TRANSFORMATIONS: TREATMENT OF ALCOHOL ADDICTION AS A PROCESS OF CONSCIOUSNESS EXPANSION

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Dylan Duran Payne, candidate for the degree of Master of Arts in Clinical Psychology, has presented a thesis titled, *Transformations: Treatment for Alcohol Addiction as a Process of Consciousness Expansion*, in an oral examination held on August 24, 2012. The following committee members have found the thesis acceptable in form and content, and that the candidate demonstrated satisfactory knowledge of the subject material.

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Abstract

A body of research has suggested that an understanding of the lived experience of addicted individuals is an important yet neglected part of developing effective treatments for addictions. In an attempt to further understand the subjective experience of addiction, a phenomenological study was undertaken with the aim of understanding if consciousness studies could inform and enrich current treatments for addiction. Specifically, the study examined the utility of conceptualizing an addiction as a problem of restricted consciousness and its treatment as a process of consciousness expansion. This study attempted to further understanding related to changes in consciousness, and the development of the self-concept, that occur as a person moves towards recovery. In particular, it attempted to identify those experiences, or shared characteristics of different experiences, that precipitated movements to expanded forms of consciousness and more integrated self-concepts. Semi-structured interviews were conducted with six individuals who purported to have an addiction to alcohol. The results were analyzed using the methods of Interpretative Phenomenological Analysis. As well as providing insight into the lived experience of addiction, an argument for the utility of introducing consciousness development into the treatment of an addiction to alcohol is presented.
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Dedication

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1. **INTRODUCTION**

I developed my interest in addictions research as I began working with youths in a wilderness therapy program in Alabama. Many of the clients in the program attended substance abuse programming offered at the facility and I worked with them in addressing some of their addictions related issues. After leaving this position, I worked as an addictions counsellor for youths in group homes and adults involved in the criminal justice system. While working in these settings, I spoke with clients who grew up with parents with an alcohol addiction and saw how the dysfunctional familial patterns of their childhood transposed to adulthood. In extreme cases, the legacy of their parents’ alcohol addiction was apparent in their very bodies as was the case with clients diagnosed with Fetal Alcohol Spectrum Disorder.

I saw how an addiction could disrupt an entire family system and impact subsequent generations for years to come; the ripple effect as subtle as ice dropped into a glass of Scotch or as extreme as the churning vats of a distillery. In all of these individual clients, those with addictions and those impacted by them, I saw an enormity of lost potential that struck me as tragic. I wondered what people’s lives would have been like if addiction had never taken hold, either of the addicted individuals or the people close to them. I have had conversations with bright young teenagers from very wealthy families who would never have to want for anything. They would never have to worry about tuition fees, making rent, or wonder where their next pay cheque would come from. They had so many opportunities available to them and their addictions were depriving them of making the most of their advantages. I saw clients with FASD who struggled with an array of physical and cognitive deficits. In clients who were acutely aware of their
limitations, I saw their sadness and frustration as they tried to push past physical and mental limitations that would not yield. It was experiences like these that prompted me to learn more about alcohol addiction and its treatment. I wanted to be involved in work that could help curb the devastating toll of addiction and prevent that tragic loss of potential.

Ever since its discovery, the potential to become addicted to alcohol has loomed as a potential threat amongst those who consumed it. Though some have been able to indulge in its consumption in moderation, there has been a significant number of people who have found themselves unable to do so. For addicted individuals, the procurement and consumption of alcohol becomes their predominant focus and has a detrimental impact on various aspects of their lives. It would appear that a large percentage of the population is susceptible to an addiction to alcohol.

Currently, it has been estimated that 2 billion people worldwide consume alcohol to varying degrees (Barr & Lovi, 1999). Though a relatively small number of individuals will develop an addiction to alcohol, it has been reported that “levels of addiction have been increasing over the past 200 years” (Kemp, 2009, p. 11). With its prevalent usage in societies and the rising rates of addiction in general, it is of paramount importance to quell these rising rates and ameliorate the problems associated with alcohol use. As Hoeppner, Kelly, Pagano, and Stout (2005) explained, “4% of all deaths worldwide are attributable to alcohol, greater than those due to human immunodeficiency virus/acquired immune deficiency syndrome (HIV/AIDS), violence or tuberculosis, and alcohol is the leading risk factor for death among males aged 15–59 years” (p. 289). It is no wonder that some have deemed alcohol “the most dangerous drug” (Goldstein, 2001, p. 159).
Though the statistics cited above are recent, there is a long historical record of alcohol being associated with personal health problems and wider social concerns. Since its discovery, societies have experimented with restrictions on the consumption of alcohol and there has been continued debate and discussion as to the best way to deal with the negative consequences of alcohol abuse (White, 1998). These differences in opinion continue today and are evident in such things as differing provincial age restrictions for the purchase and consumption of alcohol and differences in the legal limits concerning blood/alcohol content.

As well as differences in opinion at the levels of government, there are differences in opinion amongst individuals in society regarding the use of alcohol. Some parents permit their teenage children to drink in their homes as long as they are supervised by an adult. Some of these parents claim that they are teaching their children to drink alcohol responsibly and that they are keeping them from drinking in unsafe environments. Conversely, other parents would never dream of having their underage children drink alcohol. These parents argue that such a practice will put their children at risk for developing drug problems in the future. Clearly, the use of alcohol and the methods for treating alcohol addiction are the subject of much debate and there are diverse opinions regarding its use at all levels of society.

Not surprisingly, these differences of opinion are also found within the academic community and are reflected in the research literature. Not only are there differences in opinion regarding approaches to treatment, there are differences in the terminology used by researchers and other addictions professionals. As Jongsma and Perkinson (2001) explained, there is “much disagreement among the so-called experts in the addictions
field about how chemical dependencies are developed and what is meant by the term addiction and dependence” (p. 43). In my own review of the literature, I saw these terms used interchangeably along with the term “alcoholism”. Although, as Erickson (2000) explained, “alcohol dependence is in much wider use than the term alcoholism” (p. 2), this term is considered to be misleading by some researchers. As Erickson (2000) explained, some people use the term “addiction” rather than “dependence” in order to differentiate addiction from physical dependence — a term that is typically used to refer to symptoms of tolerance and withdrawal. This is an important distinction because “although tolerance is a characteristic that often accompanies the abuse of some drugs, it does not by itself constitute a determination of ‘addiction’ or of an addict” (Betz, Mihalic, Pinto, & Raffa, 2000, p. 11). For the purposes of this thesis, the term “alcohol addiction” will be used.

Adding to the confusion is the fact that the DSM-IV-TR (2000) does not use the term “addiction”. Instead of addiction, the DSM-IV-TR uses seven criteria to diagnose what it refers to as Substance Dependence. These criteria are shown in Table 1. When these criteria are applied to the use of alcohol, they comprise the diagnostic criteria for the Substance Related Disorder called Alcohol Dependence. In this classification system, the diagnosis of alcohol dependence could be considered synonymous with alcohol addiction.

Though there are objective criteria for the diagnosis of addiction, it is important to acknowledge the subjective aspects of an addiction. People vary in terms of their alcohol intake. An amount of alcohol that is problematic for one person might be manageable for another person.
Table 1

_Diagnostic Criteria for Substance Abuse in the DSM-IV-TR_

| Tolerance symptoms (requiring more of the substance to achieve the same effect) |
| Withdrawal symptoms |
| Taking larger amounts than intended |
| An inability to reduce the amount used |
| Spending a great deal of time on obtaining the substance and recovering from its effects |
| A reduction in recreational and social activities |
| Continuing to use the substance despite knowledge of its adverse effects |

With all the problems associated with alcohol use, it begs the question of why its use is so prevalent and why addiction rates have escalated. In regards to the epidemic of addiction, Kemp (2009) stated “there is no coincidence that this has happened in the same time that modern industrial city-based society has developed” (p. 11). From this perspective, the development of modern industry radically transformed the structure of society and disrupted the patterns of social interactions that restricted the consumption of alcohol and other drugs. As Walters (1999) explained, “informal social control networks were breaking down under the weight of the Industrial Revolution” (p. 2). Without these informal social control networks, which were in part disrupted due to individuals leaving their communities for work and changes in lifestyle, people might have been prone to unbridled drinking that had the potential to develop into an addiction.

While working in the Canadian Arctic, I saw firsthand how disruption of a way of life could create conditions for addictions to develop. The rate of alcohol addiction is far
higher in the North than in other parts of the country and this has been attributed to the dislocation of the First Nation populations that reside there (Dingle, MacMillan, MacMillan, & Offord, 1996). Many believe that the disruption of their way of life significantly altered Aboriginal people’s sense of identity, place, and purpose in the world and that alcohol addiction was rooted in an attempt to cope with these changes (McCormick, 2000). From this perspective, alcohol addiction could be viewed as a product of either structural violence or victimization (Barakett, James, Johnson, Raghavan, Lemos, & Woolis, 2003). The impact of social forces on individual problems, including addiction, was also recognized by Jung (1933/1955) who described how the contents of consciousness are impacted by social conflicts.

However, addiction is not typically viewed from such a broad and global perspective. Though social factors are considered in the etiology of addiction, social factors tend to “account for proximal environmental factors and social properties” (Buchman, Illes, & Skinner, 2010, p. 42). In other words, social factors such as governmental drug strategies and initiatives, laws of the land, and social attitudes towards certain classes of substances are typically not considered. When their connection to them is minimized or ignored, a person with an addiction can be viewed as existing apart from these larger social factors. In such a situation, the person who receives treatment might re-enter an environment that is rife with social pressures that put him or her at risk for relapse. The failure to view addicted individuals in the context of their unique life circumstances is but one of many criticisms of current approaches to treatment that will be discussed in this thesis.
Though service providers and researchers vie to take a biopsychosocial approach in regards to the treatment and study of addiction (Buchman, Illes, & Skinner, 2010), as will be discussed throughout this thesis, they often fall short of this goal and fail to reflect an understanding of the lived experience of individuals with an addiction. Though much is known about the methods employed by clinicians and addiction service providers, there seems to be less information regarding the lived experience of individuals with an alcohol addiction as they work towards recovery.

A body of research has developed that indicates that an understanding of the shifting internal states and motivations of the person is an important factor for providing effective interventions for addictions (Clegg, 2006). A review of the literature will show that although a variety of approaches have attempted this task, they each have criticisms leveled at them regarding their limitations. Though these approaches touch on similar aspects of addiction, and are sometimes combined to produce a more complete portrayal of addiction (Hogg, Terry, White, 1999), their common deficit can be summarized as an inability to explain the development of the sense of self, or subjectivity, within the context of recovery.

In light of the above criticisms, this thesis will involve analyzing transcripts from interviews with individuals with an alcohol addiction in order to increase our understanding of the recovery process and to gain insight into the lived experience of addiction. As this project focuses on the subjective experience of individuals, I will examine how an understanding of consciousness and its development may inform and enrich our conceptualization of addiction. By framing addiction as a problem of a restricted consciousness, and its treatment as a form of consciousness expansion, perhaps
those who treat addictions may be better able to understand the process of change that occurs in individuals who are struggling with an addiction.

With the recent surge of interest in consciousness studies (Delacour, 1997), some authors suggest that an understanding of consciousness could help with comprehending the process of transformation that has been described in recovery in rich detail but has not been adequately explained. As Baillie and Corrie (1996) stated, “writers concerned with the actualization of human potential are increasingly advocating the view that consciousness is the central faculty of human beings that is fundamentally involved in personal transformation” (p. 305).

In making an argument for the inclusion of the concept of consciousness in the treatment of addictions, this thesis will lay out a working definition of consciousness and describe how an emphasis on understanding the consciousness of the person could help improve treatment. In building support for this position, this thesis will explore how consciousness was neglected in the discipline of Psychology and why there is renewed interest in its study. This is an important point to consider because, as will be shown, the exclusion of consciousness from Psychology helped set a research agenda that determined what aspects of human experience merited further investigation. This history is significant as current conceptualizations of addiction, and approaches to treatment, were developed within the boundaries of the Behaviourist paradigm. To support the inclusion of descriptions of consciousness into addictions treatments, this thesis will also look at how addictions have traditionally been treated and the strengths and weaknesses of these approaches. As this project focuses on understanding the process of recovery from an addiction, through gaining insight into the personal changes experienced by
individuals, emphasis will be given to the development of the self along with an explication of its fundamental relation to consciousness.

Before proceeding further, a few comments should be made regarding the term “self”. Though the term might seem straightforward initially, it requires clarification as it can be used in a variety of senses. As Baumeister (1987) said, “Different features of the self are defined in different ways” (p. 171). In terms of our personal identity, the self can be thought of as “the outcome of our being conscious and the continuity of our own consciousness, namely remembering that we are the same person today as we were yesterday” (Stam, 2006, p. 102). Elaborating further on how the self can be defined, Baumeister identifies three “self-definition processes” (p. 171) that represent different aspects of the self. According to Baumeister, “components of self-definition can be acquired by being assigned to the individual, they can be acquired by achievement, or they can be acquired by acts of choice” (p. 171). It is the presence of these different processes of self-definition that causes the self to be viewed in multiple ways rather than as a static, single entity and leads to confusion in how the term is being used. In order to address this confusion around the term, Stam (2006) suggested that we must consider the theoretical or conceptual framework the term “self” is referring to. With this in mind, it will be stated clearly how the term self is being used throughout this paper.

1.1 Psychology Experiences a Loss of Consciousness

In its nascent stages as a course of scientific study, consciousness was the primary subject matter of research in Psychology (Hergenhahn, 2009). Wilhelm Wundt, considered the founder of experimental Psychology, focused much of his research efforts on examining the immediate experiences of consciousness. Edward Titchener continued this work in his development of structuralism which attempted to explain conscious
experiences through understanding the elements of thoughts and sensations which comprised them (Hergenhahn, 2009). In the USA, William James (1890/1983) wrote at length on the topic of consciousness and advocated in his book, *The Principles of Psychology*, that consciousness should be a central concern for the discipline of Psychology. However, in time, consciousness was usurped as the primary subject of psychological inquiry. As O’Neil (1995) explains, “with the development of comparative Psychology, there was increased stress on observed overt behaviour and a reduction in explanations in terms of higher mental processes attributed to subhuman animals” (p. 285).

Over time, the discoveries and advancements made by these comparative psychologists led to a shift away from the study of consciousness to a new approach in understanding human behaviour. Collectively, the work of these individuals helped chart a new course for the direction of research in Psychology. For instance, Thomas Huxley expanded Descartes’ idea that animal behaviour was mechanical and applied it to human behaviour (O’Neil, 1995). In Russia, Ivan Pavlov and Vladimir Bekhterev worked to develop the understanding of conditioned reflex, each of them emphasizing the role that it had in explaining human behaviour (Hergenhahn, 2009).

This new approach in Psychology sought to explain human behaviour with singular reference to observable behaviour. For behaviourists, the functional analysis of behaviour was based on a stimulus and response (S-R) model. In explaining its adoption by behavioural psychologists, O’Neil (1995) explains, “the (S-R) mode of analysis became explicit when Watson adopted the concept of the conditioned reflex developed by Pavlov and Bekhterev” (p.286). With the adoption of the S-R model, behaviour was seen
as the product of external reinforcements in the environment. In this framework, there is no need to consider the internal states of an organism as “subjective experience is only considered to the extent that the experience is manifested in observable behaviour” (Cloninger, 2000, p. 274). This approach to human behaviour brought an end to research attempting to describe the inner life of a person. As O’Neil explains (1995), “the objectivity that behaviourists demanded in their research excluded the study of subjective, mental phenomena and consciousness was cast aside” (p. 286).

Upon removing consciousness from the purview of Psychology, researchers worked within this new behaviourist paradigm for decades. As O’Neil (1995) explains, “behaviourism dominated mainstream academic Psychology in America for some four or five decades from the 1920s to the 1950s or even 1960s” (p. 289). While working within this paradigm, a major emphasis was placed on understanding reinforcement principles and their causal role in human behaviour. Though behaviourism was the dominant school of thought for much of Psychology’s history, as it stands today, “within the larger Psychology and cognitive science community behaviourism has become viewed as an outmoded approach” (Keijzer, 2005, p.124). Though behaviourism has its critics today, and the limits of its explanatory and predictive power have been revealed, it is understandable why psychologists, especially in the early days of Psychology, would put such a strong emphasise on observable behaviour.

The main reason that consciousness was cast aside by behaviourial psychologists was to align Psychology with the other scientific disciplines. To achieve this end, behavioural psychologists adopted the tenants of Positivism. As Breen and Darlaston-Jones (2010) explained, “The epistemology of Positivism asserts that knowledge is
objective and value free (or neutral), and is obtained through the application of the scientific method” (p. 68). In founding their research paradigm on the tenants of Positivism, Psychology aligned itself with the same objectives as other scientific disciplines; namely, the “description, prediction, control, and explanation” (Breen & Darlaston-Jones, 2010, p. 68) of phenomena.

In taking this course of action, it was thought that the study of human behaviour could gain a legitimacy that was comparable to other natural sciences. As O’Neil (1995) explained, “Behaviourists were tempted by the hope that Psychology would be reducible to biology, just as it was being hoped that biology would be reducible to physics and chemistry (p. 290). From this perspective, the adoption of this approach represented a belief that “Psychology should seek to formulate deterministic or causal laws and give up talking about purposes or teleological goals” (O’Neil, 1995, p. 286). Accordingly, there was no consideration of internal states and their influence on behaviour. As with the other sciences, causal laws could be uncovered to predict and control behaviour based on the observations of a researcher.

The inherent assumptions of this approach were based on the scientific thinking of the time which saw the universe as Newton described it. As Atwood and Maltin (1991) explained:

Our earliest scientific traditions led to the belief that the world was divided into space and matter, with discrete particles which constitute the building blocks of nature. Models of the world were erected, based on formulas of force, motion, mass and energy, which were immeasurable help in manipulating the environment (p. 370).
Within this framework of belief, human beings exhibited the same sort of mechanism found in natural phenomena and thus fit easily into the S-R model described above.

However, advances in physics began to suggest that the Newtonian conception of the universe was incomplete and inaccurate. As a result, the natural sciences began to incorporate a systems approach that recognized this fact (Lickliter & Lewkowicz, 2007). A systems approach acknowledges that simple cause and effect relationships do not always exist and that, while many aspects of nature can be described in this way, there are other phenomena that cannot. As the other sciences adjusted to the development of a new view of the universe, and the limitations of behaviourism became more apparent, Psychology began to undergo changes of its own due to this new worldview.

As well as the advancements made during the so-called cognitive revolution (Miller, 2003), another likely impetus for a move away from behaviourism was the emergence of quantum mechanical descriptions of the universe that began to supplant the Newtonian conception. These discoveries initiated a change, both in how Psychology viewed itself and its subject matter. As Atwood and Maltin (1991) explained, “With the impact of the new physics, systems theories, and many other conceptual revolutions, the old theoretical structures have begun to crumble” (p. 371). Within the old paradigm of behaviourism, there was a clear distinction between subject and object. Behaviour could be measured objectively as the subject and object were viewed as separate entities. In Newtonian terms, “the universe was viewed, at least through the eyes of classical physicists, as a magnificent but inarticulate collection of separate things and events, each perfectly isolated by definite boundaries in space and time” (Wilbur, 2000, p. 35).

However, advancements in quantum physics showed that the separation that was once
believed to exist was no longer true in reality. Within this new worldview, the world appears as “a complicated tissue of events in which connections of different kinds alternate or overlap or combine and thereby determine the texture of the whole” (Atwood & Maltin, 1991, p. 370). This understanding required a complete re-evaluation of the fundamental assumptions of the discipline of Psychology as philosophers of science began to emphasize the role of subjectivity in empirical science (Wilber, 1977). These findings also had ramifications for Psychology and the other social sciences.

As Baillie and Corrie (1996) explained, “until recently, scientific approaches to the study of mind and behaviour tended to treat reality and its discernment as unproblematic. Reality was either simply viewed as a ‘given’ or as something that could be readily construed” (p. 295). With the recognition that the physical world was not as simple as it seemed, a concern arose regarding the interpretability of scientific findings and what could be considered fact. The separation between the subject and the object was seen as an artificial, human creation. This was recognized by the social sciences and found expression in the sociological theory of social constructivism. As Baillie and Corrie (1996) explained, “one of the fundamental characteristics of social constructionist thinking generally is the denial of subject-object duality; namely the idea that a clear-cut distinction can be made between the inner life of the mind and the external world of social reality” (p. 298). As it pertains to Psychology, it seems that the separation of subject and object, at least for higher order phenomena, requires a consideration of consciousness in the interpretation of what has occurred. As Atwood and Martin (1991) explained,
with the collapse of the old paradigms, we are witnessing the movement in the
West in physics and in social systems theory toward a general theory base which
supports the notion of the possibility for a new stage of development — that of
expanded consciousness toward a psychological awareness of the interrelatedness
of all things (p. 372).

Before examining the work that has been done towards establishing this general theory
base, and how it might be applied to the treatment of addictions we will first look at
consciousness and how it is defined. As well as aiding in the understanding of the
experience of recovery, a working definition of consciousness will aid in understanding
how the self-concept changes over the course of recovery.

1.2 Towards a Definition of Consciousness

Defining consciousness is considered by many to be a difficult proposition.
Without question, consciousness is a complex topic that has generated much debate since
human beings have had the capacity to ponder their own existence. In regards to the
difficulties in studying consciousness, Tulving (1985) said, “of all the mysteries of
nature, none is greater than that of human consciousness” (p. 1). What makes
consciousness difficult to define is its dynamic nature and our involvement with the very
phenomenon that we are trying to understand. The existence of consciousness is
personally experienced by researchers and therefore cannot be studied in isolation like
other phenomena. Researchers are enmeshed with the very object of their investigation,
more so than any other phenomena, and this compromises our ability to study it outside
of that relation. As Cook-Greuter (2000) stated, “named concepts are always abstract or
split from the underlying seamless Reality. Hence we face the inevitable paradox of
trying to express with words that which is ineffable and beyond any conjecture we ever make about it” (p. 232). However, this does not mean that we cannot study consciousness or make any progress in furthering our understanding of the topic. It has been noted that support for consciousness as an object of scientific inquiry has been growing (Delacour, 1997).

In terms of the psychological study of consciousness, Henri Ey (1978) stated that psychologists have primarily taken three approaches in attempting to explain consciousness: They have denied consciousness completely; made it into an epiphenomenon; or reduced it to a simple property of wakefulness. In light of this, it is no wonder that consciousness has proven to be so difficult to define. Though there are a variety of schools of thought in Psychology that advocate a particular approach to a psychological topic, there is typically a consensus regarding the basic features of the topic. This has not been the case with consciousness. However, as we shall see, although consciousness has not been explained as easily as other phenomena, a definition, or at least a clear description, of consciousness has emerged through the course of its study.

Though explanations of consciousness have been put forward throughout the centuries, accounts of consciousness can be described as either naturalistic or phenomenological (Clegg, 2006). Though it is beyond the scope of this thesis to delve into the distinctions among these outlooks, it is necessary to provide an explanation of how they differ. From a naturalistic perspective, researchers are attempting to uncover the biological underpinnings of consciousness. As Clegg (2006) explains, “The strongest form of a naturalized consciousness would claim that consciousness is unambiguously and fundamentally reducible to the brain” (p. 341).
From a naturalistic perspective, the so-called hard problem of consciousness (Chalmers, 1995), is what researchers are attempting to resolve. Briefly stated, the hard problem is identifying “the point of critical neural complexity at which phenomenal consciousness is first constituted” (Miller, 2007, p. 168). Within a phenomenological perspective, the goal is not to attempt to explain how consciousness arises; rather, consciousness is taken as a real phenomenon, as a given in the world, that can be explained and studied without having to account for how it came into being (Miller, 2007). For the purposes of this project, the questions related to defining and describing consciousness will be viewed from a phenomenological approach.

A phenomenological account of consciousness is one that recognizes that, as human beings, “we construct complex conceptual frameworks to organize our beliefs about who we are and about the world we live in” (Miller, Schlitz, & Vieten, 2010, p. 14). From this perspective, it is acknowledged that human beings are “aware that our own thoughts belong to us in a separate, unique personal self” (Farthing, 1992, p. 25). Though a phenomenological approach to consciousness is different from a naturalistic approach which focuses on the biological foundations of consciousness, the two approaches are not necessarily distinct. For instance, “a growing body of evidence suggests that people’s brains respond and grow through pathways of meaning, and are born with a built-in capacity and drive to search for purpose and to reflect on their role in relationships to others and to their environments” (Miller, Schlitz, & Vieten, 2010, p. 27). As will be discussed throughout this thesis, this is an important point in regards to the treatment of addiction, which is viewed by some as due to dysfunction of this innate capacity for finding meaning. The notion that we have a “drive to search for purpose” is also a key
point in regards to the treatment of addiction as it gives support to humanistic concepts of self-development that have been applied to the change process that has been observed in recovery.

The notion that we construct conceptual frameworks to organize our experiences speaks to the fact that as human beings we are open systems that are constantly influenced by processes of stasis and change (Todres, 2000). These frameworks that we make are temporary and serve a purpose for periods of our lives, or even brief moments, and are capable of being arranged into new adaptive configurations as we continually engage the world. With each encounter or interaction, these frameworks have the potential to change in order to allow us to meet the demands of a new situation. As we learn, through a synthesis of imagination and experience, new information is integrated into these frameworks and their complexity increases along with their capacity to change. From this view, a connection between the self and consciousness begins to become clearer as both can be characterized as processes that are continually underway. As Fischer, Gauchet, Perarnaud, and Tarquinio (2001) explained, “the conceptualizations of self as a process, with the emphasis on how the overarching narrative sets the individual toward the existential givens, suggests attention to the landscape of consciousness” (p. 89).

