with the objects of our consciousness, such as thoughts, feelings, emotions, body, world, and so on. In developing a meditative practice, we learn to identify with our higher context (or Higher Power) as opposed to our content (the objects that arise in thought). We identify with being the paper instead of the words on the paper; or with being the sky itself and not the clouds; or with the pure Transcendent Witness or consciousness versus the “things” that arise in consciousness. These moments of translucence, when the light of the eternal penetrates the relative passing world, can become moments of profound healing and reordering of our lives, and their effect spills out beyond the meditative hour to flavor and influence every aspect of our lives. This is why a profound, ongoing, contemplative, meditative practice is essential to Integral Recovery.

Let us listen to the words of the great Catholic monk and mystic Thomas Merton:

From the viewpoint of our separate self and smaller, will,
it's normal to act on the basis
of our own desires and preferences;
When we surrender our smaller self and will to the guidance of a higher will
and dedicate our actions for the highest good of all concerned,
we feel an inspired glow at the center of our life.
And again.
Life is this simple:
We are living in a transparent world, and God shines through in every moment.
This is not just a fable or a nice story; it is living truth.
If we remember God, abandon ourselves to God, and forget ourselves,
we may see this truth:
God manifests everywhere, in everything.
We cannot be without God.
It's impossible.
It's simply impossible.

1:4 Integral spirituality in '12 Step' program

The Transformational Event

Traditionally, in AA terminology the transformative event that leads to the willingness to do the necessary work is called "hitting bottom." This is when the shame, failure, and suffering caused by using drugs are simply no longer options or acceptable to the addict. The precipitating transformational motivators often come in the form of lost jobs, changed locks, criminal charges, and jail time. Bill Wilson described this as the utter deflation and demoralization, which were the precipitating factors that led to his spiritual awakening and eventually to the creation of Alcoholics Anonymous. In many cases, if not most of the time, the motivators are of an external nature: the intervention of family, friends, the law, or bosses simply leaves the suffering addict no wiggle room, and this leads to surrender and acceptance. "Okay, what do I have to do?"

While Bill Wilson was in the hospital dying from alcoholism (around the same time that his spiritual awakening occurred, after which he never drank again), he came across the book *The Varieties of Religious Experience*, by William James. In this classic volume on psychology of spiritual experience, James says that powerful transformational experiences are often preceded by a powerful ego deflation or what is called in spiritual circles a "dark night of the soul" (St. John of the Cross).

At the point of deepest despair, the light breaks through, and it is the dawn of a new day and a new level of depth and understanding. This dark night is the transformational chaos that allows the next higher order to emerge. Many recovering addicts whom I have known speak of their disease of addiction as their greatest gift and blessing, because it set the groundwork and conditions for their eventual recovery and transformation. The dark energy of addictive suffering becomes the negative entropy of spiritual emergence and renewal.

Very interestingly, we find that as we continue our Integral Recovery Practice, we experience new dark nights that are part of the ongoing journey of awakening and transformation. This is not a one-time deal, but as we achieve mastery, we can welcome and work with these chaotic dark spots on our journey and actually bless them as they arise, for we know that chaos is truly the mother of our individual and collective evolution.

One of the great wisdoms of Bill Wilson and Alcoholics Anonymous was Bill's willingness to allow members of AA to connect with "a God of their own understanding." Bill Wilson came from a Christian tradition; in fact, he took many of the principles of AA from a Christian Evangelical organization known as the Oxford Group. Bill could have easily gone with the line that in order to become sober you must receive Jesus as your Lord and Savior, but he did not. He was not about saving souls, but getting people sober, and he realized early on that it was important not to alienate anyone, so he made the only necessity for membership in AA "a desire for sobriety."

Building on this tradition in Integral Recovery, we should not push any brand of religion or tradition. Instead, we give our clients the resources to begin their own journeys to the center of their beings. What they find at their deepest levels is just what they find. They may return from this journey a Christian, a Jew, a Moslem, a pagan, an agnostic, a Buddhist, or something else,

but what they *will* encounter is a great mystery that answers the deepest longing of their hearts.

Step Eleven of the Twelve Steps of AA reads, “Sought through prayer and meditation to improve our conscious contact with God as we understood him.” Time after time, I have heard from those who have successfully maintained their sobriety through AA that spirituality was the key. I also noted that generally AA did not avail itself of the tremendous reservoirs of contemplative wisdom both from the East and from the West; there was precious little information or injunctions on how one should conduct a meditative practice, maybe the most important of the steps. Most of what is presented in the *Big Book* of Alcoholics Anonymous are formulaic, petitionary prayers such as St. Francis’ prayer, “Lord make me an instrument of your peace . . .” The prayers contained in the *Big Book* are wonderful and very noble, but they are not a substitute for a contemplative/meditative practice.

Few people enter treatment unless they really need it. Those who don’t, don’t. Those who can drink moderately, do so. So how are the teetotalers doing it? One way is spiritual. “This study supported previous findings indicating that attendance at Alcoholics Anonymous was strongly predictive of abstinence.” Hence the use of the Twelve-Step philosophy in treatment. Interestingly, however, it all started with a small group of alcoholics who figured out, with some outside help and in the dark of the Depression, a way to get sober with the help of God or something quite like God.

If impaired spirituality and addiction go hand in hand, which comes first may never be fully established. For addicts, however, drugs become a counterfeit God. Rather than escaping, alcoholics are seeking, usually God or serenity or a spiritual life, a point made by Carl Jung, Bill Wilson, and other thinkers, by numerous addicts the author interviewed. Some spoke of trying to fill a “God-sized hole” with drugs or alcohol. Said Joseph Molea, a doctor who treats addicted physicians in Tampa, Florida, “Addicts discover the cure for their symptoms in substance abuse.”

Research confirms, “That most alcoholics do not drink to sedate psychological problems, but for the lift, the glow and the positive effects of alcohol. They are not looking for the sedation so much as for solace, trying to satisfy the hunger of the heart.” In alcohol or drugs, they find such a superior force, alas, one that can kill them. Yet admitting this seems a hurdle for many alcoholics whose debility can be characterized by self-centeredness and delusions of omnipotence. This is overcome by admitting that they have lost control over their drinking and a greater force, or higher power, is needed to defeat this compulsion.

William James, the psychologist and philosopher, provided the founders of AA with insights into the utility of faith. Bill Wilson learned from James’s 1902 work, *Varieties of Religious Experience*, that spiritual beliefs could have concrete results. The prerequisite, for many people, would be personal shipwreck—precisely the state of the hopeless alcoholic. Given its practical bent, AA sailed a route that combined, as Ernest Kurtz explains in *Not-God: A History of Alcoholics Anonymous*, two currents of American religiosity: the Pietist/ Evangelical,

emphasizing salvation from a power outside the self, and the Humanist/ Liberal, stressing human participation in salvation.

At the same time, the AA approach—then as now—embodies a deep wariness of organized religion and its dogmas, creeds, rituals, and hierarchies. In more than a hundred interviews the author conducted with recovered addicts, dozens expressed a caution if not hostility toward religion in language that echoes AA's founders. One of AA's central contributions was in disentangling morality from the debate. It determined, for its members, that while alcoholics were not necessarily to blame for their conditions, they were responsible for doing something about them. Powerful in the 1930s, when the condemnations of nineteenth-century reformers were still echoing over the land, this insight continues to liberate prospective members and patients in treatment from self-castigation.

The workings of AA have been discussed and examined in hundreds of books and are rehashed and refined daily by members. Its methods and suggestions inspired dozens of other mutual-aid fellowships and guided the work of rehabilitation centers. At AA's core is its spiritual program of recovery, the Twelve Steps as developed by its founding members and described in their main text.

Here are the steps we took, which are suggested as a program of recovery:

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."

AA, *Alcoholics Anonymous*, 59-60

These are aimed at fostering a spiritual awakening that will keep the alcoholic sober on a daily basis. Spirituality allows life without alcohol. One supplants the other. As Carl Jung wrote in a 1961 letter to Bill Wilson, the formula is "*spiritus contra spiritum*." Or "spirit against spirits." At meetings, of which there are endless varieties, members recount their drinking past and the benefits of sobriety and discuss how they live sober and useful lives. The book, *Alcoholics*

Anonymous, serves as a kind of bible and excerpts are often read aloud. Senior members exercise some leadership, usually as sponsors to newer members. Helping others is paramount. Members find as much companionship, in and out of meetings, as suits their needs. “Sobriety is maintained through sharing experience, strength and hope at group meetings and through the suggested Twelve Steps for recovery from alcoholism.” This applies, generally, to other Twelve-Step fellowships.

Spirituality into Treatment

Today, simply put, AA and other Twelve-Step fellowships continue to view the lack or distortion of spirituality as the cause of addiction and an improved spiritual life as the solution. AA is a way of life, not a treatment. Only the first step mentions alcohol, the others concern spiritual processes. Abstinence merely allows a journey toward wholeness to begin. However, after the early successes of AA, medical and other facilities began incorporating its methods into their treatment.

What became known as the Minnesota Model developed cooperatively among several institutions—Pioneer House, Willmar State Hospital, and Hazelden—during the 1940s and 1950s. This approach treated the addiction rather than its causes, emphasized spirituality, used multidisciplinary teams of doctors, nurses, social workers, and others, and recruited recovered alcoholics as counselors. Today the Minnesota Model continues most of these practices. It treats addiction as an involuntary disease for which abstinence is the cure and makes the patient responsible for recovery. Patients learn about, begin working on the Twelve Steps, and attend AA, NA, or other meetings on-and off-site. Patients participate in-group and personal therapy and attend classes on addiction, and receive medical, psychological, social, and pastoral care. Exercise, nutrition, meditation, and prayer are emphasized. Near the end, patients agree to an after-care plan, which usually includes Twelve-Step meetings and finding a sponsor.

1:5 Critiques of Spiritual or Twelve – Step Methods

Twelve-Step fellowships can be a big target. There are two common features of popular critiques as illustrated by Wendy Kaminer’s 1992 book - *I’m Dysfunctional, You’re Dysfunctional: The Recovery Movement and Other Self-Help Fashions*.

First, these often target caricatures or distortions of the Twelve-Step philosophies rather than the real thing. Critics may acknowledge that AA and NA help addicts, but then charge these groups with making members feel victimized and slavishly dependent on a higher power as an alternative to the hard work of self-realization. Even a casual reading of AA and NA literature, or a talk with several members, or attendance at a meeting, reveals a focus on personal responsibility for past wrongs and present recovery. Further, the message through these fellowships, as well as in treatment programs making use of their ideas, is that dependence on a higher power delivers maturity and independence.

Others complain that using spirituality, or God, to recover simply replaces one addiction with another. This makes little sense, since most non-addicts believe in God to no apparent detriment. Many newly recovered addicts are often intense, understandably, about their new beliefs, a state responsible for such fears. If spirituality is a new addiction for those in recovery,

then at least it is not killing them. Further, accepting the human condition of dependency on others is usually the first step to independence. Edward Sapir, the anthropologist, writes that in all cultures, religion involves accepting one's human powerlessness and, at the same time, irrationally believing that one can gain security by identifying with the unknown. Often, treatment professionals hold AA or NA accountable for misrepresentations. These often adapt the Twelve Steps to their own purposes. Then their patients graduate, attend meetings, and repeat these messages as AA truths. Consider two common misrepresentations: the "disease concept" and the issue of whether or not a sober alcoholic ever really recovers.

Alcoholism is described as a disease once in the primer *Alcoholics Anonymous*. Instead, the words "illness" or "malady" are used repeatedly, indicating the complex nature of AA's understanding of addiction as a hopeless condition in need of a spiritual solution, or as an illness of the spirit, mind, and body. In 1960, well after AA's founding, E. M. Jellinek's influential book *The Disease Concept of Alcoholism* locked the phrase into the vocabulary of treatment workers, addicts, and, to a lesser extent, the public.

Second, many critics complain that Twelve-Step groups keep members in a state of permanent bondage through the conviction that an addict is always in "recovery" or "recovering," rather than being an ex-addict or a recovered one. In a letter to the *AA Grapevine*, the monthly AA magazine, a writer insisted that the message of AA's founders was one of recovery. The "recovering" camp, he wrote, adheres to "a New Age message which began infiltrating our AA rooms several decades ago and has become accepted by many if not most of our members. Its roots originate in treatment centers and rehabs." The letter also noted that the AA book used the word "recovered" 23 times, and "recover" 28 times, but "recovering" only twice "and then in the context of the newcomer." Interestingly, a dozen or so letters in the same issue dismissed the debate as a matter of unimportant semantics. Many recovered addicts prefer to say that they are recovering, to remind themselves and others of the need for vigilance. Such positions are not central to the embrace of a spiritual approach. What counts is daily effort since AA members remain sober by keeping in "fit spiritual condition."

Of more substance are those charges leveled by Stanton Peele a clinician and author of, among other works, *The Diseasing of America: How We Allowed Recovery Zealots and the Treatment Industry to Convince Us We Are Out of Control*, and Herbert Fingarette, a philosopher and author of *Heavy Drinking: The Myth of Alcoholism as a Disease*. Much of what they fault is outside the realm of Twelve-Step fellowships or spiritual solutions. Groups such as AA and NA are easy targets for the sins of the "recovery industry." As the journalist Joe Sharkey records in his 1994 book, *Bedlam: Greed, Profiteering, and Fraud in a Mental Health System Gone Crazy*, a vast network of rehabs and psychiatric hospitals grew dramatically during the 1980s, before collapsing, by lengthening the list of problems requiring expensive "treatments." These often carried the Twelve-Step label.

Peele and Fingarette oppose seeing alcoholism as a medical disease. AA's literature refers to it as a malady of the body, mind, and spirit and generally avoids the term disease. Along the same lines, Fingarette writes, "alcohol abuse is the outcome of a range of physical, personal, and social characteristics that together predispose a person to drink to excess." Peele, and many

others, oppose the medicalization of other social problems and say drunken drinkers and others who abuse drugs should be held accountable for their actions. Personal responsibility is a primary tenet of Twelve-Step groups, their members, and, for the most part, treatment programs that use this approach. Peele states that bad or incorrect beliefs and values can cause alcoholism, and that good ones can prevent or end addiction. Similarly, dozens of recovered addicts have told me that “stinking thinking” caused their problem. The book *Alcoholics Anonymous* states, in one of its few italicized passages, “*After all, our problems were of our own making. Bottles were only a symbol.*” The antidote, repeated many times, is an end to self-centeredness and the start of a life of love and service.

What both Peele and Fingarette propose as radical alternatives are remarkably similar to the Twelve-Step approach. Fingarette argues that alcoholics are not helpless and must take control of their lives. AA suggests a way to do that. He insists alcoholics must want to change. One hears the same in most treatment programs or from Twelve-Step adherents.

Indeed, the AA approach contradicts the extreme versions of the disease concept. As therapy, this concept is doomed to fail, Jerome D. Frank and Julia Frank write in their classic book, *Persuasion and Healing*, since it implies the person suffers from impersonal forces such as bad genes, absolves the patient of responsibility, and leaves him or her to follow doctor’s orders. “More effective treatment, such as the form of psychotherapy embraced by Alcoholics Anonymous, invokes the idea of illness in order to relieve the alcoholic from fruitless feelings of guilt about lack of will power or past behavior. At the same time, the program makes the alcoholic responsible for the consequences of his or her drinking and for following the steps to recovery, which involves moral acts such as making amends to others and helping other alcoholics.”

Misunderstandings abound in this field. Even calling Twelve-Step fellowships or other spiritual methods “self-help” is a misnomer. As applied to Twelve-Step-style groups, the term self-help originated with Charles Dederich, who founded the first therapeutic community, Synanon, in 1958 as an alternative to AA for drug addicts, often those with criminal pasts. He called Synanon, with its complete reliance on the group, self-help to distinguish it from AA’s reliance on a higher power. The term has since been applied to a galaxy of support groups and it is likely to stick, though descriptions that are more accurate would be “mutual help” or “mutual aid.” William Miller and Ernest Kurtz, two respected researchers and observers, compiled various outside conceptions of alcoholism mistakenly attributed to Alcoholics Anonymous. AA literature, does not assert that there is only one form of alcoholism or only one way to recover – that alcoholics are not responsible for their condition – that moderate drinking is impossible for every problem drinker - that alcoholics suffer from denial and should be bullied into treatment - or that alcoholism is purely a physical or hereditary disorder. AA’s core beliefs do, however, resonate with or resemble those of other fields from which it has often borrowed or which it has influenced.

1: 6 Review of Four Essentials of Spiritual Practice

An extraordinary aspect of Integral Recovery is that deep spiritual experiences become the personal realizations of all those who do the practices, that do the injunctions. Spiritual

realizations are no longer just the purview of the spiritual elite or the masters in any given tradition, but of every one of us; they are our human birthright, now achievable by the many. Let us listen to Arjuna Ardagh as he describes the “radical awakening” so many people are now experiencing, which I believe is the way out of the trance of addiction. We call such a shift in awareness a “radical awakening.” It is the moment when you taste reality outside the limiting confines of the mind, the body - beyond birth and death - that you are eternally free. Despite the activity of thought and feeling, you know yourself to be the silently experiencing that movement. It is the moment when you intuit the real potential of life, free from the incessant mental machinery of complaint and ambition. A radical awakening often releases a tidal wave of creativity and generosity of spirit, a natural impulse to serve and contribute. In these moments, we know that love is who we are, not something we sometimes feel.

In our spiritual practice, when we are in meditation or prayer, as the case might be, there are three basic perspectives that we can take on divinity, God, or spirit. The third perspective, “3,” or third person, is the perspective we take in our contemplation or meditation when we think of spirit as something objective, something out there or up there, as when we might say, “Isn’t God wonderful,” or, “Isn’t God a bummer.” Here we are speaking of God as being something other than ourselves, or a person we are conversing

In the second-person relationship with spirit or God, we are talking to divinity as the other that I am in relationship with, as in, “God, I love you,” or, “Lord, show me your will.” In addition, a first-person relationship with God or spirit consists of those moments when the boundaries between our ego selves, our small selves, and God dissolve and there is no “other”; there is simply I AM. As Integral practitioners, we know that if we neglect any of these perspectives, then we have left out a perspective that is actually essential, thereby impoverishing our spiritual practice.

One of the problems that often happens in spiritual development, after people advance from a blue/mythic fundamentalist stage of spirituality, is that they tend to believe that any second-person relationship with the divine is somehow superstitious or juvenile, and they leave it behind. Often, because people equate religion or spirituality with fundamentalism, they leave religion or spirituality behind altogether. Ken Wilber refers to this as a level/line fallacy. This is where people believe that all religion or spirituality is blue fundamentalist hogwash and cannot be taken any further. The truth is that spirituality is not only expressed in blue fundamentalist terms, but continues all the way up our spiral of human development. Therefore, there is a blue version of spirituality, and an orange, green, second-tier, and third-tier version. As Rollie Stanich, a teacher of Integral Christianity, says, “We see God through colored glasses.” Therefore, with the 1-2-3 of God is that we no longer have to equate second-person relationship with God as an anachronism that must be left behind as we move from blue to higher stages of development. We can maintain, honor, and grow with a second-person perspective all the way up the spiral.

The first-person, the “1” of God, includes those moments in meditation or prayer when the boundaries between ourselves and spirit, or God as “other,” dissolve. Then there is no longer me and you, there is only I AM. The very fact that Integral theory even makes us aware that we have the option of taking these perspectives in our spiritual practice allows us to deepen and enrich our inner life. This requires careful observation and understanding of how, where and when a person is beginning the spiritual journey.

Just as many folks moving beyond blue have a problem with a second-person perspective or relationship to the divine, so also do many *blue*-level spiritual practitioners have a problem with a first-person perspective, where God is no longer other, and there is only I AM. The fear is, it seems that you will begin to believe that you are God! Which is true, in a nondual, ultimate sense, but this does not mean that your small ego, all your hatreds and foibles and loves and cravings and desires, and so on, is God in the sense that it created and runs the universe. Sorry, it just ain't so. To believe otherwise is simply a case of misbegotten narcissism. There are not too many problems with the third-person perspective, unless you are an atheist and get annoyed with God talk at all. But even an atheist can talk about the history of religion or the history of God, such as in Karen Armstrong's excellent book, *A History of God*.

A second-person relationship to the divine is one of the gifts of an Integral approach to spirituality, elucidated by Wilber in his book *Integral Spirituality*. Many of us, when we grow beyond the mythic, absolutistic stage of blue, lose this sense of intimacy and our one-to-one relation with Spirit. We think it is childish and/or superstitious. Wilber has shown how we can re-own this relationship to the divine. Not only can we re-own it, but also if we don't, we impoverish ourselves by leaving out this perspective. This is good news to all you closet lovers of God and for those of you who have never experienced this sort of relation with Spirit - give it a shot. The literature is ancient, rich, and deep that describes this sacred relationship to Spirit as Other. Using this perspective in our spiritual practice deepens the quality of our inner work. A time-honored method of establishing a second-person relationship to the divine is simply praying to your Higher Power, asking for a pure heart and good motives. As Jesus beautifully put it in the Sermon on the Mount, “Blessed are the pure in heart for they shall see God.” I would like to include the prayer I have used for years in my contemplative practice, the Prayer of St. Francis. This prayer is so right-on and powerful that it has been used and adopted by many other traditions besides Christianity. Note also, when one practices visualizations, affirmations, or prayers, in the very deep brainwave states facilitated by brainwave entrainment technology, they become deeply imprinted into your unconscious mind. They are enabled to help heal, purify, and focus the power of the unconscious, in ways we are just beginning to understand. I would like to quote the prayer in its entirety here, because of its beauty and power as a contemplative tool, but also in homage to Bill Wilson and the *Big Book* of AA, who also quote this great prayer.

Lord, make me an instrument of Thy peace.
Where there is hatred, let me sow love; where there is injury, pardon;
Where there is doubt, faith;
Where there is despair, hope;
Where there is darkness, light;

And where there is sadness, joy.
O Divine Master, grant that I may not so much seek to be consoled as to console;
To be understood, as to understand; to be loved, as to love.
For it is in giving that, we receive; it is in pardoning that we are pardoned;
and it is in dying that we are born to Eternal Life. Amen.

Four Essentials for Integral Spiritual Practice

What distinguishes our Integral approach to spirituality, and the spiritual line, are the following four aspects that must be included, comprehended, and used. They, I believe, distinguish Integral spirituality, and hence Integral Recovery, from any other approach that is currently being used, whether pre-modern, modern, or even postmodern.