Differences between naturalistic and phenomenological descriptions of consciousness are but one of the difficulties in defining consciousness. As Ey (1978) explains, “numerous philosophers have suggested that much of the definitional ambiguity associated with the term consciousness is due to the fact that a variety of meanings have been attributed to the term” (p.12). Without question, the term has been used to apply to a
range of phenomena that consciousness comprises. For instance, Miller (2007) states that consciousness can refer to

- awareness, arousal of attention, alerted or pathological states, higher order functions such as a sense of self or self-awareness, higher order conscious attributes such as the possession of propositional attitudes, an awareness of the possession of propositional attitudes in others, and awareness within a population or group of people of a certain issue or belief (p. 159).

As this definition shows, consciousness is not a single, static, and clearly defined entity. As Cook-Gruetner, (2000) explained, “consciousness is not a monolith, at least not in humans; it can be separated into simple kinds and complex kinds” (p. 295). As was described above, consciousness is a dynamic process. As such it is at once a thing that exists in a given moment of time but as well, it is something that must be viewed apart from time as its definition is not entirely temporally bound (Wilber, 1997). Anything that is defined as a process implies that a final, complete definition is always on the horizon of understanding; its meaning is sensed more so than grasped. There is no static, completed form on which to adhere a label.

Though it is difficult to place a definition on the process of consciousness, rather than coming to the conclusion that consciousness is somehow beyond definition, it can instead be argued that the term encompasses each of the above features described above by Miller. From this perspective, consciousness can serve as an umbrella term for how these aspects of the mind operate in unison. In this view, “consciousness is viewed not as a feature of the mind, which contrasts with for example the unconscious, but rather as an
intrinsic quality which allows human beings to grasp and integrate within themselves the existence of things” (Baillie & Corrie, 1996, p. 296).

To help arrive at a working definition of consciousness, and to aid in understanding more about its function and its dynamic nature, it will help to look at the work of William James, one of the first psychologists to grapple with the topic of consciousness from a scientific perspective. Not only is the work of James relevant to the topic of consciousness but, as we will see, it was also a significant influence on the development of an understanding of addictions. James (1890/1983) compared consciousness to the movement of water in a stream. He described how traditional Psychology, in its focus on the contents of consciousness, failed to recognize that consciousness was an active process. Just as a stream cannot be said to be composed of the sum total of vessels of water taken from it, consciousness could not be viewed only in terms of its contents. Because the word “consciousness” seemed to suggest a static entity, and failed to capture the fact that it was a process that is underway, James felt the term was of little value. As Combs (2009) explains, “James eventually abandoned the word consciousness completely, substituting the word experience” (p. 6).

James’ view of consciousness as a process is endorsed by modern consciousness researchers who also take into consideration James’ emphasis on functional value. These researchers acknowledge that consciousness provided an evolutionary advantage “as the volume and complexity of information coming into the brain increased and as the organism developed increasing capacity for multiple behaviors, responding in a stereotyped manner became increasingly difficult” (Oro, 2004, p. 1294). The notion that a definition of consciousness should express its dynamic and adaptive value has also been
recognized by Henry Ey (1978), a French psychologist who wrote extensively about consciousness.

Ey suggested that the term “conscious-being” be used in lieu of consciousness. As Ey (1978) explained, “conscious-being can be understood either as a mode of being which is predicated of a subject (being conscious) or as a substantive category of the objectively definite existent (conscious being)” (p.3). This conceptualization of consciousness is also in accordance with James in that it recognizes both the subjective and objective aspects of consciousness. Gray (2004) summarizes James’ position in this regard by stating that, “consciousness is not an entity but a function that determines whether subjective interior feelings or an objective external perspective dominates individual responses” (p. 1152). Similarly, Ey (1978) states, “The subject and object are constituted by being connected and combined in the very construction of the forms which link the subject to his world in and through the appearance of the meaning which confers existence and coherence upon objects” (p.5).

In describing differences in consciousness levels across species, Tulving (1985) outlines the following three types of consciousness in order of their complexity: anoetic, noetic, and autonoetic. Anoetic consciousness can be viewed as sentience that involves perception and reactivity in the environment and is bound to the present moment (Pascual-Leone, 2000). Though there might be conscious representations of objects, there is no awareness of being an active agent in the environment that can act independently.

At the level of noetic consciousness, an organism is able “to be aware of, and to cognitively operate on, objects and events, as well as relations among objects and events, in the absence of the physical presence of those objects and events” (Tulving, 1985, p. 3).
With noetic consciousness, an organism is able to form conscious representations of both objects in the world and of the self (Pascual-Leone, 2000). However, the conscious representation of the self is limited and is likely only realized through instinctual self-preservation and the need to satiate biological drives. Though an organism can have some sense of itself as existing independently from the environment, it is unable to view itself from a meta-cognitive position and engage in an activity such as thinking of its own thinking; the hallmark of autonoetic consciousness. Autonoetic consciousness, is considered “the highest level of consciousness and is based upon a probably exclusive human capacity for a self-reflective autonoetic consciousness represents the highest level of functioning of consciousness, and the sense of self, all three of the forms of consciousness just mentioned are "associated with memory-imprints subsumed to the self, the sense of self, and identity” (Vandekerckhove, 2009, 5).

It is this form of self-reflective consciousness, and its changes throughout the course of recovery, that are of interest in the current study. In order to understand how this self-reflective consciousness develops, we will look further at the subjective aspect of consciousness and its relation to the self-concept and how interactions in the world are integrated into the sensorium and lived experience of the person.

From a phenomenological perspective, “consciousness refers to the level of access that one’s awareness can have to some or many of the aspects of his or her own objective and subjective existence, the personal mental process and its variations” (Vandekerckhove, 2009, p. 12). In other words, consciousness is a mental state that permits us to have a phenomenological awareness of the various aspects of experience. Implicit within this phenomenological awareness is an understanding of a sense of self.
As Ey (1976) explained, “all experience demands a subject which is the referential center of all relations” (p. 23).

In order to be aware of the contents of our own consciousness, and in order to direct our actions in the world, we need to be able to stand apart from the present moment. As Lou (2002) stated, “self-awareness is a pivotal component of any conscious experience and conscious self-regulation of behaviour” (p. 113). We need to be able to stand in a psychological space existing outside of the present in which to behold everything that surrounds us and to comprehend ourselves within that space. In this regard, the sense of self is immanent to consciousness (Block, Flanagan, & Guzeldere, 1999). In describing the relationship between the two, one author “has likened conscious experience with a coin, with one face illustrating comparatively stable self-awareness. It is inseparable from the other face which consists of shifting non-self-contents from sensory and memory sources” (Lou, 2002, p. 113). The relationship between the self and consciousness is evident in the intentionality of consciousness; what has been called its "most defining feature" (Farthing, 1992, p. 28).

Intentionality refers to the idea that consciousness is always about something. To say that a conscious state is intentional means that it is “directed at, or is about, something other than itself” (Kriegel, 2003, p. 271). From an evolutionary perspective, the intentionality of consciousness has a functional and adaptive value. As Bartolomeo (2008) explained, “to behave in a coherent way, organisms need to select objects appropriate to their goals” (p. 4). For individuals with an alcohol addiction, there is typically a narrow range of goals to choose from as most of their activities are based on the procurement and consumption of alcohol. With the continued use of alcohol, there
can be a reduction in the cognitive flexibility that accompanies regular states of consciousness as the need for alcohol becomes paramount (Keenan, O’Callaghan, O’Donnell, & Sinanan, 1997).

As a lifestyle builds around alcohol consumption, and the body grows accustomed to functioning with the presence of alcohol, the conscious contents of experiences, in a sense, become imbued with alcohol as well. As more experiences are tinged with alcohol, the interior life of the person adapts to its presence in a similar manner to the physical body. With the continued use of alcohol, a person’s sense of identity can become founded in the consciousness that is dominating his or her life at that time. As Hobin, Nelson, and Puhakka (2000) explained, “forming an identity is a way in which consciousness objectifies itself to contents of consciousness – thoughts, feelings, images, beliefs, memories – and assumes with each of them, ‘That’s me,’ or ‘That represents me’” (p. 91).

As will be argued in this thesis, the understanding of consciousness as integral to the development of one’s identity can aid in understanding the etiology, maintenance, and recovery process related to alcohol addiction. As Gray (2004) explains, “such a philosophical framework creates meaning from the relationships revealed among the different parts of the addiction phenomenon and the changes in consciousness that are experienced with psychoactive drugs” (p. 1151). It will be argued in this thesis that it is the intentional aspect of consciousness that aligns consciousness studies with a developmental view of the person and, in particular, the concepts of Humanistic Psychology.
In understanding the change process of consciousness, we might be able to understand how concomitant changes in the self-concept occur and inform our understanding of the development of the self in the context of addiction. We may also enrich our understanding of the experience of individuals in treatment and apply this understanding towards devising more effective treatments. As Aarts and Dijksterhuis (2010) explained, “when we set, strive for, and attain our goals, we have a sense of agency or willingness in that we experience ourselves as the cause of our own behaviour as a result of decisions and actions” (p. 467). In viewing addiction as a developmental process gone awry, and aligning recovery with principles of growth in Humanistic Psychology, clinicians might be able to help clients develop a sense of purpose and meaning in their lives. As was noted earlier, it is this sense of purpose that seems to be required for overcoming an addiction.

However, as mentioned at the outset, addiction is not merely a problem within an individual. Just as there are social factors that contribute to the onset and progression of an addiction, there are social factors that influence the development of consciousness and one’s personal identity.

Implicit in the development of consciousness, and the development of a sense of self, is interaction with others. As Miller, Schlitz, & Vieten (2010) described, “with increased self-reflectivity comes a shifting awareness not only of the individual self, but also of the relationships to others and to the world” (p. 26). Our sense of who we are is based on the sum of our experiences including our interactions with other people. As Vandekerckhove (2009) explained, “our identity is based on a summary of our implicit and explicit historical past and our autobiography represented in the experience of
autonoetic consciousness” (p. 5). Our historical past can influence our activities in the present, including our self-evaluations. Through social interactions, we can evaluate how we compare to others and form understandings of other people with whom we encounter. These social encounters are instrumental in the development of the sense of self as in understanding other people, we come to understand ourselves.

Vygotsky (1978), Mead (1934), and countless other social psychologists have helped us understand the sociogenesis of mind and the important influence of social interactions on the development of consciousness. The ability to empathize with others, to understand things from a stranger’s perspective, to use and understand language; these and related abilities depend on our interpersonal relations with others and it is these relations which comprise the intersubjective aspect of consciousness. As O’Donnell and Tharp (2012) explained, “intersubjectivity develops in activity settings during joint productive activity, facilitates the activity, and becomes the shared meanings of culture through semiotic processes” (p. 23).

To be clear, semiotic processes are those processes that relate to the development of that shared plane of meaning on which individuals communicate and are developed, largely, through the use of language. As Cortina and Liotti (2010a) explained, “as long as there is higher-order consciousness there are advanced forms of intersubjectivity that involve sharing of experience from multiple perspectives through gestures or language” (p. 430). As the capacity for intersubjectivity increases, the consciousness and the sense of self of the individual have an increased capacity to grow and develop into more integrated states.
From a phenomenological perspective, the development of the consciousness and the self are interdependent processes. This is reflected in how discussions of the self accompany debates regarding the nature of consciousness. For instance, in regards to the re-emergence of consciousness as a topic of investigation, Stam (2006) stated, “Consciousness, as a new topic for philosophers and neuroscientists, inevitably led to multiple claims about the nature and status of selves” (p. 106). As with consciousness, the self is an open system that is subject to outside influences and marked by periods of stasis and change. This openness is the defining feature of both consciousness and the self as they are processes that are always in the state of becoming. In commenting on the relationship between the self and consciousness, Todres (2000) said, “there is in any moment an ontological openness at the center of identity which is always functioning, whether one is explicitly conscious of it or not” (p. 230). If we could attain complete knowledge of the self, it would be impervious to any influences or forces of change. It would exist in a completed form like other objects in the universe.

It is the dynamic nature of consciousness and the sense of self that makes them so difficult to capture and describe with the methods of Positivist science. This is also why consciousness has been viewed as a mystery for so long. In a Newtonian worldview, consciousness is an incredible anomaly. However, the dynamic nature of the self and consciousness fits well into a quantum mechanical view of the universe. From this perspective, experiencing is seen as “a complex living process that cannot be controlled or predicted” (Hart, Nelson, and Puhakka, 2000, p. 94). In the quantum world things exist as probabilities. Though things are experienced as well-defined, at a quantum level they are indeterminate. As Hammeroff and Penrose (1995) described, “A quantum system
such as an atom or sub-atomic particle which remains isolated from its environment behaves as a ‘wave of possibilities’ and exists in a coherent complex-number valued ‘superposition’ of many possible states” (p. 760). The self and states of consciousness can be thought of in the same way. Though one version of the self might exist at a given moment of time, or one particular state of consciousness, it exists amongst an array of plurapotentialities with the particular moment determining which configuration of the potential states appears in the present. As Dimaggio (2006) explained, “the ‘I’ has the possibility to move from one spatial location to another in accordance with changes in situation and time” (p. 314).

We can understand how our sense of self changes, or moves between spatial locations, in the way we can imperceptibly shift from one role to another. For instance, a person in her first AA meeting might identify herself as an alcoholic at the outset of a meeting. At that moment, her main identity might be that of someone looking for help with her addiction. This is how she presents herself to others and how she views herself in that moment. While she is listening to someone speak at the meeting, she might receive a text message from her daughter. As she reads the message, though listening to the meeting, in that moment she is a concerned parent. Even though her child is not present, in reading the message she takes on that version of the self that is evoked during her regular interactions with her child as the child’s mother. If the text message is not urgent, that aspect of the self retreats and she immediately returns to the self in the meeting. While listening to someone’s story of recovery, she might be reminded of a difficult moment in her childhood. Though she is present in the meeting, she can momentarily reconnect to that sense of self that dominated at that time in her life. If she
finds the AA meetings useful and continues attending them, at future meetings she might see herself as someone capable of offering assistance to a new member. In taking on that role, she can draw on her sense of self that dominated during her own entry into AA while identifying herself as someone who is better able to live a life that is free from addiction.

Though this is a phenomenological description of the self, it has been accounted for in naturalistic approaches to the study of the brain. As Dimaggio (2006) stated, “neuroscience offers us data that are in line with the hypothesis that the self is made up of a multiplicity of voices in a dialogue with each other” (p. 316). To better understand the development of the self and its existence as a “multiplicity of voices” it will be helpful to look at how consciousness can be characterized in a similar fashion.

As has been described above, the self and consciousness are immanently related. As Vandekerckhove (2009) stated, “that the self becomes an object of attention, or the capacity for self-awareness, represents an essential ingredient in the experience of a sense of self, identity, and personhood” (p. 7). In this respect, as the ability for consciousness to understand the sense of self increases so does the capacity for self-reflection. The relation between consciousness and the sense of self is evident in the similar processes that underlie their development and transformation.

The self, or “I-position” (Dimaggio, 2006, p. 314), that exists in a given moment is maintained by a myriad of personal and environmental factors that influence the current state of the self. A similar process is underway with states of consciousness. As Combs (2009) explained, “each state of consciousness is composed of a number of basic psychological processes such as memory, thought, sense of time, body-perception, and
the senses of hearing, smell, taste, and so on” (p. 51). As one conscious state dominates, it will contain these basic psychological processes but they will vary in the degree to which they influence the particular conscious state being experienced in the moment. As Combs (2009) described, a conscious state acts “as an attractor which in chaos theory means a pattern of activity that a system is naturally drawn into by its own dynamics” (p. 53).

The sense of self can be thought of in the same way. A sense of self will exhibit a degree of stability that will be maintained for as long as is required. In the above example with the woman at an AA meeting, if the text message from her daughter was “I got arrested,” she would likely continue to remain in that configuration of self that manifests in relations with her daughter and her identification as her child’s mother. While that sense of self, or “I-position” (Dimaggio, 2006, p. 314), is the dominant expression of the self, there are attributes that predominate more so than in other expressions of the self. Though the woman in the above example might appear somewhat passive or withdrawn in the context of her first meeting, as a mother on her way to bail out her daughter, she might present as someone entirely different.

In describing the nature of consciousness, Metzer (1994) stated that, “It appears to be the essence of consciousness that it goes through periodic fluctuations” (p. 3). As mentioned earlier, this ever-changing nature of consciousness was also recognized by William James, Henry Ey, and other phenomenologists. James (1890/1983) tried to capture this essence of consciousness with the introduction of his term “stream of consciousness”. Though we have the sense of having an uninterrupted experience, and are oriented to our environment, in reality our consciousness is in a state of flux. In
describing the movement of consciousness as a system, Ham and Tronick (2009) stated “the system is thought to move toward more complex and coherent states of self-organization as it interfaces with itself and the outer environment” (p. 620). In this sense, consciousness can be viewed as a nonlinear and dynamic system that displays movement towards more highly integrative states. The emergence of these states of self-organization can be thought of as a process of consciousness expansion.

It would appear that as consciousness expands, the capacity for self-reflection increases. As a person is able to reflect on his or her sense of self, and recognize the various aspects of their identities, individuals develop greater insight into their current lives and improve their ability to regulate their behaviours and emotions across situations. Rather than re-enacting negative patterns that have been recurring in their lives, and approaching problems with a singular focus derived from a limited view of the self, an individual can review situations from multiple perspectives that come with increased self-awareness and an expansion of consciousness. As will be discussed throughout this thesis, an understanding of the development of the self-concept and its relation to consciousness is crucial to understanding the change process that occurs in recovery, if not the therapeutic process in general. To better understand the relationship between self-concept and consciousness and their capacities for change, we will take a closer look at the process of consciousness development.

1.3 Consciousness Development

As was described in the preceding section, greater insight and awareness is facilitated by an expansive consciousness. As consciousness develops, a person can recognize and reflect upon the nuances of their personal identities with greater acuity and
manifest a self-concept, or enact an “I-position,” in accordance with what is appropriate for the given situation. Because people vary in their growth and development, due to factors such as genes, learning history, experiences, and age, people exhibit differences in their capacity for self-reflectivity and their level of consciousness. As Vandekerckhove (2009) explained, “there is a continuum of consciousness that reflects an increasing level of development, voluntary involvement, complexity, and sharpness of representation, intensity and object relatedness” (p. 18). In thinking of consciousness as existing on a continuum, we can consider an individual moving along it and each movement representing a more complex and integrated form of consciousness.

To help understand this movement of consciousness, it might be helpful to consider a metaphor for consciousness used by consciousness researcher Ralph Metzer. According to Metzer (1994), “we may think of consciousness as a spherical field of awareness that surrounds us and moves with us wherever we go” (p. 5). This sphere can be thought to represent the worldview of individuals and contain the sum total of their experiences to date. It can include not only the person’s sense of self, but all those aspects of consciousness that were previously cited (awareness, attention, attitudes, etc.). With the introduction of new information and exposure to new experiences, physical or imagined, consciousness grows and evolves. In terms of our daily conscious experience, “both contractions and expansions of awareness are normal and natural processes, and we are generally familiar with the phenomenology of such state changes” (Metzer, 1994, p. 10). However, these daily, transitory shifts in states of consciousness are not consciousness expansion. They are fluctuations in states of consciousness but they do not represent the movement of one form of consciousness to another.
To aid in understanding what is meant by the move from one form of
consciousness into a more evolved, or expanded form, it might be helpful to view
consciousness as a worldview. As Miller, Schlitz, and Vieten (2010) explained, “a
worldview combines beliefs, assumptions, attitudes, values, and ideas to form a
comprehensive model of reality” (p. 19). It is a person’s current state of consciousness
that allows them to function in the environment. A person’s actions are based on, and
driven by, the contents of their consciousness and their ability to integrate them into a
coherent sense of self. Everything a person does or thinks can be thought of as existing
within the sphere, as described by Metzer, of consciousness.

The level of consciousness, just like the sense of self, will tend to stay in its
current state. As Cook-Gruetner (2000) explained, people “slip back into their own
familiar mode of processing reality during regular waking activity” (p. 228). In every
experience, every encounter with the world, our consciousness filters the event and it can
be interpreted in a way that works to maintain both the level of consciousness and the
sense of self. As Ey (1976) describes, “to be conscious is to live the uniqueness of one’s
experience while transforming it into the universality of one’s knowledge” (p. 3).

As information is integrated into consciousness and its existing contents, the
model of reality is confirmed or challenged. If the event is significant enough, in that it
introduces information, or induces an experience, that is beyond the capacity for the
current level of consciousness to integrate, the entire system of consciousness might
adjust to incorporate it into a new worldview. As Miller, Schlitz, and Vieten (2010)
explained, “there are times when an experience is so profound or shifts people’s steady
state in such a fundamental way, that they are forced to change the way they view the world” (p. 19).

As we will discuss later, coming to terms with an event that is initially beyond a person’s ability to make sense of or comprehend is the process that seems to be at work in experiences described in recovery as “hitting rock bottom”. The change to a new level of consciousness represents a total change in how the person orients to the world and serves as a new guide, or reference center, for their subsequent actions. As Vandekerckhove (2009) explained, “the higher the level of consciousness on the continuum, the more integration of different senses are involved such as language, affect, imagination, and intentional planning” (p. 13). With the attainment of more complex and integrated levels of consciousness, a person’s worldview can alter as the result of the changed relationship between themselves and the world resulting from changes to the structures of their consciousness.

To help bring about the attainment of more complex forms of consciousness in a therapeutic context, it has been suggested that “the therapeutic aim...is to develop in an individual in whom the experience of self is diminished or stunted, a conversation that will foster the emergence of a personal reality that has the features of dualistic, or reflective, consciousness” (Butt, Henderson-Brooks, Meares, & Sami, 2005, p. 663). These changes bring the potential to develop new skills that can allow the person to maintain their current form of consciousness and lessen the likelihood of regressing to a previous level of consciousness. It is this sort of transformation which is described in the 12th Step of AA as a “spiritual awakening” (White, 1998) and is the process investigated in this thesis. The complete list of Steps in the 12 Steps program is provided in Table 2.
Table 2

_The 12 Steps of Alcoholics Anonymous_

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.
1.3.1 Early Development of Consciousness

In order to better understand how consciousness changes, it might be helpful to consider how consciousness develops in childhood. Research conducted in child development represents one area of Psychology that, though not explicitly stated as such, examines the development of consciousness. For instance, as Combs (2009) explained, “Piaget was the first researcher to map in detail how patterns of thinking change as we grow and mature and how these determine our experience of reality” (p. 60). In reviewing the developmental changes that occur in consciousness, we may gain insight into how consciousness changes in the course of recovery.

As a child grows, there are particular developmental landmarks or milestones that indicate a new level in the consciousness development of the child. For instance, the ability to form a theory of mind (the ability to form ideas of what others are thinking and consider things from another person’s perspective) that develops in early childhood represents a major change in consciousness and how the child orients to the world. As Cortina and Liotti (2010b) stated, “perspectival abilities and an expanded form of consciousness are one and the same” (p. 305).

With each change in the structures of consciousness, the potential for further growth and complexity arises with the acquisition and development of new abilities. Not only can the child consider things from the perspective of another person, and appreciate how others may be impacted by outcomes of an event, the child can reflect on his own life to a greater degree. As Cortina and Liotti (2010b) explained, “the newly acquired ability to understand other people’s intentions and to co-operate deliberately with others paves the way to a secondary intersubjectivity and higher-order consciousness” (p. 303).
Though the sense of being conscious is a private experience, the development of consciousness is a social process. For communication between people to occur, each person must operate on a plane of shared meaning. Through interactions with others, as abilities related to language and reasoning are acquired and refined, our consciousness continues to develop. With continued interaction, we gain an understanding of the larger social world in which we live and this impacts how we evaluate ourselves and our behaviour. As our ability to understand and examine the social world develops, our ability to understand and examine ourselves develops as well.

Although differences in consciousness have been studied from birth to adulthood, it seems as though there has been relatively fewer research studies regarding changes in consciousness in adulthood and beyond. From my experience studying Psychology, it seemed as though there had been a tendency to focus on changes up to adulthood and that adulthood was viewed as an end point of development that was relatively stable and merely a bridge into the more studied area of gerontology. However, the work of researchers in the area of lifespan development has contributed greatly to our understanding of changes in adulthood. One psychologist that looked at changes in consciousness that occur in adulthood is Carl Jung. As will be discussed in more detail, Jung’s notion of individuation, a process of psychological transformation involving the integration of unconscious and conscious contents, was postulated to begin in a person’s mid 30s (Jung, 1921/1964). The development of consciousness in adulthood has also been touched on in the concept of spiritual emergency (Grof & Grof, 1989).
1.3.2 Models of Consciousness Development and the Treatment Process

It is worth noting the relatively limited amount of information related to changes in adult consciousness as this might have a bearing on the treatment of addictions. This is reflected in some of the recommendations to improve treatments for addictions that have been put forth recently. For instance, Amodia, Cano, and Eliason (2005) said, “individualizing the individual’s developmental stages or levels, and recognizing the multiple lines of development is a first step to truly individualizing treatment and identifying the tools that are best suited for growth at that stage” (p. 370).

As we look at the current approaches to the treatment of addiction, we will see how they fail to appreciate differences in an individual’s consciousness and the fact that “human beings construct their reality out of potentials provided by consciousness and the shifts in consciousness that are possible” (Baillie and Corrie, 1996, p. 296). Though it might sound difficult to chart the changes that accompany personal growth, it has been suggested that the sense of self can “provide a suitable beginning to an attempt to define markers of change” (Butt et al., 2005, p. 620). In fact, this was attempted by Carl Rogers, a pioneer figure in the history of Humanistic Psychology.