The first aspect that must be included is the “essence” referred in the book. We must have a spiritual practice that allows us to experience our deepest nature or true self. This will be referred to in many different ways, according to one’s level or tradition (or non-tradition). This essence might be referred to variously as spirit, God, emptiness, Original Face, true nature, or so on. In order for our spiritual practice to be based on something more than blind faith or dogma, in other words, believing what some other person says about his experience of the ultimate, we must have a practice that allows us to voyage into this territory ourselves. This is the area that is often referred to, in mystical or integral parlance, as the nondual, or the first-person perspective of the divine. At this essential or deepest level of reality, our ego boundaries and separateness dissolve. We realize experientially that there is truly only One and that we are it and always have been. This is often referred to as Self-realization, or a mystical, unitive experience of God. In this experience, the realization is of the big Self, that beyond our ego, individuality, and history. We are That, the I AM that is spoken of in the book of Genesis.

The second essential aspect for an Integral Spiritual Practice is adding the developmental spiral to our conception of spirituality and recovery. This provides a quantum leap in our understanding of the evolutionary process of recovery and becoming the highest and best version of ourselves, as well as a hugely useful map to chart our own individual progress. It goes a long way to explaining why devout religionists are often knocking heads in their interpretations and understanding of ultimate truth. One thing we are learning is that sustained Integral practice makes our evolutionary journey up the spiral of development happen more quickly and healthily in that the growth is not unbalanced. One of Ken Wilber’s great insights into this developmental journey is that when certain lines are left behind, such as the emotional line, severe pathologies can develop, despite high spiritual understanding and realization even into second and third tier.

The author refers to his work with addicts: when they have begun to sober up, were fully green in the ethical line in their holistic, nonjudgmental, compassionate ideals; however, because of unresolved trauma in the emotional line, they were, at the same time, narcissistic, self-absorbed, and emotionally very immature. So, again, if the four essential self-related lines that we work with in our —body, mind, heart, and spirit—are not close in their developmental level, pathologies do occur, which can eventually or quite quickly lead to relapse, collapse, and even

death in the case of our addicts. By knowing this, we can prescribe extra work and care to the inferior and undeveloped aspects. In the case of the narcissistic, self-absorbed, and immature, there are a number of practices such as therapy, service-oriented work, and shadow and trauma work that can be used to strengthen and elevate this pathologically low line.

The third essential aspect is states of consciousness. As we have said before, there are certain basic states in a normal 24-hour period, such as waking and dreamless sleep, but states also include all the emotions and feelings that arise moment to moment in our lives, whether they are joy, depression, love, hate, despair, boredom, or curiosity. Remember, states are the clouds in the sky, the birds, the airplanes, and the bugs, that arise in the vastness of our own being. With this knowledge and practice, we can learn to release our negative emotions and no longer be their slaves. This also includes traumas and buried issues from our past. How do we do this? The simplest explanation is radical acceptance. We absolutely open to and allow whatever state of consciousness is arising in our awareness, without judgment, and without following the mental obsessive thoughts and chatter that accompany these states. We simply stay with the states as they express themselves in our awareness and our bodies. In this way, they pass quickly and can be welcomed as teachers and allies in our process of living and being fully awake. We learn that not all these states are ultimate in their nature; they come and go and arise in that which is ultimately our true nature or pure consciousness.

By radically surrendering and not trying to “fix,” medicate, stuff, avoid, or project unpleasant states that arise, we become free. We understand that absolutely nothing can destroy our true nature or the wisdom and equanimity that come with this understanding of, and identification with, our deepest, truest self.

The fourth and last, but not by any means least, essential aspect is the shadow, which is an essential aspect of the Integral map. Without the key of the shadow, all our work is done in vain; our spiritual communities become cults, our teachers become tyrants, our recoveries are temporary, our hope is forlorn, and our future on this planet is devolutionary and catastrophic. In the shadow, in these unconscious parts of ourselves that are truly the bottom of the iceberg, there abides great energy and power. If these shadow parts of ourselves are left locked or medicated into unconsciousness, they will destroy us. That which is locked in the basement will grow in the front yard and not only grow, but grow into something terrible and destructive. These shadow regions of our psyche hide not only our negative aspects, but also our greatest gifts and talents. Positive or negative aspects of ourselves, left in the unconscious and unattended to, will cause destructive pathologies as we either hurt ourselves or die of despair from never knowing our unrealized potentials, causing the world around us to wither from our ungiven gifts.

In so many of our religions and myths, it is clearly recognized that the hero's journey must include a descent into the underworld and the facing of our dragons, our own mortality, our fears, and death, in order for rebirth and resurrection to happen. The journey to God, as Franciscan priest Richard Rohr so clearly teaches, is through the darkness. These unrealized, unresolved, unhealed, and unilluminated parts of ourselves, if left in the shadow or the unconscious, will defeat us and eventually kill us, both individually and collectively. However, brought to light, owned, transmuted, and included, these shadow elements, both individual

and collective, become a source of unbelievable creative energy that gives us the capacity to have compassion, love deeply, and creatively and beautifully participate in the evolutionary unfolding of our time.

Therefore, for our spiritual practice and work to be truly Integral and comprehensive, these four columns of the temple must be included. Again, these are not merely intellectual understandings but must be fully embodied and incorporated parts of our spiritual practice.

1: 7 Spirituality and belief in God

Spirituality does not require belief in a God. As anthropologists and the examples of Buddhism or Jainism attest, a deity is not even necessary for religion. And beliefs alone do not make for spirituality. What is necessary is for those beliefs to lead to values through personal verification, for one's philosophy of life to be vitalized by emotion. In contrast religion is "a set of beliefs about the cause, nature and purpose of the universe, especially when considered as the creation of a superhuman agency or agencies, usually involving devotional or ritual observances and often containing a moral code for the conduct of human behavior, The spirituality used in addiction treatment lacks most of those elements. Spirituality, as seen above, is basically a search for a deity or ultimate truth or reality on a personal and flexible basis. Or consider that religion consists of beliefs and rites. Spiritual approaches to addiction have both. But unlike religion, the beliefs are not mandatory and the rites, when these exist, are generic and not prescribed.



Figure 3 : Source: <http://diagramscharts.com/tag/wellness-chart>

Perhaps no group is, informally, more responsible for popularizing this difference in the modern era than members of AA, NA, and the like. The popular mantra, "I'm spiritual but not religious," bears out a distinction held by the founders of AA and refined in blunter terms by later members. These embrace the flexible, tolerant, and practical elements of spirituality while often denigrating, or at least distancing themselves from what they call the rigidity and dogma of religion. As one recovered alcoholic put it, "Religion is the politics of spirituality." The distinction is not new. Yet some of the confusion may be, since many today are eager to push religion out of the way and apply the term spiritual to a whole galaxy of what were once known

as religious sentiments, beliefs, and practices. The 1960s rebellion against institutions continues. Many people feel aggrieved at the idea of any authority in the realm of their deepest and loftiest instincts and beliefs. But the rift is barely a new one. Almost every religious reform (see Jesus) began with a rejection of the prevailing form of organized worship. At the same time, the distinction is a real one. Spiritually based treatments, such as meditation or Twelve-Step facilitation, suggest a program of action rather than a code of beliefs. These are methods, not doctrines—the very reason for their appeal, even for people who recover without formal treatment.

Faith's Utility for the Addict

Treatment programs use spirituality to help patients remain clean and sober after they quit. “The role of spirituality is not so much for them to get off drugs as to stay off and to enhance the meaning of life,” Herbert D. Kleber, a psychiatrist at Columbia University active in treatment and research for 30 years. He estimated that spirituality is critical to recovery for about half of addicts in treatment.

The book *Alcoholics Anonymous*, written when that fellowship had about 100 members, concludes that the nondrinking alcoholic reacts to life much like other people. Once he does drink, “something happens, both in bodily and mental sense, which makes it virtually impossible for him to stop.” Then the book makes a critical point: to avoid drinking, the alcoholic has to change.

“These observations would be academic and pointless if our friend never took the first drink, thereby setting the terrible cycle in motion. Therefore, the main problem of the alcoholic centers in his mind rather than in his body.” Alcoholics are those who “have lost the power of choice in drink,” and are beyond the power of human aid. Mere moral codes, philosophies, self-knowledge and willpower did not work for these alcoholics, so something new was needed. “We had to find a power by which we could live, and it had to be a *Power greater than ourselves*.”

A higher power can defeat the lower power of alcoholic compulsion. This need not be the God of others; it could be the individual's conception: “the Realm of the Spirit is broad, roomy, and all inclusive.” Just admitting the possibility of a higher power led to a “new sense of power and direction provided we took other simple steps.” This spiritual approach combines complete flexibility with a mandate that it be undertaken.

“The great fact is just this, and nothing less: That we have had deep and effective spiritual experiences which have revolutionized our whole attitude toward life, toward our fellows and toward God's universe.” While turning to a higher power is recommended, just turning away from the god of self and addiction seems to change the person. Hamilton Beazley, an author and associate professor of organizational behavior at Butler University, spoke of the utility of prayer in these terms. “It's suggested that AA members pray in the morning, to just say, keep me sober, that is sufficient, it doesn't matter to whom the prayer is directed. And to say thank you for keeping me sober at night. This is for newcomers to orient them to the fact that they are not God.”

The remarks have a behaviorist tone. Treatment and support groups seem more directed at checking the ego of addicts by eliminating self-centeredness than at finding God. The two can

coincide. Finding a God or god or some higher power has a profound effect on a former addict whose entire life once revolved around finding, using, and recovering from drugs or drink. It has a profound effect on most human beings who are, by nature, prone to self-centeredness. But even without a deity, prayer, meditation, service, and spirituality can move people from the center of their universe such that they live differently.

In a more religious language, obtaining salvation may be a matter of dodging hell. William James saw the therapeutic process of religion in a similar light. For the damaged soul seeking respite, James wrote, conversion is “a process of struggling away from sin rather than of striving toward righteousness.” What is the result? One version is described eloquently in the other main AA text, *Twelve Steps and Twelve Traditions*. “When a man or a woman has a spiritual awakening, the most important meaning of it is that he has now become able to do, feel, and believe that which he could not do before on his unaided strength alone. He has been granted a gift which amounts to a new state of consciousness and being. He has been set on a path which tells him he is really going somewhere, that life is not a dead end, not something to be endured or mastered. In a very real sense he has been transformed, because he has laid hold of a source of strength which, in one way or another, he had hitherto denied himself. He finds himself in possession of a degree of honesty, tolerance, unselfishness, peace of mind, and love of which he had thought himself quite incapable. What he has received is a free gift, and yet usually, at least in some small part, he has made himself ready to receive it.”

Put simply, recovered alcoholics have changed their minds—about a lot of things. Rowland H. recalled Carl Jung telling him that his type of condition was usually hopeless, with exceptions. Jung continued: “Here and there, once in a while, alcoholics have had what are called vital spiritual experiences. To me these occurrences are phenomena. They appear to be in the nature of huge emotional displacements and rearrangements. Ideas, emotions, and attitudes which were once the guiding forces of the lives of these men are suddenly cast to one side, and a completely new set of conceptions and motives begin to dominate them.”

William James, who distilled the practical function of religion in his *Varieties of Religious Experience*, understood the mystical appeal of inebriation. “Sobriety diminishes, discriminates, and says no; drunkenness expands, unites, and says yes. It is in fact the great exciter of the Yes function in man. It brings its votary from the chill periphery of things to the radiant core. It makes him for the moment one with the truth.” The sober antidote is that state of mind, known to religious people, when they cease to assert their will and become “nothing in the floods and waterspouts of God. In this state of mind, what we most dreaded has become the habituation of your safety, and the hour of our moral death has turned into our spiritual birthday. The time for tension in our soul is over.” This is the same tension described by William Silkworth, the medical adviser to AA’s founders, as the alcoholic’s state of being “restless, irritable and discontent.” It is the same psychic itch described by so many alcoholics and addicts that they tried to scratch with drink and drugs.

For James, the way out lay in the exercise of free will through thought and action. The literary critic Alfred Kazin writes in *God and the American Writer*, “The whole point of *The Varieties of Religious Experience* is that the truly religious character begins as ‘a sick soul,’ is dominated by a

sense of lack, of something basically wrong, but through the mysterious accession of faith . . . is given—gives itself—that second chance in life that religion helps to provide.”

During the late 1800s, religion had lost its certitude in the face of positivism and materialism. Still, James the Harvard scientist had seen the transformative effects of faith as scientific facts. He used the example of a mountain climber whose survival depends on believing that he or she can make an impossible leap to a new ledge. Wisdom and courage involve believing in what is necessary, for such belief saves. For James, beliefs should always and only be tested for philosophical sense and moral use.

A spiritual solution to addiction follows the classic pattern of fall and resurrection, sin and redemption. First comes the sense of unease—common to many, universal among addicts. Then, James writes, “The solution is a sense that we are saved from wrongness by making proper connections with the higher powers.”

God/Not God

The starting point of almost any spirituality or religion is the recognition that the believer or practitioner is not the deity. So too in Alcoholics Anonymous, whose text declares: “This is the how and why of it. First, we had to quit playing God. It didn’t work.” When Bill Wilson first talked with Dr. Bob in 1935, as Ernest Kurtz writes, he already was able to present the four aspects of one core idea: “Utterly hopeless, totally deflated, requiring conversion, and needing others, the drinking alcoholic was quite obviously not perfect, not absolute, *not God*.” This threshold is so taken for granted that many addicts I interviewed seemed unaware that they had made such a decision. They often spoke of finding a higher power, but rarely of having decided they were not it.

Addicts do not have to profess a deity for a spiritual approach to work. Some rely on principles or guidelines for living, such as “good orderly direction,” whose acronym is a handy g. o. d. For those in treatment or new to recovery, the higher power may be their community of sober peers or a Twelve-Step group, a powerful source of hope and direction, just as some anthropologists regard society as the deity behind religion.

The process can occur within the person, without obvious divine intervention. The addict simply has to stop believing in the religion of one, to cease the cult of self. As Ernest Kurtz and Katherine Ketcham write, “It is only by ceasing to play God, by coming to terms with errors and shortcoming and by accepting the inability to control every aspect of their lives that alcoholics (or any human being) can find the peace and serenity that alcohol (or other drugs, or sex, money, material possessions, power, or privilege) promise but never deliver.” By shrinking the ego, the addict makes room for new truths and beliefs, ones that will not kill him.

The first of these is faith, the first teaching of almost every religion. Even here the way is simple: not so much does the addict have to believe in a deity as he has to stop believing in the one which is killing him. In this light, one could say that it is faith, rather than a deity, that provides the power. One certainly sees this in Christianity, where many Protestants preach salvation by faith alone. Jesus, repeatedly, told people he cured that it was their faith that saved them.

For many, however, only God can displace the god of self-centeredness. “If the definition of spirituality is the power to recognize that there is a power greater than yourself, it’s essential,”

said Ronald J. Hunsicker. “Any treatment has to enable them to acknowledge a power greater than them. Without that, any long-range recovery is compromised.”

1: 8 The Enright Process Model of Psychological Forgiveness

*Whether, when and how may persons forgive, seek forgiveness *from*, and/or effect reconciliation *with*, someone who has offended them - or whom they have offended? How may persons heal emotional wounds resulting from the real or perceived actions or inactions of others? How may persons free themselves from the effects of the justifiable anger, which is engendered by emotional, physical or sexual abuse or neglect? With these questions in mind, this paper considers the psychological processes of “*forgiveness*”: *how* people who have been offended may give forgiveness- and *how* their offenders may request and/or receive it- and of *reconciliation*: *how* two or more people, once having maturely given and received forgiveness, may re-establish mutual trust. Specifically, this paper summarizes the *Enright Process Model of Forgiveness* as theorized, researched, taught and practiced by Catholic psychologist Robert Enright and colleagues.*

Although Enright is a devout Christian, this model is essentially psychological- and philosophical- rather than religious or spiritual. The Enright model recognizes the religious mandate that to flourish spiritually, persons need to give - or request and receive - forgiveness when appropriate. In the service of this need, the model encourages those trying to forgive or be forgiven to use whatever spiritual and religious inspiration and resources are personally meaningful. However, the model offers guidance for *how* anyone- whether his or her primary motivation is religious, moral or psychological- may cooperate with the fundamental, universally human, psychological process of forgiveness.

1: 8:1 What Forgiveness Is - and Isn't -

Enright asserts that forgiveness is essentially, the “foregoing of resentment or revenge” when the wrongdoer's actions deserve it and instead giving the offender gifts of “mercy, generosity and love” or “beneficence” when the wrongdoer does not deserve them. In other words, when people forgive, they essentially give up the anger to which they are entitled and give to their offender a gift to which he or she is not entitled. Depending on the seriousness of the offense and the length of time that the person offended has lived with and- perhaps denied- the harm caused by the offense, forgiving may be a long, difficult and painful process.

Enright and his colleagues have found that a common, major obstacle to forgiving another is misunderstanding what forgiveness is. People who would benefit from forgiving sometimes mistakenly assume that to forgive they must do what is impossible or even wrong. Another obstacle may be that one's parents or primary caregivers may never have shown forgiveness, or may have modeled a *pseudo-forgiveness*. For example, saying “I forgive you” sometimes may be a denial that any harm occurred or a self-defeating effort to control, manipulate or gain “moral superiority” over the offender.

In order to be willing to work toward forgiving an offender, people often need to be educated first about what forgiveness is *not*. For example, *genuine* forgiveness does *not* mean forgetting that the offense occurred, condoning or excusing the offense, renouncing efforts to obtain restitution or legal justice, or suppressing or no longer feeling anger about what happened. In

addition, genuine forgiveness does *not* require that offenders first admit their offenses, ask for forgiveness, make appropriate restitution, or be willing and able to change their offensive ways. While it may be easier to forgive an offender who responds in these ways, one who has been offended need not remain trapped in unforgiveness due to the offender's inability or unwillingness to do so.

Sometimes the offended may be unwilling or unable to forgive for less obvious reasons. An offended person may experience "secondary gains" from the victim's role. For example, the attention or influence that one gets from having been offended, or the "power" that one may feel, or the escape from emotional pain or depression from harboring resentment may reinforce unforgiving attitude. Or the offended may genuinely try to forgive a certain offender but be frustrated because of the unknown need to forgive other, prior offenders. For example, one spouse offended by another may need to forgive an opposite sex parent, or someone who feels offended by God may need to forgive an offending parent or other authority figure.

Finally, genuine forgiveness *need not*- and sometimes *ought not*- result in *reconciliation*. True reconciliation requires not only the offer of forgiveness by the offended, but also the acceptance of this gift by the offender *and* the ability of both parties to (re-)establish mutual trust, or interpersonal safety in their relationship. Prudentially, some offenders may be untrustworthy, unwilling or unable to change their offending ways. And some people who have been offended realistically may be unable or unwise to trust that their offenders have changed or will change.

1: 8:2 Four Phases of Forgiving

In the Enright model, the process of forgiveness proceeds through four phase. They are worthwhile for our review and can be integrated into recovery program. I have incorporated Enright model into my group work with those in recovery program and the response was indeed encouraging.

a) In the **Uncovering Phase**, a person "gains insight into whether and how the injustice and subsequent injury have compromised his or her life." This involves *confronting* the nature of the offense and *uncovering* the consequences of having been offended. A fundamental step in coming to offer forgiveness to an offender is clarifying the nature of the offense and how it has compromised one's life. This means determining as objectively as possible *who did what to whom*. One cannot forgive an offense that did not occur, although one may be able to *resolve* the anger aroused by a *perceived* offense when the actual nature of the event *is* understood. And psychologically, people cannot forgive an offense committed against another, although they *can* forgive the secondary or indirect effects which they themselves *do* experience after someone else has been offended. For example, if someone abuses, or a drunk driver hurts or kills, a close family member or friend, one *cannot* forgive the abuse or drunk driving offense. But one *can* forgive the emotional pain, distress and loss experienced by oneself because one's loved one was victimized.

In addition to confronting the nature of the offense, uncovering the consequences of the offense includes understanding how both "the original unfairness" and one's reactions to this injustice have affected one's life. In this phase, a person must confront the objective nature of the offense and the objective and subjective harm or injuries caused by the offense.

Sometimes, a person may need help realizing the connection between not having forgiven and the experience of various physical or psychological difficulties that are the result of suppressed or repressed anger. In counseling, this may involve discovering and “working through” various “layers of pain” in addition to justifiable anger. Such layers of pain may involve shame, guilt, obsessive thoughts about the offender and/or one’s offense, temporary or permanent life changes due to the offense, and changes in one’s views about the justice of the world and of God.

b) In the *Decision Phase*, a person “gains an accurate understanding of the nature of forgiveness and makes a decision to commit to forgiving on the basis of this understanding.” Although there are many religious, spiritual and cultural commandments or mandates to forgive an offender, forgiveness *is* and *must be* a “free choice.” At the least, a person must be willing to become willing to forgive. For a person trapped in the “prison of unforgiveness”, deciding to forgive may involve realizing that what one has been doing to overcome the harm and suffering caused by an offense is not working. Deciding to forgive may begin when a person is- in Twelve Step words- “Sick and tired of being sick and tired.” At this point, a person not only is “pushed by the pain” of unforgiveness, but also “pulled by the hope” that learning to forgive one’s offender will free the one offended from further, avoidable suffering. So, at the end of this phase, the person stuck in and suffering from unforgiveness realizes that forgiveness *is* an option and makes a decision, however tentative or weak, to begin forgiving.

c) The *Work Phase* involves actually *working on forgiving*. In this phase, a person “gains a cognitive understanding of the offender and begins to view the offender in a new light, resulting in positive change in affect about the offender, about the self, and about the relationship.” Concrete actions in this phase commonly begin with working toward an accurate understanding of the offender. This *reframing* may involve rethinking the offensive situation or seeing the offender from a new perspective, as “a person who is, in fact, a human being, and not evil incarnate”.

Clinical experience has shown that a person usually comes to *think* differently about an offender before *feeling* more positively toward him. Other actions in this phase include working toward realistic *empathy* and *compassion* for the offender, courageously and assertively bearing the pain caused by the offense, and finally giving the offender the “moral gift” of forgiveness. Psychologically, such *beneficence* cannot be rushed or demanded, and may take a long time to achieve. Some clients struggling to forgive severe abuse find that a lessening of resentment toward their abuser is the closest they get to the ideal goal of beneficence.

d) Finally, in the *Deepening Phase*, a person “finds increasing meaning in the suffering, feels more connected with others, and experiences decreased negative affect and, at times, renewed purpose in life.” In this phase, one may discover that in the process of forgiving, one finds release from the “emotional prison” of “unforgiveness, bitterness, resentment and anger.” As one’s ability to forgive deepens, one may find new meaning in one’s suffering and new purpose in one’s life for having suffered unjustly. One also may discover one’s own need to ask for forgiveness from others, perhaps even toward one’s offender.

1.8:3 Requesting and Receiving Forgiveness

Initially, the Enright model of forgiveness focused primarily on understanding and helping people who have been offended to forgive. However, in recent years, the effects on the offender of being offered forgiveness, the process by which an offender asks for forgiveness, and the process of genuine reconciliation have been theorized and studied as well. Even when focusing on the one who has been offended, in the deepening phase those who have been offended may find it necessary to confront how they may have unjustly treated either their own offender- either before or after the offense- or others. Phases and guideposts for seeking to be forgiven parallel the phases of seeking to forgive. Offenders who want to be forgiven must confront the nature of their offense, uncover their own guilt and shame, and face the past and present consequences (including psychological) of their offense(s), both for themselves and those whom they have offended.

Deciding to *seek* forgiveness includes recognizing the need to ask for forgiveness, being willing to receive it if offered and deciding to accept it humbly, if and when forgiveness *is* offered. Working on actually receiving forgiveness involves working to understand how one's offense has affected the one offended; developing an attitude of gratitude for having been given an unmerited gift; doing whatever is possible to reconcile with the offended (including making restitution for any losses suffered by the offended, when possible); and accepting the painful humiliation of admitting that one was wrong. Finally, the process of being forgiven includes working to find meaning in one's failures, deciding to and working on making positive changes in one's life, realizing one's common humanity, and experiencing freedom from lingering, or inordinate, guilt or remorse.

Reconciliation necessarily requires that two-or more- persons come together in mutual respect and trust to (re-)establish an ongoing relationship that is acceptable to both- or all. This *may* become possible after the parties have maturely- and perhaps mutually- given and received forgiveness. At times, reconciliation may be unwise- if not impossible. The realistic possibility of re-experiencing a traumatic hurt- such as further emotional abuse- may counsel against having direct or future contact with an offender.

1:8:4 Incomplete or Premature Forgiveness?

From my own experience and consideration, the forgiveness process requires two movements, both necessary for a person to truly forgive another and free him or herself from any lingering emotions following an offense. The first Movement involves the questions and efforts of the first or *Uncovering Phase* of the Enright model, which consists in developing compassionate understanding and acceptance of oneself, one's experiences, and all one's feelings. The second Movement includes the second and third, *Decision* and *Work Phases* of the model, which consists of developing an accurate understanding and compassion for one's offender.

Sometimes, persons who begin the forgiveness process find that they have difficulty completing it. In my experience, people are more likely to be stuck for one of two reasons. In particular, clients who are religious may become stuck because they have forgiven *prematurely*, i.e., they have skipped – often unintentionally – the questions and efforts of the

Uncovering Phase, while focusing on trying to understand and have compassion for their offender. Unfortunately, an accurate and compassionate understanding of their offender may make it more difficult for those offended to admit how much they were harmed, or feel the proper level of anger. They may even feel guilty for resenting their offender if they realize the real limitations their offender had – e.g., their never having been loved well enough by *their* own parents, caretakers or significant others, as we needed them to love us. It is important remember that realizing why the offense happened, and especially if we understand that the offense was not intentional or personal, may explain but does not excuse, condone or minimize the offense – or its emotional and other consequences. Prematurely trying to give the forgiveness gifts of mercy and grace will not by themselves release the anger and other feelings, which the offense engendered.

Another place someone may be stuck is in the Uncovering Phase, becoming very aware of the emotional and other life consequences of the offense, but finding it too difficult to move into the Decision – let alone the Work – Phase. A person may have attempted the Decision or Work Phases only to find that lingering or intense feelings have led them back into the issues of Uncovering Phase. Alternatively, if a person has developed one or more self-defeating (including compulsions or addictions) as ways of “numbing the pain” or “self-medicating” the leftover feelings, s/he may find it difficult even to simply feel, let alone deal, with the feelings. Or, once a person realizes and accepts that s/he was and is a “victim,” the “benefits” of this role – sometimes not clearly perceived – and the costs of relinquishing being a “survivor” in order to become a “thrivor,” may be more than s/he is yet ready to pay. For such persons, realizing the costs of remaining a mere “victim/survivor” and the benefits of becoming a “thrivor,” as well as experiencing the witness and support of others who successfully have forgiven past offenders, may enable to would be forgiver to finish the course.

It is helpful for those stuck at *any* phase of the forgiveness process, to remember that the grieving and forgiving processes are two sides of the same coin, and that feeling and dealing with our past unmet needs, unhealed hurts, unresolved feelings, etc., always requires assertive self-care. If our offender continues to mistreat us – or others whom we care about – in the present, we must learn to self-protect and self-care, as well as help others to do so if necessary. On the one hand, we may find it necessary to limit contact with our offender. Also, as stated above, reconciliation – meaning either restoring the relationship to one as good or even a better than in the past, or developing a good enough relationship for the first time – may not be wise and/or possible. On the other hand, genuinely forgiving someone who did – and could – not love us as we deserved, may enable us both to accept their current and chronic limitations and have a better relationship with them – for all of its limitations – than we could have had without our efforts to forgive.

Chapter 2: Review of Models and Theories

2: 1 Moral Model

In this model, we discover the defective spirit and the inner choice of conscious. Society views addictions in a myriad of way, none of which is positive. There is the perspective of the addiction as being criminal. There is the moral perspective of it being a sin. This model resembles the spiritual and medical model. We usually discover the person's character defects. We emphasize that pride should overcome humility and acceptance should overcome resentment. Weakness and character defects are the result of addiction according to the moral model. This model contains very little sympathy for people that have chronic addictions. Individual choices are the main theme of this model. According to the moral model, a person that possesses moral strength would have the required strength to stop the addiction. Religion is required in order to be ethical and moral. This is why this model is similar to the spiritual model. Without the spiritual belief, Alcohol Anonymous (AA) believes that the will of the individual will not be strong enough to overcome or recover from the addiction. We do not consider this model to be a therapeutic model. (Marino, N., 2006)

2:1:1 Temperance Model

Historically, this model has been confused with the approach of the moral model. This particular therapeutic regimen began in the 1840s and continued through the late 19th century. Benjamin Rush created the temperance model. The thesis of this model is that the substance has the power of addiction and destruction; that the individual is powerless against the addiction; abstinence is the only salvation. The "mantra" is that an individual's will is diseased, and therefore they lack the control or power to resist. Rush believed that people with addictions should terminate their use of the substance quickly and completely.

Condescendingly, this model of addiction pitied, instead of empathized with the addictions of individuals. Consequently, it should be no surprise that a person with an addiction to alcohol had the label, "Drunkard." Jellinek argued that the people who supported the temperance model's idea of a disease made the temperance model weak. In this model, if the person with an addiction believed in a higher power they would possess the strength to resist use of alcohol. According to the Temperance Model, an addiction was an involuntary disease. They believed that alcohol is the addiction source and because alcohol is so easily obtainable, there was no resistance to drink. Addiction was the end-result. The tenet of this model is; a person who drinks moderately is no less guilty than a person who drinks heavily. They considered a person who drinks in moderation worse than a person who drinks heavily (drunkard). The temperance model sympathizes with the person who drinks heavily and rejects the person who drinks moderately. The temperance model feels that supporting the assistance of the person with the addiction is very important.

The largest temperance membership organization in the history of America was "The Independent Order of Good Templar." They worried that they might be viewed as persons with

addictions because their involvement was so strong in reforming individuals with addictions. They were successful in assisting individuals with addiction to recover.

The Good Templar was much like the sponsors of today's Alcoholics Anonymous (AA). In order to hold an official position in assisting individuals with addictions, sponsors had to be capable of being abstinent for a certain period. AA originated in the 19th century. Consequently, it resembled the temperance model. (Marino, N., 2006)

2:1:2 Disease Model

Some Americans began admitting being addicted to alcohol in the late 18th century and early 19th century. They openly admitted their inability to resist the desire for alcohol. They considered the addiction of alcohol a disease that struck randomly and lasted indeterminably depending on the individual. (Benn, P., 2007)

This model definition is alcoholism is a medical disorder. Something is uncharacteristic, which leads to behavioral impairment. The individual is unable to control their craving for alcohol. There is a progression of deterioration in all functions until the individual has nowhere else to go but up and applies for treatment or some type of positive support. This theory contends that an individual is not cured even if they are able to stop an alcohol addiction. According to the disease model, substance addiction affects both behavior and the brain. The neurochemical and behavioral processes are impaired during the development of the disease. They utilize this model in therapeutic settings. This model believes the cause of behavioral dysfunctions is from being dependent due to a mental or physical affliction. The evidence researched by The American Society of Addiction Medicine, states that labeling an addiction, as a disease is incorrect. The Disease model postulates that the biologic and environmental sources are the genesis of a lifelong disease.

There is a social or psychological phenomenon for drinking excessively. A discovery that one group might drink excessively for years and remain in control, while another group lost control was revelatory. Any group was considered to be "alcohol addicts" if they lost control. When a person had an abnormality that caused discomfort and became dysfunctional, they would consider this abnormality a traditional medical model of disease.

They adhere to the concept that addiction is genetic. They feel that the addiction might be due to an environmental occurrence. The people who do not believe in the disease model, especially the belief of the lifelong addiction process, argue that there are no scientific principles and that this model invokes negative effects in society. They argue that the model of disease does not identify addictive behavior due to having no biological involvement. They believe that labeling people as addicts inhibits them from developing self-control and stigmatizes them.

This theory will also include other personal and social problems such as, fetal drug exposure, driving while drug-impaired, criminal activity and violent behavior due to drug use, underage drinking and binge drinking.

The new disease model will identify the intervention and prevention techniques that we should apply to each problem. This model will include the communities' differences and utilize a greater choice of treatment goals and techniques in these different communities. The new

disease theory will officially proclaim as its essence that (a) genetic or biological factors are not the cause of addiction, and (b) there are several factors causing addiction, including other diseases. Like most chronic diseases, addictions are not progressive; some addictions will remain stable while others will deteriorate. Impulsive remission and maturation exist in addiction as in other habitual diseases. We must implement varied treatment modalities in this new disease concept...

2:1:3 Psychological or Character Logical Model

This model of addiction concentrates on what takes place in order for a person to start using substances. This model emphasizes that biology does not cause a person to take that first drink or line of cocaine. It must be psychologically motivated. This construct views everyone as being vulnerable to addiction. According to this theory, a character defect and a learned behavior is addiction. An abnormal character or personality trait is what causes a person to become dependent on chemicals. There are degrees of personal and psychological defects that pre dispose an individual to these “addictive personality” traits. Poor impulse control, ineffectual coping mechanism to stress, being manipulative, portraying a big ego, and having to be in complete control, but feeling powerless and hopeless, are traits of an “addictive personality”. Modeling influences are when an individual is in a stressful situation, for an example, a marriage separation, or work problem, this individual attends a party. He is expecting to rest and relax with his friends. The friends have been drinking and having a good time. This individual will usually be influenced by the cues of his previous association with drinking and his confidence in his self. The stress this individual is under and history of managing his drinking will determine his management of alcohol use. (Simos, G., 2009)

Behavior and psychological therapies are the treatments for persons with addictions due to learning, emotional, and psychological deficiencies. The reason for substance abuse is if a person is unable to maintain their inner life and external behavior. A person will be able to have control externally, if there is treatment provided in obtaining an inner strength. The change will be the result of External, (behavioral, interpersonal), taking the place of internal, (intra psychic). The amount, quality, and intensity of triggers identified in behavioral psychology, may be the learned behavior of substance abuse. An addiction is if we give people reinforcement every time for an addictive behavior. The effect on the central nervous system could be a positive reinforcement. (Bentley, R., 2007)

Corroboration is the acceptance by peers. The elimination of withdrawal symptoms and less anxiety could be negative reinforcement. If we replace negative consequences and punishers with reinforcements, a positive change may take place. Educating the client on how to develop coping strategies for substance use is required. Dr. Richard Solomon introduced an Opponent-process theory in 1980, which is a psychological model for addictive behavior. This theory stipulated that emotions come in pairs. If we experience one emotion in a pair, we suppress one emotion. His theory, based on the study that a person who started skydiving had more fear that a person who sky dived many times, but would have less pleasure when they landed. His

theory considers fear and pleasure a pair of emotions. In the opponent process model, pleasure suppresses fear.

Drug addiction is the result of a pair of emotions such as an emotion of symptoms of withdrawal and an emotion of pleasure in the opponent-process theory. In the beginning, there was a great amount of pleasure and very little withdrawal. As time passed, there were lower levels of pleasure from using the drug and higher levels of withdrawal symptoms from not taking more of the drug. This enhanced the use of the drug even though there was less emotion of pleasure. The belief is that for every psychological event, (A), there will be an opposite psychological event, (B). When a person finds pleasure from the use of heroin, the opponent process of withdrawal will follow it. This would be similar to a person feeling afraid when they jump from an airplane but rewarded with great amounts of pleasure when the parachute opens. Another example of opponent process when a person looks at the color red and then quickly looks at a gray area, they will see green.

In the nervous system, there are many examples of opponent processes, which include taste, touch, vision, hearing, and mobility. When opponent processing occurs at the sensory level this may lead to an addictive or habit-forming behavior.

The results of research regarding psychological or character logical therapies are positive. Not all individuals will recover as quickly as anticipated. The studies of the brain imaging will be an asset for this model. We require utilizing various behavioral therapies. This model could take less time, be less complex, and more cost efficient as per the group counseling approach. These treatments need to be more accessible.

2:1:4 Social Education Model

Operant conditioning and training are principles in this model. Behavioral and genetic influences are learned behavior in . A requirement in this model is to develop methods of reducing stress factors. This Model believes that environment plays a huge role in certain addiction behaviors. The process of socializing and observing behaviors of role models forms behavior.

Family, work, emotional relationships and social support are social and environmental factors that are the main event in shaping and controlling onset of addiction. An example is the tobacco bans in Europe. These bans will be a most powerful effect of change for many people who may not require treatment. This model belief is a small amount of people seeks professional treatment. Many social and environmental factors intervene in improving compliance and help people to take fewer substances. Improvement of social responsibility and community support will probably improve a person's motivation to abuse substances.

2:1:5 Social Learning Theory

Albert Bandura developed this model in the 1970s. Social Learning Theory, (SLT), describes the effect of thought process on goal-oriented behavior. It considers the capability of an individual to learn within a social environment through study and verbal interaction.

This model forms basis for remedial intercessions such as coping skills training and prompt exposure therapy. A key element of SLT is reinforcement. An individual will copy any behavior that they are rewarded for. Some examples of positive reinforcement are when an individual feels the pleasure and rush of using cocaine or their anxiety and stress they are feeling seem to diminish while drinking alcohol.

In SLT, the more substance or alcohol is used the more of a habit it becomes. Of course, the affects of using cocaine and alcohol are different in each individual and want they want and need. The affects are based on what personality they may have, their history, and what type of lifestyle they are living. If an individual is using to overcome personal problems, they will have different problems in trying to stop than an individual that is using to be social with their friends. When individuals use alcohol or drugs, they expect the experience they will have when they use again. Many people do not know their experience is based on dose of substance or amount of alcohol, personality and environment. The way they are feeling and the environment they are in. In time, the individual who is using will realize these factors will influence the effects compared to what they expect. The effects that an individual expects will determine how much of a problem their use will be.

The SLT plays a big part on peer roles and others who are more significant in their lives. If they have learned to drink in a social culture when they were growing up - this will determine their behaviors and what to expect when they drink. This is considered to be modeling. Modeling, in accordance to research, is a big theory. Modeling techniques are used in therapy in skills training for teaching certain substance coping skills. An effect that is important of peer and parental modeling is the growth of internal expectations for alcohol/substance effects. When a young person sees, their parents drink a few glasses of wine to ease their stress regarding work or socializing at a party, their development can be reinforced and generalized when watching alcohol-related scenes on television. They tend to see plenty of drinking in soap operas. A relationship that adapts between an individual and a stressed environment is stress. It is the result of unevenness between environmental stress and an individual's means.

Another important constituent of SLT is self-efficacy, the individual's amount of self-assurance in their capabilities to systematize and finish measures that lead to specific objectives.

An individual's self-assurance influences the objectives that they attempt, the amount of energy used to complete those objectives and the length the individual will last while encountering barriers while attempting to complete those objectives. The amount of self-assurance plays a huge role in the objective being completed.

The amount of self-assurance an individual has will be controlled by the accomplishment or disappointment that the individual has encountered attempting to complete that specific objective.

Self-assurance can be transmitted to an explicit duty such as attempting to stop using alcohol or self-assurance can be wide-ranging in description. Self-efficacy is connected to alleged restraint with consideration to her or his concepts, emotions, and surroundings, not just an individual's actions. An individual's self-efficacy will be manipulated by existing stress conditions and their history of managing in comparable circumstances. The individual will focus on positive reinforcing effects of alcohol, (fun, restful, etc.), while he overlooks the negative outcomes, (hangovers, increased anxiety, car accident, etc.) This individual will have low self-assurance when it comes to relaxing or having fun with their friends without a drink. When drinking is introduced, different reinforcing effects of alcohol come into play. The individual's expectations of alcohol minimizing his nervous tension and permitting him to obtain more pleasure in the evening will likely be established.

2:1:6 Coping models

Coping is an effort to meet the stress in a way that recovers balance or equilibrium. There are many different ways an individual can cope with stress. Coping strategies that are focused on problems are directed primarily at changing or managing a threatening or harmful stressor. Coping that is focused on emotion is directed at alleviating or controlling the emotional influence of a stressor. A form of strategy that is focused on emotion is intended to change or manage an intimidating or damaging stressor. Since using alcohol is much faster in effectiveness in dealing with events that are stressful, alcohol turns out to be the chosen coping method. This individual will become more and more dependent on alcohol use to minimize the effects of anxiety in many circumstances. They most assuredly will forget other more advantageous ways of coping with stress. However, the temporary effects of alcohol and feelings of stress will be much stronger when they return the next day after alcohol use due to rebound effect. When an individual is using alcohol in a certain circumstance, their self-efficacy for different actions may take part in a significant condition. Their self-assurance they can manage in a significant situation, and assessment of the possibilities of accomplishing, will establish the choice and execution of coping behaviors. One of these managing approaches in nerve-racking circumstances can be the ingestion of alcohol.

An individual that has developed an excessive drinking problem when using alcohol during stressful periods has usually been negatively affected. These individuals will usually feel uneasy about the use of directed approaches when dealing with hectic events. An individual who is abstaining from alcohol due to problems from drinking should discuss with their counselor in acquiring assistance in triggers that are causing the drinking. The individual should practice different coping techniques and various behaviors that they can use in complicated circumstances. The individual should also discuss with the counselor the function accustomed prompts can take part in the individual's ability to use alternative coping skills. The individual should be informed of circumstances that are more complicated. Since this individual has been

abstaining from alcohol, they should be increasing their self-efficacy through management skills and staying away from drinking. This individual should be able to relax and have fun at a party where alcohol is served without drinking.

2.2 REVIEW OF TREATMENTS

The background and critical transitions must be evaluated while planning for addiction treatment. An addict also go through 'cycle of change as described below by Psychologists Prochasko and DiClementi. Their aim was to illustrate the different phases of change that a person goes through. It was originally invented to help those who wanted to give up smoking, but since its inception, it has become very useful tool in helping people in all addictions.

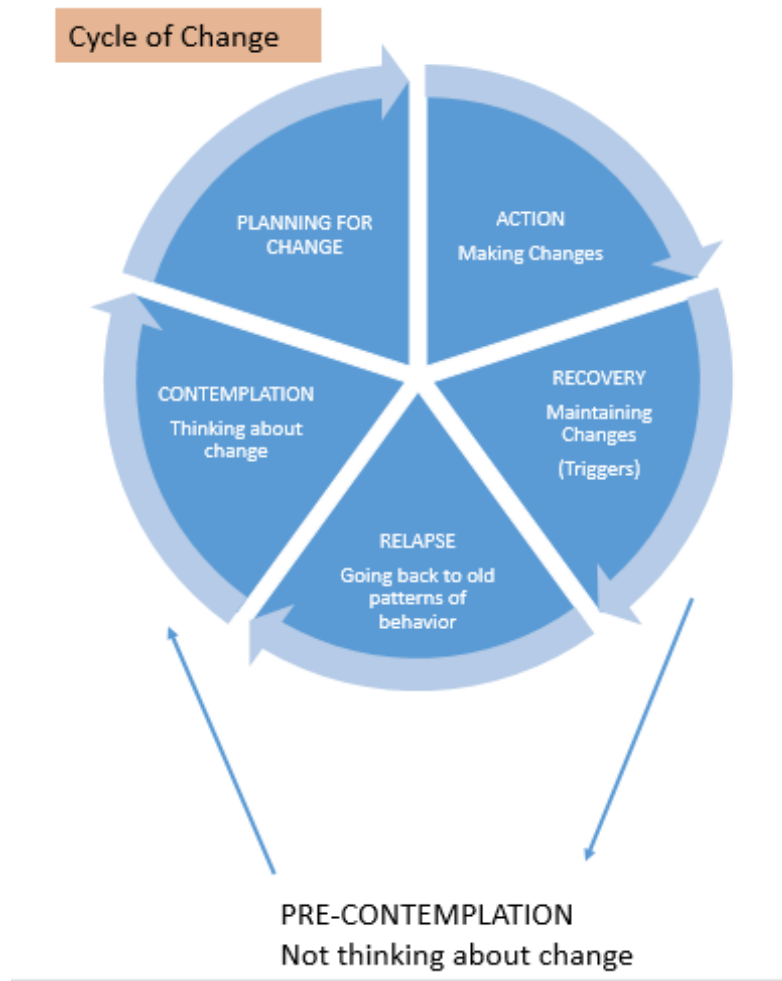


Figure 4

The word denial is often used in reference to addiction and it is relevant to include the same in this chapter while looking at various treatment as denial is an integral part of the DNA of an addiction and treatment program. Addicts, who have not accepted the nature and extent of their substance use disorder, can be said to be in a state of denial. Denial can be passive state

as well as overtly giving self-permission to continue drink and drug use. As seen in the cycle of change, before awareness of a change there is pre-contemplation phase. This can often be described as honeymoon period of drink and drug use, where there is no real change to change. It may be enjoyable; the consequences of use may be manageable etc. In the late 1990s, Terrence T. Gorski developed set of denial pattern questioners, to see how people use denial to positively disregard thoughts about having to make changes to their substance use disorder.

2: 2: 1 Outpatient Drug Rehabilitation Treatments

This type of treatment will be successful for some individuals with addictions and not as successful for others. The models of treatments in these facilities are Cognitive-Behavioral Therapy (CBT).

The medications used in this model are Naltrexone, (a relapse preventative for alcohol and heroin abuse), Disulfiram, (a preventative to alcohol abuse; currently being tested in treating cocaine abuse), and Acamprosate, (another preventative to alcohol abuse).

Another treatment method is the 12-step program. This well-known program's theory teaches and relies on individuals surrendering themselves to a higher power in order to increase their success in recovering from their addiction. They teach the 12-steps that lead to recovery. They teach individuals to take one day at a time abstaining from substances, working on the present, letting go of the past and acquiring hope for a better tomorrow. They have sponsors that have abstained from alcohol for a period that are prepared to assist those individuals who are beginning the recovery process.