The idea of viewing treatment as a process of consciousness development is by no means new. In his book, *On becoming a person*, Carl Rogers (1961) outlines seven stages that clients progress through as they continue along in the process of therapy. Rogers describes the progression through therapy and the changes that occur as “a process by which the individual changes from ‘fixity to flowingness’, from a point nearer the rigid end of the continuum to a point nearer the ‘in-motion’ end of the continuum” (p. 132). In the initial stages of the process, the client exhibits “much blockage of internal
communication between self and experience” (p. 133) and “tends to see himself as having no problems, or the problems he recognizes are perceived as entirely external to himself” (p. 133). As the client progresses through therapy, “there is a beginning tendency to realize that experiencing a feeling involves a direct referent” (p. 140) and “feelings are expressed mostly in the present” (p. 137). In the final stage, the client exhibits a “growing and continuing sense of acceptant ownership of these changing feelings, a basic trust in his own process” (p. 151). Rogers’ proposed stages were based on his observations of how clients in therapy began to change over time. With the immanent link between self and consciousness, Rogers’ proposed framework can be interpreted as a model for consciousness expansion.

Another psychologist, Len Sperry, proposed a similar means of charting the movement of clients towards higher levels of integration. Sperry (2010) proposed that individuals can be said to operate on one of four different levels of consciousness. At the first level, called Level 0, a client has “little or no conscious awareness” (p. 49). At this level, a person’s actions and thoughts are centered around their psychological problems. As Sperry (2010) described, “Their actions often seem ‘guided’ by their severe personality disorders, substance dependence, or psychoses” (p. 49). At this level of consciousness, a person lacks the coping skills and insight that could help assuage some of their difficulties. The self-referential center of consciousness is bound within the restrictive limits that are set by the person’s current problems and there is no movement towards a higher, more integrated level of consciousness that would allow for the generation of solutions and increased self-reflection. As Miller, Schlitz, and Vieten, (2010) described, “one of the most significant impacts of self-reflexivity is increased
cognitive flexibility” (p. 26). Without this cognitive flexibility, an individual is bound by their problems.

The idea that a person can be subject to the limitations of their current level of consciousness and the level of integration of their self-concept, can be thought of in terms of Carl Jung’s notion of complexes (Jung, 1934/1960). In Jungian Psychology complexes are viewed as “psychosomatic, affect-laden, intrapsychic contents, which operate in discrete split-off bundles to become ‘splinter-psyches’ with enough internal coherence and autonomy apart from the conscious personality to invade it as alien states of mind” (Beebe, Cambray, & Kirsch, 2001, p. 222). In this respect, the growth of a person’s consciousness can be prevented from continued development as all mental activity and behaviour is directed towards the complex rather than towards higher, evolved states of integration.

At the next level of consciousness described by Sperry, Level One, a client operates with a “minimal level of awareness” (p. 49). At this stage a client’s actions are “purposeful and although still somewhat egocentric, they have some impulse control and can delay gratification” (p. 49). At this level, clients can function under normal conditions but experience difficulty in stressful situations.

At Level Two, clients exhibit a “moderate level of awareness” (p. 49) and are characterized as being able “to observe themselves and others with little need to judge or blame” (p. 49). Clients at this level show an ability to distance themselves from the problem and view it as a challenge to work through rather than as a fixed problem that defines their very existence and determines their destiny.
At the final level of consciousness, Level Three, “individuals experience a maximal level of awareness” (p. 50). At this level, clients are characterized as having a “connection with a greater oneness or wholeness beyond the self” (p. 50). This level can be thought of as what Rogers described above as a basic trust in one’s own process of development and parallels Jung’s ideas of individuation that will be explored later.

In Sperry’s model, “the levels of self-aware consciousness can be recognized by level of functioning or impairment, as with Axis V DSM IV, which consists of the Global Assessment of Function” (p. 49). The Global Assessment of Function (GAF) is provided in Table 3. In reviewing the table it is possible to see how a person’s capacity for introspection can change and how a people can become more flexible in terms of their thought and behaviour patterns as their GAF scores increase or decrease.

In reviewing these models, we are provided with a framework for understanding how the self-concept changes with the expansion of consciousness. There is a self-referential center to consciousness that is evident in our subjective experience. The self-referential aspect of consciousness and its complexity and integration is related to one’s level of consciousness. Specifically, the self is only as complex as the consciousness it exists within. To use Metzer’s metaphor of consciousness existing as a sphere that was offered earlier, the self-concept can be thought of as existing within spheres of various sizes. In a restricted consciousness, or smaller sphere, there is less material for the self to draw upon in the construction of itself. As consciousness expands, as the volume of the sphere increases, there is more material for the self to draw upon as it constructs itself.
### Table 3

*The Global Assessment of Function in the DSM-IV-TR*

<table>
<thead>
<tr>
<th>GAF Rating</th>
<th>Characteristics of Individuals Associated with GAF Ratings</th>
</tr>
</thead>
<tbody>
<tr>
<td>91-100</td>
<td>No symptoms. Superior functioning in a wide range of activities, life’s problems never seem to get out of hand, is sought out by others because of his or her many positive qualities.</td>
</tr>
<tr>
<td>81-90</td>
<td>Absent or minimal symptoms, good functioning in all areas, involved in a wide range of activities, socially effective, generally satisfied with life, no more than everyday problems or concerns.</td>
</tr>
<tr>
<td>71-80</td>
<td>If symptoms are present, they are transient and expectable reactions to psychosocial stressors; no more than slight impairment in functioning</td>
</tr>
<tr>
<td>61-70</td>
<td>Some mild symptoms</td>
</tr>
<tr>
<td>51-60</td>
<td>Moderate symptoms (e.g., flat affect and circumstantial speech, occasional panic attack) OR moderate difficulty in social, or occupational functioning</td>
</tr>
<tr>
<td>41-50</td>
<td>Serious symptoms (e.g., suicidal ideation, severe obsessional rituals, frequent shoplifting) OR any serious impairment in social or occupational functioning</td>
</tr>
<tr>
<td>31-40</td>
<td>Some impairment in reality testing or communication (e.g., speech is at times illogical, obscure, or irrelevant) OR major impairments in several areas</td>
</tr>
<tr>
<td>21-30</td>
<td>Behaviour is considerably influenced by delusions or hallucinations. OR serious impairment in communication or judgement OR inability to function in almost all areas</td>
</tr>
</tbody>
</table>
1.3.3 The Experience of Change

In viewing the person as existing along a developmental trajectory from a state of consciousness that is dominated by addiction, to one that facilitates the development of a self-concept that is no longer bound to the limits imposed by addiction, treatments can be implemented based on the degree to which they will influence the process of consciousness development. In this respect, “any domain of function can be an effective target for intervention because increasing the coherence in one domain will likely impact the entire system” (Ham & Tronick, 2009, p. 622).

When we understand the relation between consciousness and the self, any form of therapy can be viewed as a process of consciousness expansion as “therapeutic action lies in dyadically expanding the coherence of patient’s self-organization” (Ham & Tronick, 2009, 622). Support for viewing the progress of clients through treatment as a process of consciousness expansion is reflected in current research efforts that examine how clients make meaning out of their experiences and how these impact their personal development. According to Angus, Gonclaves, Greenberg, Mendes, and Riberio (2010), “the field of psychotherapy research has begun to address the fundamental question of how clients construct their own process of change in effective therapy sessions” (p. 692). This is an important point as the process of change is not confined to the offices of support workers and clinicians. A client spends a relatively small amount of time in scheduled counselling sessions or group discussions. To varying degrees, at various moments throughout the day, clients are reflecting on the process of treatment and attempting to synthesize new information into their consciousness.
If clients are undergoing a common process of reflection whereby they integrate new knowledge into consciousness during treatment, it might be possible to identify similarities or shared strategies that clients use to apply the information presented to them in treatment and gain insight into their addictions. The idea that recovery involves a process of integrating new knowledge into consciousness and evolving the self-concept to a more integrated form corresponds with Dimaggio’s (2006) observation that “clinicians of various schools have shown how describing a patient accurately requires being able to identify his or her entire set of mental states, that is, the forms of subjective experience a patient’s narratives take when they surface in consciousness” (p. 316). Perhaps there are stages throughout the treatment process individuals pass through that can be identified by clinicians and clients to chart their true progress.

Though addiction treatment is not typically described as a process of consciousness expansion, this might be due more to Psychology’s historical exclusion of consciousness which has resulted in unfamiliarity with the topic amongst clinicians rather than its unsuitability for describing the experience of addiction. For instance, though clinicians do not typically conceptualize an addiction as a restricted form of consciousness, consciousness-raising has been described as a “prime target for most prevention and treatment programs” (DiClemente, 2004, p. 33).

It would seem as though understanding how consciousness expansion occurs, and how the self-concept develops to the point of no longer suiting an addictive lifestyle, would be important for understanding the recovery process. The start of a new life involves a new outlook and orientation that is incompatible with a former way of living. From this perspective, the new life can be viewed as an expanded form of consciousness
with new parameters or limits for the continued growth and development of the self. As McGinley (2011) described, “the experience of these limits demands a response in order to sustain one’s sense of self in the face of the threat to ourselves and our world” (p. 5).

In other words, a person will act in such a way as to preserve their typical level of consciousness. The sense of self, the self-referential center of consciousness, can be viewed as being bound within a new sphere of knowing that is comprised of high levels of awareness that impose limits which keep it from retracting to a more restricted state. As was noted above, though levels of consciousness exhibit periods of contraction and expansion, they tend to remain in a stable state. Once achieved, it is more difficult to regress back into a former way of experiencing the world once limits are in place that contribute to the cohesion and maintenance of the current level of consciousness (Combs, 2009).

Just as the educational process develops knowledge that will allow a person to determine the truth about the world they live in, and to achieve a level of knowledge that allows them to dismiss unfounded information and outright falsehoods, the recovery process seems to involve the development of a state of consciousness that is incompatible with addiction in that it removes conditions that restrict the development of the self towards higher states of integration. This can be understood in the concept of problematic self-narratives. As Angus et al. (2010) explained, “problematic self-narratives are accounts of the person, other, and the world that impose strict constructs on the construction of meaning, making it difficult for the person to elaborate the diversity of daily life” (p. 268).
In viewing addiction treatment as a process of consciousness expansion, and working to understand the changes that occur in structures of the consciousness and the self-concept, we might improve our ability to describe the process of addiction. In introducing consciousness to the study and treatment of addiction, we might also begin to develop and refine the explanatory language used to conceptualize the process of recovery. Next we will take a closer look at the phenomenon of addiction and review how it is conceptualized. This will allow for an assessment of its suitability for description in terms of consciousness.

1.4 Features of Addiction

Like consciousness, addiction is subject to similar complications in terms of its academic study. Though consciousness is a phenomenon that we have an intuitive understanding of, and an innate familiarity with, it has proven difficult to explain and account for. This seems to be the case with addiction as well.

As was mentioned at the outset, there are differences of opinion regarding the proper use of the term “addiction”. This is further reflected in how the term can be used in everyday language outside of academic circles. For instance, it is not uncommon to hear people state that they are addicted to certain activities that they enjoy or to foods and drinks they regularly consume. However, when a person refers to herself as a chocolate addict, it is unlikely that her fondness for chocolate is causing her to neglect her family, drain her bank account, or binge uncontrollably to satiate whatever cravings that are experienced. As Erickson (2000) said, “addiction used in this way is colloquial and not scientific” (p. 3). Furthermore, as is the case with consciousness, the study of addiction also requires an appreciation for its subjective aspects as addictions are in part defined by addicted individuals (Fraser, Kane, & Moore, 2011). As we will discuss in this section,
an addiction is diagnosed by the personal impact upon the individual and their evaluation of how their subjective sense of quality of life is being impacted.

Addiction is also similar to consciousness in that it is best conceptualized as a dynamic process. As Linkenbach (1993) explained, “the addiction process is a dynamic one in which each person develops his or her own view of life” (p. 251). As there are various states of consciousness, research on the nature of alcohol problems, “indicates that they lie along several modestly interrelated continuous dimensions of severity, rather than occurring as a single syndrome qualitatively distinct from normality” (Miller, 1996, p. S15). In this sense, addiction is similar to consciousness in that it too must be viewed from a multidimensional perspective.

The dynamic and multidimensional aspects of addictions have served as impediments to establishing a definition of addiction and have led researchers to make compromises that have led to simplified views of addiction. As Gori (1996) explained, “it is apparent that the experts became less and less comfortable with attributes of variable intensity and ended up with an all-encompassing definition lacking specificity” (p. 35). Though current definitions of addiction might fail to capture some of its salient and subjective features, there are agreed upon characteristics of an addiction that warrant examination.

Though definitions of addiction vary, it is generally agreed that addictions include common identifiable features. As DiClemente (2004) explained, the essential features of an addiction are “the development of a solidly established, problematic pattern of a pleasurable and rewarding activity; the presence of physiological and psychological
components that create dependence; and the interaction of these components that make the behaviour resistant to change (p. 4).

These dimensions of addiction are recognized in the diagnostic criteria for Substance Dependence in the DSM-IV-TR (American Psychological Association, 2000), that were mentioned at the outset of this thesis and shown in Table 1. Though on the surface this might seem like an adequate rendering of what constitutes an addiction, these criteria are problematic. As Fraser, Keane, and Moore (2011) explained, “despite their framing as objective descriptions of harm and impairment, the DSM criteria rely on ethical and moral judgments about lifestyle, conduct and priorities” (p. 876).

In this regard, psychologists’ appraisals and diagnoses of addiction might have ramifications that extend past the therapeutic relationship and to society at large. As a result, psychologists are at risk for their own personal biases and attitudes towards addiction to influence their work with clients. In addressing this situation and the impending revisions to the DSM-IV-TR, Fraser, Keane, and Moore (2006) stated, “recognizing the DSM as active in constituting addiction and those called ‘addicts’, rather than merely describing them, opens up complex political and ethical issues that should be central to future discussions” (p. 876). As an example of how the DSM criteria can influence how those with an alcohol addiction are perceived by others, Buchman, Illes, and Skinner (2010) stated that the DSM “implies simplistic categorical ideas of responsibility, namely that addicted individuals are unable to exercise any control over their substance use” (p. 37). A focus on the subjective aspects of addiction, and the lived experience of addiction, may help broaden the definition of addiction and improve upon its accuracy. As was mentioned above, an addiction is in part defined by the negative
impact on the individual. Before concluding that someone has an addiction, clinicians
must be aware of a person’s beliefs and attitudes regarding their alcohol use and the
contexts in which it occurs.

Another criticism with the definition of addiction is that it fails to address the
variability that exists between substance abusers. Working from the above criteria, there
is little “appreciation of the fact that people might be using the same substance in
different ways and for different reasons at different times” (Kellogg & Tartofsky, 2010,
p. 341).

In light of the above account, it is clear that an addiction is a long-term problem
with profound developmental ramifications. Though developmental perspectives were
considered in the treatment of addictions, with the advent of the DSM this changed. As
Sperry (2010) explained, “In the 1970s, developmentally focused forms of counselling
and psychotherapy that tended to be based on a postmaterialist perspective and
emphasized self-actualization began appearing but were quickly overshadowed by the
DSM” (p. 46). According to Sperry (2010), this change of focus was due to the advent of
managed care that called for practices that could demonstrate symptom reduction and
other outcomes that were amenable to quantification. Although a developmental
approach to treatment was no longer applied, service providers recognized the need for a
comprehensive approach to the treatment of addictions as is reflected in the adoption of a
biopsychosocial model. As Buchman, Illes, and Skinner (2010) explained, “the
biopsychosocial system model is grounded in systems theory in which knowledge occurs
at the intersection of the subjective and the objective, and not as an independent reality”
(p. 42).
1.4.1 The Biopsychosocial Approach to Addiction

Although the biopsychosocial approach was considered as a means to address addictions on multiple fronts and in a manner that acknowledged the dynamic nature of mental health problems, as we shall see, this approach has failed in this regard. To understand the current landscape of addictions treatment, and why the individual aspects of the biopsychosocial model have not yet been integrated into an effective approach for treating addictions, we will now look at the biological, psychological, and social approaches to addiction.

A biological view of addiction centers on the brain systems involved in the development and maintenance of an addiction. For instance, “recent neuroimaging studies suggest that people living with a drug addiction have considerable decreases in dopamine D2 receptors and in dopamine release which may contribute to both the rewarding properties of substances and difficulties in abstaining despite adverse consequences” (Buchman, Illes, & Skinner, 2010, p. 39). Findings such as this have led to the identification of a reward center in the brain that is thought to be responsible for addiction. As Betz, Mihalic, Pinto, and Raffa (2000) explained, “a prevailing view is that the primary brain circuits relevant to drug addiction (equated to activation of neurochemical reward pathways) involve dopaminergic pathways, such as the mesolimbic dopamine system” (p. 12). In the biological conceptualization of addiction, addicted individuals use substances due to irregularities in brain systems and because their bodies and brains have adapted to the repeated and prolonged presence of the substance.
A psychological view of addiction focuses on how an addiction is related to the mental life of the individual, in particular the thoughts, feelings, and behaviours associated with the use of alcohol. In reviewing the literature related to proposed psychological factors that influence the development of addictions there are some common characteristics among addicted individuals. For instance, it has been reported that people with addictions are lacking “an authentic selfidentity and lacking a sense of inner stability” (Tomer, 2001, p. 245) and as a result they “are prone to experience radical swings from extreme rigid self-control to extreme lack of control” (Tomer, 2001, p. 245).

The instability of the sense of self is cited as a major reason for the onset and progression of an addiction. As Gray (2004) explained, an addiction can be viewed as the result of “the need to feel connected to the diverse and changing sensations of the world that contribute to the sense of reality and self, contrasted with the equally strong need to feel separate and unique, to experience the power or energy contained in that uniqueness” (p. 1160). In this regard, an addiction serves the function of helping an individual form a sense of self, albeit an unhealthy and destructive one. As Lehman (1963) explained, “every addiction is essentially the manifestation of a person’s seeking to induce and perpetuate directly, the most desirable state of his personal existence regardless of any other opposing values” (p. 168).

As well as preserving a stable identity, it has been suggested that an addiction results from actively attempting to avoid the experience of negative thoughts and feelings. As Knack (2009) explained, “addiction has been viewed as representing attempts at self-care and self-soothing, affect tolerance, and a way of managing affect by
changing painful psychic states, such as emptiness and deadness” (p. 94). This view is known in the literature as the “self-medication hypothesis” (Walters, 1999, p. 50).

Another psychological factor that is often discussed in addictions research is the notion of an addictive personality. However, it would seem that this term is similar to the colloquial definition of addiction that was mentioned earlier. Though people label themselves as having an addictive personality, including two of the participants in this research project, the idea that there are such characteristics or personality traits has been the subject of much debate. As Allain and Sutker (1988) explained, some clinicians have assumed that personality traits make people prone to the development of an addiction, whereas others believe “that personality conceptualizations of alcohol and drug use behaviors are reminiscent of outdated, unfounded psychoanalytic theories” (p. 172). However, as it stands, there is “no support for addictive personality” (Kerr, 1996, p. S9).

A social view of addiction focuses on the social environment of the individual and how it might contribute to the process of addiction. In summarizing this view of addiction, Walters (1999) stated that an addiction is considered to be “a socializing process in which a person is taught the attitudes, values, beliefs of a particular group or culture” (p. 73). From this perspective, it has been suggested that addiction might result not only from the accessibility of drugs but from an “increasing sense of powerlessness and helplessness that so many people feel, in a fragmented society, marked by profound social inequalities and dislocations” (Metzer, 1994, p. 12). In coping with social conditions, a person may turn to alcohol to manage their stress.

For some people, the use of substances may be a way of dealing with the conditions of society or a means to transcend them momentarily as a way to promote
personal growth. For instance, it has been suggested that “some highly sensitive people are acutely aware of the anxious, limited time-bound sense of self and seek substances for consciousness expansion” (Schaub & Schaub, 1997, p. 129). The idea that people seek out substances is based on the notion that “the drive to alter one’s consciousness is a pervasive and natural feature of human consciousness” (Metzer, 1994, p. 2). With an innate drive to alter one’s consciousness, people might be striving for higher states of consciousness but have no other means, no recourse, for doing so. If there is a natural tendency to alter consciousness and society suppresses and restricts a person’s ability to do so, they may resort to whatever means are available, whether they be mouthwash, hand sanitizer, or rubbing alcohol. An important point to consider here is that although the consequences of the drug of choice might have adverse effects on the body, “seeking a high is not in itself pathological or destructive” (Schaub & Schaub, 1997, p. 129). As a result it has been suggested that “one of the reasons for the high relapse rate in drug treatment is that people are not taught healthy ways to alter their state of consciousness” (Schaub & Schaub, 1997, p. 129).

The idea that people could alter their consciousness in healthy ways was reflected in historical attempts to use LSD in the treatment of alcohol addiction. According to White (1998), early scientific research into the use of LSD for the treatment of alcohol addiction indicated that “many alcoholics reported new realizations and new perceptions that allowed them to achieve and sustain stable sobriety” (p. 229). Interestingly, the weaknesses of LSD-facilitated treatment seemed to be related to social conditions rather than individual characteristics or properties of the drug. As White (1998) explained,
While LSD-facilitated psychotherapeutic experiences could lead to breakthroughs in self-perception and awareness powerful enough to temporarily “unfreeze” compulsive patterns of addictive behaviour, the weakness of this therapy was in the lack of any ongoing program of recovery that could sustain this emotional commitment to sobriety (p. 229).

Of course, current impediments for the use of LSD in the treatment of alcohol addiction are the laws which restrict its use. Currently, LSD is included in Schedule III of Canada’s Controlled Drugs and Substances Act. Although attempts to induce similar experiences without the use of illegal drugs are being made, through the use of certain psychospiritual counselling methods (West, 2002), it begs the question as to how addiction rates would change if the laws restricting or prohibiting the use of certain substances were revised or repealed.

The above understandings of addiction are by no means a complete list. There are a variety of factors that contribute to the onset of addiction and each can impact the course of an addiction in a way that is unique to the individual. In reviewing some of the biological, psychological, and social factors associated with addictions, the intent is to show that the treatment of an addiction requires the consideration of multiple domains of functioning.

In summary, though clinicians endorse a biopsychosocial approach to the treatment of addiction, “current systems of treatment are limited and fragmented, focusing primarily on narrow behaviourist treatments while at the same time clients are increasingly presenting with co-occurring mental, emotional, physical and transmissible diseases, and are culturally diverse” (Amodia, Cane, & Eliason, 2005, p. 363).
Furthermore, with the behaviourist treatments that are endorsed in managed care, addiction is not viewed from a developmental perspective that focuses on growth and well-being. Instead, the focus is on reducing symptoms and improving function. According to Sperry (2010), “when the goal of therapy is reduction of symptoms and impairment, but not increased personal effectiveness and well-being, relapse is likely and perhaps inevitable” (p. 50). As we will see further in the following section, the way that an addiction is conceptualized influences how it is treated. The following section will review current treatment models and approaches and evaluate their level of effectiveness.

1.4.2 Medical Model and the Treatment of Alcohol Addiction

As in other areas of clinical psychology, the understanding of a condition and the treatment of the condition are inter-related. The scientific study of addiction has been guided by two schools of thought that emphasized different aspects of addiction. As Gray (2004) explained, “empirical research related to addictions encompasses two trends in addiction studies: the medical model, or disease theory of addiction, and the role of autonomy, or will and rationality, in the decision processes that result in addiction to psychoactive drugs” (p. 1152). Each of these trends, or schools of thought, has its own assumptions and areas of focus related to understanding treatment of addictions. It is important to grasp how the understanding of addiction dictates the course of treatment and determines how a clinician views a client as well as how clients will come to view their own addiction.

The medical model of addiction conceptualizes an addiction as a disease. For this reason it is also referred to as “the disease model” of addiction. From this perspective, it is assumed that “genetic, biochemical conditions create a predisposition to becoming
addicted, and that personality and situational factors act as triggers or catalysts” (Metzer, 1994, p. 5). There does seem to be support for viewing an addiction as a disease. For instance, in one study which compared alcohol addiction to diseases like heart disease, diabetes, and arthritis, it was concluded that “any attempt to define disease so as to exclude alcoholism also excludes many conditions about which there is no debate concerning their medical significance” (Erickson, 2000, p. 9).

Further support for a medical model of addiction comes from the wealth of research studies that have investigated the biological factors that are linked to addictive behaviour. This avenue of research has led to the development of a large knowledge base that details particular brain systems that are involved in addiction. In fact, the application of the medical model to describe and explain alcohol addiction is considered to be pioneering work in the application of the model to other psychological problems (White, 1998). In describing the medical model, Elkins (2009) stated that “the medical model in psychotherapy is a descriptive schema borrowed from the practice of medicine and superimposed on the practice of psychotherapy” (p. 67).

The adoption of the medical model has several implications for the treatment of an addiction. As Walters (1999) explained, “the disease model holds that addiction is a chronic disorder rather than a transient or situationally specific set of behaviours” (p. 2). In viewing alcohol addiction as a disease, the treatment of addiction follows a course of treatment similar to other diseases. However, “this medically based model, characterized by a series of discrete activities (screen, assess, treat, discharge, terminate service relationship) and directed by a professional over an ever-shortening period of time is coming under rigorous criticism” (White, 2010, p. 259). As Bohart and Tallman (1999)
described this interaction, the therapist diagnoses a problem, prescribes a treatment for that diagnosis, and monitors how these treatments change the client. In this situation, the experience of the client is reduced to secondary importance. This is but one of the limitations of the medical model that has been identified by researchers.

A broader view of recovery than that posited by the medical model is one that recognizes the multiple factors involved in the onset and maintenance of addiction. As DiClemente (2004) explained, “addiction and recovery occur in the context of human development and of an individual’s life space, which include both physiological and psychological events and transitions” (p. 20). A simple medical model fails to capture this dynamic nature of addiction and “has been justifiably criticized by some for encouraging a conception of addiction as a fixed, unchangeable condition” (Metzer, 1994, p. 1).

In recognition of the role that individuals have in defining their addiction, it seems that greater weight must be placed on understanding the lived experience of addiction. With the medical model, addiction is conceptualized as a simple movement from relapse to recovery. As Walters (1999) explained, “the practical limitation of the dichotomous (relapse-recovery) perspective on change is that it neglects the dynamic features of the change process and fails to capitalize on opportunities for effective intermediate interventions” (p. 270). With this in mind, it has been suggested that the recovery and relapse model be changed to one that recognizes the developmental nature of addiction. As Miller (1996) stated, it has been recommended that clinicians “abandon the term relapse and focus on conceptual models that are more descriptive of the normal course of human behaviour change” (p. 26).
The medical model is founded upon a materialist view of the universe, which as mentioned earlier, has been considered inadequate in its ability to capture the nature of addictions. This is echoed in the statement of Courtwright (2012) that, “the brain disease paradigm appears to be an old-fashioned monistic pathology wearing the fashionable garb of neuroscience” (p. 489). Though research driven by the medical model has increased our understanding of the brain systems involved in addiction, it would appear that the results are more descriptive than explanatory. For instance, it has been found that “probable targets of alcohol in the brain include the GABA, glycine, nicotine, acetylcholine, and NMDA receptors, but the molecular mechanisms of action remain controversial” (Goldstein, 2001, p. 154).

Despite the amount of biological research into addiction, the influence of brain systems on behaviour are unclear. In applying a medical model to addiction, and focusing on the biological factors involved in addiction, there can be consequences related to the client’s progress and his view of himself. As Buchman, Illes, and Skinner (2010) said, “this kind of neuroessentialism may bring about unintentional consequences on a person’s sense of identity, responsibility, motions of agency and autonomy, illness and treatment preferences” (p. 37).

Another problem with the medical model is that its emphasis on the biological factors of addiction creates a simplistic view of addiction. As Walters (1999) stated in regards to a biological focus of addiction, it “may result in a superficiality of understanding that ultimately stands in the way of a deeper and more comprehensive understanding of the treatment under investigation” (p. 21). Although the medical model has increased understanding of some of the brain systems involved in addiction, research
within the medical paradigm seems to be confirming the need for a broader view of addiction. For instance, as Miller, Schlitz, and Vieten (2010) observed, the “field of neuroscience is just beginning to understand how brains themselves exist in relationship to other brains” (p. 27). In looking at how brains exist in relation to other brains, the social domain becomes included by necessity and widens the scope of biological research into addictions significantly.

Perhaps the most damning criticism against the disease model is that people have been able to overcome their addictions without any intervention (el-Guebaly, 2012). If brain systems are “hijacked” (a term I encountered several times in the literature to describe how brain systems are overtaken by substance use; e.g., see Erickson, 2009; Teresi, 2011) then why are some people able to give up their addiction without treatment? If their brains are predisposed to addiction, and they live in the same environments that offer the same opportunities for using, why aren’t people continuing to use? These are the questions that suggest that a disease model is incomplete and simplistic.

Another underlying assumption of the medical model is that findings in animal research can adequately account for addictive processes in human beings. This assumption has been questioned by many who work in the field of addictions. For instance, in a review of the medical model and its contributions to understanding addictions, Rotgers (2004) wondered “how the brain changes reported in rats after repeated self-administration of drugs could be reconciled with epidemiological research suggesting that most users of drugs do not become addicted” (p. 1). Furthermore, many
Clinicians have reported that they find little clinical value applying the findings from such studies to the experiences reported by their clients (Gori, 1996).

Although the medical model has given us some answers to addiction, there are limits to its explanatory and predictive power. In light of these limitations, it would appear that an approach that seeks to understand addiction from the perspective of the addicted individual could offer insights that the medical model cannot. It would seem that a focus on the self and its development is an important part of the study of addictions and an approach that is being advocated in the addictions field (Gray, 2004). With this in mind, we will look at some of the experiential characteristics of living with an addiction and explore possible reasons for the development of an alcohol addiction. Such an approach is dramatically different from the medical model and is based on “a search for patterns of wholeness rather than on predicting and identifying causes of disease” (Kagan & Musker, 2011, p. 280).

1.4.3 Phenomenological Approach to the Treatment of Alcohol Addiction

An emphasis on the subjective experience of the person seems crucial for developing effective treatments for addictions. For instance, in regards to the formation of a treatment plan, DiClemente (2004) recommended that “the plan to change an addictive behaviour needs to be built around people’s knowledge about themselves and about their habitual pattern of behaviour” (p. 157). This is supported by Hector and Zakrzewski (2004) who stated that “in order to formulate appropriate and effective treatment plans for alcoholics, one must first gain an extensive knowledge of the alcoholic’s characteristics and an understanding of the social context in which his or her drug use is grounded” (p. 62). From a medical model perspective, these important aspects
related to self and consciousness development can be minimized and might limit our understanding of people’s inner resources and capacity to overcome their addictions.

The importance of understanding the development of the self-concept and consciousness speaks to the value of viewing addiction from a developmental and systems perspective. As Ham and Tronick (2009) explained, “the human being is an open, non-linear dynamic system consisting of many interrelated domains of functioning (physical, emotional, cognitive/symbolic, and social/behaviourist)” (p. 619). An approach to the treatment of addictions should reflect an understanding of this fact and target problem areas based on improving the functioning of the entire system. In describing the benefits of such an approach, Miller, Tongian, and Schermer (2002) stated that “a better approach is to match substance users to the treatment that best fits their personality, level of dependence, and stage of change” (p. 540). To understand the value of focusing on the subjective experience of addiction, we will look further at the development of the sense of self and how this knowledge can be applied to the treatment of addiction and inform our understanding of how the expansion of consciousness contributes to recovery.

1.5 Dialogue of the Selves

In de-emphasizing the personal experience of individuals, the medical model is in conflict with a burgeoning line of research that emphasizes the importance of subjective experience and the need to view addiction from a developmental perspective that considers the personal growth of the individual. From our review of treatments thus far, it would appear that a focus on the subjective experience of individuals, including how they find meaning in experiences and motivate themselves, is required to bring about change. Indeed, “there is growing attention in the substance abuse treatment literature to the
development of self and identities” (Amodia, Kane, & Eliason, 2005, p. 367). With a new focus and approach to treatment there comes new treatment goals. Describing treatment that occurs in a medical model and managed care programs, Hart, Nelson, and Puhakka (2000) stated that treatment providers “seek to explain or change the problematic contents of a client’s experience rather than working with the client’s overall process of experiencing” (p. 93).

In treating an addiction from a developmental perspective, the goal would be to work with a client to understand their experience of addiction and the multiple factors that influence this experience. This is important because each person has their own unique view of their addiction and of themselves in the world in general (Linkenbach, 1993). In viewing recovery from a developmental perspective, and examining the self in the context of recovery, the process of recovery can be viewed in humanistic terms as a teleological movement towards a future version of oneself. For the addicted individual, the goal is to move from a state of being that is dominated by addiction to a state of being that is free from its control.

To those familiar with Rogerian therapy, this movement is comparable to the theorized movement from the actual self to the ideal self (Rogers, 1961). Although the desired outcome is clear, the means of achieving this outcome are still not understood. However, from reviewing the studies and criticisms of addictions treatments, we can see that much of the process is mediated by the development of the self, and in turn, the structures of consciousness. As Butt et al. (2005) stated in regards to the therapeutic process, “therapy is to help the individual gain the experience of a larger form of consciousness in which there is a core of vitality and well-being” (p. 662). Although the
development of the self might seem self-explanatory, it should be made clear what is being referred to when this term is used.

### 1.5.1 Defining the Concept of Self

The term *self* might on the surface seem simple to define, but as with consciousness and addiction, it can be used in a variety of ways in different contexts. As Ghin (2005) explained, the term self is “a concept which is not only used in folk-Psychology but also in many different scientific theories” (p. 9). In terms of scientific theories in Psychology, its value is demonstrated by its inclusion in a variety of concepts such as self-esteem, self-control, self-identity, etc. From its use in Psychology and its central focus in the development of so many psychological theories, Baumeister (1987) stated that the term *self* “must be ranked...as one of the fundamental issues that has concerned social and personality psychologists” (p. 163).

The term *self* also figures prominently in the treatment of addictions. As Gray (2005) explained, “the concept of self emerges as a constituent theme in qualitative studies of addiction” (p. 119). Like consciousness, the term *self* is subject to interpretations of its meaning and variability in its application. As is the case with consciousness, this is likely due to our intimate relationship to the construct. Unlike the other things in the world that we can come to know, to understand the concept of self, or consciousness, requires personal experience with it. The word *self* represents so much more than a dictionary definition, and any dictionary definition would be meaningless without our own experience to validate the relatively simple description that is proffered. However, in reviewing definitions of the self in Psychology, there does seem to be uniformity in what the term is said to represent.
One definition that is in line with the use of the term self in this thesis, as well as with definitions of other researchers, is offered by Vandekerckhove (2009) who described the self as “an organized meaning system of cognitive-affective representations that become activated in the dynamic self-regulatory processes that [people] use in order to build up desired psychological experiences and conceptions of themselves” (p. 12). This definition is in accordance with other definitions that emphasize the growth potential of the individual and the dynamic nature of the self (Baumeister, 1987). This definition also helps link the self and its development to that of consciousness. In this respect, “the self is consciousness reflected upon itself and formed into a system of values which are peculiar to its own person” (Ey, 1978, p. 229).

1.5.2 The Self and Consciousness

In considering the relationship between the self and consciousness, the self can be viewed as a spider moving along an ever-changing web of consciousness that defines its boundaries and its access to certain areas of life. Our selves do not exist apart from the web of connections that are maintained in consciousness. Just as a spider does not hover in the air unsupported, we do not exist without the structures of consciousness to support our sense of identity. Our sense of self, as well as our personal experiences which develop and maintain our sense of self, are all influenced by the contents of our consciousness. As with consciousness, the self can be viewed as a coherent structure that exhibits a high degree of change as it works towards achieving, and maintaining, more complex and integrated forms. In an addiction, the use of a drug may provide a temporary sense of wholeness or completion and it is a desire to return to this sense of completeness that can motivate further use of a substance (Jung, 1957/2006).
When the self is viewed as a coherent structure that works towards more complex and integrated forms, the self and consciousness exhibit what Rogers referred to as the actualizing tendency. According to Rogers (1961), the actualizing tendency is “the directional trend which is evident in all organic and human life—the urge to expand, extend, develop, mature — the tendency to express and activate all the capacities of the organism, or the self” (p. 351).

Although such a description of the self might be dismissed as New Age mysticism, or at least be called into question by those who may feel a psychologist is not qualified to make sweeping statements on the development of life in the universe, it is a description that corresponds with observations from the natural sciences. As Ghin (2005) explained, “self-sustaining systems come in degrees, from single-cellular organisms, where self-sustainment is restricted to the production and maintenance of the cellular structure, up to human beings, where the system tries not only to maintain its body, but also a coherent model of itself with specific abstract characteristics, like being altruistic, creative, funny or attractive” (p. 9). States of consciousness have also been described as biological mechanisms that have their own inherent homeostatic processes that work to preserve their coherence (Beebe, Cambray, & Kirsch, 2001).

In terms of the therapeutic process, an individual’s sense of self is the target of change and both therapist and client engage in work to create the conditions for a new self to emerge. One prime example of this idea being applied in therapy is Spiritual Self-Schema therapy. As Avants, Beitel, and Margolin (2005) explained, “Spiritual Self-Schema (3-S) therapy is to help addicted clients make a shift from the habitual activation of the ‘addict self-schema’ to a self-schema that is more compatible with doing no harm
to self and others-the ‘spiritual self-schema’” (p. 168). In this framework, self-schema is the term used to describe the person’s sense of self that currently exists and is in the process of change.

Another example of an intervention that targets the self is Motivational Interviewing (MI: Miller, 1983). MI refers to “a client centered yet directive therapeutic style with the explicit goal of enhancing readiness for change by helping clients explore and resolve ambivalence toward behaviour problems” (Miller & Rollnick, 1995, p. 325). Upon hearing this definition it should come as no surprise that MI is derived from Rogerian therapy and draws on theories from Humanistic Psychology. As with humanistic therapies, MI is future-oriented in that it encourages the client to consider goals and priorities (Miller, 1983). In part, it is this focusing on the future that creates the conflict between the reflected selves that initiates motivation and movement towards integrating these selves and forming an expanded consciousness. As Hermans (1996) explained, “these selves, providing images of desired or undesired end states, motivate individual behaviour” (p. 33).

In order for the self to change, as was discussed previously, there must be some impetus for movement towards a higher form of self. For this reason, “the therapeutic aim, to put it at its simplest, is to develop in an individual in whom the experience of self is diminished or stunted, a conversation that will foster the emergence of a personal reality that has the features of a dualistic, or reflective, consciousness” (Butt et al., 2005, p. 664). In achieving this, a tension is created between the current state of self and an idealized one and it is the resolution of this tension that results in obtaining a more coherent self-concept and expanded level of consciousness.
A reflective consciousness is necessary as it acts as a catalyst that spurs on further development. In the process of integration of states of consciousness, and the development of a more complex self-concept, the states of consciousness “which had once been experienced at different times, in succession, are now experienced at a single time, simultaneously” (Butt et al., 2005, p. 664). In the process of turning inward to examine one’s experiences, a process facilitated by the increasing reflective power of the developing consciousness, an integration of the self and structures of consciousness occurs that results in a more complex form.

As fluctuations in the self-concept occur, new selves form and, like states of consciousness, last until they are disrupted or can no longer be maintained. As Hermans (1996) said, these senses of self “provide an interpretative and evaluative context for the current self” (p. 33) as the self strives towards a higher, more complex structure. This idea is echoed by McGinley (2011) who stated, “our understanding of ourselves as human only happens both within a previously given context and as part of the further development or unfolding of that context through which, within which, and out of which we establish our self-understanding” (p. 4).

The act of reflection and turning inward as a means to promote growth of the self is characteristic of a variety of therapeutic techniques. Regardless of the approach, it is critical to form a connection with a client that serves to facilitate the development of clients and the emergence of healthier self-concepts. In discussing the development of the self, it seems as though there are a variety of identities that comprise it. This makes sense when the self is thought of as a process that is constantly changing. As a dynamic system, the self exhibits a fluidity in how it changes states or identities that is similar to shifts that
occur in states of consciousness. Although the self has tended to be viewed as a unitary, static entity, “the idea that behind the façade of a single, coherent identity an individual can be made up of a multiplicity of facets has been gaining ground among clinicians, researchers, and psychologists in recent years” (Dimaggio, 2006, p. 313).

In focusing on the development of identities, it is necessary to understand that “the self is made up of a multiplicity of characters or voices, each of which is an independent thought center” (Dimaggio, 2006, p. 313). This is an important point to consider for the treatment of addiction. As noted above, Rogerian therapy involves comparing the actual self and the idealized self and reducing the incongruity between them. As Stein (2008) explained, “individuals picture to themselves various images of self and other, of the relationship between them, and the way in which the relationship leads them to achieve or fail to achieve their desired goals” (p. 314). As individuals create more psychological distance from their self-concept, and view it from another vantage point, they create conditions for new self-concepts to emerge. As Bidwell (1999) stated, “the more one can introspect and reflect on one’s self, then the more detached from that self one can become, the more one can rise above that self’s limited perspective” (p. 85).

However, this is not to suggest that only two selves are involved in this process; the self being reflected on and the self in the act of reflection. As Dimaggio (2006) stated, “the dialogical self can be described as a dynamic multiplicity of relatively autonomous I-positions” (p. 314). In this respect, the self can be thought of as a diamond with its facets representing aspects that present themselves when the light of the current moment reflects upon them. We are always the person we are, but at different times different
aspects of ourselves predominate. A psychologist teaching a class slips into the role of the teacher. When delivering counseling services, the same psychologist slips into the role of a counselor. When returning home, the same psychologist might slip into a variety of roles including parent, husband, neighbor, lover, and friend. Although the person remains the same, each role or identity is subject to different expectations or rules of conduct that determine what is appropriate behaviour for that particular role. These expectations are determined by our past interactions with people and our level of intimacy or closeness. They are determined by cultural beliefs, social mores and the law. All of these things work to maintain the coherence of these identities and collectively contribute to the overall coherence of our own personal sense of identity.

As we can see, the sense of self is a dynamic process that is influenced by a multiplicity of factors as personal identities are created and maintained. As Dimaggio (2006) stated, “the self is composed of various characters, each of them portraying an aspect of an individual, and these characters, starting out from their various separate positions, enter into a dialogue and negotiate the meaning of events with each other” (Dimaggio, 2006, p. 313). The way the self can display a unity while being comprised of potential identities can be understood in Jung’s description of the Self. To be clear, “In Jungian writing, Self is usually capitalized, which helps to distinguish it from the more conscious and social self of other theorists” (Cloninger, 2000, p. 75). As Urban (2005) explained, the Self is “a matrix of all those potential faculties of the organism which await the process of deintegration and reintegration in order to become operative and so actualize themselves” (p. 575).
Because these shifts in self are subtle and difficult to detect, it may be helpful to examine Dissociative Identity Disorder (DID); an extreme and disordered example of how various aspects of the self can exist within a person. DID has been described as “the most extreme response to psychological trauma, the most striking feature of which is the presence of two or more personality or identity states that recurrently take control over the body” (Pica, 1999, p. 404). As for the etiology of DID, it has been postulated that dissociative states of consciousness lead to the formation of distinct identity states that are separated from the overall sense of self (Nickeas & Stickley, 2006). Each identity exists in association with a particular state of consciousness and though it exhibits its own individual coherence and stability, it is parceled off from other identities and states of consciousness and not subject to their influences (Nickeas & Stickley, 1999). Rather than the selves being in dialogue with one another, each self is completely self-referential and acting independently from the others. The full immersion into a whole other state of being is reminiscent of William James’ quote regarding consciousness and its many forms. James (1902/1929) said,

“Our normal waking consciousness is but one special type of consciousness, whilst all about it, parted by the flimsiest of screens, there lie potential forms of consciousness entirely different…apply the requisite stimulus and at a touch they are there in all their completeness” (p. 278).

An addiction can be thought of as the dominance of one state of consciousness and the identity associated with it. In fact, “people struggling with addictions will often comment on this dualistic perception of their personality” (Linkenbach, 1993, p. 250). As was noted above in regards to motivational interviewing, the tension in this dualistic
perception can serve as the means for self-development that is associated with recovery and a lifestyle that is incompatible with addiction. This is the purported change mechanism that occurs when a person hits what is referred to in the literature as “rock bottom”; the absolute end point at which the only thing left for an addiction to take is your life. As Nixon (2005) said, “in recovery, through hitting bottom, a person is forced to disidentify with the addict subpersonality and begins to identify with a recovering subpersonality” (p. 59). At this extreme point, the choices become simple; live or die, and any movement towards life and living creates the tension that can lead to the emergence of a self-concept that supports that basic goal.

In light of this review, we can see that a crucial component of the course of addiction is the impact it has on the development of a person’s sense of self. As the self develops, it moves towards a state of further integration. As Koltko-Riveria (2006) stated, “the greatest attainment of identity, autonomy or selfhood is itself simultaneously a transcending of itself, a going beyond and above selfhood” (p. 303). In the humanistic notion of self-actualization, the idealized self acts as a teleological attractor that helps shape the development of the self. The self, as was described above, is a process and therefore always in a state of becoming. As Todres (2000) explained, “the tension between the personal and the transpersonal is revealed from the beginning as constituting a fundamental existential ambiguity which is always calling” (p. 228).

1.5.3 The Spiritual Self

The movement towards a higher level of self-integration, and an expanded consciousness which could facilitate this integration, can be viewed not only as a process that is in opposition to the processes that lead to addiction but as a process of spiritual
development as well. As Metzer (1994) explained, “whereas an addiction can be defined as seeking sources of satisfaction in the external, material world, recovery involves an attitude of psychological-mindedness, or interiority, or spiritual growth, all of which involve directing attention inwardly, to interior states and experiences away from the external world” (p. 2).

In my work in addictions, I have heard of treatment providers using an approach that they referred to as a “biopsychosocial-spiritual” model. The addition of a spiritual aspect to the biopsychosocial model makes sense when one considers the value some people place on spirituality in their lives. This value is expressed well by Cook-Greuter (2006) who stated, that the “spiritual core is the deepest center of the person, it is here that the person is open to the transcendental dimension, it is here that the person experiences ultimate reality” (p. 540). Furthermore, spirituality has a significant influence on the development of a person’s self-concept. As Lu, Lukoff, and Turner (1998) explained, “spiritual dimensions of culture are among the most important factors that structure human experiences, beliefs, values, behaviours, and illness patterns” (p. 24). In light of these findings it makes sense that spirituality would be part of a model for recovery in the treatment of addiction.

Not surprisingly, there is increasing interest in the spiritual aspects of recovery and recognition of its role in recovery. According to Kissman and Maurer (2002), “social science literature increasingly emphasizes deconstructing the spiritual healing process in substance abuse recovery” (p. 36). In this respect, it is thought that aspects of spiritual healing could help understand the process of recovery and the concomitant changes that occur within an individual. This is due largely to the fact that “spiritual beliefs have been
linked to positive mental health outcomes in general and more specifically to recovery from addiction” (Avants, Beitel, & Margolin, 2005, p. 168). With this in mind, we will examine how spirituality can inform our understanding of consciousness expansion and the development of the self and how it is reflected in these processes and contributes to them.

In some ways consciousness expansion, self-development, and spiritual growth could be seen as the Holy Trinity of the Father, the Son, and the Holy Spirit in that they may represent aspects of the same thing that are difficult to untangle and consider independently of one another. In looking further at the role spirituality plays in the recovery process from alcohol addiction, we will first look at the work of Carl Jung. As we will see, Carl Jung played an influential role in the incorporation of spiritual ideas in AA. Jung’s work related to consciousness and self-development, as well as his understanding of the spiritual factors that can facilitate recovery, he makes a good starting point for examining the relationship between spirituality, consciousness, and the self.

1.6 The Relationship between the Spirit and the “Self”

Carl Jung was a pioneer in the study of consciousness, or more accurately, unconsciousness. Jung equated the growth of the mind with an expansion of the range of consciousness and postulated that this development involved both conscious and unconscious processes (Jung, 1933/1955). In regards to the process of individuation he spoke of how contents of the unconscious integrate into consciousness as the Self developed. For Jung, the Self refers to the totality of an individual’s mind and includes both its conscious and unconscious elements (Jung, 1921/1964). It has also been described
as including “all of a person’s qualities and potentials, whether or not they have become apparent or conscious at a particular stage of life” (Cloninger, 2000, p. 75). In describing the process of individuation, Jung used metaphors of transformation that have a spiritual connotation and as a result it parallels concepts found in religion. As Schoen (2009) describes, “The true Self in Jungian Psychology shares much, is even identical in many ways, with our concepts of the image and likeness of God within each person” (p. 49).

In thinking of the development of the Self, and what was referred to earlier as the “ontological openness” (Todres, 2000) of consciousness and the self-concept, I was reminded of the well-known Biblical passage where God, in the form of a burning bush, reveals his name to Moses. In Exodus 3:14, God tells Moses, “I Am that I Am.” This phrase speaks to a wholeness, a completion, that we as human beings are moving towards. Though we may not arrive there in our lifetimes, each person strives to attain the supreme existential surety inherent in that claim. Although there are larger implications for human destiny and the movement towards a unitary consciousness, as described in Vedic literature (Wilber, 1977), these implications are beyond the scope of this current project.

The spiritual connotations of individuation are similar to those in the humanistic notion of self-actualization as they both are seen as processes whose internal dynamics induce further growth and development. As Todres (2000) explained, “a dialectical tension of polarities underpins individuation” (p. 232). The tension in individuation is that between the conscious and the unconscious and the process that leads to further integration of the two which advances the development of the Self and consciousness. As
Schoen (2009) explained, “consciousness confrontation with the unconscious has the effect of expanding consciousness” (p. 34).

As for the ultimate goal of individuation, “Jung’s concept of self-actualization refers to his theory that man will eventually substitute the Self for the ego as the stabilizing center of personality” (Angers & O’Byrne, 1972, p. 242). Whereas the goal of self-actualization is to resolve incongruity between the actual self and the ideal self, the process of individuation “requires the co-operation of the ego in an alignment with the Self, which is the humbling and revitalizing of the ego in relation to the Self” (Schoen, 2009, 75). Though not explicitly described as a process that expands consciousness, Jung’s description of the individuation process and its end result is at its heart an account of the expansion of consciousness resulting from engaging in a therapeutic process. Furthermore, Jung’s conception of the Self and its development is an excellent model of the process of consciousness expansion and the transformation from one state of being into another that results from successful treatment.

Jung’s work also highlights the importance of spirituality in the process of recovery. Although Jung did not write or speak much about the topic of addictions, there is evidence that he believed that spiritual experiences were important to overcome addiction. In fact, as Cashwell, Clarke, and Graves (2009) stated, “Carl Jung’s perspective on addiction influenced the spiritual foundation of AA” (p. 38).

In a letter to Bill Wilson, a founder of AA, Jung described how he viewed a patient’s addiction to alcohol. Jung wrote, “His craving for alcohol was the equivalent, on a low level, of the spiritual thirst of our being for wholeness, expressed in medieval language: the union with God” (as cited in Schoen, 2009, p. 19). The patient Jung was
referring to was a man named Rowland Hazard III. Jung worked with Rowland and advised him that a spiritual experience would be the only thing that could free him of his alcohol addiction. In developing the AA program, Bill Wilson drew on conversations with Rowland about his experiences and his own readings of Jung’s work.