Motivational Interviewing, problem-solving groups, and talk therapies are part of the treatment modality employed. These outpatient rehabilitation settings offer different types and duration of treatment depending on each individual's requirements. There are outpatient programs and detoxification centers that use the most modern medications and utilize compassionate care. These types of therapy are useful in stopping the cycle of behavioral problems. The detoxification phase provides services approximately seven to ten days, according to the client's individual needs assessment.

2: 2: 2 Residential Treatments

These treatments are for the clients with more severe AODA problems. The client will stay in a therapeutic residential environment 29 days to twelve months. There are clients that have serious impaired social functioning, have been involved in criminal activities, or have long histories who are eligible for residential treatment stays. These treatments assist the client in functioning in a community free of crime and drugs.

2: 2:3 Group Therapy

Clients can see their problems in reality, learn of the negative consequences, and enhance their motivation to remain alcohol and drug free. Clients can learn effective methods of coping with their personal and emotional problems without the use of alcohol or drugs.

2: 2:4 Empirically Supported Therapies (ESTs)

We most assuredly need to implement ESTs in our practice. There should be more education on public health and improve natural recovery, early access to interventions and better compliance, retention and outcome. These types of measures are not only low cost but also simple. We will minimize the encumbrance of substance abuse and improve patient outcome faster and easier than only transferring highly sophisticated ESTs into practice, and should be part of a comprehensive alteration idea.

Selecting therapists when they have just begun their practice or for a particular patient might also improve the treatment outcome at a greater degree than ESTs. We have collected many treatments as active treatments or controls, and the differences in the reported results have been meta-analyzed by sophisticated data programs. The outcome proves that we now have over a hundred different types of ESTs. We must think of the adversities the therapists will be facing in trying to sustain to ESTs in their practices. We classify therapy as a black box. We have not attempted to sort through the many different therapies thrown together to see which ones are effective for what certain problems, and for which persons.

We need highly selected groups in strictly controlled therapeutic settings, far from the variety and complexity of patients and therapeutic challenges in the real world. The most important question of all is how do they work in the real world?

Chapter 3: Object Relational Dimensions in Therapeutic Alliance

3:1 Object Relations Theory

The object relations approach emerged out of psychoanalytic theory and had its inception from understanding that early relationships influence human development and psychological well-being. Object relations approach understands relatedness and mutuality as basic motivators for human behavior. Internalized images from relations with past significant others, especially caregivers, result in object representations which are then projected onto current relationships, particularly when individuals somehow stir up one's response to prior relationships (McDargh, 1983; Mirman, 2012; Wenar & Kerig,

2005). Relying on these prior relationships, individuals form ideas and perceptions about themselves. The social construct called self is the product of these self-images. If individuals experience a nurturing and protective childhood, they will develop accurate views about themselves, their strengths, and their weaknesses. Conversely, experiencing conditional love and poor caregiving generates inaccurate perceptions of oneself that can influence psychological well-being and current relationships.

This unfolds through three developmental stages of ego functioning: symbiosis, differentiation, and individuation/rapprochement (Mahler, Pine, and Bergman, 2000). The symbiotic stage is featured by dependence on the caregiver as the object for satisfying the infant's basic needs. The infant in this stage neither makes distinction nor is aware of boundaries between himself or herself and the external world. This includes the caregiver, who is perceived in this first stage as inherently good and unthreatening (McDargh, 1983).

The second stage, which begins around six months of age, is characterized by differentiation and splitting. It results from the caregiver's unavoidable failure to completely satisfy the infant's needs. Such needs are often delayed due to other duties the caregiver must fulfill in his or her daily life. As a result, frustration emerges and the child begins acquiring awareness of separateness related to the caregiver and external world. Consciousness is somewhat manifested in this stage because the self, facing good and bad features of the separated caregiver, is forced to recognize and accept both aspects of the caregiver, therefore establishing a new relationship with the caregiver (Mahler et al., 2000). This new relationship can be either functional or dysfunctional to the extent the child perceives the caregiver's attitude of rejection and abandonment or acquires a more realistic psychological representation that integrates the caregiver's separateness and polarity. This last alternative is a necessary condition to the development of the next stage.

In the third stage, individuation/rapprochement, the child is able to acknowledge and accept the caregiver's uniqueness and identity. Here the child is able to assimilate an internal representation about himself and others and the good bad polarities are integrated into this representation (Mahler et al., 2000). Accordingly, the child gives up a representation of the caregiver as an omnipotent entity and displaces it with a representation that aggregates the caregiver's ambiguity, complexity, and individuality.

Individuals' psychological functioning increases to the extent that they are able to efficaciously achieve separation and differentiation, internalizing psychological representations of themselves and others that are more accurate and integrated. Thus, caregivers play a

significant role in this process, such that their ability to provide a safe, nurturing and supportive environment not only promotes, but also softens significantly the separation and individuation process.

In contrast, poor relationships, abusive parents, threatening, and unstable environments may leave lasting psychological sequelae such as splitting of the self, continuous sense of worthlessness, powerlessness, and incompetence. This may lead the individual to replay the dysfunctional relationship pattern in future relationships. Since the psychological drama had its origin in an unhealthy relationship, the healing process goes through a warm and empathic relationship, which can be found in a therapeutic setting. Indeed, the psychotherapeutic goal in the object-relational framework is to break the maladaptive relationship template. This is accomplished through remodeling the dysfunctional relationship pattern and helping the individual become aware of the maladjusted template. The individual is assisted by the therapist to develop and replay, in a therapeutic setting, a healthier relationship template and generalize this new template to real situations.

3:2 From Object Relation Stages to an Ego Developmental Blueprint

Considering the theory of object relations and its developmental conception of ego, Mirman (2012) proposed a developmental model of spirituality based on three stages as well: primary or defenseless, secondary or defensive, and transcendent or non-defensive. It is important to keep in mind from the beginning that individuals can experience these stages not only progressively throughout their spiritual process of development, but also carry them into adulthood in alternate fashion, sometimes progressing, and at times regressing, in continuous struggle.

Individuals who dwell in, or are more prone to stay in, the primary or defenseless stage usually have a primitive, fragmented, and fragile ego (Mirman, 2012). Moreover, according to Mirman, characteristics such as innocence, timelessness, powerlessness, defenselessness, and separateness are easily observed in these individuals. Although they have a sense of awe and wonder, it does not indicate spiritual maturity but rather lack of insight and inability to transcend. Further, since the world is a new reality, they experience it as magic and mysterious (Mirman, 2012).

The secondary, or defensive stage, houses individuals who are strongly grounded who tend to accumulate supplies, both material and psychological (usually narcissistic supplies), as consequent need to defend themselves from the perceived threatening and demanding external world, and from the good and bad polarities of others. Therefore, the ego in this stage is markedly materialistic, self-oriented, and rigid. Moreover, there is great tendency to be controlling, on guard, cynical, and slave to time and agendas (Mirman, 2012). According to Mirman, people in this state usually see the world as predictable, knowable, controllable, and ordinary.

The last stage, named non-defensive or transcendent, can be described as the stage to which individuals overcome the ego rigidity of the defensive stage and are able to experience a sense of freedom, gratitude, love, and openness to inner experiences (Mirman, 2012). According to Mirman (2005, p. 4344),

The yearning to return to a younger, non-defensive way of being – to recapture lost innocence, to experience awe, wonder and a sense of the sacred, and to feel the sense of being part of something larger than one’s own “skin-encapsulated ‘I’” (Watts, 1969) – is universal.

Additionally, the ego here is featured by non-defensiveness, maturity, flexibility, transcendence, receptiveness, timelessness, trustworthiness, and openness (Mirman, 2012). Besides having an attitude of faith, another meaningful imprint of individuals who attain this stage is proactive love, contrasting to those in the previous stage who long for being loved (Mirman, 2012).

According to Mirman (2012), people are continuously struggling to avoid regressing to the first stage because they fear being defenseless and are not willing to give up the sense of security acquired in the second stage. They maintain themselves tightly on guard, which prevents experiencing the spiritual joyfulness and sense of fulfillment that can be reached in the transcendent stage.

Actually, this basic internal dialectic that can be observed in each human being, is not solely due to cultural and personal characteristics, but is also ontological, constitutional, and intrinsic to individuals’ motivational system (Rulla, 1987). Therefore, one of the most peculiar features of the human being is yearning to be challenged by something that goes beyond their narrowness; their finiteness. This yearning for the infinite surrounds the human being without annihilating the finite that exists in him is properly fulfilled when they give up material security and dare to embark in the self-transcendent consistency process. According to Dias (2010), this process consists of an ongoing attempt to overcome the actual self (which tends to be markedly rigid) as a means to realize the ideal self (that should be receptive and proactive). This is accomplished through the process of internalization of transcendent values such as openness, proactive love, gratitude, and faithfulness.

3:3 Enhancing Meaningful Relationships

An emphasis on relationships underlies both spirituality and object relations theory. In fact, one of the aspects that pervade the definition of spirituality is a relationship with a perceived transcendent being. In addition, spirituality usually encompasses the unique idea of searching for the sacred (Pargament, 1999), or searching for relatedness that goes beyond oneself, which manifests desire for separateness, transcending the here-and-now, and culminating in the I-Thou (Ich und Du) relationship (Buber, 1986). In Buber’s relational model of spirituality the “I” is the conscious self and the “Thou” is the other or the transcendent being that can only be known through relational involvement (Hill & Hall, 2002). A spiritual individual usually perceives this transcendent being as something beyond consciousness and materiality. Likewise, object relations theory places relationship as a core element on its comprehension of human development. To put it differently, the object relation perspective, the way relatedness and attachment unfolds and how the individual perceives himself or herself and others are fundamental sources of internal motivation (Hansen, 2000). These meaningful patterns are internalized, reinforced, and replayed throughout adulthood. In sum, human beings are primarily driven by internalized patterns of interpersonal relationships, and seek interpersonal connections generally.

Therefore, I-Thou, or relatedness experience, is a strong point of convergence for both spirituality and object relations theory. Such a reality is a mysterious and dynamic experience to be achieved, a goal to be pursued, and yet a driving force to be guided by. Paradoxically it comes from within the self, but is satisfied thru self-transcendence.

3:4 Strengthening Attachment Bonds

Bowlby joined the British Psychoanalytical Society in the 1930s and received his training from Joan Riviere and Melanie Klein, he became increasingly sceptical of their focus on the inner fantasy life of the child rather than real life experience, and tended towards what would now be termed a relational approach. Thus, in searching for a theory, which could explain the anger and distress of separated young children, Bowlby turned to disciplines outside psychoanalysis such as ethology. He became convinced of the relevance of animal and particularly primate behaviour to our understanding of the normal process of attachment. These relational concepts presented a serious challenge to the closed world of psychoanalysis in the 1940s, and earned Bowlby the hostility of his erstwhile colleagues for several decades.

The maintenance of physical proximity by a young animal to a preferred adult is found in a number of animal species. This suggested to Bowlby that attachment behaviour has a survival value, the most likely function of which is that of care and protection, particularly from predators. It is activated by conditions such as sickness, fear, and fatigue. Threat of loss leads to anxiety and anger; actual loss to anger and sorrow. When efforts to restore the bond fail, attachment behaviour may diminish, but will persist at an unconscious level and may become reactivated by reminders of the lost adult or new experiences of

Attachment theory, combined with the human relatedness experience and demand for relationships, seems to be closely linked to the basic source of human motivation proposed by the object relations theory. According to Bowlby (1988), children develop an internal working model that encompasses either a confident and secure attachment (resulting from proximity and centrality) or anxious, insecure attachment (founded on caregiver's unavailability and inconsistency). Consequently, attachment style contributes to individuals' development of sense of self, such that a confident and secure attachment results in a competent, skillful, and healthy self. An anxious and insecure attachment leads to poor self-esteem and unsteady sense of self. According to Krause and Haverkamp (1996), the developed internal working model during infancy, either secure or insecure, tends to persist throughout the individuals' life and serve as a model for their future relationships.

Similarly, the quality of relatedness with a transcendent being may either outline the internalized individual representations, or be modeled by individual attachment bonds. According to Rizzuto (1979), from the object relations understanding of spirituality, there are two types of transference: (1) correspondence, that is, individuals unconsciously arrange their relations with others corresponding with how they unconsciously experience the sacred; or (2) compensatory, which means, individuals perceive spirituality as a compensatory object, something yearned for but never fully experienced. Building on this notion of transference and spirituality, Kirkpatrick (2005) stated an individuals' blueprint for relations with a transcendent being as an attachment figure may be featured either by the correspondence hypothesis or by the compensation hypothesis. In the correspondence hypothesis, an individual's relationship to

the transcendent being is similar to his or her relationship to the caregiver. In the compensation hypothesis, an individual's relationship to the transcendent being is a substitute for his or her relationship to the caregiver. This last hypothesis may explain reported findings that people with inadequate object relations history are more prone for religiousness (Kirkpatrick & Shaver, 1990). Particularly, because the sacred may symbolize the idealized attachment image and work in compensatory fashion for people with avoidant or inconsistent attachment bonds.

Hill and Hall (2002) emphasized an individual's internalized representation of the sacred or the divine assists them in deepening the sense of who they are. Using object relations language, the purpose in life, the belief in a vital force that provides vigor and a sense to the material realm, and the feeling of being loved by a transcendent being, enhance the development of a secure and confident internal working model. This seems to be especially noticeable in individuals who perceive the relationship with the transcendent being as an attachment relationship featured by proximity and centrality.

Indeed, Loewenthal (1995) stated religious adults tend to report more consistent coping abilities, more adaptive stress management, greater sense of personal efficacy, and sounder feelings of social support than nonreligious ones. A recent literature review found spirituality and religion may help individuals improve emotional adjustment; maintain purpose, hope, and meaning of life (Hefti, 2011). According to Kirkpatrick (2005), religiousness is facilitated by social and psychological mechanisms of attachment, partnership formation, social exchange, and mutual altruism. A constructive relationship with a transcendent being may provide feelings of comfort, security, sense of belonging, partnership, and alliance (Hill & Hall, 2002).

3:5 Spiritual Nurture in therapeutic alliance

Many who missed nurturance of 'a good enough mother' as Winnicott conceptualised, later in life turned to deviant behavioral problems. Many of my patients are my 'living human documents. I have been able to accompany some of them through their extremely dark moments in life, where in their 'sense of rejection by 'primary care takers imported into their present life, they believe their anger and their feeling of abnment is not acceptable to their new relationships. Some of them rejected me fearing that they might form an attachment with me and eventual rejection by me. It took a lot in me and my own constant commitment to personal growth so that I could provide them both transitional object and transformation object for them to reconstruct their self. I have often experienced transcendence of My self when I felt most helpless in therapy and in that process, I experienced 'the divine' or the presence of the 'third party 'became a brilliant unspoken and intangible dimension of some of my therapeutic encounters that were originally had the influence of attachment work and object relational perspective. Many a times, my patients shared about 'holding place 'they experienced in their therapy. I call recall those were the moments, when I felt I was not capable of 'sitting in ' there or I lacked intellectual skill to comprehend their complex conditions, but however there was a deep sense of longing in to be there in their ' brokenness' . I simple ended some sessions with '*serenity prayer* ', tears rolled down for me and tears and smile for my patients. One of my patients commended in our follow up session "I felt some powerful energy beyond you and your skills in the last session".

Spirituality is the essence of all human experience. It is present in the most denial. Everyone struggles with questions about the meaning and purpose of life. Nietzsche, as he negated God, sought to elevate human spirit. Sartre wrote about 'bad faith' as a failure to affirm existence, even as he said faith as a principle is undermined by the ultimate absurdity and meaninglessness of our lives. A human being has to find meaning and purpose in life even in the midst of losing 'all hopes and crushing experiences. This has been part of my curiosity and observation in accompanying those who longed to recover from the suffering of addiction. The search for meaning is a critical facility in working with those whose lives have been shattered by near death experience because of addiction. In the later half of the 19th century, intellectual revolution that shook the European civilization became disillusioned with spirituality, only recently spirituality came to be considered as a legitimate aspect of mainstream psychology and Psychoanalysis.

Psychotherapists outside the specialized discipline of psychology of religion often understand religious/ spiritual beliefs as a unitary aspect of individual differences. However, laypersons seem able to recognize distinct vectors in such beliefs (Zinnbauer et al., 1997). Although a growing number of individuals in Brazil claim no religious affiliation, approximately 95% of this unaffiliated group still believe in God (Instituto Brasileiro de Geografia e Estatística, 2010), and may consider themselves as spiritual but not religious. Actually, the statement "spiritual but not religious" forms the title of a scholarly book (Fuller, 2001) that discusses contemporary metaphysical religion and "unchurched," eclectic, and "psychological" spirituality. Consequently, understanding the difference between religiousness and spirituality is growing in both conceptual and methodological importance (Aldwin, Park, Jeong, & Nath, 2014). In studies of the effects of religiousness, spirituality, and health, religiousness is often assessed through simple measures of affiliation or service attendance, while spirituality is generally assessed as feelings of closeness to God and self-transcendence and/ or as engagement in practices such as meditation or mindfulness (Fetzer Institute/National Institute on Aging Working Group, 1999).

Nevertheless, numerous definitions of religiousness can be found in the psychological literature. There are concrete, abstract, metaphysical, prescriptive, relationship-oriented, inner-motivation oriented, and existential-quest-oriented definitions (Zinnbauer, Pargament, & Scott, 1999). Argyle and Beit-Hallahmi (1975) defined religion as "a system of beliefs in a divine or superhuman power, and practices of worship or other rituals directed towards such a power" (p. 1). The emphasis this definition places on worship and rituals implies community activity that binds or ties people together. Indeed, such an understanding of religion favors one of the two most common etymologies of this word found in ancient authors. According to Aiken (1911), the origin of the term "religion" goes back to Cicero and Lactantius. While in Cicero's writings religion is derived from the Latin verb *relegere* (i.e., to go over again in reading, speech, or thought; to treat carefully), in Lactantius' texts "religion" comes from the Latin verb *religare* (i.e., to bind, to tie up) (Aiken, 1911). Medieval authors such as Augustine and Thomas Aquinas ultimately favored Lactantius's comprehension of religion, which seems to capture much of what religion has become in its simplest form across different modern Western cultures. Such a notion of religion implies the idea of being bound to, having a personal relationship with, and voluntary subjection to a transcendent being (Aiken, 1911).

Further, it encompasses a set of beliefs, practices, and body of doctrines with a certain number of adherents who generally perceive themselves as motivated by faith. Obviously, this definition of religion inherited from medieval authors is strongly rooted in the Judeo Christian tradition and certainly neglects the cultural, sociological, and historical multiplicity of the religious phenomenon. However, it serves the purpose at hand of providing a basic definition of religion, which is necessary in order to illustrate how the terms religion and spirituality are not necessarily interchangeable.

Definitions of spirituality, on the other hand, usually put more emphasis on the individual and on subjective experiences. The word spirituality comes from the Latin word spiritus, which in turn comes from spirare (to breathe; Wulff, 1997). Shafranske and Gorsuch (1984) defined spirituality, broadly, as “a transcendent dimension within human experience (...) discovered in moments in which the individual questions the meaning of personal existence and attempts to place the self within a broader ontological context” (p. 231). Vaughan (1991) provided a useful, more specific, definition: “a subjective experience of the sacred” (p. 105). Emmons (1999) pointed out spirituality may be related to religiousness in some contexts, but this may not always be the case. For Emmons, spirituality involves “a search for meaning, unity, connectedness to nature, humanity, and the transcendent” (1999, p. 877), thus having a strong subjective element.

However, it is important to notice that, even though the definition of spirituality is broader and more inclusive than religiousness, it is still limited by the notion of transcendence and search for the sacred based in an intersubjective relationship, which may encompass Judeo Christian values that may not be shared by other types of spirituality. In line with this notion of spirituality, it is assumed that human beings have the capacity to go beyond themselves and their daily struggles in search for transcendence and not just strive for natural goods. This fundamental capacity within the human person is understood as ability for self-transcendence, which is evoked by the word transcendence. However, the distinction made here and the decision to use the construct spirituality instead of an interchangeable use of religiousness and spirituality is more for a matter of being inclusive than for compartmentalization intent.

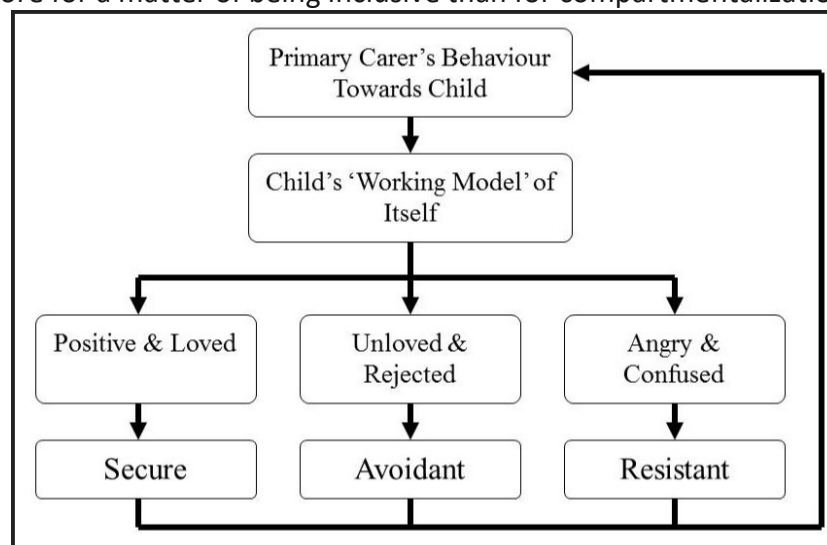


Figure 5: John Bowlby's attachment theory

<https://www.simplypsychology.org/internal-working-model.jpg>

Chapter 4: Psycho-analytical Understanding of Addiction

4:1 Tenants of Psychoanalytical realities

Psychoanalysis is considered as a theory, a treatment, and a way of thinking about the human motivation. A psychoanalytic perspective includes conscious, and repressed unconscious motives and desires. Psychoanalysis is traditionally conceived as an opportunity for a motivated person to reflect deeply about everything he or she is feeling and thinking without editing or censoring. Freud developed the first systematic approach of how unconscious mental life exerts its influence on our view of the world. The so-called structural theory organizes the functions of the mind into three conflicting parts:

- 1) The ego (governed by the “reality principle”);
- 2) The superego (the conscience, a sometimes too rigid commitment to the rules of society);
- 3) The id (the desire for pleasure, sooner rather than later).

The id contains the reservoir of energy, and is commonly referred to as the libido (sexual energy and aggressiveness). It only seeks immediate gratification and is very “selfish” operating according to the so-called “animal spirits.” Contemporary neuroscientists might locate the id in the amygdala, the ancient part of the brain involved in primitive emotional functioning. The concept of the ego (i.e., one’s sense of “I”) is relatively compatible with contemporary knowledge of the prefrontal cortex (self-control). The ego responds to id and superego impulses by modifying them as a way of managing conflict and danger. The superego emerges through the internalization of social values and norms.