In developing AA, Wilson was also drawing inspiration from William James’ (1902/1929) book *The Varieties of Religious Experience* (White, 1998). Though James’ name may not immediately spring to mind when one thinks of the 12 Steps Program, his influence was significant enough for Wilson to state that “James deserved co-founder status” (Finlay, 2000, p. 3). As well as influencing the development of AA, both James and Jung “emphasized that alcoholics were seekers, usually of God or serenity, in attempting to relieve emotional distress” (Goldstein, 2001, p.281).

It is fascinating how two psychologists whose work has been so influential in the development of Psychology, whose contributions have punctuated theoretical discussions and inspired so much research and thought, would both be cited as contributors to the 12 Steps program. More fascinating is that two men from outside of Psychology, the founders of AA, would find value in the works of these men for treating an addiction, while those within the discipline seemed to neglect them. However, with more research showing the importance of spirituality in the treatment of addictions (Cook, 2004; Galanter, 2006), the concept is gaining more acceptance and attempts are being made to further our understanding in this direction.

A leading figure in the application of spiritual ideas and beliefs to addiction is Christina Grof (1993), who helped develop the concept of spiritual emergency. Spiritual emergency refers to the idea that crises in one’s life may be due to an inner struggle to
move towards a higher level of functioning and spiritual awareness. As was the case with the development of AA “the work of William James and Carl Jung helped lay the framework for the concept of spiritual emergency to develop” (Krippner & Viggiano, 2010, p. 119). As it stands, “many therapists agree that there is great value in orienting treatment to spiritual realms” (Morgan, 2001, p. 90). Furthermore, “research investigations have provided support for a relationship between spiritual/religious involvement and prevention of relapse” (Goldstein, 2001, p. 90). However, the study of spirituality and the manner in which to apply the results of such studies has been problematic. In fact, like consciousness, “the dimension of spirituality was ushered out of the legitimate purview of Psychology” (Atwood & Maltin, 1991, p. 373).

1.6.1 The Scientific Study of Spirituality

Although its role in the treatment of addictions has been recognized, researchers in the field of addictions have struggled with how to conceptualize and study spirituality. As Chen (2010) reported, “researchers from the addictions field have grappled with a scientific conception of spirituality” (p. 365). As with the terms consciousness, self, and addiction, the term spirituality is one that we intuitively understand. However, as with those other terms, there can be much variability in how the word is used. For instance, a review of how the term has been defined in substance abuse literature over the past 25 years “found diversity and lack of clarity of understanding of the concept of spirituality” (Cook, 2004, p. 539). Though the term has proven difficult to define, which has contributed to its exclusion from empirical study, a revived interest in understanding spirituality, prompted largely in part by the success of the 12 Steps Programs, has led to further consideration of the concept. As Galanter (2006) explained, “on the basis of
findings drawn from diverse, empirically grounded disciplines, it is now possible to better understand the construct of spirituality” (p. 286).

In a review of the literature related to spirituality, I found that there are two assumptions inherent in the term. According to Chen (2010), several researchers have offered definitions of spirituality that “relate to it as a multidimensional concept characterized by relatedness to self, to the environment, to the existence of a ‘Higher Power’ (that is not necessarily associated with God) and to the meaning in life that enables self-transcendence” (p. 365). This emphasis on self-transcendence as part of spirituality relates to our preceding discussions of the relationship between the self and consciousness and how they can inform our understanding of addictions. With this in mind, it is no wonder that “spirituality is a concept which is encountered with increasing frequency in the contemporary addictions literature” (Cook, 2004, p. 539).

In preceding sections we looked at how the person and her environment must be treated as a single unit in the study of human experience. We also saw how in the treatment of addictions, a holistic approach is advocated; one that takes a broader view of people as they exist in their environments and how they form meaning. With this in mind, spirituality is of great importance in establishing a framework for the study and treatment of addiction. As Cook (2004) explained, “spirituality is a distinctive, potentially creative and universal dimension of human experience arising both within the inner subjective awareness of individuals and within communities, social groups and traditions” (p. 549). The multidimensional nature of the term spirituality makes it well suited to tackling many of the problems associated with addiction. As Galanter (2006) explained, “the multi-faceted nature of spiritually oriented recovery is such that it may infuse rather
different approaches to addiction rehabilitation” (p. 289). Spirituality, in this respect, may touch on those aspects of the self that need to be addressed but are not considered in current models of addiction. This seems to be the case as “empirical studies found that spirituality plays a crucial role in increasing sense of coherence and meaning in life, and in decreasing the intensity of negative emotions among addicts” (Chen, 2010, p. 366).

Although there is a recognition in the research literature for the benefits of including spirituality in treatment, spiritual concerns are not often addressed in the context of treatment. As Amodia, Cane, and Eliason (2005) reported, many treatment services “lack the spiritual and cultural components of treatment and give only lip service to the transformational change needed for long-term recovery” (p. 364). However, the AA program does seem to fill this gap as research shows that “the most purported mechanism of recovery from alcoholism is identified as a spiritual awakening brought about by completion of the 12 Steps program” (Kelly, Magill, Stout, Tonigan, 2010, p. 455) As testament to the effectiveness of AA, it has been recommended that “an important goal of psychotherapy should be to encourage and maintain AA involvement” (Knack, 2009, p. 87).

With so many people involved with AA, and so many addiction professionals referring clients to AA, it is necessary to understand what this program offers and why it seems to be effective for many people. In the following section we will examine the extent to which it touches on areas identified as beneficial for treatment.

1.7 The Role of Alcoholics Anonymous in Recovery

AA was founded by Bill Wilson and Dr. Bob Smith as a means to overcome alcohol addiction. The 12 Steps of the AA program, which are provided in Table 2,
developed out of the association the founders had with a recovery program known as the Oxford Group. According to White (1998), the Oxford group “emphasized the principle of self-survey, confession, restitution, and the giving of oneself in the service to others” (p. 16). In reviewing the 12 Steps, it is evident “the method rests on peer support, honest self-examination, self-accusation, confession, and guidance by a higher power” (Goldstein, 2001, p. 149). In particular, the emphasis on social support and spirituality was a direct influence by Carl Jung (Schoen, 2009). Upon a review of its effectiveness, it was concluded that “more alcoholics have been rehabilitated through AA than through the efforts of medicine, Psychology, and psychiatry combined” (Finlay, 2000, p. 3).

As well as having an impact on millions of people struggling with an alcohol addiction, AA has had an impact on addictions research. For instance, as Elmer, Friedman, and McDonald (2003) explained, “the changes that members of AA and other Twelve Steps fellowships undergo have been described as a transformation of identity, a terminology that impacted on the literacy on addiction and recovery” (p. 162).

According to Kelly et al. (2010), “increasingly rigorous research conducted in the past 15 years supports the notion that AA participation is associated with better short and long-term outcomes and may be a cost effective treatment adjunct” (p. 454). Further support for AA is seen in the number of treatment programs that incorporate the 12 Steps into their programs. For instance, the Minnesota Model for addictions treatment involves familiarizing people with the 12 Steps philosophy and encourages involvement with 12 Steps programs after discharge (White, 1998). Although there are many accounts of people benefiting from participation in 12 Steps programs, their success is not merely anecdotal. The Minnesota Model that incorporates the 12 Steps philosophy is “believed
to be the most widely practiced therapeutic orientation in the United States for treating severe substance abuse among adolescents” (Latimer, Opland, Stinchfield, Weller, & Winters, 1990, p. 602).

AA has also shown results that are similar to other interventions. For example, the results of Project MATCH, a study that is often cited in alcohol addiction literature, showed that participation in AA produced outcomes similar to cognitive behavioural coping skills therapy and motivational enhancement therapy (Walters, 2002). In fact, in one study that compared AA with CBT, the results showed that “the AA group achieved higher abstinence rates and used less clinical services than the CBT group” (Knack, 2009, p. 87).

With the favorable outcomes of involvement with AA, researchers are looking for methods to encourage attendance at AA meetings. As Hoeppner et al. (2012) explained, there are “numerous empirically supported interventions designed specifically to increase AA participation” (p. 297). Although the facilitation of spiritual growth is viewed as an important benefit of AA attendance, there are other benefits that have been shown to produce favorable outcomes for individuals with an alcohol addiction.

Another important facilitator of change is the strength of people’s social connections. According to Hoeppner et. al (2012), “the most consistent pathway overall through which AA confers its recovery benefits is by facilitating changes in the social networks of its members and by simultaneously enhancing abstinence self-efficacy in high risk social contexts” (p. 295). As an example, someone who begins attending AA may ask to be partnered with a sponsor. Grof (1993) describes a sponsor as “a regular touchstone, someone with whom an individual maintains a consistent relationship” (p.
This person can act as a guide and serve as a role model. For some people, sponsors may be their only examples of someone who is not living an addictive lifestyle. As well as social connections, “there are aspects of the AA experience that facilitate the development of, and consolidation of, the sense of self” (Knack, 2009, p. 90).

It has been suggested that adherence and dedication to the 12 Steps of the program can help keep a person focused on making changes in their life. As Grof (1993) explained, “in order to benefit from the 12 Steps, participants need to consistently work at the 12 Steps and incorporate the principles of the program into their daily lives” (p. 195). In this sense, the 12 Steps can act as a guide for the person to follow as they begin the task of constructing a life; an identity that is free of alcohol.

The spiritual aspects of AA may also help individuals transcend to more integrated forms of the self by touching on areas in their life that more formal treatment approaches may not cover. As Atwood and Maltin (1991) explained, “Western Psychology has dealt very poorly with the spiritual side of human nature choosing to either ignore its existence or to label it pathological” (p. 369). As a result, involvement with AA may provide a “language and methodology to address human suffering” (Morgan, 2001, p. 90) that can help a person make sense of their addiction and find meaning in recovery.

Despite the successes of AA, there are several criticisms that should be discussed and addressed. According to White (1998), criticisms regarding AA include: treating symptoms without getting at underlying causes; discomfort with the spiritual aspects of the program; success with only particular types of individuals; use of religious language; and a focus on the individual that ignores environmental factors. Additional criticisms are
that AA is “dogmatic, lacks flexibility, encourages dependency, demands permanent commitment, requires the acceptance of limited wellness, and focuses on continual illness” (Nixon, 2005, p. 56). Though AA was comparable to other treatment approaches for alcohol addiction, it seems to garner more criticism than them. Though it is beyond the scope of this project to examine all of the criticisms mentioned, and may be another research question entirely, some of these criticisms will be addressed throughout the remainder of this thesis.

Before reviewing the results of this project, it should be made clear that this project was not an evaluation of AA. Although most of the participants were involved in AA, the purpose of the project was to understand more about the process of recovery. In particular, I was interested in how individuals maintain their sobriety and the changes they experience during the recovery process. As with any research project, before beginning, the researcher must explicate a focus for the investigation. In this study, the focus is on the lived experience of individuals in recovery and the shifts of consciousness and the self-concept that occur throughout the recovery process.

2. METHODOLOGY

2.1 Ethics

Before conducting this research project, I sought approval with the Research Ethics Board at the University of Regina. The study was approved after concerns over the minimal risk to participants were addressed. Because participants would be talking about difficult times in their lives, and discussing experiences that could arouse negative thoughts and feelings, the project was deemed to involve minimal risk to participants. To address these concerns, I informed the REB of my counselling background and my ability to follow a proper course of action should any of the participants experience intense
emotions. I also informed the REB that I would provide participants with contact information for further support if they required any. After submitting these revisions, the project was approved. As for recruitment, I informed the REB that I would attend AA meetings to recruit participants. A copy of the notification of approval from the REB is included in Appendix A.

2.2 Consent

The names of the participants have been changed to protect their anonymity. The names given to the participants are provided in Table 3. Upon making contact with each participant, either through phone or in-person, I informed participants about the project. I let participants know that our conversation about the project was confidential and that there was no obligation to participate. Each interested participant was emailed a copy of the consent forms related to journaling about their experiences and participating in the interview. These forms are provided in Appendix 2 and Appendix 3.

2.3 Participant Selection

Six participants were chosen based on time constraints and availability. It is a lengthy process to analyze interview transcripts of participants and six participants afforded me the opportunity to conduct a worthwhile study within the time frame of completing the requirements of a clinical psychology Master’s degree. I also believed it would be difficult to find any more participants beyond what I considered a requisite minimum number. I did not anticipate finding many people who would be interested in taking time to participate. However, towards the end of the data gathering phase of this project, I received inquiries about the project from service providers and had to inform them that I had reached the number of required participants for the project. It would seem there are people out there who want to share their stories and contribute something to
addictions research. As well as the time commitment required by participants, I thought it may be difficult to recruit participants as they may simply be disinclined to discuss their addiction with a stranger.

In terms of participant selection, I wanted to find individuals with an addiction to alcohol who were at different stages of the recovery process. I chose to interview three people who were working towards their first year of sobriety and three individuals with at least two years of sobriety. My reason for having two groups at different stages of the recovery process was to obtain a clearer picture of the change process. I surmised that the first year of sobriety would be a challenge and that individuals would have struggles that would be different from individuals who had already attained a significant length of sobriety.

In interviewing individuals with less than a year of sobriety, I wanted to understand the difficulties experienced by individuals who were taking the first steps towards changing the lifestyle that accompanies addiction. I know that many individuals in the early stages of recovery will revert back to their addictive behaviours and I wanted to understand the factors that draw people back into their former lifestyles.

As for interviewing individuals with over two years of sobriety, I wanted to understand how these individuals were able to negotiate the challenges they faced in their first year of recovery and how they maintained a lifestyle that precluded the use of alcohol. I wanted to understand how they managed to make a change in their lives that other individuals were unable to generate.

As well as understanding more about the experience of the participants at their different stages of recovery, I wanted to see if it was possible to view any differences
between the groups in terms of consciousness. The time frames of “under one year of sobriety” and “over two years of sobriety” were based on clinical experience and the DSM-IV. According to the DSM-IV, one year without relapse is technically considered to be recovery. I chose 2 years and above for the long-term recovery group as I felt that 2 years without using alcohol was simply more indicative of lasting change than a single year.

2.4 Procedure

Theory of Procedure. For this project, a form of phenomenological research, called Interpretative Phenomenological Analysis, was the chosen method. With research literature suggesting a need to understand the subjective experience of addiction, and the development of the self-concept in recovery, an IPA project seemed like the best method for studying the experience of addiction. As Flowers, Larkin, and Smith (2009) explain, “the aim of interpretative phenomenological analysis is to explore in detail how participants are making sense of their personal and social world” (p. 53). With the personal and social world of the person acting as major contributing factors to the onset and progress of alcohol addiction, it makes sense to use IPA methodology.

As well as understanding the lived experience of alcohol addiction, so as to identify factors that contribute to successful recovery, the project was an attempt to identify those experiences, or shared characteristics of different experiences, that precipitated movements to expanded forms of consciousness and more integrated self-concepts at different stages of recovery. Through learning of the experiences of those who have dealt with addictions, a better understanding of the transformational processes that lead to recovery from addictions to alcohol was sought.
In conducting a phenomenological study, there is no fixed, single method for investigators to employ. As Hector and Zakrzewski (2004) stated, “the methods employed depend upon the purpose of the study, the investigator’s skills and talents, the nature of the research question, and the data to be collected” (p. 73). Such an approach is ideal for the study of the mind for, as we saw in the treatment of addictions, there is little utility in making subjects conform to a particular strategy for understanding their addiction. Without question, certain modes of investigation are more appropriate for certain phenomena than are others. Failing to recognize this can limit a study by creating very narrow parameters through which investigators view the objects of their inquiry. You can place a fingertip under a microscope and learn a great deal about the cellular structure of skin and the composition of fingernails, but it tells you very little about the person who is standing there, waiting for you to finish with his finger. In this respect, phenomenological studies are a means to address the methodological problems that have limited our understanding of the development of consciousness and the self, and in turn our understanding of addictions. As Wertz (2011) said, phenomenology, “offers researchers a philosophy of science that contrasts sharply with others ranging from positivism to constructivism and helps establish a crucial foundation for research focused on the essential characteristics of human experience” (p. 130).

In focusing on experiences, phenomenological approaches acknowledge that human beings are embedded in a socio-cultural matrix that is just as influential to their development as their own intrinsic motivations and imaginations. Although this approach is different from traditional psychological approaches to the study of mind and behaviour, it is in line with the systemic approach being adopted by other sciences in their attempts
to understand higher-order phenomena in nature (Lickliter & Lewkowicz, 2007). In order to understand the experience of individuals, and gain insight into the processes of their consciousness, we must adapt our methods to correspond with their dynamic nature rather than impose artificial and arbitrary constraints that may exclude important aspects of the phenomenon in which we are interested.

Although every phenomenological study is a unique endeavour, there are common features amongst these studies that can be described. As Eckartsberg (1998) said, “there is a clear-cut general progression in the various genres of this type of research” (p. 21). As with consciousness, these studies are best viewed as a process; they are an unfolding narrative or adumbration. The method is only fully understood once the study has ended and the stories of the participants have been told. Nevertheless, like any story, there is a fundamental underlying structure in which the story unfolds. In a phenomenological study there is a similar structure.

Although there are a variety of ways to conduct a phenomenological study, there is a generally agreed upon structure to which each study will conform. As Wertz (2011) described, “since the 1960s specific formal procedures for conducting phenomenological psychological research have been used as a guide for researchers and as a framework for scientific accountability” (p. 131). To guide the development of the current project, the work of Amedio Giorgi (1970) and Flowers, Larkin, and Smith (2009) were the primary references. Giorgi is a major contributor to the field of phenomenological inquiry and is recognized for making “the procedures of phenomenological psychological analysis explicit, systematic, and accountable” (Wertz, 2010, p. 131). Flowers, Larkin, and Smith contributed to the development of IPA.
2.5 Participant Recruitment

As mentioned earlier in the Ethics section of this thesis, I informed the REB that I wished to recruit participants from AA meetings. My choice to recruit participants from these organizations was based on my understanding of phenomenological research. As Flowers, Larkin, and Smith (2009) explained, it is typical in IPA research (the method for the current project) that the researchers work to find a “closely defined group for whom the research question will be significant” (p. 57). My choice to recruit from AA also factored in my decision to involve six participants. Protecting the anonymity of individuals is central to AA, as it is viewed as an essential part of recovery. Meetings are meant to be a safe place for people to share their stories and to learn from others in a similar situation without any fear that their disclosures will leave the room. I wondered how I would be able to access this organization and gain the trust of potential participants.

To begin my project, I read books on AA and searched for information about the organization on the Internet. I learned that there were “Open Meetings” that were open to anyone with an interest in the recovery process of alcohol addiction. As well as being open to family and friends of people who have an alcohol addiction, I found that researchers of alcohol addiction were included in a description of who could attend an open meeting. As a researcher this was a relief but it was also a surprise.

For me, there was an aura of secrecy around AA and I thought I would at least have to contact someone before I attended a meeting and made my research pitch. Although, from what I could tell, I could simply attend an Open Meeting. I thought it was best to connect with people from the meetings before I attended. I felt it would show my
respect for the privacy of the meetings and be a good first step in building trust with the group. While searching on the Internet, I found a contact name and number for a meeting. I contacted this person and described my project. This person invited me to attend an Open Meeting that occurred every Sunday morning.

At the end of the first meeting I attended, when people could talk about additional business, I took some time to describe my project. After attending four or five meetings, I was eventually approached by a woman who agreed to take part in my project. In the following weeks, a man approached me at the end of the meeting and we had a good conversation about his experiences in recovery. At the end of our conversation, he said he would participate in my project. These two participants, who were included in my long-term sobriety group, were attending a meeting in Northern Saskatchewan. My other participants were located in Regina as I moved there to complete my studies.

With a higher population in Regina, and based on the permission to contact AA groups granted to me by the REB, I chose to contact the Regina Area Intergroup Office for AA and let them know about my research project and my intention of attending Open Meetings. In attending meetings in Northern Saskatchewan, I learned more about the structural organization of AA from the helpful attendees of the meetings. I learned that geographical areas had committees that helped foster a spirit of co-operation and unity among various AA groups in a region. I figured that if I was going to be contacting AA groups in Regina, I should inform the Regina Intergroup Office, the committee that is affiliated with all of the registered groups in Regina. The contact person at the Regina Intergroup Office was helpful and she gave me a list of Open Meetings and contact names and numbers for each of the meetings. She appreciated that I was planning on
calling contact people before I attended an Open Meeting and wished me luck on my recruitment.

I called one of the numbers for an Open Meeting and spoke with a contact person for the meeting. The response from this individual was quite different from my previous encounters with AA members. This contact person said that he did not want a researcher coming to a meeting. Although I described the project as collaborative, he said he did not want members of “his” group being treated like “guinea pigs”. In addressing his concerns and attempting to demonstrate that my intent was solely to learn more about the recovery process, I mentioned how another AA meeting had allowed me to sit in and that I had spoken with the Intergroup office about attending meetings. This contact person said he believed these groups were going against the traditions of AA and that a researcher should not be allowed to attend groups. I thanked him for his time and we ended our call.

In hearing this person’s views regarding the appropriateness of researchers attending meetings, and those of others who believed it was acceptable and actually advocated for members of the research community to attend meetings, I thought of the debates among religious scholars regarding religious texts. While attending AA meetings I read through the literature that was laid out for members and I got the impression that AA was open to anyone with an interest in alcohol addiction and the process of recovery. While talking to the person who did not want me to attend the meeting, I was struck by how he referenced passages from the literature which he felt precluded researchers from attending. It seemed that some group members had interpretations of the literature which differed from other members and that certain groups had their own hierarchies and traditions.
This encounter highlighted how each AA group has its own culture and that individual members can have a strong influence on a group. If this person had been my first contact with the AA organization, I may have viewed AA much differently. In regards to the criticisms leveled at AA, this experience led me to believe that much of the dissatisfaction with the program is due to personal conflicts among members in specific groups rather than AA as a whole. Fortunately, another contact person for an Open Meeting was much more inviting and I was able to connect with a person who wished to participate.

After recruiting three participants for the long-term recovery group, it occurred to me that AA might not be the best place to recruit individuals in the early stages of recovery. Although there were people who were new to AA and the recovery process at the meetings I attended, I was only being approached by individuals who had achieved years of sobriety. When I interviewed the participants who had attained years of sobriety, they said that I may have trouble finding participants who were just starting their work towards recovery. They informed me that people who were new to meetings may be more reluctant to disclose details of their lives with a researcher than people who have attended meetings for an extended period of time. For some people in the early stages of recovery, the act of attending a meeting may be all that they feel capable of doing in addition to their other responsibilities. They may have a host of other concerns to deal with that preclude involvement with a research project. With this in mind, I contacted the REB and requested permission to recruit participants from addiction treatment service providers. This request was granted as is shown in Appendix D.
When it came to recruiting from addiction treatment providers, I figured that service providers may have concerns about protecting the anonymity of clients or concerns that involvement with a research project might interfere with a person’s treatment plan and scheduled activities. Before I spoke with potential participants, I informed staff members of my project and what would be required of potential participants. I contacted an addiction service program that helps individuals with overcoming their alcohol addiction. Through this organization, I was able to connect with two individuals who were working towards their first year of recovery.

I recruited the third member of the short-term recovery group when I contacted an addiction treatment provider that offered services for clients with addictions. While talking with a staff member at this agency, he disclosed to me his struggles with addiction. He said that he was working towards his first year of sobriety after relapsing a few months ago and volunteered to participate in this project.

The participants with more than two years of sobriety were called the Long-term Recovery group. The participants with less than a year of sobriety were called the Short-Term Recovery group. The names of the participants are shown on Table 4.

Table 4

*Names of Participants and Groups*

<table>
<thead>
<tr>
<th>Long-Term Recovery</th>
<th>Short-Term Recovery</th>
</tr>
</thead>
<tbody>
<tr>
<td>Randy</td>
<td>Tom</td>
</tr>
<tr>
<td>Lisa</td>
<td>Seth</td>
</tr>
<tr>
<td>Peter</td>
<td>Jake</td>
</tr>
</tbody>
</table>
2.5.1 Long-term Recovery Group

Randy is a man in his mid-40s who has lived for approximately 15 years without meeting the criteria for an alcohol addiction. Randy attended a treatment center for alcohol addiction and was introduced to AA through his participation in treatment.

Lisa is a woman in her mid-40s who has lived for approximately 18 years without meeting criteria for an alcohol addiction. Lisa attended a treatment center for alcohol addiction and was introduced to AA through her participation in treatment.

Peter is a man in his mid-60s who has lived approximately 40 years without meeting the criteria for an alcohol addiction. Peter attended a treatment center for alcohol addiction and was introduced to AA through his participation in treatment.

2.5.2 Short-Term Recovery Group

Tom is a man in his mid-40s who was living in a Sober Living House. He attended AA meetings in the past sporadically. He said his attendance was mainly to please his wife and others who were concerned about him. Tom attended a treatment center in the past but began drinking days after his discharge. After getting into a car accident while driving while intoxicated, Tom entered a second treatment center. He said he was more committed to the treatment program. Tom attends AA meetings regularly. Tom relapsed last summer and is working on a full year without using alcohol.

Jake is a man in his 50s who was living in a Sober Living House. Jake was in an automobile accident and sentenced to time in jail for driving while intoxicated. After his time in jail, Jake attended a treatment center. Jake is nearing one full year without using alcohol.
Seth is a man in his late 30s who is working towards a full year without alcohol after a relapse 4 months ago. Seth has never attended a treatment center for alcohol addiction and does not attend AA meetings.

2.6 Generating Data

2.6.1 Interview Questions

The next step in a phenomenological study is generating data. For this study, interviews were conducted with the participants. However, two weeks prior to the interview, participants were asked to keep a record of their experiences related to their addiction. The purpose of the journal was to help participants engage in the process of reflection and focus on the subtle shifting aspects of their lived experience. Participants were asked to consider the following questions:

1) Are you aware of changes that occurred in your lifestyle, thinking, and behaviour that were a result of your addiction?

2) How did addiction affect your outlook in terms of future goals/plans, relationships, and other areas of life?

3) How would you describe your identification as someone who was addicted to a substance and its development over time?

4) What situation, what challenge or crisis led you to fashion a new being?

5) What situation or realization precipitated the journey that made possible the discovery of who you are?

These questions are based on questions that appear in the opening of a book by Clarke Moustakas (1977) called Turning Points. Moustakas is a well-known phenomenological researcher and regarded as an expert in humanistic theory and clinical
Psychology. In his book, Moustakas explored the idea that “each person experiences a number of critical turning points that move the person increasingly toward a unique and incomparable selfhood” (p. 3). His book, like the proposed study, is an attempt to understand the shifts in the concept of self and changes in consciousness that lead to further personal growth. In his book, Moustakas posed questions that relate to these ideas and it is these questions, along with his thoughts related to the process of identity development, that have guided the development of the questions used in this study. Two weeks prior to the interview, these questions were given to the participants to serve as a means of generating ideas to record in their journals. During the interview these recorded responses were to be reviewed and discussed, along with other topics related to the process of recovery.

The above questions were designed to encourage participants to reflect upon the recovery process. I felt that in considering these questions, participants would be aided in identifying changes that occurred as they worked towards recovery. I felt that the questions would serve as a means for participants to take a broad view of their individual journeys and help them recall how they lived at the height of their addiction with greater clarity. In attending to the questions, I thought clients could provide greater insight into their experiences both as a person who drank alcohol in an addictive manner and as a person who was working to maintain sobriety.

Though these were primary questions to generate thinking and discussion, they were by no means the only questions that were asked. In accordance with the recommendations by Barone and Switzer (1995) for conducting qualitative interviews, I
developed an interview guide with tentative and probing questions to help stay on topic while encouraging detailed responses. The interview guide is shown in Appendix E.

The questions in the interview guide were related to structures of consciousness that have been identified by phenomenologists (Eckartsberg, 1998). By including questions related to these structures of consciousness, I hoped to gain insight into how they might have changed during the recovery process and identify group differences in these structures. Throughout the interview process, open-ended questions were framed with the aim of attempting to capture as closely as possible the experience of the participants and help them inform their accounts with as much detail as possible. As Eckartsberg (1998) stated regarding the goals of phenomenological interviews, “it is a matter of clarifying the pre-thought ‘lived’ experience of an action, that is, of bringing the subject to the point where he describes what he really does, and not what he thinks or imagines he does” (p. 46). In order to receive a detailed narrative, questions and discussions aimed towards greater clarity of the issues that emerged and were framed in such a way so as to encourage self-reflection.

### 2.6.2 Journaling

As was noted above, participants were asked to record their thoughts throughout the two week period prior to our interview. Participants were told that they could write as little or as much as they could or wanted. The intent was to gain a window into the experience of individuals who were working towards recovery from alcohol addiction. Furthermore, the journaling was meant to prepare participants for the interview and ensure that there would be material to discuss.
Originally, I intended to analyze the transcripts of the interview along with the materials from the journals of the participants. Although all participants reported looking over the questions, participants varied in the amount they wrote. Randy and Seth wrote almost every day. Lisa made notes but did not bring them to the interview. Jake, Tom, and Peter reviewed the questions but felt they could speak about their experiences without making notes.

The feedback from the participants who did not record journal notes was a lesson in research design for me and a perfect example of some of the criticisms of research studies in addiction studies. As a researcher, I thought that journaling would be a good way to access the day-to-day thought process of participants. As participants began to tell me that they could comment on their thoughts without reference to a journal being made every day, I realized that I may have been imposing a condition on them that was not necessary. However, in another study, I think it would be fruitful to include journaling related to a broader range of questions or have participants journal on topics that they chose for themselves. As a result, the analysis was conducted on transcripts from the interview.

2.6.3 Interviews

Originally, I thought that each interview would take approximately one hour to complete. However, my first interview with Lisa lasted approximately two hours. After this interview, I informed the participants that the length of the interview would likely range between an hour and two hours. As I proceeded with my interviews, the average length of time for each interview was approximately 90 minutes. The shortest interview was approximately 84 minutes and the longest interview was approximately two hours.
To begin the interview, I asked participants about their thoughts related to the list of questions that had been given to them two weeks earlier. After I addressed these questions with each participant, I asked the participants about their first experiences with alcohol. As the participants described their early experiences with alcohol, I asked questions to clarify their statements and to encourage them to elaborate on points of interest. The tone of the interview was conversational as I let each participant speak about the topics that were relevant to them. Rather than going through my interview guide question by question, I engaged the participants in a conversation about their addiction.

Throughout the interview, active listening and reflective techniques associated with therapeutic settings were employed. Although the interview was not a therapy session, it involved the imparting of sensitive information and warranted a similarly high regard for the participant’s confidentiality and well-being. As well, I was mindful of the fact that a qualitative researcher “needs to listen carefully to the responses given in order to discover topic areas of importance to the respondent that may not have been a part of the interviewer’s original plan or guide” (Barone & Switzer, 1995, p. 177). Throughout the process, participants were encouraged to describe their experiences in their own terms.

Although I had questions in mind, I wanted the participants to tell me what was important to them. I did not want to restrict our conversation to my own questions and to topics that I considered to be relevant. As much as possible I wanted each participant to describe their unique journey of recovery. Throughout the course of the conversation, I would glance at my interview guide and take note of questions that had been addressed.
Any questions that had not been asked during the interview were asked as the interview came to an end.

Before and after each interview, I reminded each participant that anything that was said during the recording could be excluded from the transcript that would be made of the interview. Each participant was satisfied with the content of the interview. After each interview was completed, I transcribed them.

2.6.4 Transcription

Since the participants were comfortable with the contents of their interviews, I proceeded to transcribe them. As was mentioned earlier, I conducted my first two interviews in Northern Saskatchewan while completing my practicum. Upon returning to Regina, I transcribed these interviews in January 2012. I transcribed these interviews one after another.

Upon completing each interview with the participants recruited in Regina, I began transcribing them. I transcribed each interview in the order that I completed them. In the interest of time, I began transcribing the completed interviews before I had recruited the remaining participants.

After listening to the completed interviews during the transcription process, I tried to minimize their influence on the interviews that I had yet to conduct. In encouraging participants to tell their own stories and letting them take the lead as much as possible in our conversations, I felt that each completed interview was its own unique record of an encounter. During the interviews, I made sure not to make reference to experiences mentioned by other participants and I limited my questions to my interview guide and the statements made by the participant I was speaking with at that particular moment.
Though I was careful not to let the content of completed interviews influence my questioning in subsequent interviews, I think the transcription process improved my skills as an interviewer. Once I began to feel more comfortable interviewing participants, and had developed a sense of how much time was required to address all of the questions, I found that the interviews seemed to take less time. After having transcribed some of the interviews, I found that subsequent interviews tended not to drift into topics beyond the scope of the study and avoided repetition of topics already addressed. Once all of the interviews were transcribed, the process of analysis began.

2.7 Analysis of Data

With a qualitative study, the results cannot be summarized as easily as they can be with a quantitative research project. As one researcher said, “achieving a balance between conciseness and richness is a great challenge for the qualitative research writer” (Anderson, Charmaz, Josselson, McMullen, McSpadden, & Wertz, 2011, p. 93).

Although a qualitative study can generate a great amount of data, there are recommended guidelines and strategies for analysis and interpretation. In conducting my analysis, I primarily followed the guidelines and recommendations described by Flowers, Larkin, and Smith (2009) but drew on recommendations from other phenomenological researchers as well (Eckarstberg, 1998; Giorgi, 1970).

In the beginning stages of analysis, transcripts were “read and scrutinized to reveal…their structure, meaning configuration, principle of coherence, and the circumstances of their occurrence and clustering (Eckartsberg, 1998, p. 22). Initially, the text materials were read in a process referred to as an open reading. This is a process whereby a researcher “follows the expressions of the particular participant without any
An open reading is suggested so as to aid in approaching the materials free of potential biases and encouraging a fresh perspective regarding the study of which the investigator is part. It is important for the researcher to get some distance from the materials that his questioning generated. Viewing the materials in an open, unbiased manner allowed for reflection on the data to occur and initiated the process of making meaning from it. Just as the self-concept shifts upon reflection of itself, as the tension between multiple selves leads to the emergence of higher order self-concepts, reflection upon the data can generate multiple meanings which are interpreted into higher order categories and themes. As Eckartsberg (1998) said, “the most important realization of the phenomenological researcher is that what the subject presents are not brute facts but dynamic meanings that are haloed with intentions” (p. 66).

The task of the researcher then is to capture the essence of what participants have said by minimizing their own biases. This is recognized in Husserl’s notion of bracketing; an integral process of phenomenological analysis that is intended to keep researchers from imposing their assumptions and biases onto their participants (Giorgi, 1970). As Eckartsberg (1998) explained further, “bracketing of one’s presuppositions should be conducted to help make the researcher’s presuppositions explicit and to help make clear the distinction between the researcher’s and the interviewees’ understandings and beliefs (p. 66).

In bracketing my presuppositions while reviewing the raw text, I approached each transcript in the same manner. I thought clearly about the intent of my study and re-examined my interest in the field of addictions. I thought of my interest in consciousness
studies and my sense that findings from consciousness studies could be applied to the
treatment of addictions. I wanted to make myself aware of any tendencies or biases that
might lead me to interpret the interviews in a way that conformed to, or confirmed, my
personal beliefs, opinions, or expectations. As much as possible, I wished to maintain the
message being communicated by each participant. For me, this was critical because I
wanted to honor the thoughtfulness and the commitment of each participant which was
exhibited in my interviews. In discussing personal matters with each participant, I was
given privileged access to some of their innermost thoughts and feelings. In spending
time with each participant, I felt there was a sacredness to the information that was
divulged in each encounter. Having these thoughts in mind helped me to view each
transcript in its own right and to focus on preserving the original message being conveyed
by each participant. I saw the process as one that involved the momentary silencing of
those voices within me, those voices of student, researcher, and addictions counsellor, in
order to hear the voice of each participant clearly.

Following the recommendations of Flowers, Larkin, and Smith (2009), I read
through each transcript and made notes about ideas or topics that stood out to me. I did
this separately with each transcript. Following this process, I separated the transcripts of
the long-term recovery group from the transcripts of the short-term recovery group. I
started with one group of transcripts and looked for repeating ideas shared between the
participants in that group. I looked through my initial notes as I re-read the transcripts. I
made my notes more detailed as I compared the content of the transcript with the other
two transcripts in the group. In identifying themes, one must first find relevant text. As
Auerbauch and Silverstein (2003) explained, “relevant text refers to passages of your transcript that express a distinct idea related to your research concerns” (p. 46).

In my analysis, my process mirrored the description by Anderson et al. (2011) who stated, the analysis of phenomenological data involves “a movement back and forth between parts and whole, and between the whole and its context, in order to achieve a fuller grasp of its meaning” (p. 91). As I read each transcript, I started to write down key words that I felt summarized ideas that were presented by each participant. After all three transcripts were analyzed in this manner, I compared them and looked for similar key words. After identifying similar key words, I identified them as “superordinate themes”; the nomenclature used in IPA researcher (Flowers, Larkin, & Smith, 2009). I then wrote out the passages from the transcript that reflected these superordinate themes. I repeated this process with the other group of transcripts.

The final step of analysis in phenomenological studies has been described as “clarifying the psychological structure(s) of the phenomenon” (Wertz, 2011, p. 131). This step is a holistic interpretation of the entire research process. The insights derived from the analysis were identified and elaborated upon as their meanings were explicated. This process can be likened to the process of consciousness development itself whereby a meta-position is taken in relation to what exists, and through a synergistic relationship, new, coherent structures emerge. By identifying these structures, and articulating them in relation to the narratives of the participants, my goal was to faithfully conceptualize the process and structure of mental life, how situations are meaningfully lived through as they are experienced, with “nothing added and nothing subtracted” (Wertz, 2011, p. 125).
During my interviews with the participants, they each expressed an interest in seeing the final copy of the thesis. I informed each participant that I would send them a copy via email.

3. RESULTS

At the conclusion of the analysis, several themes emerged for each group. The names given to the themes were meant to capture their overall meaning according to each person’s account of recovery. The themes for both the long-term and short-term recovery groups are presented in Table 5. In the proceeding sections, each theme will be outlined. When appropriate, quotations from the interview transcripts will be provided.

Table 5
Emergent Themes from Analysis of Interview Transcripts

<table>
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<th>Long-term Recovery Group</th>
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3.1 Long-term Recovery Group

The following themes were noted in the long-term recovery group: Belief in the program of AA; Comparison between Selves and Others; Dialectical Tension between Worlds; Dialectical Tension between Selves. Each theme is described with quotes from the transcripts of each participant.

3.1.1 Belief in the program of AA

Each of the participants in the long-term recovery group expressed a belief that their participation in AA was vital to their recovery from alcohol addiction. In the interviews, they endorsed the program and its philosophies. Each participant made reference to the social and spiritual aspects of AA. Interestingly, each participant had their own sense of a Higher Power. The belief in the program was also reflected in the use of phrases and slogans that appear in AA literature.

Peter said AA was responsible for him being able to build a better life for himself. He said, “It was through AA that I learned to live”. Peter’s belief that AA involvement led to recovery was clear in his statements that “There’s no other way as far as I’m concerned” and “everything I have I owe to AA”. Ever since his time in treatment, he has attended AA meetings regularly with varying frequency. Peter said that his attendance dropped slightly when his children were born and he was busy with work and family but he always made time for meetings. Peter said, “in the last 30 years, I averaged 3 to 4 meetings a week”. Though Peter attended many meetings, he said his reasons for attending the meetings changed. He said, “I just went enough to stay sober. Now I go because I want to. I enjoy it”.

...
Peter shared many of the beliefs of the program. The AA program characterizes alcohol addiction as a life-long affliction that cannot be cured and Peter shared this belief. Although he recognized that others held different opinions on the topic, Peter stated that he had “the disease of alcoholism”. Peter said that in the beginning he “had no belief in God” but in time he came to believe that some force greater than him was looking out for him. Throughout the AA literature, there are references to the importance of humility in regards to one’s sobriety. This was reflected in the following statement by Peter who said, “The minute you say you understand everything about drinking then you’ll go and get drunk”.

Lisa also felt regular attendance at meetings was important for her recovery. In the early stages of her recovery, she said she was “probably hitting 4-5 meetings a week”. She stated feeling that one meeting a week is good for her now but she would attend more if she feels it is required. Although the number of meetings she attended over the years varied, she incorporated attendance at AA meetings into her life and believed that continued contact with AA was responsible for her recovery and her ability to maintain her sobriety.

Lisa’s continued reflection on the 12 Steps of the program is something she does regularly. She said, “I work the Steps and I probably go through them every 2-5 years…or if something major happens in my life”. She endorsed continued involvement with AA for anyone who wanted to overcome an addiction to alcohol. Lisa knew people who had relapsed and she said it was because “they quit opening their book and reading it (i.e., the “Big Book” of Alcoholics Anonymous which is a compilation of personal stories and AA traditions) and they quit working the Steps”. Like Peter, Lisa described herself as
having “the disease of alcoholism”. Like Peter, Lisa also did not begin her recovery with a belief in God. She described having a difficult time accepting the spiritual aspects of the program but in time came to embrace them. Over her time associated with AA, her conception of a Higher Power changed. Lisa said, “My Higher Power when I first came in was the group”. After three years in recovery, a tree on her farm became her Higher Power. She described how she visited it whenever she was feeling lost and would sit under it and cry. Lisa said, “it was part of my healing, part of my journey”.

Randy has consistently attended approximately one or two meetings a week. Randy endorsed involvement in the program and said “the whole point of this program is hope”. The idea that a person will always have the “disease of alcoholism” was reflected in Randy’s reference to himself as an “alcoholic”. According to Randy, “you’re a drunk til the very end”. Randy also believed that continued attendance at AA was a vital part of recovery. Randy said “a lot of newcomers just got to keep coming back”. In describing alcohol addiction, Randy used a phrase from AA and said it was “an allergy of the body and an obsession of the mind”. Randy, like the others in this group, came to embrace the spiritual aspects of AA during recovery. Randy described his view of a Higher Power as “not religious, spiritual”. According to Randy, the “concept of a Higher Power changes every day”. Randy also expressed a belief that some higher force was at work in his life. As a result of his experiences in recovery, he said “there are no coincidences in life, there just isn’t”.

3.1.2 Comparisons between Selves and Others

In the interviews, each participant commented on how they viewed their addiction and the social influences that contributed to their drinking. Throughout their stories, it
was clear that a process of social comparison was at work, both in recovery and in the midst of their addiction. As well as feeling out of place amongst family and friends, each participant described themselves as people whose premium on independence, and desire for freedom, isolated them and brought them to the point of engaging in anti-social behaviour.

In describing his process of recovery, Peter frequently described how he compared his lifestyle with other people. He recounted a time when he was single and on his way to work. He drove past a church on Sunday and saw families outside of it. He wondered if he could ever live a life like theirs. He mentioned another time he watched through the front window as his friend’s family interacted during breakfast. He had slept in his car and parked in their yard when he returned there from a night of drinking. Peter said, “I knew that I wasn’t living a normal life”. Peter sensed this about himself but was also told outright by others who said “You’re different”. Peter said he felt, “the alcohol affected me differently than the average person”. Peter compared himself to other people who seemed far worse off than he was and this allowed him to justify his drinking and minimize his accidents. Peter also valued the freedom that he associated with his alcohol use. He appreciated the fact, “I could do what I wanted”. As Peter began to work on his addiction, and encountered more people without an addiction, he compared his behaviour with theirs. He said, “I started treating people good and they treated me good” and cited this as a factor in learning how to live a life free of addiction.

Lisa also had the experience of feeling out of place. She said, “I think I’ve always been the different one in our family”. There were differences between her and her peers. When it came to friends staying over at her house, she said “their parents knew there was
drinking and craziness going on at our house and they were not allowed to spend the night at my house”. In time, Lisa said she, “became a loner”. As well as comparing her home life with that of her peers, she used her family to gauge the extent of her alcohol use. She said it was difficult to see drinking as a problem when “everybody else was doing exactly the same thing”. For instance, while growing up, she thought “my brother gets sick just like I do all the time, it’s what you do”. Lisa said she worked hard and was one of the most productive employees at her workplace. Despite her excessive drinking, she thought, “I’m totally functioning” as she completed more work than her co-workers. Part of Lisa’s drive was related to maintaining her independence. She said, “I never wanted to need anybody”. Lisa said that during her days of addiction, she had to “have somebody who is just a little bit worse than me”. After maintaining her sobriety and reflecting on her upbringing, Lisa said, “I look at my family and I think you guys are really whacked”. She said that when she returns home for Christmas parties, “nobody wants to be drunk when I am there”. She said her parents and siblings still drink in excess. These comparisons with her family seemed to play a significant role in Lisa’s sobriety.

Randy said, “I always felt a little bit off keester from the rest of the world, I didn’t fit in”. Like Lisa and Peter, he compared himself to other people to gauge the severity of his drinking behaviours. He said, “my perception of what a drunk was was somebody with a brown paper bag...they’re dirty...they’re puking their guts out...somebody sloshing their drinks”. He believed, “they’re drunks, I’m not a drunk”. Randy mentioned times when he drove while intoxicated and an arrest for drug dealing and mentioned that he did not like following rules during his addiction.
Randy also described himself as being able to function during his addiction in the sense that he was still able to work. In recovery, Randy’s social comparison continued. He said that in recovery, “you start to see the separation of people as you start sobering up, cleaning up”. He said that while in a treatment center he listened to a guest speaker share his story of recovery. Randy said the speaker “pinpointed my life almost to the tee”. This was a powerful experience for him and contributed greatly to his recovery. Randy saw social comparison as a major factor in recovery. To begin the recovery process he said people have to compare themselves to other people with alcohol addiction and “have to admit they are just as bad as them”. He also advised newcomers to “stick with the winners”. (“Stick with the winners” is a slogan from AA which refers to aligning oneself with long time attendees).

3.1.3 Dialectical Tension between Worlds

Each participant spoke of their current life and described it as being fuller and richer than their life while addicted. They spoke about their current life with enthusiasm and seemed relieved to have developed a new lifestyle that did not revolve around alcohol use.

Peter said his social network expanded with recovery. He said, “I could phone lots of people whereas before I couldn’t”. In describing his addictive lifestyle, Peter said he tended to keep to himself. Peter said “nobody could hurt me and I couldn’t hurt anybody else”. When talking about how his friends used to go to dances, Peter said “I’d sooner sit in the car and drink”. Before recovery, Peter described a lifestyle that revolved around work and drinking. He did not see the value of friendships or relationships. He said, “I thought you just lived to survive”. In recovery, Peter began to find value in relationships.
In comparing his activities and interests in recovery to those during his days of addiction, Peter said, “now I got other outlets”.

Lisa spoke enthusiastically and in grateful terms about her recovery. She said, “it still keeps going beyond my wildest dreams. I don’t know how else to explain sobering up”. In reference to people who might be struggling with their own addiction to alcohol, she expressed remorse for them and wanted them to know that “there’s another way of life and they’re missing it, they’re totally missing it”. When Lisa reached a point where she felt she had freed herself from her addiction, she said, “I wanted to go yell it from the mountains”. Lisa described herself as being more open now than in her past. She described herself as being armored to the hilt” during the height of her addiction. She said she was guarded and “the wall went up” after relationships did not work out due to her alcohol use. Lisa described her life in addiction as being very limited. She said, “all I did for sure was work and drink, work and drink, work and drink”. She said, “I just remember being a zombie, no life”. As Lisa moved further away from her former lifestyle, she said she felt herself become more open as a person. She said “that armor is absolute dust”.

Randy described major differences between his current and former lifestyle. He said that in recovery, “your world grows enormously”. Whereas most of his time revolved around drinking, he described things in his life as being “a lot more equal than they used to be”. Randy described how alcohol consumption took priority and “everything is a little leg off of it”. Randy said, in his addiction, “your priorities are booze, how do I get it, how to recover from it, how am I going to do it again”. Like Lisa, Randy also divided his time between working and drinking. As well as describing himself
as an alcoholic, Randy said, “I was a workaholic”. Looking back at this life, Randy said “drinking overtakes everything” and said “that one thing used to be the center of attention”. In describing the life of an addicted individual, Randy said, “We live our life in a little bubble.”

3.1.4 Dialectical Tension between Selves

Each of the participants cited changes in their attitudes, beliefs, and self throughout the recovery process. In listening to their descriptions of their past lives, at times it seemed as though the participants were describing other people. They spoke about their past behaviour with a detachment that added to the sense that they had moved on from their former way of life.

Peter said that in his past, he did not think much about his life. Even after rolling a few cars, he never thought much about his mortality. He said, “I didn’t care”. Peter listed some major changes in his personality and attitude. He said that he often fought with others and “always retaliated”. He described himself as someone who “ruled by intimidation”. He said, “I was mean and if someone crossed me there was trouble”. As for now, Peter said he is more accepting of others and patient. He said, “I look for the positive things and I don’t look at the negative things”.

Lisa also described major changes in herself that occurred over the course of her recovery. She said, “I’m totally not the same person that I used to be”. In describing herself in the past, Lisa said she was “selfish and self-centered all the way”. She also described herself as someone with something to prove. When she was a child growing up, she said she “had no self-esteem”. She said as she got older and entered the workforce,
she tried to compensate for her low self-esteem. She said her attitude back then was, “I’m going to do it better than anyone else”.

Randy felt he had undergone major changes as well. He said in the past, “I was very selfish”. In describing his former self, Randy said, “He drank to oblivion and beat his wife and drove drunk, not a nice guy”. It was interesting that Randy said “He” rather than “I”. It underscored the idea that he viewed himself as a different person. Randy said that during his addiction, “I didn’t like who I was but I knew I didn’t care enough to do anything about it”. He said, “20 years ago I wouldn’t be here talking to you” and described himself as being a “self-centered, big shot” before he gained sobriety.

3.2 Short-term Recovery Group

The following themes were noted in the short-term recovery group: Need for Control; Influences in the Environment; Health and Healing Potential for Recovery; and Rock Bottom as an Initiator of Change. Each theme is described with quotes from the transcripts of each participant.

3.2.1 Need for Control

Each participant focused on the onset of their addiction and how it began to dominate their lives. Though they stated that they did not consider alcohol to be an ever-present, looming threat, they expressed reservations about their ability to refrain from drinking under certain circumstances.

Tom described the development of his addiction as “a continuous slide”. He said that over time he “became more and more dependent” on alcohol. He described alcohol as “a necessity”. Tom said that a big part of his recovery was admitting that, “I’m powerless” (i.e., the first step of the 12 Steps program as seen in Table 2). Tom said that
his employer might transfer him to a remote worksite where he would not be able to attend AA meetings or connect with other supports. The last time Tom was in a similar situation, he relapsed. Tom expressed some concern over his ability to remain sober in the same situation.

Seth described himself as someone who wants to be in control. He said he did not even like to dance because, “I don’t want to lose control of my body”. Seth said it was very important for him to be “in control of my choice-making abilities”. Seth had experienced moments during his addiction where, “you say you’re not going to do it again then the next thing you know you’re doing it again”. He said he did not want to lose control of his ability to stop drinking. The extent of this concern was evident when Seth said, “even talking about it makes me want to drink”.