For Freud, the goal of psychoanalysis was to strengthen the ego, and to give it more control over the id and more independence from the superego. He believed that most mental disorders (e.g., anxiety) were due to the effect of unrestrained feelings. Increased awareness through psychoanalysis can help the individual to become less self-punitive and be able to tolerate their emotional experiences. Psychological growth requires self-acceptance, which is a state of mind that marks the end of the life-consuming struggle to transform oneself (and others) into the person one wishes one were (or wishes they were) . Becoming aware of the unconscious motives helps the individual to increase the ability to manage and integrate unconscious wishes, and ultimately to self-acceptance. Freud argued that whenever desires (wishes) from the id threaten to emerge in thought or action, anxiety is generated. The anxiety acts as a signal, causing the ego mobilize repression, along with a broad range of other defenses (withdrawal, denial, projection), in order to block or disguise the anxiety-provoking wish.

The intensity of anxiety differs according to the gap between external demands (dangerous situations) and the person’s self-protective resources to handle them. Inability to deal with external events (traumas) could lead to feelings of helplessness and powerlessness. Lacking the capability to cope with negative states, patients will erect powerful, sometimes intransigent, defenses in a desperate effort to avoid feeling them. The person using a defense is generally trying to accomplish the management of anxiety and maintenance of self-esteem. For instance, alcoholics insist they have no drinking problem. Keeping the unacceptable feelings out of

awareness result in the development of a “false self.” The price for this protection is inability to develop resilience.

Addiction is described as a defensive strategy to avoid feeling of helplessness or powerlessness. Drug abuse is a futile attempt to compensate for inner emptiness without success. The addict tries to compensate via addictive behavior for painful subjective states of low self-esteem, doubts and anxiety. The use of drugs supplies a feeling of acceptance and feeling of temporary self-confident. Addict substitutes an imaginary world, where he is in complete control, for the real world, where he feels useless and out of control. Repeated use of drugs to gain relief becomes a way of life. Relief is momentary, but in the long-term drug, use becomes an end in itself. The addiction problem prevents the user from understanding about her distress, as well as the development of emotional capacity to self-soothe.

The psychoanalysis view suggests addiction is a disorder of self-regulation. For instance, individuals with histories of exposure to adverse childhood environments (e.g., physical and sexual abuse) tend to have diminished capacity to regulate negative emotions and cope effectively with stress. These individuals may be self-medicating anxiety and mood disorders. It is instructive to note that many individuals experiment with drugs but few become addicted. The success of therapy and the lasting change require the patients encounter previously inaccessible aspects of their inner feelings. Helping patients increase the ability for engaging in self-reflection, and identifying alternative ways to manage difficult emotions are part of the psychodynamic approach to addiction treatment.

Connection between Psychoanalysis and Spirituality

4:2 The Unconscious

Human personality is a complex one. In our day today life, we are not fully aware to what extent and how human organs are involved in our functional capacities. For example: To what extent are we aware that every minute of life, the human heart silently pumps five liters of blood to the vascular system to nourish and keep every single human cell alive? In the same way, we need to understand human mind is operational at all times unconsciously and consciously. In our understanding of human psyche, the unconscious remains to be a mystery for human kind because it unfolds deep reservoirs in front of us. It is important for us to understand that long before Sigmund Freud or even William James, the idea of the unconscious was a subject matter throughout history.

Therefore, it is worthwhile to underline remarkable influence of opposing views of Sigmund Freud and Carl Jung even as we wrestle to comprehend the ‘concept of evolving human psyche’. For Freud it was sum of repressed memories and for analytical and spiritual mind of Carl Jung (analytical psychologist), the individual unconscious is open to the collective unconscious of the archetypes, which according to the nature of his work is the collection of symbols and images. It functions as a link between the personal unconscious and the collective unconscious “....for Freud his first concept of the unconscious as being the total of repressed memories and tendencies.” As the unconscious represents different levels and rich layers of

human personality, we can be curious to grasp its operation. It contains emotions and memories that connect the personality of the person with the past life. Our journey through the fantasies and dreams can unfold many revelations that make the link with the present and the future. As Freud termed dreaming “the royal road to the unconscious”.

According to Freud, unfulfilled wishes and urges are in the unconscious. Our realm of consciousness has many gaps that prevent us from recalling our experiences from the past life. We do not know where some of our personal ideas and assumptions come from and consciousness does not provide us any proof, this I believe should broaden our horizon to explore the unconscious. Jung coined his understanding of unconscious in three ways and they are personal unconscious, collective unconscious and consciousness. Jung’s unconscious evolved unlikely to Freudian’s concept as it connects through the archetypal images, symbols and dreams in communion with humanity.

However, we need to acknowledge Freud’s revolutionary contribution in a developing arena of unconscious and bringing it forth to the systematic study of the subject. During the 19th century the dominant trend in the Western thought was positivism, i.e.; positive affirmation can come from authentic scientific knowledge and such a period of revolution subscribed to Freudian thinking. Crucial to the operation of the unconscious is ‘repression’. According to Freud, people often experience thoughts and feelings, which are so painful that people cannot bear them and associated memories, Freud argued, be banished from conscious mind, the number of gaps in the conscious mind paves for the unconscious to gain edge over human memories. An example I can think here is transference experience in therapy, (memory of the past reflecting in therapy room in a lighthearted manner) something shared intentionally in therapy either by a client (patient) or by therapist becomes a healing agent. Jung developed the unconscious in such a way to understand that unlocking the unconscious can offer deep reservoirs for our personal growth and development.

4:3 The Unconscious is dynamic

This is a process of interplay of the driving forces in the unconscious. It explores mental phenomena as the result of the interaction and counteraction of forces. A dynamic system examines the phenomena in terms of processes of development of progression or regression. These are both urging forces and checking forces, there is reciprocity between urging forces and checking forces. For example, a person’s id urges him to pay injustice with injustice, like the memory of the murder of his father that happened when he was a child. Now he is of age and he wants to take revenge, but his superego comes into play strongly to remind him of his need to transform his life and subsequently of the legal consequences. What is the role of spirituality in this effort of transformation? How can the therapist utilize psychological resources and tools in spirituality for effective intervention? How can he be present in the patient’s suffering? A caring therapist who is willing to walk in the shoes of his client or a doctor who’s able to engage with the suffering of his patient can and will develop and integrate spiritual tools to offer compassionate care. In this process, there is consistency in altruistic effort in patient centric care.

The nucleus of the unconscious consists of instinctual representatives, which seek to discharge their wishful impulses. These instinctual impulses co-ordinate with one another, exist side by side without being influenced by one another and exempt from mutual contradiction. Therefore, it could be a primary tenet in the psychoanalytic circle, those deeply painful memories inhabited in us, part of the psychopathology of everyday life, which the psychic process does not bring into consciousness, but is dealt by the mental energies in the dynamic unconscious.

4:4 The Idea of Illness

The idea of illness and cure was associated with various cultural and religious meanings. The religious leaders and clergymen assumed crucial roles in alleviating illness and pronouncing cure. There were myths and beliefs about the nature of illness and in many ways, it added to the development of illness and the cure of it. There was a basic understanding that unequal distribution of energy could be the cause for the illness. It is interesting to note how persons like Mesmer viewed etiology of illness. It could be that there is a connection between what happens in our mind-body systems and cosmos. Health and wellbeing depends upon man's inherent relationship to the environment and if there is an imbalance in that connection, a lack of effort to repair the imbalance can possibly lead to breakdown.

4:5 The unconscious can be accessed and interacted with

We can access and interact with the unconscious through symbols and images. When interaction takes place with the unconscious, there is transformation of psychic energy and removal of the mental blocks result in cure and healing. Before the emergence of modern psychiatry, there were culturally bound beliefs that contributed to various methods of treatment. There were exorcists who had exercised power over what was called long discussions with the evil spirits and the spirits agreed to leave at a given time and under certain conditions.

The most crucial aspect that evolved in terms of entering into the unconscious was the therapist's ability to establish rapport with patient and his resilience to continue in that rapport. There is transmission of psychic energy into patient to elicit response. The result depends on the outcome of reciprocity of patient in response to the shared rapport between patient and therapist. Freud believed in free association that helped him to journey with his patients into their unconscious. Freud traveled well along the "Royal road" to the Unconscious. The modern psychoanalytic model has evolved through trials and errors. There is no doubt that Freud made an outstanding contribution in the discovery and the promotion of the unconscious, despite certain dogmatic approaches to the subject. Jung's contribution to the subject with the expansion of collective unconscious opened the gates in such ways to look at the functioning of the unconscious from cultural and universal perspectives.

"The unresolved traumas become split-off shadow elements that cause great suffering. These dissociated or repressed parts of us, these beasts in the basement of our consciousness, do not go to sleep but create absolute havoc in the pathological symptoms of depression, rage, self-

hatred, hatred of others, anxiety, and chronic, inescapable stress. In the brain of the addict, the stress can manifest in triggering uncontrollable cravings for drugs, which is the disease of addiction. The very act of using these substances can be seen as an attempt to heal the suffering our split-off parts and repressed emotions produce”.

Carl Jung in his work on the collective unconscious refers to the unreached dimensions of the shadow side of the personality. A spiritually oriented therapeutic covenant has bandwidth to shed light on the elements that cause suffering through addiction, “This is what Carl Jung was referring to when he taught that God comes through our rejected parts

4:6 Spiritual care and psychoanalysis

There are fundamental differences and similarities between spiritual care and psychoanalytical work. At the outset, it should be noted that spiritual care may be based on the confession of faith and psychoanalysis is based on the medical model. Traditionally, spiritual caregivers are expected to play a direct role in solving the problems of the people based on the faith tradition of their congregation or community and in line with dogmas. In psychotherapy, the patient along with the therapist in and through therapy engages in searching for the meaning of the lived past and current experience in joint venture. Personal experiences, thought process and emotional experiences of the patients accorded significance in the context of therapeutic relationship.

Jungian model of therapy involves with the tradition and any form of faith and images which patient brings into therapy. Both Psychoanalysis and spiritual care aims to facilitate healing process. The challenge is to learn to develop resources and culturally relevant approaches to bring about the relationship and usefulness between faith traditions and modern psychological thought. . Jung offers vast resources to enhance skills of the spiritual caregivers and provides great insights in understanding the struggles of individuals in multicultural context.

The study of spiritual resources/religious dimensions for the benefit and wellbeing of persons in illness and suffering can be very inspiring and challenging. The area of discovery may not be a comfortable journey, but a road less travelled. However, there is constant drive across the cultures, groups and societies to search for meaning of life in the midst of chaos and breakdowns.

Chapter 5 – Case Studies and Reflections

This chapter consists of case studies, which are part of clinical work with addicts and related issues over a period from a broader spiritual perspective, especially of the approach derived from learning and practice of Clinical Pastoral Education. I have interviewed two recovering addicts and both of them have worked with me within an addiction recovery program. While the first interviewee, Theo, has attended a recovery program and Christianity was an integral part of his program, while he is an ardent believer and supporter of Buddhist spirituality (audio recording is attached separately). Finally, I have included a detailed case study of a substance user who was assisted by my associate Gerry at the Riverbed Counseling & Wellness, Winnipeg, Canada.

5: 1 Case Study 1

Jerry* (name changed) was admitted to a luxury rehab. I was the lead group therapist. Jerry was initially skeptical in sessions; he was condescending in his interactions within the group. One day I was taking a psycho-education session on personality disorder with a special focus on histrionic personality. As we started the session, I sensed a deep sense of anxiety within the group and felt guided to lead the group into a mindfulness meditation, which energized the group into a state of alertness. The group started to relax by deliberately paying attention to thoughts without judgement.

I had a checklist for the group to identify traits with histrionic personality. The American Psychiatric Association defines histrionic personality disorder (HPD) as a personality disorder characterized by a pattern of excessive attention-seeking emotions, usually beginning in early adulthood, including inappropriately seductive behavior and an excessive need for approval. Histrionic people are lively, dramatic, vivacious, enthusiastic, and flirtatious.

Jerry became thoughtful, quiet and reflective unlike his usual pattern of condescension and many times raising his eyebrows in denial, he began to speak "I must admit I am a pervert and I used many women and I never had respect for anyone of them that I sex with." I could experience a deep sense of comfort, tranquility and connection within me and I started observing a wave, a deep sense of connection and compassion unfolding within the group. The group members had the freedom to confront and ask questions, yet there was a conspiracy of silence within the group, but in that moment of quietness, I observed that some others in the group saw their own realities in Jerry.

Jerry continued, "I recently met with a Psychiatrist and I started seducing her into a sexual relationship. When I look back, it was like fantasy, but I had no reason to disbelieve my client's confession as his life history was documented in his admission file. As the session progressed, Jerry's personal story started affecting others and a fellow client opened up his life to the group, admitting his multiple sexual relationships were responsible for the separation from his wife and substance use only a small part of his life. Clinical Pastoral Education is a meeting point between psychotherapy and spirituality, which fosters a connection higher than anything else, does.

Working as a professional in addiction treatment can be an intimidating experience and the day-to-day interactions with addicts can make one feel insane. “Since addictive behavior in large part consists of running away from self-awareness and emotional integrity, this emotion/shadow work is an important front in the battle for recovery. As we learn to hold our issues and our egos in an ever-larger context, they do not go “poof!” and disappear in a single blaze of glory, but they do become lighter and lighter. We become less fearful and attached as we move through and release our old knots, traumas, and conditioning. The alternative is to stay stuck in our old conditioned patterns of understanding and behavior, which is exactly what we want to avoid. Eventually our emotional triggers lose their hold over us, and with that goes their power to cause relapse and suffering”

Spirituality in clinical practices embrace those broken pieces and bleeding hearts in therapy. It gives you a sense of reflection when you nurture intrapersonal, interpersonal and transpersonal connections. It grows in one both consciously and unconsciously. You are reminded that you are a wounded healer. This experience and learning can become contagious for a shift within a group. Jerry started breaking down. He is a real estate mogul who had the capacity to live the life he wanted. There was an outpouring of energy and longing for the path of recovery and a felt need for change in Jerry and the fellow client who identified with his disclosure.

Jerry was also struggling to find balance in his body and his experience of himself. Jerry was hurting, I followed up with a mind-body scan exercise for Jerry, and others joined.

Identify the hurt in your body

- identify the thoughts associated with the hurt
- bracket or let go of the thoughts
- stay with the feeling in your body until it releases

I was expected to do psycho-education, but instead it turned to be a process group with an expression for healing and recovery. They decided to hang in there, listening to each other. The entire session converged into making a long-term treatment plan to deal with sexual addiction for Jerry and a few others in the group. He was on the verge of leaving the program, but made a commitment after this session to go through the entire treatment.

There is caution here; lack of self-awareness and sensitivity to the individual needs, purpose and context can become counterproductive as the unconscious in the wounded healer can misguide a process. I will substantiate it with another encounter, which I witnessed at the Luxury Rehab.

5:2 Case Study 2

Rita (Name changed) came to a luxury rehab from New York for alcohol and drug recovery. She was a strip dancer since her high school days. She decided to come to the rehab for treatment at the insistence of her boyfriend who was undergoing treatment for his addiction. He sold a million-dollar business in the States before he embarked on the path of recovery. He met Rita about 4 years ago in a nightclub in Canada. Rita walked into my first group therapy and she had nothing to offer, but remained quiet throughout the session. She felt comfortable that I allowed her to be a passive participant, which is not my mental preference. As time passed, she started

requesting for additional therapy sessions with me and she opened up her life without any inhibitions. She started trusting the process and me as a therapist whole-heartedly.

I was scheduled to weekend managerial duty monitoring the moments of clients in all areas including their planning and executing their weekend safaris. I personally objected to the weekend assignment, considerable understanding and being aware that such job has the potential to damage your rapport with the clients, but however regardless of my objections, the management insisted on the weekend duty which starts from Saturday 8 AM to Sunday 10 PM with meal breaks. I was suddenly caught up with an emerging chaos, as there was stand off between the management and the clients about preferences for weekend excursions. I had several rounds of discussions between the management and the clients. It was a stressful morning and the clients were ready to hit the roof if their demands were not met. I gave them a break to discuss the options and return with a consensus.

The luxury rehab had a beautiful property with a river flowing through the centre. I informed about a past incident when a client slipped into the river critically injuring himself.

The floor manager rushed and reported to me that he saw Rita along with of couple of other clients and he had a hard time to exhort them back from the riverside. I was taken aback and called Rita and confronted her about the incident, she apologized and I thought everything went well, but however I had most humbling learning from Rita the incident had a sudden effect on my therapeutic connection. I believe she experienced me as I controlling. One of the core dimensions of spirituality in clinical practice from CPE perspective is to get in touch with your tension instantly while you are 'staying back' with the feelings and experiences of the other person. I must say no other system in psychology teaches you on going work of 'self awareness' unlike CPE.

In CPE Circle, you are expected to 'be with yourself while you called upon to 'be there 'for the other person. It took a while for me to realize the moment, I felt the pressure of the weekend assignment and related complications, and I started feeling a 'disconnection' myself and extended that connection for those clients who got into conflict with the management on that day. I was still professional and displaced sense of duty and responsibility, but I was unable to offer a 'holding place 'for Rita so that she could relate to the tension and distraction, which let her accompany the clients to the river. Psychologist Winnicott talks about considering that "the foundations of health are laid down by the ordinary mother in her ordinary loving care of her own baby" central to which was the mother's attentive holding of her child". As a child, Rita never experienced 'holding place' from her mother as she was always drinking and drugging, even watching little Rita being sexually abused by her mother's boyfriend left her orphaned in early on in her life.

Rita's mother dominated her life in every sense of the world until she became independent to break free from the vicious circle at home. It was natural for Rita to have experienced a sudden 'transference with me and I felt rejected by Rita. It was one of those days, when I could not relate to my 'sense of helplessness' so that I could offer soulful connection for Rita. As I look this is a critical facility, regardless of the vast training and exposure in psychotherapy, you could simply become vulnerable and feel dismissed by your client. It is also binding and responsible to examine the background and lack of self-awareness, which blocks the flow of energy and connection from you to your client. It is not always about how technically and ethically correct I

am, but how I need to continue to work on humanity, wisdom and non-judgemental attitude and treatment plan that includes listening and respecting unspoken voices in therapy.

5:3 Case Study 3

I remember many years ago when I stood by the side of a Norwegian ship captain, an acute alcoholic with HIV. A sharing of the needle infected him. He was angry, shocked and terrified, He yelled at the top of his voice demanding answers from God, “ I hate God, He is cruel why me, I got two kids why should they go through my loss, why did the hospital messed up? May be there is no God”. He broke down and his anger and frustration brought tears to my eyes ... I did not answer any of his why questions. Why? Because I felt a sense of loss and helplessness ... I had nothing to say”. There was no standard therapeutic approach. I must confess that I was equally angry with God. I just held him and stayed there for about thirty minutes. He was experiencing high pitch emotional pain and it was deeply moving, but at the end of that meeting, he whispered “Thank you”. I wonder if we together wrestled with the invisible third party in our meeting.

I completed my verbatim for the group seminar and presented the segment to my group and the supervisor. My peer group was critical of me going through such an emotional turmoil with the patient; however, this verbatim seminar was a turning point not only for me, but also for the entire group. Our supervisor commented, “In your helplessness and unskillfulness, you did not run away, but you were ready to be broken with the patient, you became part of his grieving moments, in being there, both of you shared the reincarnation of Christ in utter broken human condition”.

Spirituality in clinical practice is not dogma driven, but rather an offer of the presence of a compassionate caregiver who is willing to hang in there and sit in there even as One fails to provide answers for multitudes of ‘why’ questions. It is indeed challenging to note from lived experiences that variety of experiences beyond presumptions of how and what constitute ‘God experience or God awareness or even of the absence of any beliefs still provides ‘large room’ to explore ‘sense of hope, direction, meaning and connection in the midst of broken human experiences.

5:4 Questionnaire

I created a self-assessment inventory for recovery addicts. The objective was to evaluate personal attitude and realization of ‘spiritual dimension’ in addiction treatment program. Below is the inventory and the response.

Theo Calssen: Interviewee 1

Theo has worked as a recovery coach at a Luxury Rehab. Today he is a certified recovery coach and a well sought after therapeutic worker in South Africa.

Q. What was the critical turning point in your addiction?

A. When I desynchronized from my primary (unreliable) source of truth and synchronised around a reliable source of truth, which for me was Jesus Christ & The Bible, created a new reality that included hope.

Q. What are the areas of your life covered in your rehab?

A. Sharing my own personal struggle and successes in recovery, skills development, personal development and relationship.

Q. Briefly describe your experience with Psychotherapy.

A. It increased my perspective and helped me formulate a constructive reality to base future decisions on.

Q. What was the spiritual dimension of your rehab experience?

A. The all my needs that were being met in addiction, can be met is my faith.

Q. How do you define 'God awareness' in your addiction recovery program?

A. For the team to conduct themselves in a Godly manor. To include residents in a spiritual development program.

Q. In what circumstances have you ignored your inner voice and Why?

A. In times of self-judgement or in judgement towards others. In times of not resting when I need to.

Q. What are the consequences of ignoring your inner voices?

A. Risk of burnout.

Q. Who are the people who undermined your growth and recovery?

A. Only myself.

Q. Who are the people who support your recovery?

A. My family, close friends.

Q. What is the purpose of your life?

A. To be a voice to the voiceless, to empower the disempowered and to set the captives free.

Q. Have you experienced any signs of relapse?

A. Yes, I experience the signs, but have strategies in place to divert. Warning signs have steadily decreased of time.

Q. What have you done to take charge of your triggers?

A. Learnt to love, appreciate and value myself

Q. What you have you done to strengthen your inner voices?

A. Stop, spend quality time with myself, and listen to my somatic intuition.

Rob Huf: Interviewee 2 (Audio file attached)

The second Interview is recorded in the audio from a Psychotherapy intern Rob Huf at another Luxury Rehab in Chang Mai, Thai land. I spent a month, delivering psycho-education sessions and interventions. Rob assisted me while managing an extremely difficult suicidal client. His personal experience with addiction and multiple crises he has successfully overcome has provided much impetus in our work together.

5: 6 Case Study 4 - Regarding: Mr. S; DOB: January 25, 1986

Mr. S. was in the outpatient program for assessment and treatment of alcohol addiction at the Riverbend Counseling and Wellness Clinic, Winnipeg, Canada. The Clinical work was carried out by Gerry Goertson, Senior Psychotherapist who has entered into a contract with me recently to provide him clinical supervision for his permanent membership with the College of Registered Psychotherapists of Ontario (CRPO). Gerry and I discuss case studies and I have his consent to include the below case study for this thesis. Gerry is a certified professional counsellor specializing in addiction and would assess clients for substance abuse and co-occurring disorders, and provide treatment as necessary. Mr. S. has understood the limits of confidentiality, particularly with respect to my report for court purposes, and has agreed to proceed with counselling.