Jake also expressed concerns about being able to control his drinking. In thinking back to his drinking binges he said, “I couldn’t stop drinking”. Jake had currently created a lifestyle for himself that was designed to help keep him from drinking again. In reference to his former occupation, he said, “I know if I go back on the road, I’ll probably end up drinking again”. Jake felt that a loss of control was a major factor in the development of an addiction. He said, “sometimes you need an intervention in order to stop. That’s how I had to stop”. For Jake, the intervention he referred to was his arrest for drinking and driving.

3.2.2 Influences in the Environment

Each participant identified how their environments contributed to their drinking. They described how their contact with others led to the onset, and contributed to the maintenance, of their addiction to alcohol.
Tom said he began drinking in high school and attributed this to “peer pressure”. He also said he looked up to older kids and wanted to be like them. Tom played hockey as a teenager and would drink alcohol with his teammates. When he played old-timers, this pattern continued. Tom said, “any road trips you went on just added to the mess”. When Tom was working in a remote worksite, he said “there was a lot of drinking in there and I held on for two and a half months”.

Seth said he was brought up in a home where alcohol use was a regular part of living. He said, “that’s what I was exposed to”. Seth said he got away from his addictive behaviours when he entered the workforce but his entry into university led to their return. He said he mostly worked by himself and would “sit in front of a computer for 10 to 12 hours a day” and drink alcohol. As well as his family and friends, Seth found the larger social environment contributed to his struggle with alcohol addiction. Seth said, “I find it is more difficult to quit because it is more prevalent and it is socially acceptable”.

Jake was raised in an environment where alcohol use was celebrated. He described it as part of his cultural heritage. Jake’s family made alcohol and he saw alcohol use as being part of his family traditions. Jake said, “I felt it was part of growing up”. Jake said alcohol was readily available and he “could get it anywhere”. In adulthood, many of Jake’s friends and co-workers also drank alcohol and he frequently attended drinking parties with them. According to Jake, “if you didn’t drink you weren’t a friend”.

### 3.2.3 Health and Healing and the Potential for Recovery

Each participant mentioned their overall health being impacted by addiction. Health problems alerted them to problems caused by their addiction and prompted them to make changes in their lifestyle. Each participant commented on how their former
lifestyle contributed to health problems and recognized how their lifestyle reduced the likelihood of recovery. Improvements in their health were hopeful signs that positive changes were underway.

Tom talked about attending to his responsibilities while recuperating from periods of heavy drinking. As a youth playing junior level hockey, Tom said he could remember participating in games while feeling the effects of alcohol. As an adult, there were occasions when he would complete the duties of his job while coping with the effects of alcohol. These experiences led to some feelings of guilt for Tom and led him to question if his drinking was becoming a problem. Jake also reported completing the duties of his job while coping with feelings of sickness. Jake’s job required concentration and alertness and there were times when he worked while impaired. As for Seth, he recalled times when he would be “stumbling after 15 beer….while cooking food” for his children. Feeling the effects of alcohol, while completing tasks of daily living, seemed to act as personal indicators for the participants that their drinking was becoming problematic.

Tom said that others commented on his appearance and questioned his health and this led him to examine his behaviour and his pattern of drinking. After extended periods of drinking, he would feel sick or hungover and said, “the only thing that made me feel better would be more alcohol”. Tom said that during times when he was drinking heavily, “I was losing weight. I wasn’t eating properly”.

In reflecting on his past behaviour, Seth commented on the unhealthy nature of his former lifestyle. Seth felt that his poor health was a major motivator to change his lifestyle. He said he was concerned over, “seeing my physical health be destroyed”. Seth recalled times when he woke up after a night of drinking and found bruises on his body
that he could not explain. Experiences like this were disconcerting for him. In reflecting on his past lifestyle, Jake said that after weeks of being on the road with his job he would “sit at home in the backyard with my big barbecue sucking down a 40 of rye or a Texas mickey of something.” In looking back at this lifestyle, Jake recognized that it was not healthy and consisted of patterns that promoted his addiction.

Many of the health problems experienced by the participants prompted a change in lifestyle. Jake cited current health problems that resulted from his excessive drinking. Jake said, “I would stagger” and described how he used to correct his walk to appear sober. Additionally, Jake said he still had “short term memory loss”. In particular, Jake mentioned the physical changes he experienced while in detox. He said, that he had, “the shakes. The runs. The nervous twitches. The convulsions. The headaches. The dry heaves”. Seth also reported experiencing withdrawal symptoms of alcohol.

As well as describing health problems, the participants spoke of positive changes that occurred when they stopped drinking. Seth noticed major differences in his health status that came when he stopped drinking. When he stopped drinking, he said that he lost weight, had more energy, and felt better. Both Tom and Jake spoke of increases in their energy level as well. Jake said “My health has improved, I eat better.” Tom reported improved health as well.

3.2.4 Rock Bottom as an Initiator of Change

The phrase “hitting rock bottom” refers to an experience that causes people with an addiction to acknowledge that their substance use is creating problems in their lives. If we view an addicted person as someone who is in free fall from a healthy lifestyle, rock
bottom is the point where one cannot fall any further. Each participant had experiences that had a profound impact on them and prompted them to change their lifestyle.

Tom reached a point where he felt he had nothing left and no one to help him. He said, “I had no money, no one would answer the phone, and I was beaten…that’s what sparked me”. In describing why he had not been able to achieve a measure of recovery in the past, Tom said, “I hadn’t lost it all”. The idea that one must lose everything in order to change their lifestyle was echoed by Jake. In discussing why people were unable to quit drinking, Jake said it was because, “they haven’t lost enough”.

Tom said a car accident that occurred while he was drinking and driving, an accident that left him in the hospital, was a major turning point for him. Although he considered his accident to be “hitting rock bottom”, he felt his struggles after the accident also prompted him to change his lifestyle. After his release from the hospital, Tom lived on the streets for about a month. He saw this period of time as particularly difficult and a motivator for change as well. The idea that rock bottom experiences can include a number of events was echoed in Seth’s comments. Seth expressed an idea that people might experience a number of rock bottom experiences on their way to recovery. Though he felt he had experienced a number of rock bottom moments, he identified the death of his father as being a particularly difficult time for him. He said it was, “a realization, an epiphany that we are all mortal”.

For Jake, the experience of hitting rock bottom was clear-cut and easy to define. Jake said that his rock bottom moment came after he was involved in a motor vehicle accident while drinking and driving. Jake described the experience as, “a wake-up call”. Jake lost his means of making an income, his savings, his home, and his freedom when
he was incarcerated for drinking and driving. As difficult as the experience was at the
time, Jake describes it as an intervention that ultimately saved his life and the life of other
people who might have been injured or killed due to his actions.

4. DISCUSSION

4.1 Phenomenological Description

The following is a phenomenological description of the emergent themes from
both sets of interviews. Each theme is interpreted in relation to the relevant literature and
the research process as a whole.

4.1.1 Long-term Recovery Group

In the long-term recovery group, a strong belief in AA was evident. Each
participant had attended AA meetings for over a decade and identified their regular
contact with AA as being a crucial factor in maintaining their sobriety. Each participant
became involved with AA during their time in an addictions treatment center and
continued their involvement after they left. For individuals in recovery, this is a common
occurrence. As Kaskutas and Subbaraman (2012) explained, “Although 12-step groups
are not really an extension of treatment, they are often used that way, mostly because
aftercare support post-treatment is underfunded by both the public and private sectors”
(p. 1).

For each participant, frequent attendance at AA meetings in the early stages of
their recovery was cited as the primary reason for maintaining sobriety. In describing
their experiences in AA, participants described the benefits they derived from connecting
with people who had managed to stop drinking alcohol. They discovered a whole
network of people that served as role models and guides for a building a life without
alcohol. The importance of the social aspects of AA in the recovery process is evident in other research projects as well. As Hoeppner et al. (2012) reported, it is consistently found that treatment gains related to involvement in AA programs occur “through mobilizing adaptive changes in the social networks of attendees and enhancing socially relevant abstinence self-efficacy (p. 297).

Although none of the participants in the group identified themselves as religious, they each professed to have spiritual beliefs, including their own unique conceptualization of a Higher Power. Before their involvement with AA, participants did not give much thought to spiritual concerns. As their involvement with AA increased, and as they progressed in their recovery, participants seemed to develop a greater sense of spirituality. Research findings suggest that this is a common occurrence for individuals involved in the AA program. As Hoeppner et al. (2012) explained, “among the more severely alcohol impaired patients, AA additionally increases alcohol abstinence by enhancing individuals’ spiritual/religious practices” (p. 297).

Another major theme for the long-term recovery group was the engagement in a process of comparison between themselves and others. In listening to their stories, it was clear that a process of social comparison was at work, both in recovery and in the midst of their addiction. Social comparison is a means of helping establish a sense of identity. As Chen and Lam (2007) explained, “When people are uncertain of their self-evaluation, they usually compare themselves with others to gain information about where they stand” (p. 197). As their addiction developed, the participants associated with others who drank a comparable amount. Interestingly, each of the participants reported engaging in downward social comparisons when comparing their drinking behaviour with others.
Downward social comparisons are viewed as defense mechanisms which involve comparing oneself to others who are less fortunate or in a worse condition (Lobel & Taylor, 1989).

In the interviews, each participant described how their addiction was influenced by either peers or family members. This finding corresponds with other research that shows that alcohol consumption of individuals who developed an addiction first began “under nonstressful conditions as part of a more general socialization process” (Bradizza, Carey, & Maisto, 1999, p. 112). In hearing about the development and maintenance of their addictions, it was clear that participants had associated themselves with others who engaged in similar behaviours. Friendships, romantic relationships, and even professional relationships were mediated by, if not founded upon, the consumption of alcohol. With alcohol having a central place in their lives, the addictive behaviours of the participants were normalized and the activities of non-drinkers appeared aberrant. As Chen and Lam (2007) explained, “social comparison sets the standards or frames of reference” for appropriate behaviours (p. 197). In the midst of their addictions, surrounded by others who engaged in similar patterns of excessive or dangerous drinking, the world beyond their addiction was seen as if through a glass, darkly.

As the participants progressed in their recovery, it was apparent that their references for normal behaviour had changed. In their interactions with people in recovery, they were exposed to new role models with whom they could compare themselves. As they progressed in their recovery, they were able to broaden their comparisons of themselves. As their lifestyle began to change, it seemed that the
participants began to compare themselves with other people in recovery as well as with others who were drinking excessively.

Another theme from the long-term recovery group was referred to as a dialectical tension between worlds as it related to a perceived conflict between a life of addiction and a life of sobriety. The participants spoke of their current lives and described them as being fuller and richer than their lives during the height of their addictions. They spoke about their current lives with enthusiasm and seemed relieved to have developed a new lifestyle that did not revolve around alcohol use. Participants stated unequivocally that their current lives had improved in every aspect. They felt more connected and involved with the world and felt free from the demands that alcohol had imposed upon them.

Participants described lives that revolved around the consumption of alcohol. The participants spoke of having more time to engage in other activities and to pursue opportunities. The lifestyle that they had built for themselves now seemed to be one that they wished to protect and preserve. It seemed that memories of their past lives helped in this regard in that they served as a reminder of what might happen if they took up drinking once more.

The final theme that emerged from the long-term recovery group was referred to as dialectical tension between selves. Just as the participants were able to note tremendous differences between their current and former lifestyles, they noted major changes in their personality and attitudes. All participants were able to view their former life, and self, with a sense of detachment. At times, it was as if they were speaking about another person. In relation to the notion of dialogical self theory, it seemed as though the addicted self no longer had a say. Though the participants could reflect upon their former
addicted self, it seemed unlikely that their former self could usurp them and take center stage. In talking with this group, it seemed as though they had truly attained the “spiritual awakening” that is referenced in the AA literature, in that they had undergone a transformation that would be difficult to reverse. Participants spoke of their world opening up to an awareness that they had been living a life that was less than it could be. In speaking of their recovery, they used the language of liberation. I got the sense that they felt they had made an escape. Although they did not discount the possibility of once again developing an addiction, this seemed more due to humility (perhaps instilled from the program of AA) than the perception of alcohol as a threat.

4.1.2 Short-term Recovery Group

For the short-term recovery group a loss of control was a major theme. Each participant described how the addiction took over their lives. This was emphasized more than the long term group. Although the participants said alcohol was not a threat, there was a sense of reservation in regards to it. There was a joyfulness and relief in the long-term group that was not present in this group. I got the sense that the short-term recovery group was on a narrow ledge as they walked their way up and out of the ravine of alcohol addiction and that one false move would send them sprawling back.

To stay with the metaphor, the long-term group seemed to be on a level ground away from that ravine with the threat of addiction being “somewhere over there” - so obvious a threat if one got close but one that was easily avoided from their current vantage point. Participants in the short-term recovery group did not speak with the assurance of those in the long-term recovery group. The emphasis on loss of control in this group also highlighted the importance that beliefs of control have in the treatment
process. As Morgan-Lopez and Patock-Peckham (2006) reported, “a lack of perceived control over drinking was positively associated with both impulsiveness and alcohol-use problems” (p. 118).

Although both groups spoke of the role that their social environments contributed to their addiction, the short-term recovery group seemed to report on the concrete features of their environment more than on their personal meaning. Whereas the long-term recovery group spoke of comparing themselves with others and how the influence of others caused them to evaluate their behaviours, the short-term recovery group primarily reported on the conditions they believed contributed to their addiction. The difference between the groups regarding the appraisal of their social environments suggests a difference in self-reflectivity associated with a more integrated self-concept and expanded consciousness in the long-term recovery group. The emphasis on social environments in the short-term recovery group also supports the findings of other studies, which highlights the importance of addressing social environmental factors in the treatment of an addiction (Bond, Galloway, Korcha, Lapp, & Polcin, 2010, p. 443).

Another major theme of the short-term recovery group was health concerns. As with the other themes of this group, this theme seemed like an issue that had a proximal connection to their addiction. In the long-term recovery group, poor health was more of a distant memory. It might be that at the early stage of recovery, the negative aspects that can be seen are only the most obvious. Because the long-term recovery group had more experience living away from their addiction, they may have been more able to comment on subtler changes that occurred in recovery and simply had experienced more changes. For the short-term recovery group, improved health might have been the only significant
measure of change. However, this does not minimize the importance of health as the health of the body relates to the self-concept.

We experience ourselves as inside our bodies and part of our identity is based on our physical appearance and our physical abilities. However, the connection is more than body image. As Dimaggio (2006) explained, “one of the characteristics of a healthy self is the ability to decode physical arousal and to give it the right emotional labels” (p. 314). The body in the world is the medium through which we construct reality. As Todres (2000) explained, our body and the world share “a fundamental intimacy in which perception is only possible because of our bodily participation in the order and unity of experience” (p. 229). Changes in the body may also stand out for individuals as the body begins to function without the presence of alcohol. As Buchman, Illes, and Skinner (2010) explained, “somatic markers are acquired by experience and are under control of a neural ‘internal preference system’ which is inherently biased to avoid pain, seek potential pleasure, and is probably pretuned for achieving these goals in social situations” (p. 40). Changes in the body might be the first step towards recovery and changing one’s orientation from one of addiction to one of recovery.

As with the other themes, the theme of hitting rock bottom was proximal to the addiction of these participants. Each participant identified an event that led them to take stock of their current lives and make efforts to improve them. This is in line with research that indicates that “through hitting bottom, a person is forced to disidentify with the addict subpersonality and begins to identify with a recovering subpersonality” (Nixon, 2005, p. 59). It would seem that the experience of hitting rock bottom was a pivotal moment for these participants that led them to reflect upon their current situation. Rather
than rock bottom being viewed as a jagged, impenetrable conglomerate that halts further descent, it may be better seen as a clean slate of obsidian stone in which one may finally see their reflection.

4.2 Summary of the Phenomenological Descriptions

In reviewing the themes that emerged in the course of the interviews and analysis, it was evident that there were differences in how the participants in each group viewed themselves. Those in the long-term group were able to describe themselves with a level of detachment that suggested movement to a more integrated sense of self. It was as though they were describing people who had lived other lives; their former lives seemed foreign to them. I related the long-term group to the process models of Rogers and Sperry that were discussed earlier. They seemed more in control and in possession of the characteristics listed in Rogers’ seventh stage (i.e., “a basic trust in his own process”) and Sperry’s third level (i.e., “connection with a greater oneness or wholeness beyond the self”). This was reflected in what I termed a “sense of how it is.” Each of the participants seemed to have developed their own theory on addiction. Although they met the criteria for addiction in their past, for these participants the term seemed to be imbued with meaning beyond the clinical definition.

4.3 Discussion of Findings

In regards to the suitability of framing an addiction as a problem of restricted consciousness, it was striking how the participants independently addressed questions from the interview guide (see Appendix E) that were related to the structures of consciousness during the course of the interview. These structures of consciousness included: temporal awareness, attentional processes, self-awareness, kinesthetic
awareness, intentionality, and intersubjectivity ((Eckartsberg, 1998). With each interview, I noticed how the natural flow of conversation seemed to touch on these topics without much prompting. While giving participants the freedom to describe their experiences in their own terms, each made reference to these structures in their own way. Furthermore, participants used metaphors of consciousness in describing their experience of working towards recovery. Both Jake and Randy described the desire to make a change as a light coming on. Both Lisa and Jake described recovery as coming out of a fog. Lisa described moments of clarity, a little heartbeat of an enlightening moment as she called them, where she could see things clearly until her next alcohol binge. These moments seemed to mark movement from one way of life into another. They were suggestive of tension between two ways of living — a life dominated by addiction and one free from it. This was most evident in accounts of participants slipping back into patterns of thought and behaviour associated with addiction. For instance, Seth described this process as being “like sleeping and waking up” and said that at times he felt like he was on “automatic pilot”. Randy also described falling into old patterns with a similar automaticity. In reviewing the themes that emerged in the course of the interviews and analysis, and relating them to the themes in the literature review for this thesis, it would seem that addiction and recovery can be conceptualized as processes that involve the restriction and expansion of consciousness.

In the literature review for this thesis, I spoke of our inability to reach a final completed form of consciousness. This would be impossible because the self would become an object of consciousness and lose the ontological openness that is its defining feature. As Pearce (2011) explained, “to arrive at a complete knowledge of the self would
be to see the self as an object, and this would be something we are unable to do” (p. 84). However, it seemed that individuals in the long-term recovery group were able to view their addicted selves as objects in consciousness. These selves seemed devoid of their former power to influence the person any longer. Although they still belonged to the person, they were stored away like old clothing that is never worn. In entering a broader world than that offered with addiction, and achieving an expansion of consciousness, they seemed to orient themselves towards a new purpose in life. Although the participants described a belief in a Higher Power as a guiding force in their lives, their accounts of recovery seemed to resonate with descriptions of the processes of self-actualization and individuation described earlier. Regardless of the metaphor used to describe the process, it seemed that they had come to find a sense of meaning and purpose that helped guide them towards expressing their full potential and finding fulfilment in life. In this regard, the recovery process seemed to involve the development of a new center of personality that led to the development of a new mode of being that was incompatible with the lifestyle and mindset of addiction.

As for the individuals in the short-term recovery group, they still seemed to be influenced by their addicted selves. Whereas the long-term recovery group spoke about other aspects of their lives, a major focus of attention for the short-term recovery group was maintaining their sobriety. Perhaps to keep themselves from relapsing, the lives of the short-term recovery group seemed more routinized. I could not help but wonder if their lives showed a similar degree of fixedness or inflexibility in recovery as they did during addiction. There was a regimented quality to their lives that was not observed in the long-term recovery group. Participants in the short-term recovery group seemed to
have a clear but narrow path to recovery from which they dared not deviate. In contrast, the long-term recovery group seemed more able to involve themselves in other activities while still staying mindful of their health and behaviour. Although participants in the short-term recovery group were actively working towards distancing themselves from their former lives, at this point, it seemed as though they had yet to fully separate from them and undergo a transformation in consciousness. If they could imagine the life of a sober person, and could understand what it meant to be a non-addicted person, they could simply live that way. The addicted self would be an object of consciousness, something to reflect on and examine, and devoid of its former influential power.

In thinking of the struggle of people in the early stages of recovery to change their lifestyles and patterns of thought and behaviour, I thought of children trying to imagine what it would be like to live as an adult. The way that children view an adult’s life is typically simplistic and stereotyped. They see adults as “Mommies or Daddies” and people that go to work. This is the extent of their descriptions because they have no other reference to the adult world other than its most obvious characteristics based on their own level of understanding. This is similar to people in the early stages of recovery. Often people with addictions to alcohol think that someone who does not drink must live a boring or mundane life. In talking about their attitudes during the time of their addiction, both Peter and Lisa spoke about their view of non-drinkers as nerdy homebodies who did not know how to have fun. The idea that someone can have fun without alcohol can be an ungraspable concept for some people with an addiction. In speaking with the short-term recovery group, it was evident that recovery can be a long and involved process of learning that requires fundamental changes across multiple dimensions of life.
The idea of recovery as a learning process was evident in the important role that socialization with peers played in the recovery of the participants and the development of their addictions. In describing their experiences, it seemed as though participants took on some of the attitudes and beliefs associated with their peer groups at the time. While living in the midst of their addictions, they were primarily involved in superficial relationships that were based on the tenuous commonality of alcohol consumption. These relationships worked to maintain their addictive behaviours as they provided no alternatives to their current mode of living. In thinking back to the literature review and sections dealing with the development of the self, I can see how the process of communicating with peers in recovery is similar to the dialogue postulated to occur between the selves. A person can identify with others in the group, hear alternative opinions and perspectives, and begin to develop an identity free of addiction.

As was mentioned earlier, the social aspects of the AA program have been consistently associated with recovery (Hoeppner et al., 2012). Though opportunities for connection can come from anywhere, it would appear that AA is the most readily available option to meet other people in recovery. In connecting with other people in recovery, individuals can see that they are not alone in their struggles and that others are undergoing a similar process of change and facing similar challenges. For all of the participants who were involved in AA, it seemed as though connection with AA allowed them to develop an understanding of life free from addiction. Within their new circle of associates, their sphere of consciousness, to use Metzer’s earlier metaphor, expanded and they were introduced to a whole new way of living. It seemed that social interactions
were crucial in helping the participants remove themselves from their addicted lifestyles and adopt a position outside of themselves that encouraged self-reflection.

The social aspects of addiction were also evident in how, to one degree or another, each of the participants made reference to feeling out of place. In examining the source of this feeling I thought of the larger social context of addiction. According to Walters (1999), “addictive behaviour is construed as a person’s socialization to culturally aberrant definitions of behaviour and failed socialization to conventional definitions of behaviour” (p. 74). Although the addictive behaviour of the participants could be described as aberrant to “conventional definitions of behaviour,” I wondered how well the conventional behaviours of modern society actually promote health and wellness. It was interesting that each of the participants believed that as long as they were making money and completing their shifts at work, they were functioning well. During their addiction, the participants had purchased houses, vehicles, and property. At times during their addictions, they were making a good income. However, their material wealth did not provide the contentment that they seemed to be finding in recovery. Although society offered one path in life, that of the attainment of material wealth, it seemed that the participants lacked guidance or role models for attaining personal growth and finding meaning in life. In speaking with the participants, it seemed as though they had developed a belief that contentment in life came through leading an examined life and working towards one’s potential. They seemed to develop a sense that personal growth meant more than the growth of personal fortunes and this was most evident in their views on spirituality.
I know that some people express discomfort with the spiritual aspects of AA but I wondered how much of this was a projection of their own dissatisfaction with, or even mistrust of, religious institutions. Although some people are suspicious of the spiritual aspects of AA (Vaillant, 2005), this was not the case with the participants. Each participant had come to develop a personal sense of a Higher Power and embraced the spiritual aspects of the program. Interestingly, the participants all began attending AA meetings without any strong spiritual convictions. I did not get the impression that the participants had been brainwashed or compelled to attend meetings. It seemed as though their spiritual beliefs grew in accordance with their recovery and that the spiritual aspects of the program seemed to touch on the personal changes they were experiencing. I could not help but wonder if negative attitudes towards AA were a sign of people being out of touch with their own sense of spirituality.

4.4 Limitations

There were some limitations with this project. Ideally, I wanted each of the participants to journal regularly about their thoughts and feelings prior to the interview. However, as was noted, the journaling was inconsistent across participants. To increase the amount of journaling in a future study, it might help to devise questions with the participants rather than give them a list of questions.

Another limitation of the study relates to the heterogeneity of the group. One participant was female and the rest of the participants were male. One participant was approximately 20 years older than the other participants.
4.5 Implications and Future Directions

Carl Jung and the founders of AA believed that overcoming an addiction involved a spiritual awakening which they saw as a profound transformational experience. This is an idea that has gained acceptance amongst addiction researchers. As Shinebourne and Smith (2009) stated, “the path to and away from addiction has often been described as a transformation or change in identity and developing a new sense of self” (p. 162). Although recovery is seen as a transformational process, there is still much to be discovered about how this transformation occurs and in what context. In terms of future relevance, the results of this study could help elucidate our understanding of those pivotal moments that initiate and maintain changes in the lives of individuals with an addiction.

In regards to this study, themes emerged that could be relevant to individuals at different stages of the recovery process. After analyzing the transcripts of the long-term recovery group, the following themes emerged: Belief in the program of AA; Comparison between Selves and Others; Dialectical Tension between Worlds; Dialectical Tension between Selves. If recovery depends on consciousness expanding to a degree that allows for the addicted self-concept to become an object of consciousness, clinicians might draw upon these themes to help clients evaluate their progress in recovery. For instance, a clinician may employ methods that encourage the sort of self-examination and comparisons that are reflected in these themes. As well, if a client is able to describe himself in a way that touches on the above themes, it could indicate that the client is moving closer to a lifestyle free of addiction. In this regard, a clinician could aid a client in understanding how he or she is developing thought and behaviour patterns that are
associated with a level of consciousness that is not dominated by addiction. If clients tend to recognize more obvious signs of change in the early stages of recovery, as was suggested by the participants in the short-term recovery group, developing the ability to identify more subtle signs of change could help to enhance a client’s self-efficacy and self-esteem throughout the recovery process. For instance, if clients in the early stages of recovery demonstrate a need for control that is similar to the descriptions of the participants in the short-term recovery group, an increase in self-efficacy could help address this issue.

In continuing to pursue research that focuses on the subjective experience of addiction and how the self-concept changes over the course of recovery, researchers might gain greater insight into aspects of the recovery process that have been difficult to conceptualize and understand. For instance, as Kambouropoulos and Rock (2008) explained, “despite the importance of craving to our understanding of addiction, no consensus regarding definition, measurement, and interpretation has been reached” (p. 127). Although cravings are a common experience of individuals with an addiction, their subjective nature has made them difficult to study. By focusing research on the consciousness of individuals, we may increase our understanding of the phenomenological experience of alcohol cravings and generate helpful strategies for coping with them. Interestingly, in regards to the current study, cravings were not cited as a major concern for most of the participants. Although cravings are often associated with an addiction, the results of this study suggest that they are not a ubiquitous feature of addiction. In focusing on the subjective experience of addiction, researchers might learn
more about the degree of variability that could exist for other aspects of addiction that are thought to be common amongst those with an addiction to alcohol.

As was noted earlier, although a biopsychosocial or systems approach is recommended for the treatment of addiction, this model is often not put into practice and fails to achieve the full integration of perspectives and approaches to treatment that it promises. To unite these different approaches, this study suggests that it would be beneficial to view the biopsychosocial model in relation to consciousness development. The study of consciousness fits perfectly with the dynamic nature of addiction, which is itself a system that includes “periods of perturbation and disruption as well as stability” (DiClemente, 2004, p. 20). Although addictions have not been described in terms of consciousness, this is likely due to its historical dismissal as a topic for investigation rather than its lack of heuristic value. With consciousness itself being a dynamic system, one that is best described in biopsychosocial terms, its introduction into the study of addictions might aid researchers in finding the means to fully integrate biological, psychological, and social perspectives of addiction.

Although the biopsychosocial approach acknowledges the role of social factors in the onset and development of addiction, these social influences are less amenable to change than factors within the individual. To truly take a biopsychosocial approach to the treatment of addictions, the work of those in the field of addictions will have to extend beyond the work with their individual clients. Although much work can be done with individual clients, there are social conditions that contribute to the development of an addiction that also need to be addressed. For researchers and workers in the field of addictions, the ultimate goal might be to help addicted individuals understand their
connection with the larger community while helping to build communities that promote the well-being of individuals. This might require researchers and academics to move beyond classrooms and treatment centers and develop ties with community members. A starting point for this co-operation might be collaboration between AA and Psychology.

With so many addicted individuals being involved in the AA program, collaboration between AA and Psychology could be of great benefit for a number of people. Although Psychology and AA both provide support for individuals with an alcohol addiction, there has been little communication between them. As Diamond (2000) stated, “With the exception of the psychoanalyst Carl Jung, psychiatrists, psychologists, and social workers have ignored the potential for rich dialogue with AA” (p. 127). As Psychology begins to move away from a Positivist approach to the treatment and study of addictions, the channels of communication may begin to open between Psychology and the AA program. In introducing a consideration of consciousness into the treatment of addictions, Psychology might start to develop a framework of understanding that includes social and spiritual aspects of treatment that are part of the AA program.

Based on the interviews with the participants who were involved in the AA program, and their willingness to share their stories, it seems that there are people in AA who would be open to a dialogue with psychologists.

In the application of consciousness studies to addictions research, we may be better able to understand the developmental nature of addiction. In light of some of the weaknesses of the medical model, many researchers in the field of addictions are advocating a developmental approach to addictions. As McGue (1999) explained, alcohol addiction is “usefully conceptualized as a developmental disorder, as arising when
inherited vulnerability factors interact with experiential risk to influence the progression from adolescent drinking initiation and experimentation to adult problem drinking and dependence” (p. 374). In viewing alcohol addiction from a developmental perspective, we might better understand how consciousness and the self-concept changes over the course of recovery. As Beebe, Cambray, and Kirsh (2001) explained, “human consciousness behaves like other biological systems with built-in homeostatic mechanisms” (p. 217). In understanding these mechanisms, and their relation to the sense of self, we might be better able to understand the process of change that occurs in addiction. With the recovery process being a unique journey that varies for everyone with an addiction, we will not identify specific causes for addiction or reasons for recovery that will generalize to others. However, in understanding more about the lived experience of addiction, we may develop guiding principles for helping clients through the often turbulent process of recovery. Just as the practice of Motivational Interviewing is guided by a philosophy or spirit rather than specific techniques that are applied to everyone uniformly (Miller & Rollnick, 1995), clinicians might develop similar practices or methods for helping individuals understand how their consciousness and self-concept change over the course of recovery.

Framing an addiction as a problem of consciousness might also aid in our understanding of spirituality and its role in the recovery process. As Gockel (2011) reported, “we have very little in-depth information about clients’ perspectives on spirituality in the counselling relationship” (p. 154). Including the development of consciousness into the treatment of addictions may allow us to better understand the multidimensional nature of spirituality and how it impacts various aspects of recovery.
Currently, there is support for including spirituality into a biopsychosocial model of addiction. As Galanter (2006) explained, “integrating biomedical and spiritual options yields greater improvement than having such treatment provided in separate settings” (p. 289). The relationship between consciousness expansion and spiritual development, as described in this study, suggests that an understanding of consciousness could aid in understanding the subjective dimensions of spiritual growth. In reviewing the transcripts of the interviews for this study, it was evident that spirituality played an important role in the recovery process of most of the participants. Based on this finding, it would seem that continued research related to the spiritual dimensions of recovery might provide valuable insights into the recovery process.

There is a widespread belief that current approaches to the treatment of alcohol addiction are inadequate in terms of capturing the dynamic nature of addiction. This has been attributed to the very epistemological foundations of the approaches to treatment. According to Diamond (2000), “the phenomenon of alcoholism defies Western medicine and know-how and cannot be captured with a 20th century mind-set” (p. 7). By introducing consciousness into the treatment of addictions, a topic that has been excluded from the purview of Psychology, researchers might start building a foundation for a new mode or approach to treatment that is aligned with an emerging worldview based on quantum physics. In applying what is known about consciousness to the treatment process, researchers might be able to develop interventions that are free of the biases and assumptions inherent in Western medical models that seem to impede the development of alternative treatments. According to Morgan (2001), “a body of work was begun in the 1950s that established a dialogue between spiritual disciplines of the east and western
psychotherapy as it then existed” (p. 89). In introducing consciousness to the treatment of addictions, this dialogue can continue and perhaps improve the application of Eastern approaches that are already being incorporated into the treatment of addictions (Atwood & Maltin, 1991).

In being able to move away from a traditional, Western medical approach, researchers might be afforded the opportunity to inform and enrich some of the current models for conceptualizing and treating addiction. As was discussed earlier, many of these models lack an appreciation for the development of an individual’s self-concept. Including a consideration of consciousness into the treatment of addictions could help researchers address the weaknesses of their models and aid treatment providers in taking a broader view of addiction that extends beyond the current difficulties experienced by an individual in treatment.

Although this study has implications for the field of addiction studies, it also has implications for the participants who were involved. Personally, I know that I learned a great deal about the field of addictions through engaging in the research process. As I familiarized myself with the research literature, I became aware that I was developing a degree of expertise related to addictions as a result of my work on the project. I began to recognize that I was becoming an expert in the field of addictions and was moving closer to my academic and career goals. In reflecting on my own process of development, it became clear that participants could experience changes of their own as a result of their involvement in this project. From the outset, I viewed this project as a collaborative effort with the participants. Like me, they had their own motivations for involving themselves in this project.
Each of the participants liked the idea of being involved in a project that might benefit others who were struggling with an addiction. It seemed as though the long-term recovery group wanted to discuss what worked for them in an effort to pass on anything they learned that might be helpful for others. These participants were involved in the AA program which emphasizes the value of service (White, 1998). This sense of duty may have prompted the involvement of the participants in the long-term group. In participating in this project, the participants of the long-term recovery group may have felt that they were engaging in an activity that was further affirmation of their sobriety.

Upon receiving a copy of the thesis, and a summary of the results, I think the participants in the long-term recovery group will be satisfied that they helped to complete a study that yielded suggestions for improving treatment for alcohol addiction.

The short-term recovery group also expressed an interest in helping other people and a hope that the interviews would provide insight into improving treatments for alcohol addiction. They also shared a sentiment that participation would be one more positive activity that could help them in the early stages of recovery. For those in the short-term recovery group, I think involvement in the project could help them differentiate themselves from their former lifestyle and addicted self-concept. Along with their involvement in the AA program and their adherence to their individual relapse prevention plans, involvement in the project could have been one more activity that facilitated their move towards a life free of alcohol addiction. In their reflection on the questions for this study, I think the participants could have benefited by having further incentive to refrain from drinking alcohol. By participating in the project, they might have bolstered their confidence in their ability to avoid alcohol as well. Upon receiving a
copy of the thesis, and a summary of the results, I think the participants in the short-term recovery group will experience a sense of accomplishment when they see that they helped identify experiential aspects associated with the early stages of recovery and that their participation helped shed light on how consciousness might be incorporated into how addictions are conceptualized and treated. I think in reviewing the thesis, participants might recognize that they are engaging in the type of social activity and self-reflection that is part of the recovery process and will have further evidence that they are making progress in their own recovery.

4.6 Conclusion

It would appear that a new approach to the treatment of addictions is required. Approaches to treatment that are derived from a medical model of addiction seem unable to address some of the important aspects related to recovery and addiction. In particular, these approaches give little attention to a client’s subjective experience and perceptions of self-growth. In interviewing the participants in this study, it was clear that the long-term recovery group experienced major shifts in their self-concepts. When comparing their current selves to their addicted selves, it was as though they were describing different people. These participants reported significant changes regarding their beliefs, attitudes, and even changes in their personalities. A purely medical conceptualization of addiction does not attend to these sorts of impactful and deeply felt personal changes that can occur within individuals. Through including an understanding of consciousness into the treatment of addictions, researchers and clinicians might develop their understanding of how the self-concept changes in the context of recovery.
Though there are a variety of treatments available for individuals who are struggling with an addiction to alcohol, “the available evidence fails to indicate that any one form of treatment offers particular advantages in terms of success over any others” (Davies & O’Doherty, 1987, p. 127). This was evident in my conversations with the participants. Although the participants shared some experiences in common, each participant walked their own unique path of recovery. In listening to their experiences in treatment centers and AA, and their reflections on their lives outside of treatment programs, it was clear that there was no simple formula for attaining sobriety. However, by introducing consciousness into the study of treatments for addictions we might be able to better identify what aspects of treatments are working, and more importantly, how they are working. With a focus on the subjective experience of recovery, researchers might identify certain aspects of experiences that precipitated movements to expanded forms of consciousness and more integrated self-concepts.

As was discussed earlier, Carl Jung viewed spirituality and positive social interactions as important parts of the recovery process (Schoen, 2009). Although this study was not an evaluation of AA, in examining AA, I was afforded an opportunity to examine the spiritual and social aspects of recovery that seem to play a key role in the change process and the maintenance of recovery. In analyzing the interviews it was clear that these factors were significant contributors to the sobriety of the long-term recovery group. Even the members of the short-term recovery group, who were involved in AA seemed to value these aspects of their recovery. This is an important point to consider as social and spiritual aspects of treatment are often secondary additions to recovery programs. For instance, each of the participants who attended a treatment center also
attended AA meetings as an adjunct to their treatment. Further support for incorporating social and spiritual aspects into recovery is suggested by the continued involvement of the participants in the AA program and their endorsement of it.

In neglecting to consider the social aspects of addiction, a person who makes treatment gains in the secure, routinized confines of a treatment center might not be prepared to re-enter the environments from which they were temporarily removed. To frame this problem in terms of the notion of dialogical selves that was discussed earlier, an emphasis on the biological and psychological aspects of addiction and recovery only considers the voices within the person. In my conversations with the participants it was clear that social interaction played a key role in their recovery. For a treatment to be successful, it would appear that it must recognize the existence of an ongoing dialogue with the social world. For instance, the participants compared themselves with non-drinking peers and others in recovery. This process of comparison was an important part of the development of a lifestyle and identity apart from those that were centered on their addiction.

All but one of the participants commented on the importance of spirituality to their recovery. Interestingly, during my interview with Seth, the only person who claimed not to have spiritual beliefs, he said that he envied people who had a sense of spirituality and was open to the idea that he might develop spiritual beliefs in the future. He knew that spiritual beliefs played an important role in recovery and said that he was beginning to give more consideration to spiritual matters. Although spirituality played an important role in the recovery process of the participants, as was mentioned earlier, Psychology has tended to either dismiss spirituality or view it in pathological terms. This is an important
point to consider as people may seek out spiritual guidance from Psychology professionals who lack experience related to spiritual concerns.

In reflecting on the interviews, it seemed that AA provided one of the only opportunities for the participants to explore and develop a sense of spirituality. With spirituality being an important part of recovery for so many individuals with an addiction, this poses a problem for people with addictions as their options for spiritual growth may be limited. For instance, in my conversations with Lisa, she stated that her family viewed AA as a cult and viewed her association with the program with suspicion and contempt. Lisa’s story reminded me of people who have told me that they do not want to participate in the 12 Step program due to the program’s references to God. Unfortunately, this attitude could keep people with addictions from accessing something that could benefit them as they work towards recovery. By framing spirituality in non-religious contexts, individuals in recovery may be more open to exploring these concepts with therapists, counsellors, and other people in their support networks.

It would appear there is a growing need for clinicians to develop an understanding of spirituality and its role in the treatment process. As Morgan (1991) stated, there is an increasing number of people who enter treatment due to “dissatisfactions in establishing an identity in the world, relating and finding meaning and happiness” (p. 90). Although Morgan was referring to the population in general, it is likely that people with addictions will enter treatment with similar concerns. With this in mind, it is of paramount importance that clinicians develop a broader view of addiction that takes them “well beyond the frame of reference of most of western healing and psychotherapy, and necessitates an exploration of ontological, existential, and spiritual realities” (Morgan,
Incorporating an understanding of consciousness into addictions treatment, and grappling with the philosophical debates associated with the study of consciousness, could assist clinicians in developing an understanding of some of the existential crises experienced by their clients.

There has been a growing interest in the subjective experience of addiction and this has impacted the work of those in the field. By including consciousness into the conceptualization of addiction, clinicians could work with a broader perspective while helping clients move through the recovery process. In framing addiction as a movement from one state of consciousness to another, and one sense of self to another, a clinician might be more equipped to help clients recognize and interpret the tensions that come with change and help them prolong what Lisa referred to in her interview as that “heartbeat of an enlightening moment”.
References


Appendix A

Office of Research Services
Memorandum

DATE: October 13, 2011

TO: Dylan Payne
Psychology Intern
Battlefords Union Hospital
1092–107 Street
North Battleford, SK S9A 1Z1

FROM: Dr. Bruce Plouffe
Chair, Research Ethics Board

Re: Transformations: The Treatment of Alcohol Addiction as a Process of Consciousness Expansion (File #15S1112)

Please be advised that the University of Regina Research Ethics Board has reviewed your proposal and found it to be:

☑ 1. APPROVED AS SUBMITTED. Only applicants with this designation have ethical approval to proceed with their research as described in their applications. For research lasting more than one year (Section 1F), ETHICAL APPROVAL MUST BE RENEWED BY SUBMITTING A BRIEF STATUS REPORT EVERY TWELVE MONTHS. Approval will be revoked unless a satisfactory status report is received. Any substantive changes in methodology or instrumentation must also be approved prior to their implementation.

☐ 2. ACCEPTABLE SUBJECT TO MINOR CHANGES AND PRECAUTIONS (SEE ATTACHED). Changes must be submitted to the REB and approved prior to beginning research. Please submit a supplementary memo addressing the concerns to the Chair of the REB. **Do not submit a new application. Once changes are deemed acceptable, ethical approval will be granted.

☐ 3. ACCEPTABLE SUBJECT TO CHANGES AND PRECAUTIONS (SEE ATTACHED). Changes must be submitted to the REB and approved prior to beginning research. Please submit a supplementary memo addressing the concerns to the Chair of the REB. **Do not submit a new application. Once changes are deemed acceptable, ethical approval will be granted.

☐ 4. UNACCEPTABLE AS SUBMITTED. The proposal requires substantial additions or redesign. Please contact the Chair of the REB for advice on how the project proposal might be revised.

Dr. Bruce Plouffe

cc: Dr. Angelina Baydala—Psychology Dept.

**supplementary memo should be forwarded to the Chair of the Research Ethics Board at the Office of Research Services (Research and Innovation Centre, Room 100) or by e-mail to research.ethics@uregina.ca. Phone: (306-585-4775), Fax: (306-585-4893)

Appendix B
Informed Consent Form for Two Week Journal Keeping

Dear Potential Participant,

I am a Master’s student at the University of Regina. I am interested in changes that occur in individuals as they work towards recovery from their addictions. Specifically, I am interested in identifying changes in mental states, and the sense of self, that may occur throughout the recovery process.

For this project, you will be provided a list of questions. For a period of two weeks, you will be asked to consider these questions and take note of any thoughts related to them. You will be provided with a journal to record notes in. You are free to write as much as you want related to the questions or other thoughts that come to mind. The purpose for this is two-fold. Firstly, keeping track of thoughts related to these questions can help provide insight into changes that occur in consciousness. Secondly, consideration of the questions will allow for more elaboration of your answers when the questions are posed to you at the end of the two week period in an interview.

At the time of the interview, you may choose to share as much information from your journal as you are comfortable with. After discussing your use of the journal and concluding the interview, there are several options for what may be done with the journal. You may choose to give me your journal and allow me to have access to all of its contents for analysis. You may wish to retain the journal and allow me to make a copy of it. You may choose to retain the journal and provide me with selected items from the journal. You may wish to retain the journal without giving any portion of it to me. You have the right to choose what is done with the journal and how much of its content you wish to share.

All data gathered from this interview will be confidential. Only the researcher and supervisor will have access to the data which will be kept in a locked cabinet at the University of Regina. All data will be stored in the locked cabinet for 3 years. After that time, it will be destroyed. Any identifying information (such as consent forms and journals) will be kept in a separate filing cabinet from the interview transcripts. Your name will not appear on the interview transcripts and you are encouraged not to put other identifying information in your journals (should you allow those to be kept with the researcher). Journal entries can reflect your thoughts at a moment but you are not required to provide specific names or details related to events that come to mind. Because you will be asked to talk about yourself, it is possible that you will be identifiable even though your name will be changed in the write-up of this research. However, every effort
will be made to protect your anonymity and only the relevant details of your experience will be shared. Reference to specific people or events that could potentially identify you will be made with regard for maintaining your anonymity. However, the length of your sobriety will likely be mentioned as it is information that could help provide further context for your experience. Direct quotes from your interview may be included in these reports as well. The results of this research will be included in my Master’s thesis as well as in manuscripts that will be submitted for publication and conference presentation.

There are limits to the confidentiality of this interview. If I believe you are at risk for harming yourself or another person, I must notify proper authorities and those who are at risk for being harmed. If I am told about the abuse of a child, I must notify child protective services and disclose any information that will aid in helping the child receive their services.

By signing this form you are giving your informed consent to keep a journal of thoughts related to the research questions. However, you are able to withdraw your consent to participate at any time, without penalty. There are potential risks associated with participation in this study. If you find that you are becoming distressed by recalling past moments of your life, and require counselling services, you are invited to contact the Battlefords Mental Health Centre @ 446-6500.

If you agree to participate in this study, please sign and date this form in the space provided below. You will receive a copy of this form upon giving your consent to participate. This project was approved by the Research Ethics Board, University of Regina. If you have any questions or concerns about your rights or treatment as a participant, you may contact the Chair of the Research Ethics Board at 585-4775 or by email: research.ethics@uregina.ca. If you have any questions or concerns about this study, you may also contact either myself (payne20d@uregina.ca) or my supervisor, Dr. Angelina Baydala (Angelina.baydala@uregina.ca).

Once more, thank you for taking the time to consider participating in this study!

Sincerely,

Dylan Payne

Department of Psychology, University of Regina

Signature_________________________________________ Date: _____________

Appendix C
Informed Consent Form for Interview

Dear Potential Participant,

I am a Master’s student at the University of Regina. I am interested in changes that occur in individuals as they work towards recovery from their addictions. Specifically, I am interested in identifying changes to consciousness, and the sense of self, that may occur throughout the recovery process.

The following interview will be approximately one hour. However, the duration of the interview will depend upon what you have to say in response to the interview questions. During the interview you will be asked the questions that were provided to you earlier. You will also be asked about the process of keeping a journal and reflecting on your thoughts. Though the interview will be focused on the questions that were provided to you, the interview will not be limited to those questions. In order to learn more about your experiences, other questions will be asked to clarify and aid in understanding. You have the right to decline to answer any question posed to you. Subject to your approval, the interview will be audio-taped for the purpose of transcription. Only my supervisor would have access to this recording. The recording is verification that I conducted a legitimate study.

All data gathered from this interview will be confidential. Only the researcher and supervisor will have access to the data which will be kept in a locked cabinet at the University of Regina. Any identifying information (consent forms and journals) will be kept in a separate filing cabinet from the interview transcripts. All data will be stored in the cabinet for 3 years and then destroyed. Your name will not appear on the interview transcripts and you are encouraged not to put other identifying information in your journals (should you allow those to be kept with the researcher). Journal entries can reflect your thoughts at a moment but you are not required to provide specific names or details related to events that come to mind. Because you will be asked to talk about yourself, it is possible that you will be identifiable even though your name will be changed in the write-up of this research. However, every effort will be made to protect your anonymity and only the relevant details of your experience will be shared. Reference to specific instances or events that could potentially identify you will be made with regard for maintaining your anonymity. However, the length of your sobriety will
likely be mentioned as it is information that could help provide further context for your experience. Direct quotes from your interview may be included in these reports as well. The results of this research will be included in my Master’s thesis as well as in manuscripts that will be submitted for publication and conference presentation.

There are limits to the confidentiality of this interview. If I believe you are at risk for harming yourself or another person, I must notify proper authorities and those who are at risk for being harmed. If I am told about the abuse of a child, I must notify child protective services and disclose any information that will aid in helping the child receive their services.

By signing this form you are giving your informed consent to participate in this interview. However, you are able to withdraw your consent to participate at any time, without penalty. There are potential risks associated with participation in this study. If you find that you are becoming distressed by recalling past moments of your life, and require counselling services, you are invited to contact the Battlefords Mental Health Centre @ 446-6500.

This project was approved by the Research Ethics Board, University of Regina. If you have any questions or concerns about your rights or treatment as a participant, you may contact the Chair of the Research Ethics Board at 585-4775 or by email: research.ethics@uregina.ca. If you have any questions or concerns about this study, you may also contact either myself (payne20d@uregina.ca) or my supervisor, Dr. Angelina Baydala (Angelina.baydala@uregina.ca).

If you agree to participate in this study, please sign and date this form in the space provided below. You will receive a copy of this form upon giving your consent to participate. Thank you for taking the time to consider participating in this study!

Sincerely,

Dylan Payne

Department of Psychology

Signature____________________________________         Date: _____________
DATE: December 13, 2011

TO: Dylan Payne
Psychology Intern
Battlefords Union Hospital
1092 – 107 Street
North Battleford, SK S9A 1Z1

FROM: Dr. Bruce Plouffe,
Chair, Research Ethics Board

Re: Transformations: The Treatment of Alcohol Addiction as a Process of Consciousness Expansion (File # 1551112)

Please be advised that the changes outlined in your memo of December 12, 2011 have been approved.

Please contact us if you have any further questions.

Sincerely,
Appendix E

Interview Guide

Listed below are structures of consciousness that have been identified by phenomenological researchers. To help understand the changes, if any, that occurred to these structures, additional questions related to them will be asked. Beside each structure of consciousness, there are sample questions that will aid in understanding any changes that have been experienced by participants as they worked towards recovery.

temporal awareness: What was the experience of time like for you? Did they create plans for the future beyond obtaining alcohol? Do they feel as though their habitual use had them stuck in a moment? Did they think much about their past or future? (what they were like before their addiction?) What does the AA phrase “taking it day by day” mean to you, if anything? Is that meaning different from before?

attentional processes: Was there a narrowing of attention? Did alcohol stand out more during times of addiction? What is it like now to see alcohol or hear references to alcohol? Were they drawn to it? What is the relationship with alcohol now, in terms of attention?

awareness of one’s own experience (self-consciousness): Did you ever identify yourself as an “addict”? If so, at what point did you? How did it feel to have this term applied to yourself (by you or others)? Did you feel you were unable to keep yourself from drinking?

self-awareness: Were you aware of how much and how often you drank? Did you see any negative consequences to drinking? Were there warning signs to stop?

the self in different roles (as thinking, acting, etc.): How did drinking impact your other roles and responsibilities? Did the “addict role” overtake other roles?

embodied action (including kinesthetic awareness of one’s movement): What sort of physical changes, if any, occurred in your body as a result of drinking? How aware of these changes were you? Was there one moment where they became a concern to you?

purpose or intention in action: Did your interest in other activities fluctuate during the course of your addiction?

awareness of other persons (in empathy, intersubjectivity, collectivity): How do you think others perceived you? How did these perceptions impact you?

social interaction (including collective action): Were there changes in your social life that occurred during your addiction? Were there certain people you associated with more during certain periods of your addiction?