Introduction

Gerry carried out a broad assessment from which he concluded that Mr. S. does indeed suffer with the illness of Substance Use Disorder. Mr. S. agreed to this analysis and understands that abstinence is necessary saying, *"I can never have one drink. It has a life of its own, so instead I am committed to a life of sobriety. In the past, I gave up and sold everything for my addiction. Now I'm filling my life with good things."*

Exposition

Mr. S. is a 30-year-old male Caucasian. He is married to N, and they do not have children. Mr. S is employed full time in housing construction. He reports to be in relatively good physical health and is not prescribed any medication. Mr. S did not complete high school education. He intends to enter a program called YWAM (Youth with a Mission) for the sake of personal and spiritual development.

Mr. S conducted himself well in all the interviews. His communication is average with slight manifestations of pressured speech. His appearance is consistently well groomed. He presents a respectable attitude and indicates a resolve to participate in the assessment and treatment. His eye contact is good. He is alert, engaged and expressive, conveying information without hesitation. He exhibits traits in keeping with Adult ADHD (Attention Deficit Hyperactive Disorder); however, this did not interfere with productive interviews. His patterns of thought were reasonably organized. There was no presence of hallucinations nor delusions, and he stated that he has never had such occurrences nor has he been under psychiatric care. He did not have any complaints indicative of Dysphoria (unease or distress about life, body or gender), Suicidality, Anhedonia

(inability to experience pleasurable emotions), Anergia (chronic state of lethargy or low energy), eating disorder nor sleep disorder.

Gerry was provided with a copy of the particulars with respect to the arrest and charges dated May 8, 2015 and May 24, 2014. I was also notified that he had prior contraventions with the law including an arrest on May 27, 2011.

All these factors are taken into account regarding the overall assessment and ongoing work with Mr. S. In addition, Psychotherapist took into consideration a number of factors in the assessment of substance abuse based on my expertise including the following collaborates:

- NCADD; National Council on Alcohol and Drug Dependence screening instrument.
- SASSI-3; Substance Abuse Subtle Screening Inventory
- Co-Occurring Screening and Assessment: Mood and personality disorders
- TJTA; Taylor Johnson Temperament Analysis Profile
- Interviews with:
 - Mr. G S – employer
 - Mr. M F – mentor
 - Mrs. N - spouse

Substance Use

Mr. S clearly indicated that alcohol has been his drug of choice. He is not a stranger to cannabis and other drugs; however, he consistently turned to alcohol as his primary intoxicant. He remembers having an occasional beer at age 15, but it was after his mother's death at age 16 that he started to drink heavily. He also brought marijuana to school and was suspended for that. He suffered a lot of trouble in high school and eventually was kicked out and never returned to complete grade 12.

Over the course of time, Mr. S found himself resorting to the use of various illicit drugs, but he settled mainly on the use of Methamphetamine for roughly one year. Due to difficulties in his home, he moved into the home of his friend's parents. They were able to help him wean down and eventually quit Methamphetamine, but in the process, he turned more heavily to the use of alcohol in its place. His consumption pattern continued with increasing frequency and quantity. Occasional periods of abstinence generally lasted only a few days, interspersed with periods of moderate drinking on weekdays and heavy drinking on weekends. He had difficulty maintain employment and his life was generally spiraling downward.

Over all, Mr. S history of alcohol consumption indicated an increasing level of loss of control. His tolerance evolved as well as other factors consistent with alcohol addiction such as - steady increasing frequency and tolerance, withdrawal symptoms when attempting sobriety, unsuccessful attempts to control it, associating primarily with other addicts, and his consumption interfered with regular life activities. All of this led to what he explains as a "deep and spiritual fatigue" which affected everything in his life including finances and relationships. Upon reflection of his history with alcohol abuse he has gained insight about these factors and explains, "*I know what it is – alcoholism - and if I use I will lose – time, money, friends and peace with God*".

During the sessions, Mr. S indicated a consistently keen interest in and familiarity with spirituality. He reported having made a complete turn-around and credits God and his spiritual pursuits for this new life he is experiencing. He regularly attends church services and small group meetings that help hold him accountable. Other addicts in recovery are also a part of these gatherings and they find comradery in their sobriety together. He has attended AA in the past, but has found a church that takes a similar approach and provides the resources he needs. Mr. S has gained an understanding and gratitude for the healthy outcomes of this sobriety-focused life style. He is also aware of the danger of feeling good enough to be tempted not to need these supports, and therefore does not miss meetings even at times when he is feeling stronger. He says, "I'm on fire with this (church group meetings). The deeper I go the more excited I am".

Upon reflection, Mr. S does not like the person he was while being controlled by alcohol. He recalls the feelings of hangovers and sickness, broken relationships and financial loss due to consumption. There were times his drinking binges were so great that he was too drunk to remember what happened or where he was. Along the course of time, he faced many seemingly breaking points and participated in various recovery programs such as "The Orchard Recovery Center" on Bow Island in British Columbia and "Four Winds Recovery Center" in Steinbach, MB. Although he hoped that those programs would cure him, he was not able to abandon the old life style completely, the excitement and the cravings. He recalls being back home after treatment, sitting on the couch alone at the farmhouse and devising ways he could get beer and whisky. Now, upon reflection, he acknowledges the dangers he has posed to himself but also on others when intoxicated. He has expressed a humble relief that his substance abuse did not cause the type of damage or harm to people that it could have and often does when driving under the influence. He says, *"I'm learning the difference between living spiritually and living selfishly. Prior, I seldom cared about other people's needs. I managed my life to suit my addiction. Now I am pleased that people see I have changed. They often seek me out for support. I cannot go back. I won't."*

Mr. S states, *"Alcohol has been a darkness over my life, and brought shame, guilt and danger. My problems are of my own making, and it's up to me, with the support of God and others, to repair the past and keep building the new life I have."* Mr. S and N married in January 2015. He says, *"My wife loves me and I've put that at risk. I will not do that anymore. She is staying with me and we are committed to building a good life together. She suffers with depression and I need to be there for her"*. Statements like these appear to come from an emerging self-awareness indicating that he is not in denial, but is striving for something better than what he has had. For example, he understands that he cannot have even one drink without putting himself in danger of a binge. He comprehends the reality that alcohol addiction is a biological and psychological affliction that requires ongoing and vigilant abstinence.

Mr. S has abstained from alcohol/substance use since May 8, 2015. His wife, employer and mentor corroborate this. That was the day of his arrest, which he views as "the hand of God." He states that the spiritual element of recovery is what was missing in his earlier attempts, and

as is commonly expressed among addicts, Mr. S is grateful that God opened the gates of hell and let me out.

Although his history prior to May 2015 indicates that law and punishment was not generally enough to keep him sober, several other factors helped Mr. S remain on the road of sobriety now. For example, he discovered the joy of serving others. He is committed to the group of men that support each other and do out-reach activities for the sake of others in the community. They carry out practical expressions of thoughtfulness as well as listen, uphold and pray for others with heavy burdens. This is a regular, weekly endeavor. Mr. S also serves in his church by participating in the worship team. Another contributing factor is his wife, N. She does not drink at all, and together they consciously work at keeping a dry and clean lifestyle. Furthermore, Mr. S recognizes he is a relatively young man with a long future on which to build a solid legacy. He became honest with himself about the dependency on substances and how it was ruining his life. The longer he is sober, the greater his realization of how drunk he really was and the devastation that accompanied it. He is putting the past behind him and focusing on a vivid picture of the future.

NCADD

Gerry utilized this examination tool, offered by the National Council on Alcohol and Drug Dependence (NCADD), as a resource to determine if alcohol abuse and/or other drugs could be problematic in a patient's life. If positive results are indicated, He typically follow through with more sophisticated testing such as the use of SASSI-4. Mr. S's NCADD test indicated a score of 20/26, suggesting a high likelihood of serious alcohol-related problems. This test was administered with the perspective of his over-all life behaviors related to alcohol consumption pre-dating May 2015. Furthermore, it came clear that his family lineage is familiar with alcoholism. His dad is an alcoholic and his dad's brother, John, is a heavy drinker. In addition, his uncle Randy on his mother's side is an alcoholic, and several cousins are heavy drinkers.

5:7 SASSI-4

The SASSI-4 is a psychological questionnaire designed to screen individuals for Substance Use Disorder. Backed by over 25 years of clinical research, the recently updated SASSI-4 delivers an over-all rating of 94% accuracy. Further more it provides meaningful clinical insights in regards to a variety of areas such as: the client's ability to acknowledge problematic behavior, defensiveness, self-esteem, sympathy for others, self-regulation and the relative risk for being involved with the legal/justice system.

In regards to Mr. S, the results of this assessment are as follows:

1. He responded to the SASSI examination in a meaningful way, indicating an unbiased validity score, which establishes accuracy for interpretation.
2. Classified as high probability of moderate to severe Substance Use Disorder, and high risk of involvements with the legal/judicial system - based on the 12 months prior to his May 2015 arrest.
3. No evidence of defensiveness.

4. He is able to acknowledge problematic behavior and has insight into potential personal problems.

In summary of the SASSI-4, Mr. S is diagnosed with Substance Use Disorder. This is based on information pertaining to his overall adult life history (it may not be indicative of his attitude and behavior at the time of the test). The test also indicates he is a good candidate for treatment and recovery because he acknowledges his problem, is non-defensive and sincerely prefers not to act out.

Mood Disorders

As earlier indicated, Mr. S presented symptoms of pressured speech, which is an indicator of tension or edginess. Examining this further, for example using the Burns Anxiety Inventory and the T-JTA, both revealing that he suffers with symptoms of generalized anxiety however with insufficient evidence to diagnose an acute mood disorder. Mr. S admits that he has lived his life without self-awareness of these problematic symptoms. He has learned to cope largely by overcompensation, particularly in social settings where his charisma and fluidity of speech has often been the counter-balance.

Although no mood disorder is technically apparent, he does present noteworthy features of anxiety that are important for consideration in the overall treatment plan.

Adult ADHD

Mr. S exhibits many of the most common symptoms of Adult ADHD (Attention Deficit Hyperactive Disorder). He confirmed that as a child, his parents had concerns about ADHD and they tried to deal with it in their disciplinary measures including withholding sugar from him, but he was never diagnosed as a child with ADHD nor was he prescribed medication. Others in his extended family had been diagnosed ADHD. For example, his cousin Tim who was also administered medication for it. Tim and Mr. S spent a lot of time together and referred to each other as brothers throughout their teen and early adult years. Mr. S and Tim often got into trouble together, and in fact, the last two times Mr. S was arrested he was with Tim. Mr. S says, *"It's sad, because we've been like brothers. However, Tim is kryptonite to me – makes me weak and I relapse. I've had to cut Tim out of my life to remain sober."*

Psychological investigation identified the following list of symptoms, which are relevant to Mr. S. confirming adult ADHD:

- Difficulty paying attention to details and tendency to make careless mistakes.
- Easily distracted by irrelevant stimuli or interrupting ongoing tasks to attend to trivial things.
- Will eagerly start tasks that require problem solving, but difficulty finishing it once the challenging parts have been done.
- Frequent shifts from one activity to another; restlessness, trouble relaxing, thrill seeking.
- Difficulties with prioritizing tasks and/or procrastination.

- Fidget and squirm when having to sit for a long time.
- Frequent shifts in conversation, not listening to others well enough, talking excessively and/or failure to follow customary relational etiquette.

Many of the strengths and abilities often accompanied by ADHD are present as well, such as a magnetic attractive personality, courageous energy, and optimism and confident, determined and ambitious.

Adult ADHD is taken into consideration in my overall assessment of Mr. S with particular interest in it's correlation to addiction. Comparison studies have documented that the use of alcohol and other substances is considerably higher in the population of people diagnosed with ADD/ADHD. ADHD is 5 to 10 times more common among adult alcoholics than it is in people without this condition. Among adults being treated for alcohol and substance abuse, the rate of ADHD is about 25%. Furthermore a child with ADHD who has a parent with alcoholism, in this case, Mr. S' dad is an alcoholic, is more likely to develop an alcohol abuse problem. Researchers point to common genes shared between ADHD and alcoholism, and the tendency to be impulsive further exacerbates the issue.

5:8 T-JTA: Taylor Johnson Temperament Analysis

This instrument is used to measure a number of important and comparatively independent personality variables, attitudes and behavioral tendencies. These temperaments are central in the influence of personal, social, behavioral and attitudinal adjustment. The T-JTA is designed to aid a counsellor in evaluating the significance and role of these traits in the overall problem or circumstance of the patient. It makes possible the early detection of emotionally troubled individuals so that assistance can be provided before the problems become acute. The T-JTA also provides indications of serious personality problems, which may require immediate or intensive remediation.

The T-JTA assessment of Mr. S indicated an unbiased validity score, which established accuracy for its interpretation. The following points are noteworthy regarding the outcome of this test:

- His Overall Adjustment percentile is 89%, indicating he has a sense of emotional strength, a sense of security and self-confidence. He is generally a self-actualized person who is adaptable and of agreeable disposition. He has sufficient confidence to cope with the vicissitudes of life.
- His Emotional Wellbeing as it pertains to Self-Esteem is not a concern, meaning he feels capable and accountable for personal conduct, performance and accomplishments. He is assertive, energetic, enthusiastic and untroubled by feelings of inadequacy.
- He tends to be an Outgoing/Gregarious person who strives to be sociable, and his Interpersonal Effectiveness is high, indicating he establishes and maintains close interpersonal relationships. He is not alienating, but rather exhibits patience and consideration for others.
- He is average in Perseverance. Although he is highly energetic and does not tend to give up, he does struggle with impulsivity and being disorganized.
- He is Anxious, or perhaps more accurately, on edge, intense or high strung.

In summary of the T-JTA assessment, Mr. S is generally a people-centered outgoing individual who is energetic and persistent. He does not suffer with interpersonal difficulties, yet he is not readily calm nor is he methodical - both of which point to the combination of generalized anxiety and ADHD traits. Overall the T-JTA indicates that Mr. S does not have any apparent psychological pathology and that he is cognitively fit. He possesses strengths of temperament and has opportunities for growth.

General

In search of a sober and clean life style, Mr. S has attended a treatment center, AA, a church recovery group, a men's support group, and addiction counselling. Throughout my clinical examinations, he exhibited open communication and no defensiveness nor resistance. At times, he unintentionally diverted conversation and seemed to rely on his charismatic vernacular; however, he was consistently willing to return to the topic at hand.

In regards to his sociability, Mr. S prefers to get along with others rather than experiencing conflict. He may at times have a tendency to amplify his personality. He admits that during the years of his drinking and drugs he often used people for his own purposes or simply avoided people with whom he did not feel comfortable. He has grown to recognize that his own shame and guilt were present at that time, and has since made a significant turn toward cultivating sincere friendships and to generally being friendly and servant-like whenever possible, even to strangers.

At the time of acting out with excessive alcohol and drug consumption Mr. S knew he was trying to escape something troubling, but he did not clearly understand what was going on inside him. All he really knew in the moment was that it somehow felt better to escape the negative feelings within himself. Alcohol and/or drugs provided this escape. However, he has gained understanding and insight into the troublesome aspects of his inner life and how consumption was motivated by an effort of avoiding hurtful realities. The most obvious points of distress were the following:

- At age 12, his parents split up. He was angry and confused for a short time but adapted and seemed to do well. He lived with his mom.
- At age 16 his mother died. He was devastated by this, and had to go live with his dad.
- Conflict with his dad included aggression and abuse in the name of discipline. Spankings resulted in bruises and bleeding. Criticisms and name-calling were the norm. Overall, it was a disparaging existence in a home with an alcoholic father.

Remorse

Psychotherapist examined Mr. S for indicators of glibness or superficial remorse, however It is noted that Mr.S exhibits sincere regret for the years of unhealthy living and the subsequent damage he's caused. Mr. S' memories of events associated with drinking and drugs cause him an unsettling but productive sense of discomfort. His remorse includes an awareness of having lost many good years of his life, which could have been put to better use. He grieves the difficulties that his addiction has placed on his family and friends. The financial losses are

significant. Furthermore, he accepts responsibility for the poor and dangerous decisions he has made while intoxicated, including driving while under the influence of alcohol.

Although the conversations about specific details regarding his remorse were uncomfortable, Mr. S was willing to open up to it and never resisted conversations about the regretful behaviors. He wished he had not gone down the path he did. He is regretful of the entire journey into alcoholism and drug abuse. We explored how the distressing feelings of guilt and shame have been transformed into new ambitions associated with forgiveness and love according to his religious beliefs. We discussed how he has turn his emotional energy into acts of service in ways that help people in need and protect people in his community from harm. This was confirmed by the collaterals I spoke with, and seems to be a redemptive outcome, which coincides with the AA principle of making “living amends” in his sobriety. He indicates a solid commitment in this regard.

Psychotherapist noted with satisfaction “Mr. S is experiencing bona fide remorse and is committed to live humbly before god and man”

Mentor

Gerry spoke with his mentor (similar to an AA sponsor), Mr. F, a free-lance writer, performer and speaker. Mr. F confirmed that Mr. S attends their weekly men’s meetings where they discuss theological issues, share their stories and struggles, find support among each other and do outreach activities. Mr. F is aware of Mr. S’ history of substance abuse and the life style that went with it, and he confirms Mr. S’ sobriety during this past year. He refers to Mr. S as *“a man of integrity and passion, lives up to his word and follows through on his promises.”* Mr. F went on to say, *“Mr. S does not bend to influences that others might impose. He’s remarkably bold – living a life style that counts.”*

Employer

In speaking with Mr. G.S, he refers to Mr. S as having an excellent work ethic and being very good at his job. Mr. S has worked for Mr. G.S for roughly 3 years recently, but also had been an employee a number of years ago. Back then, Mr. G.S had trouble with Mr. S and “it didn’t work out so well”. However, Mr. G.S described being glad for having given Mr. S a second chance. *“It’s worked out better than I imagined”*, he said. *“Mr. S is always on time, works overtime when necessary and is responsible. I can leave him at work sites and he gets the job done.”* When asked about Mr. S’ history of alcohol and drug use, Mr. G.S said, *“I’m not a religious man, but it seems Mr. S is cured. He is definitely changed. He has never come to work drunk or high in the past 3 years. He’s made a good life for himself.”* Furthermore, Mr. G.S indicated his full support of a curative discharge and is committed to helping Mr. S. stay clean and sober.

Spouse

N. married Mr. S on January 17, 2015. She is 28 years old. They had known of each other in their teen years but did not strike up a relationship until three years ago. While dating, Mr. S was drinking but N did not know how much of a problem it was until a few months into their relationship. His DUI in May 2014 was a shock to her, but it also opened her up to the realities

of his struggle with addiction. She confirms that Mr. S' last drink was the day of the most recent DUI in May 2015. She says he is *"doing very well, attending groups, involved in the church and doing outreach. He's been very apologetic about the drinking problem and promises he won't go back."*

N went on to say that, she herself doesn't drink at all, nor smoke, and she doesn't have liquor in the home. She says, *"It helps that I don't drink. And we pray together for the strength that he will stay sober. I believe he will because Mr. S has a natural high for life itself."*

Summary:

Upon review and analysis of all relevant information in the assessment and as disclosed in this report, it is understood that Mr. S has a history of suffering from Substance Use Disorder. This diagnosis is consistent with chronic patterns of compulsive dependency on alcohol plus a significant stretch of dependency on Methamphetamine followed by various attempts at quitting and multiple infractions with the law. Furthermore, his history of excessive substance use along with ADHD features have aided in the development of an addictive personality, which, by definition, is able to switch between activities that are emotionally exhilarating.

In my discussion with Gerry on this case study, he expresses deep sense of satisfaction that Mr. S. has a clear understanding of the seriousness and consequences of his poor behaviour. This client is genuinely remorseful for harm he caused, insightful into the gravity of his actions associated with substance abuse including driving while intoxicated, and has a bona fide commitment to living above the realms in which he erred.

It is important to consider his journey into substance abuse began immediately following the death of his mom and was exacerbated by the influence of an alcoholic and abusive father. He was in deep emotional pain. Bottling up his feelings and started down the path of substance use to filter out the pain. In time, it became obvious that using substance to avoid pain was simply adding making things worse. A wise philosopher pointed out that the surest way to go to hell is by trying to avoid going to hell. Mr. S. experienced many years of hellish living, and he recalls the way in which alcohol captured his attention to the point that all he lived for was to find a way to get another drink.

His search for recovery began at age 25 when he was arrested (DUI) in May 2011, after which he attended The Orchard Recovery Center for 28 days of treatment. In the years to follow, he attended AA and church meetings, although his success was interspersed with occasionally relapses and hence resulting in the DUI has dated May 2014 and May 2015. Interestingly these three DUI arrests all occurred in the month of May, the anniversary of the death of his mom as well as mothers day. Insights like this have afforded him a greater understanding of the emotional pain he has tried to cover up with substance abuse. He has learned that the surest way to create more pain is to try ignoring the original distress, so instead he has turning his attention to healing the unresolved sorrow.

In light of the insight the client has gained and changes he has made, we can expect Mr. S' at low risk of re-offending. The assessment bears witness of an adequate self-awareness of his

behaviours including the motives, the meaning, and the impact of those behaviours. Gerry expressed confidence in the elimination of concern regarding criminal mindedness and/or other co-occurring psychopathology. It is also apparent that the resources are available for him to maintain successful sobriety and that the client willing to avail himself to those resources for sustaining the appropriate changes and reparation he is presently experiencing. In treatment, Mr. S. worked on a “Life Plan for Sobriety”. It involves ten decrees, including daily, weekly, monthly and yearly activities to help guide him on the journey. He also completed a “cost-benefit” exercise regarding consumption, and his analysis of the benefits of sobriety far outweigh being drunk or high. By focusing on his needs surrounding sobriety, flourishing in his employment and serving in his church, he is a contributing member of society. Furthermore, he is an outgoing person who sincerely wants to get along with others and his therapist believes he is adequately building sincere and productive relationships.

5:9 Treatment

Psychotherapist Gerry opines that Mr. S will benefit from substance abuse counselling. This needs to coincide with REBT therapy (Rational Emotive Behavioral Therapy) and/or Life Coaching for management of adult ADHD traits. Recovery from is never an easy road, and the treatment is best when adapted to the individual’s circumstances and needs. Research indicates that episodic treatment, which most addicts receive, falls short of their long-term needs. Approaching the chronic nature of addiction with longstanding resources and treatment aids is the reason for Mr. S’ present success of sobriety. He has embraced a new life with a full compliment of recovery activities that are working for him. I have no evidence to doubt his present commitment to continue the intensity of these activities, and in fact, he is demonstrating a bona fide attitude by applying himself to recovery. By observation of his willingness to be guided in therapy, to be in fellowship with support groups similar to AA programs, to be accountable to his employer and to be mentored by a sponsor, Gerry opines that Mr. S is a good candidate for successfully dealing with his addiction and rendering himself as an honourable and contributing member of society.

The assessment process itself was no small endeavor, requiring a significant investment of Mr. S’ time, energy and financial commitment. His response throughout this process contributed to the discernment of his good nature and his preferred value for living an affable and constructive life.

He engages appropriately; accepts responsibility for himself and is making genuine effort for his sobriety and overall maturation.

Mr S. experienced occasional challenges during the summer and fall that required extra mental effort and self-discipline, mostly due to the strenuous work schedule and hard physical labour at the construction job sites. He has appropriately coped with these stressors, first by being aware of how he feels, acknowledging those feelings to supportive people, and making the time for suitable activities including, rest, meditation and prayer. He reports having consistently attended his church group meetings, and finds strength and purpose in these activities. I do not find him to be superficial about his religious beliefs. He consistently refers to his faith and spiritual practices as the core element of support for his addiction recovery. His tone is such that he finds significant purpose and meaning in this, and that God – his higher power – is

instrumental in achieving and maintaining his sobriety. He also maintains employment and is actively involved in home activities with his wife.

Mr. S evolving as man of character and consistent in his responsible living, which are aimed at abstinence from alcohol/drug abuse, but also a lifestyle that expresses care and concern by offering practical help to others in need. His behavioral choices are also aiding his coping with anxiety and ADHD symptoms. In this case, work treatment model focuses considerable attention on mood disorders and personality traits, as they can be contributors to relapse if unattended. Mr. S. is growing in his knowledge and understanding of his over-all personality, which has often been governed by features of ADHD including impulsivity, restlessness, distractibility and procrastination. He is learning to consciously adjust his thoughts and decisions as a way of realigning those personality features to his preferred values on things such as: making thoughtful decisions, not interrupting others as they speak, staying on topic, prioritizing tasks, meditation as relaxation, and so on. Day to day management of these small items accumulate over time and contribute to his over-all rehabilitation and ongoing success.

Regarding future intervention, following steps are recommended for Mr. S.

- Continue abstinence and being of good character.
- Continue attendance at his church and the support group meetings.
- Attend counselling for the duration of one year, every two months, for continued substance abuse treatment.
- Attend 3 to 6 sessions with a qualified Life Coach for skill development regarding ADHD characteristics and behaviors.

Upon review of Mr. S's progress to date, it is noted that he is sincere about his sobriety, has a bona fide desire to live above the realms, which he erred and is willing to abide by the rubrics of recovery from substance use. His continued demonstration of successfully striving for an affable, sober and productive life aide in my assessment that his level of risk to reoffend is low.

5: 10 Clinical Implications for Considerations

Even though many clients wish for clinicians to address spirituality and religiousness during psychotherapy (D'Souza, 2002), they usually manifest two main concerns about addressing it in a clinical setting:

- (1) The fear their spiritual beliefs could be reduced or trivialized by the clinician; or
- (2) The concern their beliefs and spiritual experiences could be regarded as symptoms of psychopathology.

Therefore, when treating clients with strong spiritual and religious backgrounds, clinicians should display a respectful attitude regarding clients' unique experiences and make an effort to integrate spirituality into the psychotherapeutic process whenever it is beneficial to improve their psychological functioning.

It is firmly established within the scientific literature that religiousness and spirituality are associated with both mental and physical health. In general, the effects tend to be positive,

including lower levels of psychological distress and depressive symptoms, better health-related quality of life, and decreased morbidity and mortality. Therefore, appreciating and incorporating clients' religiousness and spirituality in the clinical setting may enhance their mental and physical health.

Assessing clients' spiritual representations may be a helpful instrument to identify their internal working model and opportune in understanding their ego stage of development. Indeed, individuals whose internalized representations are less functional tend to have relationships that are more dysfunctional on a spiritual level. For instance, a client who is more inclined to please others may feel more compelled to please the divine, due to an unconscious defense against rejection. Conversely, one who perceives others as insensitive, critical, and aloof may have this same perception regarding the transcendent being (Hill & Hall, 2002). Perhaps this explains Kirkpatrick and Shaver's (1992) observation that individuals who experienced avoidant attachment lean more towards agnosticism, while those whose attachment history was marked by ambivalence and anxiety display more atheistic and antireligious preferences.

Several aspects need to be considered in the challenging task of integrating spirituality into psychotherapy. For instance, being able to assess and understand the ways in which spiritual expressions may enhance or impair psychological functioning, developing skills to address spirituality without intrusiveness or reductionism, and being aware of counter transference that may occur due to the clinician's own spiritual/religious experiences or bias (Koenig, 2002) are key areas the clinician should be aware of. Additionally, psychotherapists should be aware that regardless of the nature of transference, it is actually the feelings, thoughts, and experiences that surface from initial relationships, and those that result from clients' "search for the sacred" (Pargament, 1999) that are useful as relational blueprint.

Finally, even with those apparently more resistant, the psychotherapist should assist them with a warm and empathic therapeutic relationship, offering his/ her "couch" as a safe, nurturing, and supportive environment by which they may be challenged to reach self-transcendence and enhance psychological well being. Putting this in a metaphor, a psychotherapeutic environment should work as a safe harbor in which individuals can anchor themselves to reframe or remodel relational blueprints in order to move to deeper waters of an authentic experience of consistent self-transcendence.

Gerry works with clients who mostly had a Christian orientation in life. Its critical facility for a therapist to help his patients to revisit their faith, being conscious of the approach as they continue to bargain with God – experience and angry at the omnipotent for some of the atrocities committed by significant persons in their early childhood. It has long drawn process to for a patient to relate to the meaning of the divine here. Broken and shattered this client when Gerry encountered him first, but however his life began to change and in his drive for transformation, community, family and church played key role. The object relational dimension of therapist being a 'container' is a dynamic resource in psychotherapy with those who have experienced betrayal and rejection in their lived past.

The nurturing and relational object reconstructed by the therapeutic alignment offered authenticity, reconstruction of the 'Self' which Carl Jung refers 'signifying and unification of the

consciousness and unconsciousness in a person and representing the psyche as a whole'. In this regard, therapeutic alignment started to bring together the 'Self' that was divided by the impact of alcohol abuse, breakdown of relationships and lawlessness that encircles a person's life.

5:11 Personal Encounter: Psycho-spirituality

I would put on record the discovery of the therapist in me and my experiences and conviction about theoretical formulation and clinical interventions I found practically safe and rewarding in my encounter with clients.

I started my journey as a pastoral youth worker in the year 1991 with the hope of becoming a clergyman in the Indian Anglican tradition. During this period, I came across many alcoholics and chain smokers. I was 21 years old and to young religious mind, those smokers and drinkers were sinners to cast out into fire. In some way, I wanted to reach out to them to save them, but I felt helpless. My attitude began to change when I met Christy, became my mentor for next couple of years. I was a fanatic Christian, but deep within me, I was not sure about what approach. I started experiencing 'paradigm shift' when enrolled myself for seminary formation after working as a youth worker for a year.

I came out of the seminary with more questions in my mind about my role as a pastoral caregiver. There was a desire in me to become a compassionate caregiver when I returned to the diocesan ministry, besides the church ministry, I got involved in the regional YMCA program, which paved for the local YMCA and exposure with YMCA opened many opportunities for community initiatives. I became eager and curious to understand more whenever troubled family with alcohol related domestic violence met me. I became less judgemental about such deviant behavioral challenges within the church and in the society. I was in more in a religious role than in spiritual role. I was at a cross road- there was realization for new sense of direction addressing the spiritual challenges of those who sought my help. I was not skillful, but I started becoming less religious. I was eager to learn about the conditions and circumstance which drove many young people to drugs and alcohol. I felt the love and affection of the youth, public and the parents of youth who believed that my relationship with the youth provided new direction to some of them and I came to know years later that some of them stopping their excessive drinking after they became partners in our community work.

I felt my training was still inadequate to address future challenges, which led to the decision to quit my position at the Church, and I got myself enrolled in Clinical training at the Christian Medical College & Hospital, Vellore India. The clinical training at CMC Vellore offered units of Clinical Pastoral Education (CPE) and general therapeutic modules to work with addicts and those diagnosed with HIV positive status. The clinical training at CMC Vellore was executed in collaboration with Advocate Health System, Illinois. The supervisors Will Wagner, Myron Ebersole (now deceased) and Mary Wilkinson brought from ACPE, USA helped me rediscover my 'sense of identity' and showed me a road map for my future. The training at CMC Vellore started transforming me as therapeutic professional. There was a clear 'paradigm shift' in me as I started learning to care for patients; I was able to stay back with their feelings without any judgement about stories I heard. Many a times, my heart melted, especially whenever I encountered those living with HIV and some of them contracted the virus as they shared

needles. I can proudly put on record here that the seed sown at CMC Vellore stayed with me over the years and as after 16 years of practice. I continue to rely on my novice exposure from CMC Vellore as a mental health practitioner, especially my therapeutic work with men and women who come into addiction recovery program. The focus of CPE is spirituality in Clinical Practice and 'action reflection model' envisaged within the framework of CPE helps the practitioner to employ therapeutic tools for effective interventions. I will be discussing later how CPE tools helped me to build therapeutic alliance with those in recovery and over the years, CPE approach became an integral part of my mental health work. The CPE approach is not risky and non-controversial when integrated into other evidence based therapeutic activities.

CPE is a strong bridge for those who are spiritually driven (religiously too), fence sitters with existential questions, many others who are fallen out with God or anti religious, unspiritual, skeptics, Christians, evangelicals and different faith orientations.

In my further education and training, CPE model of learning has always found an integral part. I evolved as a psycho-dynamically oriented and integrated practitioner over the years since I undertook psychoanalytical residency program at Blanton- Peale New York. I have observed that initial impact of the CPE training continued to shape the therapist in me, especially in spiritual dimension of clinical practice regardless of the settings I am involved in. I started believing that the art of therapy is more 'being with the suffering of your patient is the heart of therapeutic relationship. In the midst of crisis management, many a times I have felt helpless, in my helplessness learned 'being is more than doing'.

My spiritual tools in psychotherapy is generally beyond the formulation of the language associated with it. In the case of Norwegian shift captain, we experienced a sense of solidarity in our frustration with God. A language of freedom to question God is relevant. I felt in my heart to wrestle with God just like the story of Jacob in the book of Genesis. We fought with God together in the midst of his shock and anger precipitated by his HIV condition.

In the case of Jerry, the addict who attended recovery program at the Luxury Rehab, it was the experience of safe environment to recognise his truth and character and his story deeply touched everyone in the group. He remarked to me personally, he experiences 'paradigm shift' in the program, as there was no 'morality talk' about his experience despite his knowing about his socially unacceptable behavior. The group process for him was a shared experience and fellow clients identified with them and he did not experience any emotional threat within the group. This is significant in working with complex nature of addiction, especially in dealing with concurrent disorders in treatment.

In the audio interview with Rob, it appears that his out of touch with any concrete form of spiritual dimension in his recovery, but yet one needs to understand that it's not required to qualify or quantify spiritual quest, for Rob it's a journey. It is a complex struggle and a road less traveled. Dr. Scot Peck, critically discussed his spiritual journey in his best selling, *The Road less Travelled'*, in his exploration of core themes such as spiritual discipline and personal growth, he himself encountered multiple ways of wrestling with 'spiritual realisms' before he reached the point in his spiritual quest to accept baptism in the Presbyterian communion.

As a spiritually driven psychotherapist, I feel more connected and comfortable with my patients when I do not need to convey any spiritual preference, which I might find, is good for them. In interactions with Theo, I found him to be comfortable in his growing stature as a certified recovery coach. He discussed with me while working together at the Luxury Rehab, of his deepest appreciation for therapeutic program, which offers Christian perspective for addicts. An equilibrium of psychotherapy and spirituality in clinical practice can engage with patients effectively and spiritual reflections arising out of psychological moorings can support healing and recovery.

An integrated spiritual perspective is the need of the hour to address complex human nature, especially in responding to some of the driving forces and root causes of addiction. Dr. Gabor Mate who conducted outstanding research and clinical interventions among addicts in Vancouver downtown east side testifies categorically that beneath the layers of criminal activities of men and women from Vancouver East, they are our brothers and sisters. Dr. Gabor exhorts *'in the realm of Hungry Ghosts: Close encounters with Addiction'*, they have gone through abandonment and suffered severe emotional and spiritual damages. Dr. Gabor challenges the conscious of the elite, law enforcement and policy makers for a comprehensive approach, which includes spiritual response, search for meaning and sense of purpose in life. It is observed, while actively working within addiction recovery program, addicts have revealed that through substance use, they were trying to tell their stories and suppressing their shame and rejection. In the case of my patient from the Luxury Rehab, while she admitted that her job as strip dancer worsened her craving, she was still ashamed of her mother's conduct in her early childhood. She wished her mother was not an alcoholic and protected her from her stepfather's sexual assault, but unfortunately, Rita's mother failed to provide her little daughter the basic 'safe guards' in her early childhood. She is candid about her apathy towards spiritual direction and inputs in the recovery. She is not looking for validation of her experience at this point. Her need is not compassionate attention or acceptance of her, as he put it across to me in one of our segments, " I am not looking for sympathy and understanding, but rather guidance to stay away from drugs "

Rita relates to experiential component, boundary based intervention for her for self-management, the absence of the guardian, and omnipotent continues remain relevant in her life.

As Rita embraces recovery program, she becomes relational and in this process, she is willing to let you enter into the shadow side of her personality. She became more receptive to engage with her archetypes, baring a single stand off. She allowed me to offer her 'holding place' in some of our therapy sessions. We struck code of friendship in our work. I realized that Rita's life story was not a barrier and the spiritual process in therapy generated a deep 'sense of relatedness', value and respect for her struggle for recovery. Working with addicts can teach us much, chaos, loss and meaning of grief, depth of broken relationships, ever day craving for substance and many challenges and barriers to recovery and sobriety. Above all, for a professional, the experience raises many questions, confusions, internal battles and moments of celebration for those who embark on the path of recovery and transformation.

Emotional and spiritual healing involves communication at the deepest levels, and it includes both talking and listening. Many people, when they are listening to someone else speak, are not really hearing what the other person is saying. They are waiting for a break in the conversation so that they can make their next point. This is not really the best atmosphere in which to have a healthy discussion.

During treatment, a client will be able to learn about effective ways to communicate with others and how to truly listen to what another person is saying. There are healthy ways to deal with conflicts that do not end up with someone feeling as though they “need” to tune out by using drugs or having a drink. Clients will also learn that it is possible to resolve issues without resorting to emotional blackmail, trying to “guilt” someone into doing what you want you want, storming out and disappearing or any of the other strategies they may have been using in the past.

A recovering addict is slow to pick up the pieces and it is evitable for those around him to understand the new beginning. He needs to discover his creative abilities and find ways to expand the knowledge, skills while discovering the potential for their gifts with others. Creating a safe environment for a recovering addict is the collective effort of a responsible society.

Chapter 6: Psycho-Spiritual Treatment Planner

Part 1

Primary sources of the treatment planner in this chapter comprised of insights drawn from the review of literature, theoretical formulations and from experiential learning from my interventions with clients and insights from the stories that contributed to bod of this thesis. The secondary source for this treatment is plan is drawn from the research from the ‘The Complete Adult Psychotherapy Treatment Planner’ 5th Edition, which also includes DSM.

6: 1: LONG -TERM GOALS

1. Clarify spiritual concepts and instill openness to connect with higher power.
2. Increase belief in and development of relationship with a higher power
3. Incorporate faith into support system
4. Resolve issues that have prevented from committing to the higher power.
5. Develop spiritual and psychological safeguards
6. Maintain a regular exercise on relapse prevention plan

Short – Term objectives:

Objective	Therapeutic Interventions
Discuss ‘God – awareness ‘and summarise your personal journey to date	<ul style="list-style-type: none"> • Ask the client to talk about / write the story of his journey. • Work on homework planner. • Ask questions. Do I believe in God or not? • Assign the client to work on autobiography within week of a commencing the treatment.
Describe beliefs around the idea of a higher	<ul style="list-style-type: none"> • Assign the client to list all his beliefs related to a higher power, process beliefs. • Assist the client in processing and clarifying his / her beliefs regarding the higher power. • Explore the causes for the emotional disconnect with the higher (Eg. fears, hurts, childhood rejection, abandonment by significant people.)
Provide pre assessment about potential transferences in therapeutic relationship	<ul style="list-style-type: none"> • Assess the client’s level of insight about the presenting problem and behavior towards relationships. • Work with emerging transference if any. Address any concerns of the client immediately.
Provide behavioral , emotional and attitudinal toward an assessment of specifics related a DSM diagnosis , the efficacy of treatment , and the nature of the therapy relationship	<ul style="list-style-type: none"> • Assess the client for evidence of research- based correlated disorders (e.g., oppositional defiant behavior with ADHD, depression secondary to an anxiety disorder) including vulnerability to suicide risk. • Assess for the severity of the level of impairment to the client’s functioning to determine appropriate level of care(e.g., the behavior noted creates mild , moderate , severe , or very severe impairment in social , relational , vocational, or occupational endeavors)

Objective	Therapeutic Interventions
Describe early life training in spiritual beliefs and identify its impact on current present life.	<ul style="list-style-type: none"> • Therapeutic intervention • Review the client’s early life experiences surrounding belief in higher power and how it affects current beliefs • Review early relationship with primary care takers, their influence in assisting the client’s relationship with a higher power.
Describe the topic of forgiveness and client’s understanding on his current life.	<ul style="list-style-type: none"> • Discuss about requesting and receiving forgiveness • Learn to enter into open conversation with oneself • Follow Enright process of psychological forgiveness with the client.
Discuss the Maslow’s stages of hierarchy and client’s psychological blocks	<ul style="list-style-type: none"> • Identify basic and unmet needs in life and explore ways to come to terms with them or identify with substitutes. • Explore significant current relationships to replace old relationships. • Identify meaningful and purposeful activities to prevent relapse. • Assist the client in identifying specific issues or blocks that prevent the spiritual journey.
Verbalize separation of beliefs and feelings regarding one’s earthly father from those regarding a higher power	<ul style="list-style-type: none"> • Assist the client in comparing his/ her beliefs and feelings about his /her earthly father with those about a higher power or heavenly father • Urge separating the feelings and beliefs regarding the earthly father from those regarding a higher power to allow for spiritual growth and maturity.
Acknowledge the need to separate negative past experiences with religious people from the current spiritual evaluation	<ul style="list-style-type: none"> • Assist the client in evaluating religious tenets separated from painful emotional experiences with religious people in his or her past • Explore the religious distortions and judgementalism that the client has been subjected to by others. • Client can read ‘Serenity : Companion for 12 Step Recovery – all readings to AA Steps two to Three, The Road Less Travelled by Dr. Scot Peck
Ask a respected person who has spiritual depth & psychological understanding of addiction, to serve as a mentor	<ul style="list-style-type: none"> • Help the client to find a mentor to guide in his/her spiritual journey • Help the client to set his/ her eyes on the path of personal transformation as her struggles to maintain sobriety. • Walk with the client in his/her need to rediscover ‘need for belonging’. • Support the client in his deepest longing for self- actualization in spite of many shortcomings along the way.
Identify ways to deal with bodily sensations, stress and disturbing feelings.	<ul style="list-style-type: none"> • Teach mindfulness meditation • Training on systematic breathing exercise • Train to develop non-judgemental attitude • Stop rumination and stay focused.

Part 2: Relapse Prevention Strategy

Relapse is a process not an event. In order to understand relapse prevention, you have to understand the stages of relapse. Relapse starts weeks or even months before the event of physical relapse. In this process, there are day-to-day events that trigger a recovering addict. Terence T. Gorski, originally published in *Alcoholism & Addiction Magazine: Relapse Issues and Answers* outlines three stages of relapse (1) Emotional relapse (2) Mental relapse (3) Physical relapse.

Part 2:1 Signs of Emotional relapse

- Anxiety
- Intolerance
- Anger
- Defensiveness
- Mood swings
- Isolation

Part 2:2 Signs of Mental Relapse

- Thinking about other people , places and things you used with
- Glamourising your past
- Lying
- Fantasising about using
- Thinking about relapse

Part 2:3 Signs of Physical relapse

- Start hanging with old friends
- Driving down to a pub
- Driving down to drug dealer
- Completely giving up all the safe guards.

In our context, I would expand the relapse prevention strategy in a broader perspective as self-assessment and safe guard tool to manage psychological challenges. Life is full of critical events, there is very little awareness most people carry about the interaction between cognitive process, affective conditions and subsequent physiological reactions. It is imperative to creative awareness about lack of equilibrium and ways to generate it by creative and skilful self-management.

We are faced with critical events from time to time, many a times our knee-jerk reactions aggravate conditions. A recovering addict is more vulnerable to triggers than others. Therefore , it is significant for him to carry certain psychological first aid with him so that when he is faced with critical choices , he would be able to cordon off his vulnerable areas with psychological tools available at his disposal, but however they don't come handy , he must be brushing up his on his safe guards ahead of time. I remember an addict returning home having spent three

months in recovery only to be trapped by a former inmate who visited his home town. He received a call from the woman informing him that she was in a crisis and she needed his help, despite all the efforts of his family to restrain him, he decided to drive down to rescue the friend, but they ended up drinking together and finally chased the drug dealer.

He returned to the rehab and decided to engage me for two weeks of intensive sessions with me, besides meeting his primary therapist for follow up. We worked on the psychological toolbox to manage critical events that contribute to his craving and relapse. He admitted to me In spite of attending many therapy sessions, he spent a lot of time waning and moping about his early childhood relationship with his mother, he left the program without psychological kit for home work to enhance the safe guards to prevent him from crumbling down under pressure. A recovery addict needs to work on parameters of self-awareness and action plan through out the program and continues efforts for risk management. As mentioned above, while relapse is not a sudden event, personal vulnerabilities to day-to-day stress conditions can lead to the breaking point.

The triangle below highlights cognitive disorientations, mental, emotional and behavioral dysfunctions and subsequent choices that are counter productive in dealing with depressive episodes and crisis. A careful attention of developing conditions can foster resilience to toward healthy choices as shown in the diagram below. I have found it beneficial for recovering addicts and other patients suffering from depression, anxiety and interpersonal conflicts. The triangle below can be used for psychoeducation sessions for patients in variety of settings.

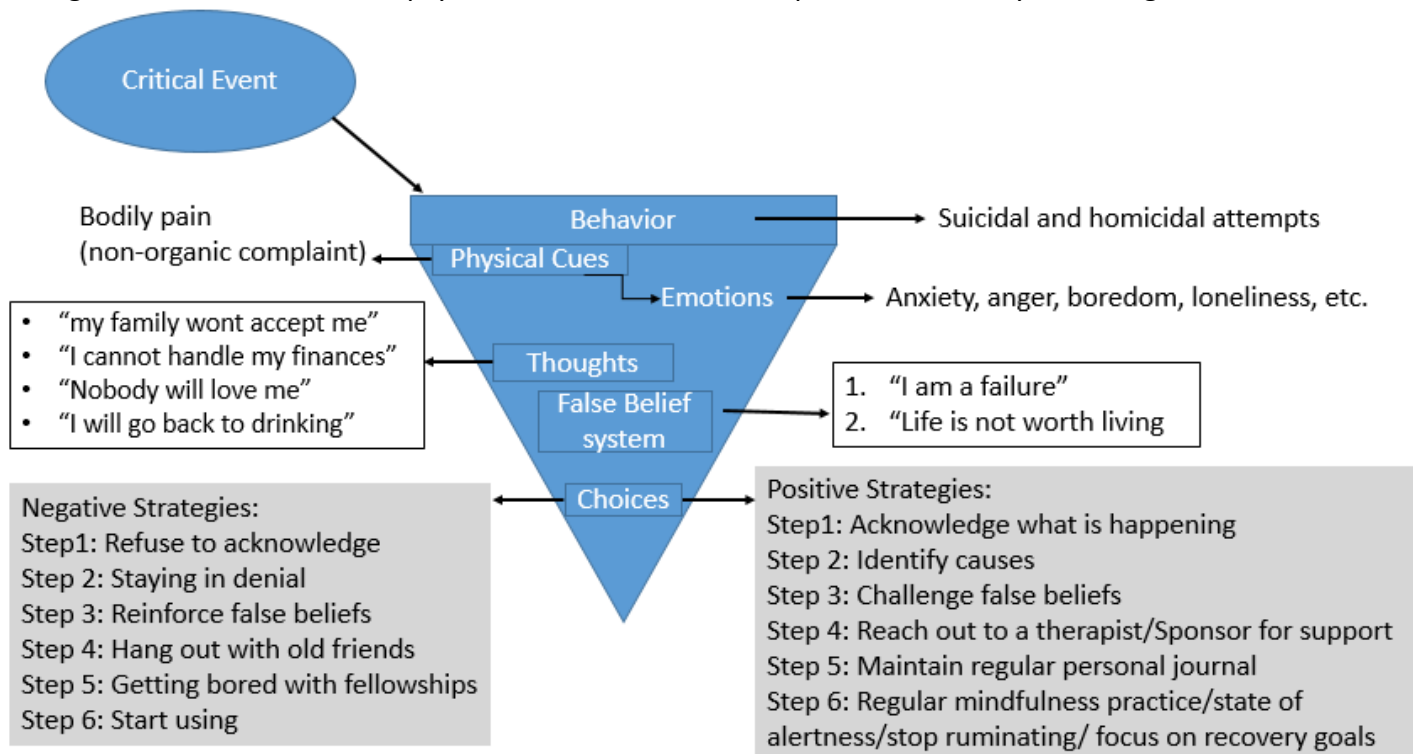


Figure 6: Behaviour modification activity

Conclusion: Road Map to Recovery and Rebuilding Life

In conclusion, let us underline the fact spiritually driven integral, transformative therapeutic engagement can only be offered by a therapist or doctor who has worked on himself or herself, having gone through personal tragedies beyond addictions related to catastrophe. They continue to be in the transformation mode. Many times life crisis breaks a person within. Many therapists and counselors have been through broken conditions in life, when they embark on journey with those who need recovery, they should not be bleeding, but rather in a 'healing place' within themselves. Patients need to experience stream of living water of healing with their addiction counselors. Those who are in the healing work are not perfect, they must yield to the process of healing and transformation, but however continues integral engagement of 'self awareness' provides them with sufficient safe guards so that the memories of the personal wound is prevented from getting in their way.

When patients begin to recover within the addiction treatment program, they embark on a journey of restoration and in that process, a spiritually focused recovery program works as the new chart of 'Wellness'. Spiritually based psychotherapy can not be compartmentalized, but has to merge into an evidence based integral model of therapy without dilution of the spiritual foundation of the recovery journey. The primary focus of this thesis was to explore spirituality in clinical practice and the struggle to integrate the same into psychotherapy within the controlled environment, but often taken lightly by many caregivers in my personal observation of some of the recovery programs in different countries. This work avoided inclusion and detailed discussion on statistics and pathology of addiction.

There has been a conscious attempt to include 'spiritual diagnoses' as part of the assessment for admission. In this regard, a clear distinction has been drawn to separate 'spiritual component' from religious orientation. The most comforting dimension is to relate to spiritual sense of life as a path of awareness of the 'here and now' and 'deeper search for meaning' in the midst of turmoil and darkness precipitated by the suffering of addiction.

Recovery program offers a holistic treatment and right from the very beginning of the treatment, clients need to rediscover every aspect of their breakdowns and the resources to find ways and means to recreate their future.

Someone who is in the throes of an active addiction may lie about how much they are drinking, how many drugs they are taking or even that they are taking drugs at all. This is of the symptoms of the disease, and it's quite common for addicts to manipulate loved ones if it means they can get resources (money, food, cell phone) that will support their addiction. Family members may also react to a loved one's addiction by stepping into help. Their motives may be for the best intentions, at least at first. It can take time for a family to realize that they are dealing with a loved one who has developed an addiction to drugs or alcohol. The early days of the disease can be subtle. Addicts can be very good at persuading family members that an episode where under the influence was an isolated one and that it will never happen again. "Unfortunately, in the case of someone who is living with an addiction, it always happens

again.” Not everyone in the family will agree with trying to help the addicted family member. There may be people who think that taking a tough stance is the way to handle the situation. When family members disagree about the best way to deal with someone who has an addiction issue, conflict ensues and the person with the addiction is left to continue drinking or using drugs while the discussion or arguing goes on. The addict realizes that as long as the family is in turmoil, they will be able to feed their addiction relatively undisturbed. They are not going to allow anything to get in the way of feeding their addiction.

Rebuilding Relationships in Recovery

The key to healing from addiction and rebuilding trust after the addict in your family has hurt all of you, let you down, disappointed you and caused chaos more times than you can count is a drug and alcohol treatment program. Professional help is needed for people struggling with drug addiction to learn to live a sober life style and learn to live without their drug of choice. Part of this process is helping addicts come to term with the fact that their lives do not immediately become better once they stop using chemicals. Clients in recovery have to take responsibility for, and deal with, the aftermath of events, which occurred while they were still using drugs or alcohol. It was not their choice to use while they were in the cycle of addiction, but the harm caused to relationships with intimate partners, family members and close friends still needs to be dealt with. While in a drug and alcohol treatment centre, the staff and counsellors can help clients using several different techniques.

Set Realistic Expectations

A newly sober client need scrunches and shoulders to hold on to focus on multiple areas as described in the chart below (Figure 4) these issues cannot be resolved immediately, even if the client offers a sincere apology for past actions. Any action taken toward rebuilding life a victory and these small steps need to be celebrated.

After a pattern where trust has been betrayed (and likely several times), rebuilding is going to be a lengthy process. Someone who is living with an addiction will always put feeding his or her disease first. To ensure that they keep a steady supply of their drug of choice, they are prepared to lie, cheat and steal if it means they can get their next fix or drink. This pattern is also used to hide the addiction (or the extent of it) from others to keep it going. The details discussed in the diagram can be incorporated into psycho-education program towards the end of the treatment and therefore can be included in the aftercare program.

Eliminate Unhealthy Relationships and healthy environment

Not all relationships in a client’s life are healthy and positive ones. The bad ones will not contribute to a healthy recovery. In fact, they will end up doing just the opposite – they will become a reason for a client to start to slip towards a relapse. People in a client’s life who are still using drugs and alcohol no longer have a place in his or her life, neither do those who are, or have been, abusive towards the client. A recovering addict is vulnerable to physical, emotional and mental triggers. Therefore, family, community, significant others around a recovering person has several responsibilities as they navigate through this difficult phase to earn their livelihood.

Co-dependent people present another problem for clients in recovery. Some family members can take on a role where they “need” to look after the person with the addiction and want to shield them from the consequences of their actions. Once a client moves into recovery and is learning to take responsibility for their own actions from the past and to move forward in a chemical-free lifestyle, there is no room for someone to be making excuses for them anymore. The co-dependent family member needs to seek counselling to learn new behaviour patterns.



Figure 7: <http://diagramcharts.com/tag/wellness-chart/>

Glossary

Complex	A feeling toned autonomous content of the personal unconscious, usually formed through psychic injury or trauma
Transcendence	Existence or experience beyond the normal
Archetype	An innate potential of imagination, thought, or behavior that can be found among human being in all times and places.
Ego	The Center of consciousness, the “I”.
Psyche	An Inclusive term covering the areas of consciousness, personal unconscious and collective unconscious
Self-actualization	The realization or fulfilment considered as a drive or need present in everyone
Self	The center, source of all archetypal images and innate psychic tendencies toward structure, order, and integration
Shadow	The rejected and unaccepted aspects of the personality that are repressed and form a compensatory structure to the ego’s self ideals and to the persona
Unconscious	The portion of the psyche lying outside of conscious awareness. The contents of the unconscious are made up of repressed memories and material, such as thoughts, images, and emotions, which has never been conscious.
Wholeness	The emergent sense of psychic complexity and integrity that develops over the course of a complete lifetime.
Object Relations	Object relations theory is an offshoot of psychoanalytic theory that emphasizes interpersonal relations, primarily in the family and especially between mother and child. Object relations theorists are interested in inner images of the self and the other and how they manifest themselves in interpersonal situations.
Concurrent disorder	Concurrent disorders are mental disorders and substance use problems that happen at the same time.
False Belief System	Individual’s belief or internal representation about the world may contrast with reality
Transference	Redirection to a substitute, usually a therapist, of emotions that were originally felt in childhood.
Anachronism	The action affirming something to a period to which it does not belong

Appendix: 1 Robert Enright model of Psychological Forgiveness

Uncovering Phase:

1. To what extent have I denied - or attempted to forget – that I was offended and the suffering which I have experienced as a result?
2. In what ways have I *avoided* feeling and dealing with my anger and suffering?
3. In what ways have I *attempted to* feel and deal with (i.e., face) my anger?
4. To what extent do I experience, and avoid exposing, any shame or guilt?
5. In what ways does my unresolved anger affect my physical and emotional health, relationships, and work productivity?
6. To what extent am I obsessed or preoccupied with *how* I was offended and/or with my offender?
7. To what extent do I compare my own life situation with that of my offender?
8. To what extent has the offense caused permanent, difficult change(s) in my life?
9. How has the offense changed my worldview, i.e., in what ways do I now believe or perceive that “the world” – or God – are (no longer) as just or loving?

Decision Phase:

1. What is – and isn't – forgiveness?
2. To what extent do I experience that, although I have tried – or am sincerely trying – to forgive, I realize that emotionally I haven't?
3. What stops me from courageously confronting my offender's unjust actions toward me – both internally and directly?
4. To what extent may I “idolize” or “demonize” my offender (i.e., regard him or her either as not needing my forgiveness or as being unforgiveable)?
5. Am I willing to consider forgiving my offender (i.e., willing to become willing to forgive)?
6. What *hasn't* worked for me so far in trying to forgive my offender?
7. What stops me from *being (or becoming more)* willing to try to forgive *now*?
8. To what extent have I *decided* to forgive – am I *committed* to trying to forgive *now* – (perhaps *again*)?

Work Phase:

1. Have I developed an understanding of how I was offended and the past and immediate consequences of the offense, as well as a deeper self-compassion?
2. In what way(s) have my prior attempts to understand, develop compassion for and forgive my offender, made it difficult for me to fully realize and feel the consequences of the offense?
3. What in justice, do I need to do now, if anything, to seek restitution, i.e., deal with the lingering affects of the past offense(s) and/or to protect others or myself from actual or new offenses?
4. What, if anything, stops me from seeking restitution for past offenses by the offender and/or protecting others and myself from future offenses by him or her?

5. What may I do *now* to accept and resolve the pain and consequences of how my offender did and did not treat me?
6. *How* may I grieve my sadness and pain and use my anger to assertively care for myself – and if relevant, others?
7. How safe – or possible – is any direct contact with my offender at this time?
8. What human and spiritual help do I need in order to forgive my offender as I may chose to, and how will I seek and cooperate with this help?
9. What *was* and *is* my offender really like?
 - What was my offender’s life like when he or she was growing up?
 - What was my offender’s life like at the time he or she offended me?
 - What is the long-term history of my relationship with my offender; specifically, what is good as well as bad, true as well as false about it?
 - How does my offender treat me – and others – *now*, and how do I treat him or her?
 - What is my offender like as a human being, and to what extent does he or she deserve my respect simply for being another human being?
 - How does God view my offender – and me – and our potential for conversion, redemption, and constructive change, and how would God want and help me to treat my offender *now*?
10. What specific word, action, gesture or “gift” may I do for or give to my offender – even if s/he is dead – as an expression of my intent to offer him or her compassion or mercy at this time?

Deepening Phase:

1. In what ways have I grown through my efforts to feel and deal with my suffering and anger, and to act with compassion and mercy toward my offender?
2. In what ways have my efforts to forgive set **me free** – free **from** unwanted emotional suffering and free **for** having a better relationship with the offender (perhaps), others, God and myself?
3. In what ways do I recognize that I am not alone in my suffering – that others share my suffering and I theirs, whether we suffer for the same reasons or not?
4. To what extent have I discovered my own need to be forgiven, to seek and ask for forgiveness, perhaps even from my offender, or from someone else whom I have offended?
5. What *meaning* am I discovering in and through my suffering and my trying to forgive and, if appropriate, to *be* forgiven?
6. What am I learning about my purpose in life and how I may be called to serve others?

Appendix: 2 Clinical Pastoral Education

Clinical Pastoral Education (CPE) is [education](#) to teach [pastoral care](#) to [clergy](#) and others. CPE is the primary method of training hospital and hospice [chaplains](#) and spiritual care providers in the United States, United Kingdom, Canada, Australia and New Zealand. CPE is both a [multicultural](#) and [interfaith](#) experience that uses real-life ministry encounters of students to improve the ministry and pastoral care provided by caregivers.

An underpinning theory of education that structures clinical pastoral education is the "[Action-Reflection](#)" mode of learning. CPE students typically compose "verbatim" of their pastoral care encounters in which they are invited to reflect upon what occurred and draw insight from these reflections that can be implemented in future pastoral care events.

Although the practice of pastoral care has a long tradition in Christianity and to some extent in other faith traditions, the systematic analysis of pastoral practice associated with clinical pastoral education had its beginnings in the early 20th century. In 1925, [Richard Cabot](#), a physician and adjunct lecturer at the [Harvard Divinity School](#), published an article in [Survey Graphic](#) suggesting that every candidate for ministry receive clinical training for pastoral work similar to the clinical training offered to medical students. In the 1930s, the Rev. [Anton Boisen](#) placed theological students at the [Chicago Theological Seminary](#) in supervised contact with patients in mental hospitals, a flagship program that later resulted in the forming of the ACPE.

Appendix: 3 Questions for exploration

A. Conducted with Theo Calssen,

Recovery coach at a 5 star luxury rehab, South Africa

1. What was the critical turning point in your addiction?
2. What are the areas of your life covered in your rehab?
3. Briefly describe your experience with Psychotherapy?
4. What was the spiritual dimension of your rehab experience?
5. How do you define 'God awareness' in your addiction recovery program?
6. In what circumstances have you ignored your inner voice? Why?
7. What are the consequences of ignoring your inner voices?
8. Who are the people who undermined your growth and recovery?
9. Who are the people who support your recovery?
10. What is the purpose of your life ?
11. Have you experienced any signs of relapse?
12. What have you done to take charge of your triggers?
13. What you have you done to strengthen your inner voices?

B. Audio interview was conducted with Rob Huff,

Recovering addict and psychology intern at a 5 star luxury rehab, Thailand

27 B. Video file attached.

C. Case study of addict was carried by Gerry Goertson,

Senior Psychotherapist at the 'RiverBend, Counseling and Wellness, Winnipeg, Manitoba.

The researcher was assigned a supervisory contract with Gerry for two years and has the consent to include the case study in this study.

Appendix: 4 Diagnostic and Statistical Manual of Mental Health Disorders (2013)

The DSM-5 states that in order for a person to be diagnosed with a disorder due to a substance, they must display two of the following 11 symptoms within 12-months:

1. Consuming more alcohol or other substance than originally planned
2. Worrying about stopping or consistently failed efforts to control one's use
3. Spending a large amount of time using drugs/alcohol, or doing whatever is needed to obtain them
4. Use of the substance results in failure to "fulfill major role obligations" such as at home, work, or school.
5. "Craving" the substance (alcohol or drug)
6. Continuing the use of a substance despite health problems caused or worsened by it. This can be in the domain of mental health (psychological problems may include depressed mood, sleep disturbance, anxiety, or "blackouts") or physical health.
7. Continuing the use of a substance despite its having negative effects on relationships with others (for example, using even though it leads to fights or despite people's objecting to it).
8. Repeated use of the substance in a dangerous situation (for example, when having to operate heavy machinery or when driving a car)
9. Giving up or reducing activities in a person's life because of the drug/alcohol use
10. Building up a tolerance to the alcohol or drug. Tolerance is defined by the DSM-5 as "either needing to use noticeably larger amounts over time to get the desired effect or noticing less of an effect over time after repeated use of the same amount."
11. Experiencing withdrawal symptoms after stopping use. Withdrawal symptoms typically include, according to the DSM-5: "anxiety, irritability, fatigue, nausea/vomiting, hand tremor or seizure in the case of alcohol."

Appendix: 5 On Becoming an Integral Treatment Provider

Ken Wilber explored integral medicine in his writings, it is not only the body and mind of the patient that matters, but also the consciousness of the physician. The consciousness of the treatment provider is particularly important in the addiction recovery process, since one of the first steps in treatment is eliciting the client's buy-in to the very notion of practice as a path of recovery. If the treatment provider is transmitting health and wholeness by his mere presence, it goes a long way toward attracting the client to own her own recovery process.

It is important to remember that if the choice is perceived as a choice between depression, chronically feeling bad and addiction. In almost all cases, addiction will win. It is essential, from the very beginning, that the client see and sense that she is onto something that is much better than addiction. She needs to sense the health, happiness, and integrity of the treatment providers, in their depth of understanding, their caring, and their support.

Integral Recovery treatment providers adopt Integral practices not only to communicate a healthy presence to those in need of our help, but also because as we practice ourselves, as well as becoming physically, emotionally, and spiritually healthier, we become more creative, more empathic, and greatly more capable of opening our hearts to our clients and their suffering. As we, as Integral treatment providers, continue to work on ourselves, we also become more integrated in our own lives and less susceptible to the exhaustion and burnout that often accompany this type of work.

We learn to be open to all that arises, moment to moment, to simply be aware of and allow, not grasp or hold onto, our feelings. Our increased capacity for mindfulness and non-clutching empathy is an extraordinary tool that enables us to be present and allows our patients to know that they are not alone. Remember, the root of the word "compassion" comes from the Latin "to suffer with." As our abilities grow, emerging from our Integral practice, we "suffer with" our clients yet remain centered and healthy ourselves, and even increase our spiritual and emotional health, as our ability to be present and healthily compassionate deepens with time and practice.

Remember, too, when we practice and work on ourselves, it is not just our kinesthetic or body awareness, or our intellectual capacity, and it is not just our emotional intelligence, our spiritual depth, or our ethical clarity, but it is all these things together, the sum of all these healthy parts, that makes an extraordinarily healthy and brilliantly capable whole. We are qualified to take our students there because we have done, and are doing, the work ourselves—day-to-day, week-to-week, month to month, year to year. This takes us beyond the dichotomy of doctor/patient, therapist/client, sober/not sober, this/that, to create a new, more coherent and unified field of treatment, which allows for a much healthier environment and greatly increases the potential benefits of treatment for those we serve.

Jesus warned the religious leaders of his time that they should not place heavy burdens on their followers—ones which they themselves were not willing to take up. In the same spirit, we cannot, with integrity, ask of others that which we are unwilling to do ourselves. It simply will

not work in the long term, and when we are out of integrity, it is very difficult to ask it of others. In the beginning this might seem a bit overwhelming and overly challenging, but with a little work and time, when we realize our own responsibility and ability to transform ourselves into ongoing, improved versions of ourselves, the journey and the practice become less and less of a burden and more and more an open-ended delight of self-exploration, creativity, and transformation.

Relevant resources to set you on your way to becoming integrally informed. First, there are Ken Wilber's books. *The Integral Vision* is a very condensed version, and many have told me it is very helpful. See also, *Integral Psychology*. If you want to go for the brass ring, learn the secret handshake, and win the secret decoder ring, go for *Sex, Ecology, Spirituality*.⁴ For the less ambitious, the Integral Life website, integrallife.com, and integralnaked.org are excellent resources, full of articles, papers, video clips, and MP3 audio files. They provide a huge archive of some of the most brilliant teachers on the planet discussing the many aspects of the Integral vision. Have fun!

AA meetings can be important training tools, as well as NA meetings and MA meetings, they have always been a source of wisdom and amazement. Just when you think you have heard it all, there is a new level of betrayal, and often depravity, that the latter stages of the disease of addiction can cause. One also learns hope—that millions of people can and do get well. This informs the addict that you do listen and have been listening, and that you actually know what you are talking about. You can also use stories from your own life and the lives of family and loved ones who have been addicts. This emphasizes the point that, addicts or not, we have all suffered from this disease and all have a stake in its defeat.

Incorporating states of consciousness is also essential, especially since we are using new brainwave entrainment technologies that deal with different brainwave frequencies, which correlate directly to different states of consciousness. We are living in a golden age of brain research and are discovering that the brain is inherently changeable, transformable, and evolutionary at its core. The more we understand this most essential and human of our organs, the brain, the more this will translate into a quantum leap in the quality of the healthcare that we are able to provide.

Learning the basic typologies of masculine and feminine and studying such typological systems, as the Enneagram and Myers-Briggs is another essential element in Integral treatment. For a masculine-identified client, many of his emotional and relational pathologies will evolve masculine, narcissistic. With your more feminine clients, pathologies will typically involve giving themselves away unhealthily in relationships. Healing for the masculine, therefore, involves becoming more caring and relational, and for the feminine, it often involves achieving more autonomy.

Gaining an understanding of types is a tremendous tool for each individual's self-growth and understanding, as well as an invaluable aid in learning how to skillfully engage with others for essential relationships in our lives. A deeper appreciation of types also helps us understand our own often-unconscious ways of dealing with others—and specifically with our clients. When we do not understand different types, we may fall into the error of thinking what works for us will

work for everyone. Different types have different essential core issues that must be dealt with in different ways. A knowledge of types is a great aid in getting away from an unskillful, cookie-cutter approach to treatment.

Appendix 6: St. John of the Cross

St. John of the Cross, was a major figure of the Counter-Reformation, a Spanish mystic, a Roman Catholic saint, a Carmelite friar and a priest, who was born at Fontiveros, Old Castile. John of the Cross is known for his writings

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